



**Kuwait Institute for Medical Specialization
Faculty of Primary Health Care
The Family Medicine Specialty Training Programme**

Resident's Guide to the Curriculum for Training in Family Medicine

Preface

This curriculum document marks a watershed in postgraduate training for general practice. Set within a framework for a structured educational programme; it is designed to address the wide ranging knowledge, competences, and clinical and professional attitudes considered appropriate for a doctor intending to undertake practice in Kuwait Ministry of Health services.

The curriculum is a challenging and complex document that will change and develop as medicine changes and develops.

This curriculum is intended for doctors training for general practice and their trainees and educational advisors. It covers the period known as "Specialty Training for Family Medicine".

How this curriculum was developed:

A curriculum working group was developed from the panel of senior trainers and examiners in the Family Practice Specialty Training Programme. A literature review was done. An extensive exercise was carried out through:

- A general questionnaire survey of the views of trainees and trainers on training and on the previous curriculum
- Meetings with trainees and trainers and hospital educational supervisors
- Meetings with responsible people in the MOH, KIMS and RCGP

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Contents:

• Introduction.....	4
• The Family Physician's role description.....	5
• The obligations of the family practitioner.....	6
• The specialty of family medicine.....	6
• Aims of the Speciality Training Programme.....	6
• Admission requirements.....	7
• The Components of the Family Practice Speciality Training Programme.....	7
• Description of the four year vocational training period.....	7
A. GP-based practice period.....	7
1. Learning methods	8
2. Formal courses.....	8
3. One day study course.....	9
B. Hospital base- practice period.....	11
1. Learning opportunities.....	11
2. Hospital attachments.....	11
• Required competencies.....	12
• Reading & resources.....	18
• Assessment.....	19
• The Work Place Based Assessment (WPBA):.....	19
• References.....	21
• Appendices:	
1. Professional competences – definitions	
2. The Clinical Supervisor's Report	
3. The Consultation Observation Tool (COT)	
4. The Case – Based Consultation Tool (CCBD)	
5. The Audit Project Assessment Sheet	
6. The End of Course Feedback	
• Operational Guide to the Four Exam Modules.....	32

Introduction:

International evidence indicates that health systems based on effective primary care, with highly trained family doctors practicing in the community, deliver care that is both cost-effective and achieves high levels of professional responsibility of doctors to provide a high standard of care. ^{1,2}

Published studies suggest that vocationally trained GPs are better in terms of the quality of patient care, confidence and self-perception as GPs as well as in knowledge, practice skills and attitudes. ^{3,4,5,6,7,8}

Family Practice is a key element of all health care systems in Kuwait, and is recognized by health service providers as being of ever increasing importance.

Kuwait is considered as one of the pioneers in the Middle East region to introduce the concept of job description for the family practitioner and to realize the necessity of vocational training programme for his preparation. ⁹

Kuwait Institute for Medical specializations (KIMS) started the Family Practice Specialty Training Programme to train family physicians in 1983. ¹⁰

The residency programme in family medicine provides supervised learning opportunities and clinical experience in both hospital and family practice.

In 1987 the first batch of family physicians graduated from the programme.

An examination and passing diploma certificate equivalent to that of the Membership of the Royal College of General Practitioners examination was issued by the Royal College of General Practitioners In 1991.

These were important factors leading to increasing choice of family medicine as a career by Kuwaiti medical school graduates.

In 2000, the programme duration changed from 3 to 4 years, and in 2002 a system was developed for enhanced evaluations and assessment of trainees ¹¹. An accreditation was awarded to the graduation certificate as MRCGP(INT) in 2005.

The trend that emerges when reviewing the selection of specialties for postgraduate training and qualification during previous 4 years is that Family Medicine is preferred among the training programmes conducted locally. ¹²

The Family Physician's role description: ^{13,14}

- The family practitioner is a medical graduate with specific training to give personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness; it is the synthesis of these functions which is unique.
- He/she will attend his patients in his consulting room and in their homes and sometimes in a clinic or hospital. His aim is to make early diagnoses and acts accordingly.
- He will embrace a person-centred approach including physical, psychological and social factors in his considerations about health and illness.
- He has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patients.
- He will make an initial decision about every problem which is presented to him as a doctor.
- He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses.
- He will make efficient use of healthcare resources. He will practice in co-operation with other colleagues, medical and non-medical.
- He will know how and when to intervene through treatment, prevention and education, to promote the health of his patients and their families.
- He will recognize that he also has a professional responsibility to the community.
- He will be involved in the continuing development of their healthcare system. As an individual professional he must adapt and grow in order to meet these new challenges.
- He will seek consciously the best available research evidence and appraise and combine it with clinical experience and patient values to inform their clinical decision making (the principles of evidence-based medicine).¹⁵

The obligations of the family physician:

A professional family **physician** has an obligation to maintain a good standard of practice and care, showing respect for human life. In particular a doctor must:

- + Make the care of his patient his first concern.¹⁶
- + Treat every patient politely and considerately. ¹⁶
- + Respect patients' dignity and privacy. ¹⁶
- + Listen to patients and respect their views. ¹⁶
- + Give patients information in a way they can understand. ¹⁶
- + Respect the rights of patients to be fully involved in decisions about their care. ¹⁶
- + Be self-aware and critical of own professional standards. ¹⁷
- + Commit to continuing self education ¹⁷
- + Recognize the limits of his professional competence. ¹⁶
- + Be honest and trustworthy. ¹⁶
- + Respect and protect confidential information. ¹⁶
- + Make sure that his personal beliefs do not prejudice the patients' care. ¹⁶
- + Act quickly to protect patients from risk if he has good reason to believe that he or a colleague may not be fit to practice. ¹⁶
- + Avoid abusing his position as a doctor.
- + Work with colleagues in the ways that best serve patients' interests. ¹⁶

The specialty of family medicine:

- Family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and is a clinical specialty orientated to primary care. ¹⁸
- Family Practice is a distinct medical discipline; doctors who intend to become family practitioners require a period of special professional preparation. Specialist Vocational Training is just one phase, but a crucial one, in a continuous process of professional education and training.
- It builds on and complements undergraduate education and general professional training, ensures the acquisition of certain crucial and relevant competences, and lays a sound foundation for further Professional Development.

Aims of the Kuwait Family Practice Training Programme

- To improve the quality of patient care within the setting of primary health care in Kuwait. ¹⁹
- To enhance the level of competence in Kuwaiti doctors, enabling them to be abreast of the developments in medical specialties and patient management.¹⁷
- To provide facilities and opportunities for the Continuous Professional Development (CPD) for doctors practicing in Kuwait (Kuwait Institute of Medical Specialization educational guide 2002) ¹⁷
- To produce competent family physicians, who fulfill the role description of the family physician.

Admission Requirements and Procedures

Medical doctors who have completed their first year internship are eligible to apply through the Secretary General, Kuwait Institute for Medical Specialization. Final selection will be based on satisfactory performance in the written assessment and interviews conducted through the Faculty of Primary Health Care.¹⁷

The Components of the Kuwait Family Practice Specialty Training Programme:

1. It is a four year specialty training programme, which is described as the four year vocational training period.
2. It consists of two phases.
3. Each phase is of two years duration.
4. Each phase will end with a summative assessment examination

Description of the four year vocational training period:

The first phase:

1. Introductory general practice period: starting in January each year and lasting for seven months.
2. The following period is divided into six attachments, alternating between general practice based training and hospital based training.
3. A one month summer holiday is permissible in each year.
4. By the completion of the first phase, the candidate will be eligible to sit the first part MRCGP(INT) exam.

The second phase:

1. The first 18 months are divided into six attachments, alternating between general practice and hospital based training.
2. A one month summer holiday is permissible in each year.
3. The last six months will be spent as a general practice based training period.
4. By the completion of the second phase, the candidate will be eligible to sit the final MRCGP(INT) exam.

A. GP-based practice period:

The moment the trainee is accepted in the FPSTP, he/she is allocated to trainer. From there, the journey of teaching and learning will start.

The teaching and learning process during the GP based period, is unique, in which the primary relationship is between the trainer (educator) and the trainee (learner), a relationship that is embedded in active, professional practice.

The trainee will spend approximately 12 months in General practice in each practice phase, a total of two years during the four year programme.

1. Learning methods :

- Observing trainers and other experienced family practitioners.
- Supervised (Joint) consultations followed by unsupervised consultations
- Reflection on learning (log book, reflective diaries).
- Problem case analysis and random case analysis.
- Video case analysis.
- Formal tutorials.
- Formal courses.
- One day study course (ODSC).
- Independent self-directed learning.

2. Formal courses during the Family Practice Training Programme:

These courses are an integral part of the Family Practice Training Programme. It must be emphasized that formal courses are only one part of the overall program of vocational training. All these courses are full time, and attendance is obligatory for those trainees participating in the programme.

A. First Year:

- Diagnosis and management (7 days)
- Emergency (including CPR) (3 days)
- EBM / Critical appraisal principles (2 days)

B. Second Year:

- Audit in general practice (3 days)

C. Final Year:

- Practice Management (3 days)

No.	Name of course	Year level	No. of days	Special remarks
1	<i>Diagnosis and management course</i>	1	7 days	
2	<i>Introduction to evidence based medicine and critical appraisal</i>	1	2 days	
3	<i>Emergencies in G.P.</i>	1	3days	<i>Including CPR</i>
4	<i>Audit in G.P.</i>	2	3days	<i>Project recommended</i>
5	<i>Practice Management</i>	4	3days	<i>Including CPD</i>

3. One day study course (ODSC):

The ODSC is a full-day release course teaching for trainees. It has a long history and remains popular with trainees. What is valued most by trainees is the opportunity for meeting with peers, partly because they can feel isolated within a practice. It allows trainees to come together for small group sessions and can have a powerful influence on shaping of attitudes.

- There are six days/year for each batch.

Aims of ODSC:

- Discussion of controversial issues.
- Covering topics not covered by hospital and practice based training.
- To familiarize candidates with peer group discussion.
- A tool for candidate assessment.

Practical application of the following topics is recommended in the ODSC as appropriate:

- Ethical issues
- Preventive issues
- EBM
- Critical appraisal

Content of ODSC:

1. Ethical issues
2. Medico-legal aspects
3. Human development
4. Community orientation
5. Preventive aspects
6. Breaking bad news / Terminal care
7. Continuing professional development
8. Grey areas in Hypertension
9. Grey areas in DM
10. Grey areas in Bronchial asthma
11. Geriatric problems in GP
12. Pediatric problems in GP
13. Obstetric and gynaecological problems in GP
14. Sexual problems
15. Counselling in GP
16. Grey areas in psychiatric problems
17. Quality Assurance
18. Behavioural problems

The content of the ODSC over the four training years:

Subject	Year 1	Year 2	Year 3	Year 4
Ethics	*			*
Medico-legal	*			
Human development & Behaviour		*		
Community orientation			*	
Prevention	*			
C P D				*
Gray areas in clinical major diseases	* * *			
Paediatric Problems		*	*	
Quality Assurance				*
Epidemiology	*	*	*	*
Psychiatric Problems		*		
Geriatric Problems		*	*	
Critical Appraisal	*	*	*	*
Practice Management				*
EBM	*	*	*	*

The Design of the ODSC day:

1. Mini lectures:
 - Should not last for more than 15 min.
 - Preparation of trainees must be supervised by tutors.
 - Delivered by either trainee or tutor.
2. Journal club / critical reading/ EBM
3. Small group discussion
 - Should constitute the backbone of ODSC
 - Material discussed should reflect dilemmas and controversies of the subject discussed.

B. Hospital based practice period:

The time spent, and competences gained in the hospital setting, will form an important contribution to the development of the future GP.

The trainee will spend approximately 11 months in Hospital in each practice phase, a total of twenty two months during the four year programme.

1. Secondary care (Hospital) learning opportunities:

- Outpatient clinics can be valuable, either sitting in or seeing patients under supervision.
- Consultant ward-rounds provide good opportunities for bedside teaching and for trainees to obtain feedback on their clinical and decision-making skills.
- Hospital attachments provide exposure to higher numbers of more seriously ill patients. Although this does have advantages in offering a high concentration of experience, it should not be overstated.
- Hospitals also provide opportunities for trainees to attend multidisciplinary team meetings to gain perspectives on integrated care and team working.

2. Hospital attachments

Short attachments to different specialties are found helpful. They are mandatory for a trainee to be eligible to sit both parts of the MRCGP(INT) exam.

1. Internal medicine (8 weeks): The training period should be divided as follows:
 - General medicine: 6 weeks with particular stress on the out-patient clinics for the following subspecialties: GIT, cardiology, respiratory medicine, endocrinology, rheumatology and nephrology.
 - Diabetes : 2 weeks
2. Paediatrics (6 weeks)
3. Paediatric Surgery (1 week)
4. Neonatology (1 week)
5. Orthopaedics/physical medicine and rehabilitation (4 weeks)
6. Obstetrics & Gynaecology (4 weeks)
7. Surgery /urology (3 weeks)
8. Medical/ Surgical Casualty (4 weeks)
9. Psychiatry (including Addiction Centre) (3 weeks)
10. Dermatology (2 weeks)
11. ENT (2 weeks)
12. Ophthalmology (2 weeks)
13. Nutrition (2 weeks)
14. Genetics (1 week)
15. Cancer / Terminally Ill patients (1 week)

Required Competencies:

Upon completion of the four years vocational training, the trainee should be able to demonstrate that he/she has gained the different competencies that are required from the GP. In order to demonstrate these competencies, the trainee will need to acquire knowledge, skills and professional attitudes in a number of areas. We can summarize these areas as the RCGP domains of competence^{14,19} :

1. Primary care management
2. Person-centred care
3. Specific problem-solving skills
4. A comprehensive approach
5. Community orientation
6. A holistic approach

1. Primary care management

- To manage primary contact with patients, dealing with unselected problems
- To cover the full range of health conditions.
- To master the skills of history taking and physical examination
- To coordinate care with other professionals in primary care and with other specialists
- To master effective and appropriate care provision and health service utilisation
- To make available to the patient the appropriate services within the healthcare system

2. Person-centred care

- To adopt a person-centred approach in dealing with patients and their problems, both in the context of patient's circumstances
- To use the general practice consultation to bring about an effective doctor–patient relationship, always respecting the patient's autonomy
- To communicate, to set priorities and to act in partnership
- To provide long-term continuity of care as determined by the needs of the patient, referring to continuing and coordinated care management

3. Specific problem-solving skills

- To relate specific decision-making processes to the prevalence and incidence of illness in the community
- To selectively gather and interpret information from history-taking, physical examination and investigations, and apply it to an appropriate management plan in collaboration with the patient
- To adopt appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerate uncertainty
- To intervene urgently when necessary
- To manage conditions that may present early and in an undifferentiated way

4. A comprehensive approach

- To simultaneously manage multiple complaints and pathologies, both acute and chronic health problems
- To promote health and wellbeing by applying health promotion and disease prevention strategies appropriately

5. Community orientation

- To reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources.

6. A holistic approach

- To use bio-psycho-social models, taking into account cultural dimensions

In addition to the previous six competencies the candidate needs to show evidence of developing the following skills:

1. Critical appraisal and evidence based practice skills: by the end of the four years training, the trainee should learn the principles of statistics, should be able to apply the principles of evidence base medicine, and be able to critically appraise articles and studies.

2. Administrative and management skills: by end of the four years training, the trainee should understand how the working of the system of primary health care in Kuwait.

Clinical management:

The trainee needs to demonstrate competency in the management of the following problems:

Cardiovascular problems:

- Hypertension
- Coronary heart diseases
- Heart failure
- Arrhythmias
- Other heart disease (valve disease, cardiomyopathy, congenital)
- Peripheral vascular disease
- Cerebrovascular disease
- Dyslipidemias

Gastro-intestinal tract problems

- Dyspepsia (ulcer, non-ulcer, reflux)
- Gall bladder diseases
- Irritable bowel syndrome
- Gastroenteritis/other GI infections
- Constipation
- Malabsorption
- GI cancers
- Inflammatory bowel disease
- Diverticulosis
- Liver diseases
- Inflammatory bowel disease
- Acute abdominal conditions
- Perianal disease

Respiratory tract problems:

- Upper respiratory tract infections
- Lower respiratory tract infections
- Pneumothorax,

- Aspiration of a foreign body
- Asthma
- COPD
- Other chronic lower respiratory problems: chronic cough, interstitial lung diseases
- Lung cancer

Renal /urological problems:

- Impaired renal function
- UTI
- Renal stones
- Polycystic kidney, renal artery stenosis

Neurological problems:

- Epilepsy
- Headache: including serious causes of headache e.g. raised intracranial pressure, subarachnoid haemorrhage
- Infections – meningitis, encephalitis, brain abscess, tuberculosis, HIV
- Mononeuropathies – trigeminal neuralgia, Bell’s palsy, carpal tunnel syndrome, nerve entrapments
- Polyneuropathies
- Multiple sclerosis
- Parkinson’s disease
- Congenital conditions, e.g. cerebral palsy, spina bifida
- Stroke
- Trauma and concussion
- Brain tumours

Endocrine problems:

- Obesity
- Diabetes mellitus and Impaired glucose tolerance
- Thyroid disorders
- Pituitary disease (e.g. prolactinoma, acromegaly, diabetes insipidus),
- Adrenal disease (e.g. Cushing’s syndrome, hyperaldosteronism, Addison’s disease, pheochromocytoma)
- Parathyroid disease

Rheumatology & conditions of the musculoskeletal system

- Back pain (mechanical, disc prolapse, red flags)
- Neck pain
- Joint pain (shoulder, knee, hip, ankle)
- Soft-tissue disorders (synovitis, tenosynovitis)
- Osteoarthritis
- Osteoporosis
- Fibromyalgia
- Pain management
- Monoarthritis

- Infective arthritis
- Connective tissue diseases (rheumatoid arthritis, SLE, seronegative arthritis)

ENT problems:

- Otitis media
- Otitis externa
- Cholesteatoma
- Vertigo
- Pharyngitis; tonsillitis; laryngitis;
- Allergic rhinitis
- Sinusitis; nasal polyps
- Snoring and sleep apnoea
- Head and neck cancer
- Hearing loss
- Epistaxis
- Foreign body

Eye problems:

- Blepharitis
- Stye and chalazion
- Entropion and ectropion
- Naso-lacrimal obstruction and dacryocystitis
- Conjunctivitis, dry eye syndrome
- Episcleritis and scleritis
- Corneal ulcers and keratitis
- Iritis and uveitis.
- Acute loss of vision
- Cataract
- Squint

Dermatology problems:

- Eczema
- Psoriasis
- Urticaria and vasculitis
- Acne and rosacea
- Infections (bacterial, viral and fungal)
- Infestations including scabies and head lice
- Leg ulcers and lymphoedema
- Skin tumours (benign and malignant)
- Disorders of hair and nails
- Drug eruptions
- Other less common conditions such as the bullous disorders, lichen planus, vitiligo, photosensitivity, pemphigus, pemphigoid, discoid lupus, granuloma annulare and lichen sclerosis

Genetic diseases

- Common genetic diseases

Emergencies

- Myocardial infarction
- Pulmonary embolus
- CVA, subarachnoid haemorrhage
- Acute abdomen: appendicitis, intestinal obstruction or perforation
- Limb ischaemia
- Acute GI bleeding
- Meningitis
- Shock, drowning, poisoning
- Diabetic emergencies
- Convulsions
- Trauma

Paediatric problems:

- Neonatal problems: e.g. feeding problems, heart murmur, jaundice
- Constipation, abdominal pain (acute and recurrent)
- Fever, febrile convulsions
- Cough/dyspnoea, respiratory infections, bronchiolitis, asthma
- Otitis media: acute, chronic
- Gastroenteritis
- Viral infections
- Urinary tract infection
- Meningitis
- Epilepsy
- Chronic disease: diabetes, arthritis, learning disability
- Child abuse, deprivation
- Mental health problems such as attention deficit hyperactivity disorder, depression, eating disorders, autism
- Psychological problems: enuresis, encopresis, bullying, school refusal, behaviour problems
- Child and young person development, growth problems
- Breast feeding
- Healthy diet and exercise for children and young people
- Social and emotional wellbeing
- Child protection, accident prevention
- Immunisation
- Paediatric surgical problems

Geriatric problems

- Dementia
- CVA
- Confusion
- Infection
- Mobility problems

- Incontinence
- Visual , hearing problems
- Constipation
- Polypharmacy

Women's problems

- Abnormal cervical cytology
- Vaginal and uterine prolapse
- Fibroids/ endometriosis
- Gynaecological infections and sexually transmitted infections
- Gynaecological malignancies
- Miscarriage and abortion
- Ectopic pregnancy
- Normal pregnancy and pregnancy problems
- Sexual dysfunction
- Infertility
- Menstrual problems
- Contraception

Men's problems

- Male-specific cancers: testicular and prostate cancer
- Benign prostatic hypertrophy (BPH) and prostatitis
- Testicular conditions e.g, varicocele, haematocele, hydrocele, epididymo-orchitis and epididymitis
- Sexual dysfunction, premature ejaculation and erectile dysfunction
- Male infertility
- Sexually transmitted infections

Mental health

- Bereavement
- Dementia
- Delirium
- Alcohol/drug misuse
- Chronic psychotic disorders (including schizophrenia)
- Acute psychotic disorders
- Bipolar disorder
- Depression
- Anxiety disorders (generalized anxiety, phobic disorders, panic disorder, post-traumatic stress disorder)
- Adjustment disorder
- Unexplained somatic complaints (somatizing disorder)
- Eating disorder
- Sleep problems
- Personality disorders

Haematology

- Anaemias
- Haemoglobinopathies
- Leukaemia
- Lymphoma

List of essential reading resources:

- The curriculum provides guidance on approaches to teaching and learning.
- Clinical Evidence: www.clinical.evidence.bmj.com
- Cochrane: www.cochrane.org
- BNF: British national formulary
- KDI: Kuwait drug index
- NICE: national institute for health and clinical excellence: www.nice.org
- SIGN: Scottish intercollegiate guidelines network: www.sign.ac.uk
- BMJ Review articles & original papers
- ABC series of BMJ
- BJGP: British journal of general practice
- American family physician journal
- Family practice management journal
- AHRQ (USPSTF): agency for healthcare research and quality: www.ahrq.gov
- NHLB Guidelines: national heart, lung and blood institute: www.nhlb.nih.gov
- Tutorials in General Practice
- Harrison's text book of medicine
- Nelson's textbook of paediatrics
- DSM IV (American Psychiatric Association)
- General practice, by Murtagh
- Current medical diagnosis & treatment, by Tierney
- Primary care medicine office evaluation and management of the adult patient, by Goroll
- Essentials of Family medicine, by Sloane
- Practical general practice, by Khot
- RCGP guidelines: www.rcgp.org.uk
- The Merck manual
- The New England medical journal
- The uptodate: www.uptodate.com
- Clinical method- A general approach, by Fraser, publisher: Butterworths
- Emergencies in general practice, by A.J. Moulds, A.J. Martin, Publisher: Lancaster- MIP press ID
- Tutorials in general practice, By Michael Mead and Henry Patterson, Publisher: Churchill Livingstone
- Paediatric problem in general practice, by Modell, M. and Boyd, R. Publisher: Oxford general practice series, Oxford University
- Women's problems in general practice. Oxford general practice series. Oxford University
- The consultation: An aid to learning and teaching; David Pendleton
- Skills for communicating with patients; Jonathan Silverman and Suzanne Kurtz
- Evidence-Based Medicine: How to Practice and Teach EBM, by Sackett DL.

Assessment:

The processes of teaching and learning demand assessment. During the four years' vocational programme candidates pass through different methods of assessments. The process of measuring how the candidate is progressing over a period of time is called formative assessment. This diagnostic use of assessment provides feedback to trainers and candidates. It differs from summative assessment, which generally takes place after a period of training and requires making a judgment about the learning that has occurred 20

- A. Formative assessment: during the four years vocational training: the most important tool of formative assessment in the programme is WPBA (Workplace based assessment)
- B. Summative assessment:
 - 1. Part One MRCGP(INT)
 - 2. Final MRCGP(INT)

For details refer to the operational guide to the exam

1 The New Method of Assessment: The Workplace Based Assessment (WPBA):

Definition:

- The evaluation of a doctor's progress over time in their performance in specified areas of professional practice.
- It is a process through which evidence of competence in independent practice is gathered in a structured and systematic framework.
- Reports about candidate's performance will reviewed every six months and at the end of the four years vocational training, to make a holistic, qualitative judgment about the readiness of the trainee to sit the final exam.
- It will provide feedback to the trainee, and will also indicate where he/she is in difficulty.
- It consists of a framework of twelve areas of professional competence against which evidence is gathered through validated tools. The use of each tool serves as an episode of evidence collection.
- The WPBA tools ensure the evidence is collected in the same way for each trainee, and promote consistency amongst trainers.
- The use of the tools does not involve pass/fail assessments; the judgment will be either adequate or inadequate evidence (it indicates the need for further training).
- At regular points during training all the evidence available from the trainee is reviewed and a judgment is made about progress through each area of professional competence.²¹

Aims of WPBA:

- WPBA connects teaching, learning and assessment.
- It enables trainees to know what is expected of them and to demonstrate attainment over time.
- It allows the assessment to get as close as possible to the real situations in which doctors work.
- Some competences are not assessed effectively in any other way, e.g. physical examination skills, ethical principles and team working.
- It will provide feedback to the trainees on areas of strength and developmental needs.
- There will be clarity and transparency about the outcomes of training at regular intervals throughout the training programme.
- It is a stimulating tool for the trainees during their learning process.

Competency Areas (Appx 1):

1. Communication and consultation skills
2. Practicing holistically
3. Data gathering and interpretation
4. Making a diagnosis- making decisions
5. Clinical management
6. Managing medical complexity
7. Primary care administration
8. Working with colleagues for the benefits of patients
9. Maintain performance, learning and teaching
10. Maintaining ethical approach to practice
- 11 Community orientations
12. Fitness to practice.

Tools for WPBA:

1. Clinical Supervisor's Report (CSR) (Primary care and Hospital)
2. Consultation Observation Tool (COT) (Primary care)
3. Case Based Discussion (CBD) (Primary care)
4. Audit (Primary care)
5. Completion of courses report (Primary care)

Trainee's Reports of Workplace Based Assessment:

1. **Clinical Supervisor Report** (Appx 2): should be completed by either the trainer or hospital tutors at the end of each training period. The Clinical Supervisors Report (CSR) forms part of the evidence which is gathered through WPBA. In the report there is a section for the clinical supervisor to write a short structured report on the trainee at the end of each training post (clinic / hospital). This covers:

- The knowledge base relevant to the post.
- Physical examination skills relative to the post
- The practical skills relevant to the post.
- The professional competences.

2. **Consultation Observation Tool Report (COT)** (Appx 3): At the end of each training period (of an assigned trainee) in the clinic (5 cases, a minimum of 3 observed consultations during each general practice based training period)

3. **Case Based Discussion (CBD)** (Appx 4): Case-based discussion (CBD) is a structured interview designed to explore professional judgment exercised in clinical cases which have been selected by the trainee and presented for evaluation twice at each training period (of an assigned trainee) in the clinic (a minimum of 3 CBD during each practice based training period). The trainer should ensure that a balance of cases are represented including those involving children, older adults, chronic diseases, emergencies, psychosocial cases etc, across varying contexts i.e. clinic and home visits.

4. **The Audit Project** (Appx 5): It must be completed and submitted by the end of the 3rd year. For the candidate to be eligible for the exam, the audit project must be passed.

5. **Completion of courses report** (Appx 6): Reports should be fulfilled and submitted at the end of each course by the course tutors.

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Professional Competencies

1. Communication and Consultation Skills:

This competency is about communication with patients and the use of recognized consultation techniques. Behaviours you may wish to consider: listening well, exploring patients ideas, providing good explanations, checking the patient understanding, tailoring communication to the patient's needs.

2. Practicing Holistically

This competency is about the ability of the doctor to consider physical, psychological, socioeconomic and cultural aspects, taking into account feelings as well as thoughts.

Behaviours you may wish to consider: exploring the way in which the problem affects the patient's life, exploring the impact of the problem on the patient's family/carers.

3. Data Gathering and Interpretation:

This competency is about the gathering and use of data for clinical judgment, the choice of examination and investigation and their interpretation.

Behaviours you may wish to consider: systematically gathering information, using questions that appropriately focused, making use of existing information, choosing physical examinations and targeting investigations appropriately, makes appropriate inferences from the findings and results.

4. Making Diagnosis / Making Decisions:

This competency is about a deliberate, structured approach to decision-making.

Behaviours you may wish to consider: clarifying the decision that is required, integrating information to aid pattern recognition, using probability to decide what is likely, revising hypotheses in the light of further information, thinking flexibly around the problem.

5. Clinical Management:

This competence is about the recognition and management of medical conditions.

Behaviours you may wish to consider: recognizing common presentations, utilizing the natural history in management decisions, using simple measures when appropriate, varying management options when required, prescribing appropriately referring appropriately and coordinating care with other colleagues, responding quickly; and skillfully in emergencies

6. Managing Medical Complexity:

This competency is about aspects of care beyond managing straightforward problems, including the management of co-morbidity, uncertainty, risk and thinking about health rather than just illness.

Behaviours you may wish to consider: simultaneously managing the patient's health problems both acute and chronic, tolerating uncertainty where this is unavoidable, explaining risks associated with management to the patients, encouraging patients to have a positive approach to their health.

7. Primary Care Administration:

This competency is about the appropriate use of primary care administration systems, effective record-keeping and information technology for the benefit of patient care.

Behaviours you may wish to consider: using administrative and computer systems appropriately, keeping good clinical records (timely, coded, and sufficiently comprehensive).

8. Working with Colleagues and in Teams:

This competency is working efficiently with other professionals to ensure patient care, including sharing of information with colleagues.

Behaviours you may wish to consider: being available to colleagues, working cooperatively, sharing information with others involved in the patient's care, using appropriate methods of communication according to circumstances.

9. Community Orientation:

This competency is about the management of health and social care of patients in the local community.

Behaviours you may wish to consider: identifying important characteristics of the local community that might impact upon patient care, particularly the epidemiological, social, economic and ethnic features, using this understanding to improve patient management, identifying resources in the community, encouraging patients to access available resources, using health care resources effectively e.g. through cost-effective prescribing.

10. Maintaining Performance, Learning and Teaching:

This competency is about maintaining the performance and effective continuing professional development of oneself and others.

Behaviours you may wish to consider: appropriate use of evidence-based medicine, keeping up-to-date, identifying and addressing learning needs, participating in audit and significant event reviews, contributing to the ongoing learning of students and colleagues.

11. Maintaining an Ethical Approach to Practice:

This competency is about practicing ethically with integrity and respect for diversity.

Behaviours you may wish to consider: identifying and discussing ethical issues in the clinical practice. Treating patients, colleagues and others fairly, and with respect for their beliefs, preferences, dignity and rights. Valuing differences between people, and avoiding prejudice.

12. Fitness to Practice:

This competency is about the doctor's awareness of when his/her own performance, conduct or health, or that of others might put patients at risk and the action taken to protect patients.

Behaviours you may wish to consider: observing the accepted codes of professional practice, allowing scrutiny and justifying professional behavior to colleagues, achieving a health balance between professional and personal demands, seeking advice and engaging in remedial action where personal performance is an issue.

Clinical Supervisor's Report

Trainee Name:

Registration No.:..... **Year of Training:**.....

Hospital/ Clinic:..... **Speciality:**.....

Period: From **To**

Number of Absent Days **With Excuse** **Without Excuse**

Punctuality: Good **Poor**

1. Knowledge-base Relevant to the Placement

Insufficient Evidence	Needs Further Development	Competent	Excellent
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Feedback on areas for further development

2. Practical Skills Relevant to the Placement

Skills	Insufficient Evidence	Needs Further Development	Competent	Excellent
a. Physical Examination				
b. Other Procedural Skills				
.....				
.....				
.....				
.....				

Feedback on areas for further development

3. Professional Competencies

	Insufficient Evidence	Needs Further Development	Competent	Excellent
1. Communication and Consultation Skills				
2. Practicing Holistically				
3. Data Gathering and Interpretation				
4. Making Diagnosis / Making Decisions				
5. Clinical Management				
6. Managing Medical Complexity				
7. Primary Care Administration and IMT				
8. Working with Colleagues and in Teams				
9. Community Orientation				
10. Maintaining Performance, Learning and Teaching				
11. Maintaining an Ethical Approach to Practice				
12. Fitness to practice				

Feedback on areas for further development

Endorsement by Clinical Supervisor

I confirm that the above is based on my own observations and the results of workplace-assessments and has been discussed with the trainee concerned.

Name: **Signed:** **Date:**

Appendix 3

Consultation Observation Tool Report (COT)

Candidate: **Date:**.....

Assessor: **No. of consultations:**

1. Information Gathering:

Component	Done	Occasionally Done	Not Done	Grade
The candidate elicits relevant and specific information from the patients and their records.				
The history is in physical, psychological and social terms as appropriate				
Takes into account the patient’s family and occupational history.				
The effect of the problem(s) on the patient, family and friends; the effect on his/her work and leisure interests. .				
The doctor seeks to identify the patient’s health beliefs, concerns and expectations.				

2. Physical Examination:

Component	Done	Occasionally Done	Not Done	Grade
Performs examination and elicits physical signs correctly and in a competent manner.				
Is sensitive to the needs of the patient for discretion and privacy.				
Uses instruments appropriately and efficiently.				

3. Problem Solving:

Component	Done	Occasionally Done	Not Done	Grade
The doctor identifies problems or develops working diagnosis appropriate to the findings.				
Any physical/mental examination is chosen rationally to confirm or refute the proposed diagnosis, or if appropriate, to reassure the patient.				
Correctly interprets and applies information obtained.				

4. Communication/Explanation, Doctor-Patient Interaction:

Component	Done	Occasionally Done	Not Done	Grade
Friendly but professional, recognizes patient's verbal and non-verbal cues.				
Approach is patient-centered with open-ended questions leading to a focused history and subsequent explanation.				
Explanation is jargon free, tailored to the patient and takes into account his/her health beliefs.				
The doctor checks the patient understanding.				

5. Management and Appropriate Anticipatory Care:

Component	Done	Occasionally Done	Not Done	Grade
The management plan is made in partnership with the patient				
Management is appropriate to the findings of the history and examination, and is evidence-based.				
Referrals, prescriptions and investigations chosen are relevant and cost effective.				
Recognizes the importance of team-working.				
Modification of help-seeking behavior is attempted when appropriate.				
Follow-up and anticipatory care are appropriate.				
Records are adequate.				

Case Based Discussion Report (CBD)

Trainee Name:

Trainer:.....

Year of Training:.....

Time:.....

Subject

Summary:.....

Professional Competencies

	Insufficient Evidence	Needs Further Development	Competent	Excellent
1. Communication and Consultation Skills				
2. Practicing Holistically				
3. Data Gathering and Interpretation				
4. Making Diagnosis / Making Decisions				
5. Clinical Management				
6. Managing Medical Complexity				
7. Primary Care Administration and IMT				
8. Working with Colleagues and in Teams				
9. Community Orientation				
10. Maintaining Performance, Learning and Teaching				
11. Maintaining an Ethical Approach to Practice				
12. Fitness to Practice				

Trainer's Signature

Family Medicine Specialty Training Programme
CLINICAL AUDIT COMPONENT OF DIPLOMA IN FAMILY PRACTICE
(RCGP/ KUWAIT) MRCGP(INT)
Marking Schedule

Screening test :

Has the audit cycle been completed? YES/ NO

If No reject audit: if Yes, proceed with evaluation.

Please tick the box to indicate the extent which the criterion is satisfied.

* Assessor's Name -----

* Assessor's Signature -----

* Date of Assessment -----

Criterion

1. Reason for choice of audit	Potential for change Relevant to the practice	<input type="checkbox"/>
2. Criterion/ Criteria chosen	Relevant to audit subject and Justifiable, e.g. Current literature	<input type="checkbox"/>
3. Standards set	Targets towards a standard with a Suitable timescale	<input type="checkbox"/>
4. Preparation and Planning	Evidence of teamwork and adequate Discussion where appropriate	<input type="checkbox"/>
5. Data collection (1)	Results compared against standard	<input type="checkbox"/>
6. Change(s) to be evaluated	actual example described	<input type="checkbox"/>
7. Data collection (2)	Comparison with Data collection (1) and standard	<input type="checkbox"/>
8. Conclusions	Summary of main issues learned	<input type="checkbox"/>

A satisfactory audit project report should include all 8 criteria to pass

Pass

Refer

If refer, please comment on your reasons overleaf.

Reason for referral:-

Explicit advice for improvement:-

Completion of Course Report

Trainee Name: **Year of Training:**.....

Period: From **To**

Number of Absent Days

Punctuality: **Good** **Poor**

Preparation:

Insufficient Evidence	Needs further Development	Competent	Excellent
------------------------------	----------------------------------	------------------	------------------

Participation:

Insufficient Evidence	Needs further Development	Competent	Excellent
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Feedback on Areas for Further Development:

Tutor's Name(s)

Signature

1.
2.
3.

Kuwait MRCGP(INT) examination

Operational Guide to the Four Exam Modules

The Kuwait Blueprint for the Four Summative Exam Modules:

This blue print indicates the domains best tested in each module. It facilitates planning of the exam against the learning objectives of competencies essential to the speciality of family practice.

Module	Domains																	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
MEQ written paper																		
Multiple choice paper (Part one)																		
Oral																		
Clinical																		

- A. Factual knowledge
- B. Evolving knowledge: uncertainty, 'hot topics', qualitative research
- C. The evidence base of practice: knowledge of literature, quantitative research
- D. Critical appraisal skills: interpretation of literature, principles of statistics
- E. Application of knowledge: justification, prioritizing, audit
- F. Problem-solving: general applications
- G. Problem-solving: case-specific, clinical management
- H. Personal care: matching principles to individual patients
- I. Written communication
- J. Verbal communication: the consultation process
- K. The practice context: 'team' issues, practice management, business skills
- L. Regulatory framework of practice
- M. The wider context: medico-political, legal and societal issues
- N. Ethnic and trans-cultural issues
- O. Values and attitudes: ethics, integrity, consistency, caritas
- P. Self-awareness: insight, reflective learning, 'the doctor as person'
- Q. Commitment to maintaining standards: personal and professional growth, continuing medical education
- R. Decision making

1.Part One MRCGP(INT) Exam:

Eligibility to sit the Part one exam:

1. The trainee should have completed the 11 months hospital rotation prior to sitting the exam
2. The number of days missed during the first phase, should not exceed 35 days annual leave, 15 sick leave days per year
3. Starting in May 2010, the WPBA (Work Place Based Assessment) will be part of formative assessment, when the trainee should show adequate evidence that he/she is competent

Attempts:

- Each trainee has three attempts to sit the part one exam

Part one MCQ exam:

- This takes place at the end of phase one general practice period
- Candidates must pass the Part one MCQ before taking Part two
- The Part one MCQ will be available annually in the spring diet
- It is in the form of an MCQ written exam
- It consist of 200 questions
- All questions are in the form of 'single best answer'
- The duration of the exam is three and a half hours
- There will be no negative marking
- There will be a standard setting process prior to marking the exam
- The marking is computer scanned
- Answer sheets will be scanned three times

Purpose of MCQ paper:

- The MCQ paper tests both clinical and non clinical aspects of GP knowledge
- It assesses basic knowledge, the application of knowledge and interpretation of information, including justification, prioritizing and decision making
- It evaluates evidence, undifferentiated problems and decisions regarding patient safety to medical practice
- It assesses the candidate's knowledge of the principles of critical appraisal, evidence based medicine and statistics
- It assesses the candidate's familiarity with practice issues
- It identifies candidates who have reached a satisfactory academic and clinical standard, as well as reflecting safety to the practice up to the level of MRCGP (INT) Part one
- It ensures that those candidates who decide to exit the family practice training programme after the first part are able to practice safely and independently, since it is considered an end point assessment
- The MCQ paper is constructed so that the distribution of the questions reflect the blue print of the examination

2.Part two (final) MRCGP(INT) Examination:

Eligibility to sit the Part two final exam:

1. The trainee should have completed the 11 months hospital rotation prior to sitting the exam
2. The number of days missed during the first phase, should not exceed 35 days annual leave, and 15 sick leave days per year.
3. Starting in May 2010, the WPBA will be part of formative assessment, when the trainee should demonstrate adequate evidence that he/she is competent
4. The audit project should be delivered and passed, prior to sitting the exam

Attempts:

- Since May 2008, the exam has changed to a modular format
- Candidates are required to pass each exam module independently
- Candidates will have three attempts at each exam module

Components of the Final Part two exam:

- This consists of three modules: written, clinical and oral
- It takes place at the end of the second phase of training
- The Final Part two exam will be available in the spring and the autumn diet every year

The MEQ Written paper:

- There are 13 questions in the paper
- The time allowed is three and a half hours
- Answers should be legible and concise
- 'Notes' form may be used
- Answers should be written in the space provided on the question sheet
- Additional paper may be obtained from the invigilator if required
- Each question will be marked by two Examiners
- Immediately after marking, each examiner will nominate the pass mark for their question
- These marks will be used to calculate a provisional pass mark for the paper
- Each question will be of equal value in terms of marks
- There will be a standard setting meeting for all markers when marking is completed
- Statistical analysis of the results will be performed using a computer spreadsheet

The purpose of the MEQ

- The MEQ paper tests a candidate's ability to manage presenting problems relevant to the setting of primary health care in Kuwait, by using applied knowledge with evidence-based, professional values, communication and attitudinal skills
- It identifies a candidate's ability to evaluate & interpret written material e.g. published paper or extracts from papers
- It demonstrates a candidate's familiarity with scientific research, statistics, and critical appraisal
- It identifies candidates who have reached a satisfactory academic and clinical standard as well as reflecting safe practice up to the level of MRCGP(INT)

The Oral Exam:

- The aim of the Oral module is to test a candidate's decision-making skills, & his/her underpinning professional values and behaviour
- Questions are designed to test if a candidate can recognize issues or dilemmas, explore the range of possible responses, select a defensible approach or view-point, and demonstrate an understanding of the principles that underpin their analysis of the problem presented
- The examination will consist of four 10 minute periods of questioning with 4 pairs of Internal Examiners, during each of which 2 questions will be asked, each to last 5 minutes
- The 8 questions will be agreed at a meeting of all the examiners taking part, informed by the question grid
- The grid comprises 2 competences, *Communication*, *Professional attitude*, examined in 4 contexts, *Care of patients*, *Working with colleagues*, *Society*, *Personal responsibility*
- All candidates will answer the same questions, although not in the same order
- Questions should be prepared & planned using the approved Question Card
- Each Question Card should include the topic, the initial stem, and a series of supplementary questions.
- The initial stem should be asked of each candidate using the same form of words, as it appears on the Question Card
- Grades will be allocated using the letter grades in the Oral Grade Descriptors
- For security, all candidates will be kept in a secure location until the last group of candidates has entered the rotation
- On completion of the marking process, each candidate's grades will be passed to the Secretary of the Examination Board

The Clinical Exam:

The purpose of clinical exam is to test the application of wide-ranging knowledge, competencies, clinical and communication skills, and professional attributes considered appropriate for a doctor intending to undertake an unsupervised practice.

- The Clinical Examination will consist of a period of direct & independent observation, in consultation with patients in a family practice training centre
- Each candidate will be observed by two pairs of Examiners
- Each pair will consist of two Internal examiners, and will be observed by an External Examiner, Internal Examiner or EDA for QA purposes
- An observer may be present, e.g. an examiner in training with agreement of the director
- The period of observation for each pair of examiners will be 90 minutes, during which 5 consultations will be observed
- The consultations will be assessed against the Clinical Performance Criteria approved by the Examination Board
- Patients may be selected or unselected, selected patients being invited to attend with the approval of the Director, in order to best standardize the challenge of the Examination
- During each consultation the one of Examiners will ask some or all of the following standardized questions:-
 - After the initial history, *'What is your differential diagnosis, & how have you reached it? What are your thoughts at this stage? What examination would you like to make?'*

- After physical/mental state examination, ‘*Why did you select this examination?*’, ‘*What are your findings?*’, ‘*How do these findings affect your differential diagnosis?*’.
- At the completion of management, ‘*Justify your management plan.*’
- Wherever possible, and with the permission of the patient, one or both of the Examiners should observe the examination, and positive findings should be confirmed
- After each consultation a decision should be entered in each relevant category, using a letter grade taken from the Clinical Performance Criteria
- The decision whether or not to perform a clinical physical examination will be rewarded or penalized under ‘Problem Solving’
- The quality of any clinical physical examination will be rewarded or penalized under ‘Clinical Physical Examination’
- At the end of each observation phase, each Examiner will make an overall judgement under each criterion, still using letter grades
- A break of 20 minutes will separate the two observation phases
- The Senior Examiner will warn the candidate if there is a likelihood of fewer than 5 cases being completed within the allocated 90 minutes
- The candidate will not be penalized for time lost when no patient is available for consultation
- On completion of the marking process, each candidate’s grades will be passed to the Secretary of the Examination Board

The Simulated Surgery exam

Starting from April 2010, the Clinical Examination described above, which is based on direct observation of consultations, will be replaced by a Simulated Surgery exam

- It Offers a standardised, pre-determined level of challenge to candidates
- It provide a more validated and reliable method for testing clinical skills
- This will be able to ensure a more equal degree of challenge to candidates, so increasing the fairness of the test