FRCS (Tr & Orth) Exam-After action report: Jowan Penn-Barwell
P1 Feb '16, P2 May '16

General thoughts and ramblings:
So, my first piece of advice, is don't follow my advice. Learn from my experience, but don't do what I did. I rolled the dice with respect to my preparation, I could of, and should have been much better prepared than I was-*train hard and fight easy*.

My second would be: *train as you will fight*; prepare for part 1 by doing MCQs, prepare for part 2 by doing vivas and examining patients under exam conditions as best as you can.

Finally, my last military cliché (promise): *Amateurs practise till they get it right, professionals practise till they can no longer do it wrong*. The speed and general awfulness of upper limb short cases is ferocious. You need to have practised over and over again, so it becomes muscle memory and you can use your brain to put it together, not think about the exam sequence. Do this routinely, in clinic by yourself, in clinic with bosses, in day-case units with each other. You will not regret it one Sunday in the future!

I will say that I think people sometimes unwittingly exaggerate the amount of time they have spent in preparation. I think there is a tendency to look at the last 2-3-months of revision and extrapolate that work rate backwards for a full 12-months.

Your prep work has to be a sustainably rhythm of work that fits into your life and doesn't drive you crazy, and everyone ramps it up over time. Don't try to do 15 hours a week for 52 weeks, that isn't sustainable.

I also think when recounting their own exam experiences people remember the cases where they 'nailed it' and tend to recount those stories, forgetting that for the rest of the 15 mins they answered like a gibbering idiot! Thus creating a false impression in the mind of the future candidate of how high the standard actually is.

Also-try and keep it balanced, have something in your life that is not the exam and definitely stay active-it will help keep you sane. Personally I got my motorcycle licence the month after my part one and started lifting more than I have for years!

Books
AAOS Comprehensive Orthopaedic Review trilogy
An alternative to Miller, much more readable. I'd recommend as your core text if like me, you don't get on with Miller.

ORUK Orthopaedic basic and clinical science for the Post-Graduate examination

A good, large and very in depth book full of detailed level 8 answers, but seems to have a reasonable span of the syllabus. Also still very current with up to-date literature references.

FRCS (Tr & Orth) MCQs and Clinical Cases
BJJ 'Exam Corner' green book. Good quality MCQs similar to the real think. Nice viva examples and model answers. A little slim to be used on its own though.

Basic Orthopaedic Sciences
A little aged now, and not 100% accurate but still a very accessible text and likely to be what the examiners knowledge is based on!

Surgical Approached in Orthopaedics
The Hoppenfield Classic text, though I also used the approaches section on the AO website.

Part 1
I found this to be a fair, high quality exam. The questions are 1-2 sentences, unambiguous, clear and you know what they're after (though you might not know the answer!) It is much better than the UKITE question bank (not a criticism of UKITE!). Another difference is that most of us find the EMQs much harder than MCQs in UKITE and the other way round for Part 1.

My Othobullet exam results were 10% higher that my eventual grade and this seems to be consistent with the experience of others. My advice would be that you need to be scoring 80% consistently in orthobullets to be confident that you'll pass. Scores in the mid 70s might mean you will be pretty close!

Preparation
I subscribed to an orthobullet revision plan, where I was sent 6 topics a day, I read them, did the attached questions. I got behind, but worked through it eventually-probably took me through the whole syllabus twice. I then got into a nice routine for the last couple of months where I woke up early did a 50 questions exam (reading the answers each time) before work, and the same again after work. 100 questions a day for a couple of months. That allowed me to work through the whole question bank again.

Part 2
UL Short Cases
'Examine this [middle aged woman's] elbow'
Look (nothing really), Feel-tender medial epocondyle-demonstrated it was worse with resisted wrist flexion, move-weren't happy with demonstration of pronation/supination.

'Examine this [Rheumatoid] hand'
Should've been a gift….it wasn't! I wasn't saying what they wanted to hear! I still don't know what they were after really!

'Examine this [elderly man's] shoulder'
Just remember that rotator cuff tear is more common a cause of infa- and supra-spinatous wasting than compressive neuropathy of the suprascapular nerve which was the first thing leaping into my head!

LL Short Cases
Knee OA in lady in her 50s-the 'trap' was not suggesting a uni- when she had PFJ changes.

Limb length discrepancy in a 7 year old-Fibula hemimelia.

Failed surgical correct of a clubfoot in a 6-year old.
'Talk about management of this case'

LL Intermediate case
Missed SUFE now aged 31 with mild pain and stiffness.
Put effort into the pleasantries and taking a decent history-I think there are easy, often neglected points here.
Think they liked that I recognised that symptoms were too mild for surgery at the moment.

UL Intermediate case
Flaccid paralysis of upper limb in 17 year old.
As above-get points in the history section. Seemed to like my approach-talking about limitations of tendon transfers and fusion of wrist in a functional position.

Vivas
In general this was a lot more staccato type of questioning than posing scenarios and allowing me to talk for a while. Wasn't asked to draw anything, but was asked to identify features in anatomical drawings.

I'm afraid I can just remember snippets as it was all a bit of a blur!

Theatre ventilation systems
Mechanics of a screw
Cortical versus cancellous
Different techniques to achieve compression
Tibial Plateau anatomy
Distal Phalanx fracture with nail bed injury
Anti-coagulation treatment-modes of drug action as well as overall approach.
Posterior wall acetabular fracture.
Compression-distraction lumbar fracture.
TB spinal lesions.
ABC in a child

Good luck. This is an eminently achievable standard it just needs to be treated with respect and requires steady work over a few months. You can actually enjoy

it as we all love orthopaedics and feeling like you're getting really swept up in the subject we love can be great. The exam itself however isn't, much more like being kicked up the front repeatedly.