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FELLOWSHIP BY EXAMINATION

> I was conducted into a large hall, where I saw about a dozen of grim faces sitting at a long table; one of whom bade me come forward.
>
> Tobias Smollett, *Roderick Random* (1748)

The role of the final examination may have changed in response to the evolution of the training process, and its quality as an ordeal may have been abated since Smollett's day – even since the early days of the College – but its underlying importance remains. And although the limitations of examinations as a means of assessment have been recognised by educationists, nobody has come up with a better method of assessment.

More than that, the refinement of recent years in the examination process itself has made it even harder to see a preferred alternative.

Many years ago, when my colleague Colin Fenton was a houseman, he was somewhat disconcerted when his chief arrived in the ward after a Fellowship examination, rubbing his hands and exulting, 'Well, we fixed that senior registrar of yours!' The senior registrar concerned later played a significant role in College affairs, including a term on the Court, and that despite having been, it seems, the victim of a certain lack of objectivity in the process that delayed his entry into the College.

The whole process has been progressively refined so as to ensure that nothing of this nature could now occur. But the refinement process has gone further. I have remarked earlier that the Australasian College, from the beginning, saw its Fellowship as the mark of a trained surgeon. The development of training programmes, described in the previous chapter, helped to assure the well-trained status of candidates presenting for the final (by now Part 2) examination, so that it was able – with increasing confidence – to be claimed as an exit examination.[1]

However, the United Kingdom Colleges had never been so resolute in treating their fellowships in this way. When advanced surgical training was somewhat haphazard, this did not signify too much, but as the concept of structured training programes evolved, the question became more pressing. Is Fellowship a mark of the trained surgeon, or the part-trained surgeon, as it had tended to be in Britain, or of the ready-to-be-trained surgeon? Advanced training was now a

John Loewenthal, as president, and Bill Hughes, as his censor-in-chief, undertook the task of 'selling' the idea of an exit Fellowship; at first they made little impression. The presidential portrait of Sir John Loewenthal by Alfie Hannaford (see page 90) was done posthumously; that of Sir Edward Hughes by Paul Fitzgerald depicted the Parkinsonism that was to dog his later years.

recognisable fence, and the UK colleges, needing to come down off it, came down on the side of an entry examination for their fellowship.

This created some interesting situations. In the early 1970s Bill Hughes and his president, John Loewenthal, went to a meeting of heads of surgical colleges and described their college's decision to come down on the exit side of the fence. I was told at the time that their British hosts listened politely to their exposition, saw them off with ineffable courtesy, then turned away to laugh. Quite soon the entry-siders were faced with a problem of nomenclature: if you award your Fellowship to a man (or woman, by now – the old chauvinist days were ending) who is about to enter advanced surgical training, what do you call him/her later on? And how do you protect yourself against the possibility that advanced training may show up weaknesses such that the award of fellowship was an awful mistake? For a start the entry-siders got round the latter problem to some extent by the issue of a certificate of higher surgical training, so as to create the Orwellian situation where

1 UK Fellowship + 1 HST certificate = 1 Australasian Fellowship.

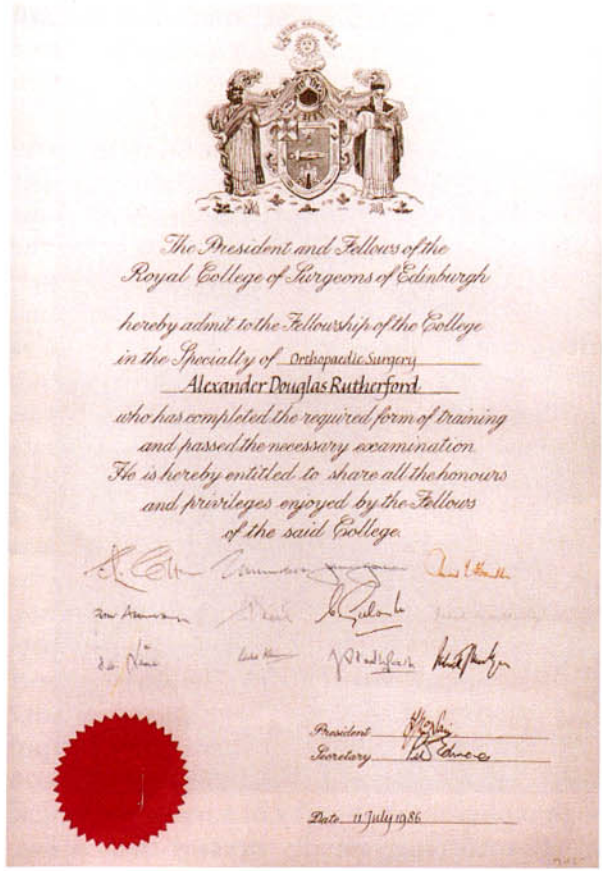
The problem of nomenclature remained a problem. The Australasian formula was simple: admission to Fellowship signified that the graduand was now to become a surgeon among fellow-surgeons, was indeed a part (if a somewhat junior part) of a fellowship of surgeons. The entry-siders made several efforts to devise a fresh title for their people after the completion of higher surgical training. The Scots even flirted with the old title 'Maister'.

But they did not find it easy.

I recall drinking coffee with a member of the Council of the English College in 1976, who shared his college's dilemma with a number of us who were in London for another of the English-speaking orthopaedic meetings. We suggested that he should stop worrying about names and jump the fence to the exit side. He was alarmed at the effect this might have on candidates from the subcontinent (and, in consquence, on the finances of his college) and less than happy at my suggestion that his college would need to decide whether it was 'of England' or 'of Delhi'.

That same year the Edinburgh College council did decide it was best to jump the fence, and brought a resolution to the annual meeting of Fellows where it was defeated at the urging of Fellows who were reluctant to see Edinburgh 'go it alone'. The council subsequently devised a substitute formula: the 'tertiary' Fellowship, taken after higher training, in the specialty concerned, so that the 'ordinary' Fellowship becomes a sort of souped-up Part 1, making the progression Part 1 – FRCSEd – FRCSEd(Orth) or whatever other discipline it may be.

This proved attractive enough to the other UK colleges to serve as the model for an Intercollegiate Specialty Fellowship, taken after



The President and Fellows of the
Royal College of Surgeons of Edinburgh

hereby admit to the Fellowship of the College
in the Specialty of Orthopaedic Surgery
Alexander Douglas Rutherford
who has completed the required form of training
and passed the necessary examination
He is hereby entitled to share all the honours
and privileges enjoyed by the Fellows
of the said College

President
Secretary

Date 11 July 1986

The 'tertiary' Fellowship of the Edinburgh College was the first move towards an exit qualification from the United Kingdom. Prominent among the examiners' signatures, in Alex Rutherford's diploma from 1986, is that of Charles Galasko, who subsequently became a vice-president of the English College, and in that capacity provided an escort for the author at his admission to the English Fellowship in 2001. It is this merging of Colleges and personalities that creates the www. of surgery.

higher training and 'referenced' back to the College in which the earlier non-differentiated entry-level fellowship was obtained. In this way the matter of standards was now addressed, but not the matter of nomenclature. At last count, the English College had moved to downgrade its qualifying diploma (part of the traditional MRCS LRCP) to a licentiate, so freeing up the MRCS diploma for its entry-level award. The Edinburgh College (constrained perhaps by the fact that its qualifying diploma was part of the Scottish Triple diploma awarded jointly with RCPEd and the Glasgow College) took two bites at this particular cherry. At first it opted for an associate fellowship, designated AFRCSEd – which looks somewhat 'dark continent' – but by 2000 it too had settled on an MRCSEd.[2]

The Australasian College has been left with the feeling that its exit Fellowship was the correct solution all along, despite the valid point that my colleague from registrar days, Peter Lord,[3] made to me some years ago, that highly-structured, pre-fellowship training programmes have a tendency to 'clone' surgeons and can leave little scope for the training ambitions of independent thinkers, of whom he is undoubtedly one.

Regardless of the position it occupies in the calendar of training, the

final examination traditionally consists of three elements: a written paper or papers, a clinical examination and one or more *viva voce* examinations. Traditionally, too, it involves examiners working in pairs.[4]

The format of the written examination used to be a series of essay-type questions. Then came the substitution, for one essay, of a number of short-answer questions and the further refinement of allowing some choice in this section. In orthopaedics this allowed probing of the several disciplines within orthopaedic surgery: paediatric orthopaedics, the various aspects of adult orthopaedics, trauma – and as an optional extra in the short-answer part, the 'cultural' aspects such as orthopaedic history, for the benefit of candidates who happen to share my own view that a foundation of understanding of what our predecessors believed, even who these predecessors were, can obviate the need to re-invent the wheel. It would be cavalier to downgrade a candidate who is ignorant of Hugh Owen Thomas and his splint, but it may help those who do know, to be allowed to display this element in their knowledge.

The clinical examination has long included 'long' and 'short' cases. The long case portion, where time is allowed for interview and history-taking and the eliciting of physical signs, before candidates report and demonstrate their findings, serves to display not only knowledge but attitude. The shorter cases need to be, not exercises in 'spot diagnosis', but pegs on which to hang discussion of a range of common conditions, where enough is obvious in the way of a patient's clinical signs to allow the discussion to range rapidly beyond these alone. They have, in fact, developed into 'medium length cases' for this very reason. And it is accepted that, since surgery is all about surgeons dealing with patients, understanding their problems and communicating with them, a special weighting should attach to the clinical part of the examination – a weighting so special that the two portions are now marked independently.

The vivas are perhaps the most flexible part of the examination process in their ability to evolve. A generation or more ago there were two interviews: the operative viva and the pathology viva. In the first a candidate was asked to describe the steps in one of the commoner operations of his specialty, and the discussion could range from preparation to after-care. It sounds crude, yet it could provide evidence not only of the candidate's familiarity with the operation concerned but, more important by far, whether the candidate followed a learned ritual procedure, or had thought about the why and how of its several stages. The pathology viva involved the passing to and fro of a succession of specimens in bottles. Various strategems for discounting the usefulness of an unfamiliar bottle (usefulness to the examiner as discovering a candidate's ignorance, that is) such as shaking up all the sludge in the bottle to make its fluid opaque, became legendary. What mattered to the examiners was the extent to which the candidate approached the problem with method and logic.

The 1894 Brooks painting of a pathology viva at the English College is spurious in the sense that the examiners depicted did not ever examine together; but it captures the atmosphere of such an event.

Then, as 'real-life' anatomy gave way to 'paper' anatomy in the Part 1 examination, it was found prudent to introduce an anatomy viva into the Part 2, with bones, prosected parts and the like available for discussion and the identification of structures.

Photographs (prints or slides), x-ray plates, CT and MRI images, all have their place in the viva process; models as well as prosected parts can contribute in the anatomy vivas. It is already possible to envisage a stage in which virtual reality enters the repertoire of the examiner.

The close-marking system provided a reliable basis for assessing candidates' performances, and its reliability was not affected by the introduction of the anatomy viva.[5] Under the system a particular segment is marked

9½ outstanding
9 satisfactory, i.e. a clear pass
8½ dubious
8 dreadful

When the various marks are totted up, obviously a clear run of 9s means a pass; a total of 63 from a row of seven marks almost certainly does too (unless the clinical mark has been an 8 or 8½, in which case

serious thought has to be given to what is, after all, an unlikely combination). Anything better than 63 makes the examiners' task very easy.

At the other end of the scale, a total of 61 or lower must indicate that blend of mediocrity and failure that is irrecoverable. It is therefore the group of scores in the range 61½-62½ that call for earnest discussion by the Court (and its offspring the mini-court). The pairs of examiners (the whole process is conducted by examiners working in pairs, and the candidate exposed to as many pairs as possible in the course of the examination) who gave 8½s or worse are invited to describe the subjects discussed, the basis for their marking down and even their willingness to move a mark back up.

To aid them in this, there is the device of the upgoing arrow ↑,[6] which they may enter privately alongside the original mark in their notebooks where they record also, as an *aide-memoire*, the topics with which they have confronted the candidate. (It begins to sound like the jurors in the trial scene in *Alice in Wonderland*.) If the process of discussion and concession improves the situation sufficiently, the total may move into the safe zone.

If it does not, the validity of the better marks is examined, and the pairs of examiners who awarded them will describe the content and outcome of their contact with the candidate. Then, if the matter still hangs in the balance, the chairman of the court will report on the candidate – the log book, the nature of the candidate's training programme and the progress reports that came out of it. At some stage there will be a motion to approve or reject and, once the whole court has heard enough, this will be voted on.

It is a comprehensive review that takes place in doubtful cases, but the important element is this: the examiners who have given a poor mark are themselves on trial in the meeting of the court. Frivolous or even malicious marking down is virtually impossible. After I finished my term on the court, I was included (on the basis of the gamekeeper-turned-poacher, perhaps) in the group who provided the pre-examination course in Wellington, and the task I was given was

Successful candidates and members of the Court can relax with a drink afterward. Formerly sherry, the celebratory drink is now *méthode champenoise*.

to describe the process of examination and its safeguards to prospective candidates. Almost without exception they were approaching the examination as an ordeal to be overcome. I was able to reassure them that the ordeal was greater for the examiners, who had to stay attentive through multiple interviews, while a candidate submitted only once to the process; that the examiners, at least if they awarded an unfavourable mark, were on trial even more than the candidates themselves; and that a well-prepared candidate such as emerges from advanced training can look forward more to a consultation with admittedly senior colleagues – but a consultation nevertheless – than to a process of grim interrogation. It is, in fact, a rewarding experience for examiners to talk with young surgeons whose ability is transparent, whose grasp of their subject heartening. I think a number of apprehensive candidates were reassured and their performance enhanced as a result.

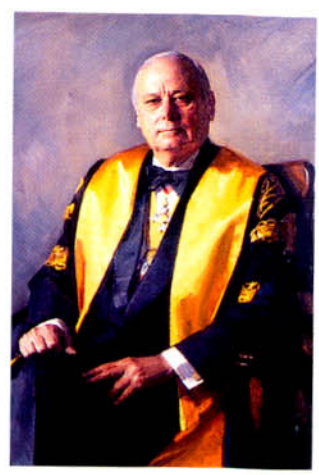
In my day, the study of x-ray films was a routine part of the examination process, that of microscope slides less so. The use of a slide projector to show illustrations of this and that was just past the stage of being innovative.

Since then, the range of imaging procedures has advanced enormously, and the use of computed aids is now routine. The examination, long scrupulous, has become far more imaginative and realistic, even if the reality is virtual. Candidates who satisfy the examiners can accept their traditional glass of sherry[7] (and the demanding of money that goes with it!) secure in the knowledge that they have been approved after thorough scrutiny.

For those who are unsuccessful, there is briefing available – counselling for those who approve the term – designed to help them at a subsequent appearance before the Court. The object is manifestly to help candidates, not simply to bring revenue into the College. Indeed, the examination is strictly self-funding and not a source of additional revenue.

One of the responsibilities of the chairman of the Court used to be to brief members on the use and interpretation of the scoring system. I have heard a number of chairmen, but none, I believe, did it better than Mervyn Smith, who was elected to the Council in 1973 and became chairman two years later. In the *Portraits* book I wrote of him:

> His urbanity when chairing a meeting of the court will be remembered by a generation of examiners. During his chairmanship the practice of examiner exchanges between the Edinburgh and Australasian Colleges was adopted to take account of their joint involvement in South-East Asia, and his leading role in developing this liaison was recognised by his election as an Edinburgh Fellow, and the award of the John Bruce Medal during the 1983 collegiate visit to Edinburgh.



Mervyn Smith ran his Court with great flair, and did much to establish good relations between the Colleges which then examined in south-east Asia. He was president 1983-85.

Membership of the Court carries with it a lifelong entitlement to attend the Court dinners which are held during each examination. Here the chairman of the Court, Tony Low, proposes the toast to the Court and College at the 2001 dinner at the Wellington Club.

He ran his court with great flair.

Membership of the Court of Examiners is one of the privileged duties the College confers. It recognises a Fellow's respectability, pays that Fellow a compliment while at the same time making substantial demands in terms of time and commitment. In the process it stimulates the examiner's surgical thinking in the same way as does the teaching of surgery.

The reward is this stimulation – and lifetime membership of the Court of Examiners Club, a totally informal organisation whose members dine at an appropriate stage of each examination. An invitation to such a dinner goes out to all past examiners.

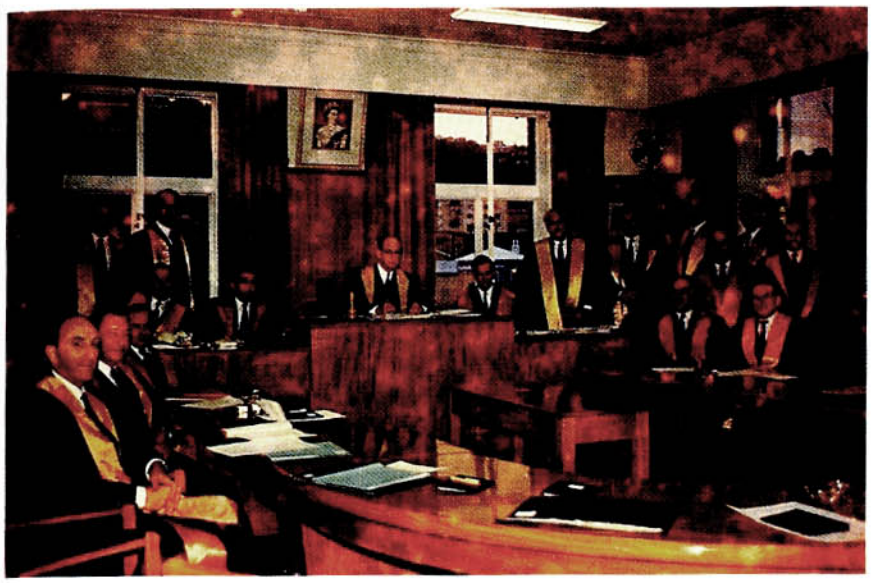
When the court system of examination took over from the Board of Censors, trans-Tasman travel was time-consuming enough to make examiner exchanges difficult. The Court chairman was by convention an Australian (this was enshrined in regulation in 1993), and he had an Australian Court which, by 1966, numbered nine general surgeon examiners, along with two each for the specialties (plus a couple of neurologists to take part in the assessment of ophthalmology candidates). There was also a New Zealand Court, somewhat smaller: six general surgeons, and that year only one plastic surgical examiner (and one neurologist). One examiner was designated chairman's deputy for New Zealand, whose task it was to oversee the local arrangements as well as deputising for the normally absentee chairman.

In the next decade things changed for two reasons: air travel enabled the chairman to include New Zealand sittings of the Court in his programme, and examiner exchanges between the two sets of examiners became simple and hence increasingly frequent. It is fair to observe that a consistently higher pass rate at New Zealand sittings prompted concern – among Australian examiners! – that the standard demanded might be lower in New Zealand, and this in turn prompted exchanges (which served to convince both parties that the standard was indeed consistent). As part of this exchange, I examined in Sydney in 1976; I can recall that I smiled or frowned in unison with my Australian co-examiners throughout.

In the decade from 1966 to 1976 the size of the court increased quite spectacularly, so rapidly was the College growing at this time. The Australian general surgical numbers rose to 17, New Zealand to 11, and six local examiners had been appointed in south-east Asia. There were now six Australian orthopaedic examiners and three in New Zealand. Most specialties in Australia now had three or four.

It used to be the practice to pair a general surgical examiner with an examiner from the specialty concerned for certain of the vivas; and it was partly for this reason that the general surgical examiners were so numerous. It can well be imagined that this did not appeal to the orthopaedic examiners in particular. By 1990 or thereabouts the paternal role of general surgery was extinct.

Previously ten years, the maximum term as an examiner is now eight. (In the case of Australian orthopaedic examiners, it is six, with



Alistair McEachern was another distinguished chairman of the Court; here he presides over a sitting in the board room of Wellington Hospital in 1969. He was, moreover, one who perceived the implications of the educational developments of the early 1970s.

a two-year extension for the senior orthopaedic examiner in each country.)

One problem with an exit examination is that its timing may not sit comfortably with a senior trainee's employment plans, especially if that trainee has ideas of an overseas post by way of 'finishing school'. The College decided that it should be possible for trainees whose progress had been distinguished enough to be allowed to present for the Part 2 examination at the end of the penultimate year.

Now that sounds simple enough, but it was surprising how many difficulties came out of such a kindly gesture. The first was the matter of nomenclature, a minor version of the malaise that has afflicted the UK colleges and their early awarded diploma. After a good deal of agonising, the Council settled on the term 'provisional Fellow' to be borne like a postulant's badge until the satisfactory completion of advanced training.

The matter of timing was more of a problem.[8] During the 1970s the court met in Australia before its New Zealand sitting, and the employment year for hospital staff turned over earlier in New Zealand so that New Zealand candidates were always closer (by the sum of these two elements) to their training 'birthdays'. They were also, their local mentors held as an article of faith, better prepared. Quite a number of them were therefore permitted to present in this third year. Quite a number did pass, and quite a number of influential College figures in Australia were concerned.

They sanctified their concern by suggesting that the best opportunity of success is a trainee's first presentation before the Court, and that it was unfair to a candidate to allow presentation so early. The truth is, I suspect, that there is a stage at which a candidate is 'ready' and the challenge, for candidate and mentor alike, is to pick that stage.

It sounds a complicated process, perhaps, this matter of using the Part 2 examination to determine a candidate's entitlement to join this particular fellowship. In a way it is, yet underlying all the subtleties of close marking and the sophistication of technique is a very simple question which the process seeks to answer fairly for the benefit of candidate, college and community alike: is this candidate safe to turn loose as a surgeon? And because of the thoroughness of the training programmes now in place (for both basic and advanced training) the answer should generally be: yes.

NOTES

1. After the 1969 meeting described in the previous chapter, the Council set up a subcommittee which reported in February 1970. Its principal recommendations were summarised by A.C. McEachern, who had been a member of the subcommittee, in his Anstey Giles lecture in 1974:
    1. Training should be the dominant theme;
    2. Examination should be a means of confirming completion of training;
    3. Fellowship of the College should be the hallmark of the trained surgeon;
    4. Travel was recognised as a desirable component before or after completion of training.

[McEachern, A.C. (1976) *Aust.N.Z. J. Surg.* 46: 1.]

2. In his annual report to the Edinburgh College for 1999-2000, A.D.G. Maran, as president, observed:
I was pleased that Council agreed to change the name... because I never saw any particular merit in being different for the sake of being different.

3. P.H. Lord, originator of Lord's treatment for haemorrhoids (crudely described as 'enlarging the circle of your friends') is a former senior vice-president of the English College. Since we met first in 1955 we have managed frequent reunions in both hemispheres, to our great enjoyment, for Peter and Shirley Lord are the most generous of hosts.

Peter Lord is a former vice-president of the English College and an innovative thinker in surgery. Moreover, he and his wife, Shirley, are generous hosts.

4. G.J.A. Clunie, the outgoing chairman of the Court, speaking at the Examiners' dinner in May 2000, reflected on this convention. Armed with an Edinburgh Fellowship, he presented in London and found himself with one examiner in his clinical. He was busy describing his findings when he became aware that there was a deep silence behind him; turning round, he observed the examiner fast asleep. He and the patient consulted quietly and decided that it would be unfair to wake him. They chatted, still quietly, about this and that until the bell woke the examiner and rescued Gordon Clunie from his dilemma.

5. This took the number of segments from four (written, clinical, two vivas) to five. It is now seven.

6. A downgoing arrow was always discouraged; now, I am told, it is not allowed (even between consenting examiners in private). If a mark is given, it should be defended.

7. These days, a glass of *méthode champenoise* has replaced the traditional sherry; as a result Elliott House has a large stock of sherry glasses in storage.

8. During the 1950s the New Zealand examination was held at the beginning of May, which represented a clash, for those examiners who enjoyed duck-shooting, with the start of the season. Accordingly, the examination was moved to October. By 1993, however, technology had advanced to the point where the written papers could be taken simultaneously in eight centres spread across both countries, and the duckshooting zeal of New Zealand examiners had abated so that the Australian and New Zealand examinations could be held in rapid succession in May, the venues alternating between Sydney and Melbourne, Auckland and Wellington, while a catch-up examination later in the year rotates through Brisbane, Christchurch and Adelaide.

Gordon Clunie brought to the chairmanship of the Court the recollection of an instructive event during his own clinical examination.

Bill Hughes was a man who got things done. In all his endeavours he was supported unceasingly by his wife Alison, who still takes a keen interest in College matters.