UROLINK TRIP TO COSESCA 2019 EXAMS – Kampala, Uganda.

On 1 December 1 2019, Steve Payne and Suzie Venn travelled from a workshop in Tanzania to examine in the COSESCA Membership and Urology Fellowship exam. Transfers were from Moshi via Precision Air and Accommodation was at the Kampala Serena Hotel, which was extremely comfortable. Transfer from the airport at Entebbe and to and from the exam were provided by COSECSA. There were daily email updates on the next day's itinerary.

Attendance at the examiners meeting on the Sunday is compulsory and around 200 Surgeons from Africa and other countries attended. The briefing was very helpful and well organised, but the accommodation was far too small for the number of examiners attending. Examiners in general surgery, urology and neurosurgery were asked to help with the following days membership exam (MCS). Break-out sessions were held to calibrate the expected standard of each individual MCS OSCE station.

Membership exam

The MCS exam had approximately 80 candidates in an OSCE style exam. These were doctors with two years of surgical training. All of the Urology examiners helped on the Monday morning, in three groups. Each of us examined approximately 20 candidates during the morning in a structured format for 10 minutes. My topic was a gunshot to the chest and Steve's was management of a compartment syndrome! The standard seemed high.

Fellowship exam

This year there were 11 candidates, which is double the number last year. Candidates progressing to the clinical exam had already passed an MCQ type written exam.

The Urology examiners met in the afternoon to discuss the format for, and the structure of, the FCS exam. Of the promised 22 examiners, 12 attended. There were 3 from the U.K. one from USA (although U.K. trained) and one from Sweden. The African examiners were from Uganda, Ethiopia, Mozambique, Malawi and Zimbabwe with an observer from Zambia.

The clinical exam comprised:

6 clinical cases lasting 20 minutes (with two examiners doing half each)
2 vivas each lasting 30 minutes (two examiners). The vivas covered:

Operative surgery / Critical care and trauma
Urological oncology / Imaging.

The exam

The exam took place at the newly refurbished but not yet re-opened Mulago Sub-Specialist Referral Hospital. The location was ideal, with spacious empty outpatient rooms and wards.

The acting head of examiners was Mr Christopher Samkange, Zimbabwe. The local team was lead by Dr Frank Rubabinda Asiimwe, supported by Dr Rosemary Nassanga and Dr Stephen Watya. They presented 11 excellent clinical case, of which 6 were chosen. These, with the topic chosen for the vivas broadly covered the exam syllabus.

The cases were:

1. Cancer of the penis
2. Urethral stricture
3. Carcinoma of the bladder
4. Benign prostatic hypertrophy - in retention
5. VVF with stones
6. Renal calculi

The viva topics were:

1. Operative surgery – open prostatectomy
2. Critical care and trauma – renal trauma
3. Imaging – PUV and PUJ obstruction
4. Oncology – prostate cancer.

Marking structure

There was a formal marking structure for each section of the exam, but the marking of each section was left up to the examiner, as the minimal standards for each section were not agreed before. Marking was performed without collusion on an open mark scale between 2 and 10 with point discriminators at the 2, 4, 6, 8 & 10 marks. A mean score of 6 was determined to be a pass. Mark descriptors were utilised and their use encouraged for poorly performing candidates. Mark sheets were collected at the end of each individual's exam to minimise bias. The Tuesday session was arduous, lasting approximately 12 hours with a break for lunch. An examiners debriefing was held afterwards.

Exam debrief

There was a lot of discussion at the debrief about the necessity for long cases to have a live patient included, as their value in demonstrating physical signs was extremely limited. Although the exam ordinances do not specify the necessity for clinical cases there was a lot of debate about whether patients should be present or not. It was pointed out that the American Boards and FRCS Urol have never had clinical cases present, although they have alternative means of determining candidate's clinical ability via workplace-based assessments (WBAs). In the absence of formal WBA in East Africa there was a lot of discussion about the value of a clinical exam which Christopher Samkange would take back to the examination Board for further debate.

The need for clinical cases has a significant impact on the format of the exam. If they are not required it would be much easier to formulate the exam in advance which would significantly shorten the first day. Obviously, exam organisation for the future is very much dependent on how the Board decides to progress the clinical case issue.

Results

8 of the 11 candidates passed. My impression is that the standard of the exam was improving, and I would now consider it not far from the level of the international FRCS Urol, allowing for the different practices and technology available in Africa.

The Gold medal was awarded to Dr Nicholas Ngowy, who is from KCMC, which was well deserved, and will hopefully be a real boast to the Institution of Urology at KCMC. The President of Uganda honoured the occasion with his presence to congratulate the successful candidates and award the medals, emphasising the rising awareness of the need to expand surgery and anaesthesia in Africa.