Personal Reflections on the FRCS (ORL-HNS) Part 1 Experience

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Currently the earliest point in training to be eligible to sit the exam is the beginning of ST7. If you are in a training programme that allows you to pick your jobs for the next year, it is important to select carefully. Now may not be the time to rank the busiest job in the deanery or the one with the longest commute. I returned to a hospital at which I had worked previously, where my colleagues were supportive and understood that my main focus over the coming months was the exam.

I have summarised my approach to the exam but this of course is very individual.

Many of my successful colleagues approached things slightly differently, so it is worth talking to those around you and so you can synthesise a strategy that suits you best. I hope this guide will give you an idea of what worked for me and what may work for you.

6 Months Pre-exam

Applications will be via the JCIE website (www.jcie.org.uk) and require you to fill in an electronic form with your work history, dates of your MRCS and university medical degree, a summary of your operative experience (a PDF of your elogbook is sufficient), your curriculum vitae, and three structured references from supervisors whom you have worked with in the last 2 years. If you are in a UK training programme this must include one from your training programme director stating that you have a ST6 ARCP outcome 1. The referees are asked to assess your diagnostic skills, clinical management, operative skills, professionalism and probity and communication and language skills. Getting the forms signed always takes longer than one might anticipate so make sure that you are organised in getting this done.

At the point of application, you have to pay for both parts of the FRCS (at the time of writing: Part 1 – £536, Part 2 – £1,313, total £1,849). Most will elect to do Part 2 FRCS in the next available sitting on the application form (3–4 months post Part 1). There have been occasions where the second part has been oversubscribed and entry is granted in order of receipt of applications, therefore in order to avoid any unnecessary stress or disappointment later an early application is advised.

Over your training you have likely been building your CV with publications, quality improvement projections and further degrees, but now is time to put all that to one

side. Accept that for the 3–4 months before the exam, you will not be doing any of those things, and try and use the 6-month mark before the Part 1 to finish outstanding projects so that you can start revising with a clean slate. I was surprised at how understanding my colleagues and bosses were about this when politely declining to take on any extra projects, and was usually met with 'of course, you have the exam – best of luck'.

4 Months Pre-exam

Gone are the days of university when you could dedicate hours on end to revision. You will likely be working in a busy job with long days, may have accumulated other things in your life such as partners and children and sadly dealing with sleep deprivation is probably not as easy as it once was all those years ago. Remind yourself that most people sitting the exam are also facing the same challenges, and you just have to manage it as best you can.

Look at your work week and try and identify areas where you can get some productive revision time in. You may have a morning or afternoon in your timetable that can be used for revision. Be disciplined in making sure that you use it effectively. Work out when you are at your most productive. For me, I know that I work better in the morning, and on looking at my timetable, three mornings I had to be at work for 7.30 a.m., but the other two were 9 a.m. Although it required a lot of dedication, and some that the alarm was switched off for, for those 2 days a week, I would wake up at 5.30 a.m. and get 2–3 hours done before work. In return, I never revised in the evenings, and made sure that I enjoyed times out with friends or relaxing at home 'guilt free'. Although this worked for me, I know that not everyone would work best in the mornings, so be honest with yourself as to what your golden hours are, make it happen and make sure you enjoy the other hours and give yourself a break. At the weekend I had one day where I was productive (sometimes both), but again never worked in the evenings.

I started my revision using a textbook to give an overview of all the areas of ENT. I read through topic by topic, highlighting things I thought were important. Everyone responds differently to different styles of books, and I would recommend asking your colleagues what they found helpful previously and going to look at a few of them in the library or sample them online, before buying one which you think you will like. You do not need a book that goes into intricate detail, this is more for an overview of different topics, some of which you may not have had as much exposure to in your training, and to jog your memory on those you have. Although most of the FRCS courses are aimed at Part 2, there are some available for Part 1 and can help refining exam technique and identify gaps in your knowledge.

It can also be good to think of something else other than your exams, such as a holiday to look forward to, or perhaps a challenge to focus on training for a half marathon, enabling you to break up your revision.

2 Months Pre-exam

I started to look at some example questions in the various books available (although some of my colleagues did start this earlier alongside their reading). Some of the books available had explanations attached to the answers so I used those ones preferentially as it is a good way to continue your revision and to learn from your answers. If there was an area where I had not got it right, or I thought it was a good 'fact', I wrote it down in my notes.

1 Month Pre-exam

Try and take some time off work before the exam. For me, this was December, and being around Christmas, there were natural days off work which were helpful, and I did not have to take that many days off surrounding them to take 2 weeks off prior to the exam, with a few interspersed on calls. I kept my format the same, waking up and getting straight to work, and then using my evenings to relax and put my laptop and books away.

1 Week Pre-exam

I typed up all my notes at the beginning of the week that I had made and then tried to reread them on top of continuing to do questions. This was a hard week as you are exhausted and you feel like nothing is going in, in fact you feel that knowledge is somehow being pushed out by anything new you learn and that you are now destined for failure. It is hard to trust in the work that you have done, but the fear of having to do the exam again if I failed helped to focus me over the last few days.

On the Day

Part 1 is done at local professional testing centres, where they were very formal about the exam. All you are required to bring is your photo ID. You may take the exam sitting in a room with others taking completely different exams. The only other items offered were tissues and earplugs, which they provide. It is computer based and very self-explanatory on how it worked with moving between questions. There is the ability to flag questions for review later on, and before finishing the exam it tells you if you had any question that you did not answer (there is no negative marking so you should attempt all questions). There are laminate sheets with marker pens available for making notes which you are not allowed to take out after. The first paper was single best answer (2 hours) and then there was a 1-hour lunch break when we were allowed to leave, and then return for the extended matching questions (2.5 hours). Results usually arrive within 4 weeks.

So Where Do You Start?

Part 1 of the FRCS is designed to test breadth, so it is impossible to give a discrete list

of topics to study. On the day of the exam you will no doubt feel that some of the topics were niche and perhaps not what you would see in your 'day to day' of ENT clinics and theatres. The following are examples of topics that have been asked previously, purely to give a flavour of the breadth required and the overlap with other related medical specialties.

Paediatrics: Syndromes affecting hearing/smell/facial features/swallowing/airway, neck masses.

Rhinology: Nasal masses, hereditary haemorrhagic telangiectasia, disorders of smell, acoustic rhinometry/rhinomanometry.

Facial plastics and reconstruction: Pinnaplasty, rhinoplasty types, reconstructive flaps, skin cancer types and treatment.

Head and neck: Neck dissection types, radiotherapy RT/chemotherapy, swallowing physiology and disorders, oral lesions, parapharyngeal masses and infections, OSA, vocal cord anatomy, TNM and staging for each type of head and neck cancer and salivary disease.

Otology: External ear masses, cholesteatoma theories, complications of acute otitis media, inner ear malformations, nystagmus types and causes.

Trauma and emergency management: GCS, Le Fort fractures, paediatric and adult resuscitation, shock treatment, neck trauma, imbalance of electrolytes with their ECG changes, symptoms and management.

Pharmacology: LA types, doses and duration of action, otological drop contents, nasal medication contents, vestibular medication, migraine medication and antibiotic types.

Radiology: CT and MRI for different pathologies, different sequences and appearance of anatomy and what they are used for.

Audiology: Paediatric testing, ABRs, hearing loss types, presbyacusis subtypes, vestibular testing and hearing aid types.

Anatomy: Skull base, sinuses, middle ear, facial nerve pathway and sections, lymphatic drainage pathways, CN anatomy and referred pain anatomical pathways.

Research: Levels of evidence, statistical tests.

Basic sciences: Bacteria and viruses relevant to ENT, inflammatory response/mediators, autoantibodies, autoimmune disease, embryology e.g. branchial arch/cleft/pouch derivatives, patterns of inheritance, coagulation pathways, cell genetics and tumour genes.

Miscellaneous: Migraine types, vestibular disorders, LASER types and uses and examination signs relevant to ENT.

Essentially, try and keep your revision broad. Do as many practice questions as you can find. The examination is marked in such a way that questions with a high variance in candidates' answers may be discarded, but you should aim to know the facts that all your colleagues know.

General Advice for Preparing for Part 2

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With Part 1 results generally taking 3–4 weeks to arrive, you will typically have a minimum of 2–3 months to prepare for Part 2. Although it doesn't feel like it, this will be enough time and it seems sensible to allow a break between the two exams. The exam runs over 3 days, though you will only be required for 2 consecutive days. The location rotates around the UK and Ireland twice a year. One of your exam days will consist of four 30-minute vivas, usually in a hotel. Your other day is based in hospital with two 30-minute clinical stations (two patients per station) and a separate communication skills station. Once you know the exam dates and location, book yourself a hotel room and travel arrangements. Nearly everyone books into the hotel in which the vivas are taking place. I would recommend this – it minimises any travel issues on the day and you can be around others as much or as little as you wish. There is a lot of waiting between stations and I personally found it helpful to have company.

Courses for Part 2 are a good idea. There are plenty advertised all over the country and going on one or two is helpful midway through your preparation. The difference between factual knowledge and exam technique will become clear and it's also a good chance to mix with candidates outside your own region. This brings me to the most significant piece of advice: be a team player. Revising in groups is crucial for Part 2. This is not an exam to learn alone purely from books. I regularly met up with five others from my region, at least once a week in the 8 weeks leading up to the exam. We gave each other practice questions and feedback. Crucially we made a commitment to sincerely try and improve each other with honest feedback and passing on inherited tips. Whenever any of us arranged viva practice with consultants in the region, we would organise it so that the whole group could come. We used group messaging regularly for both parts of the exam and shared a communal cloud storage drive for all our articles, topic lists and practice questions. Video conferencing apps are a great way to exchange practice questions with trainees from other regions and gain a different perspective. When fatigue set in, I found it particularly motivating being part of five-way online question practice session – most of all for the reassurance that you're on the right track compared with everyone else.

Finally, arrange plenty of practice sessions with consultants in your region. There is a lot of good will out there to help get you through. These sessions were really valuable for bringing into focus some of the topics that you may not have had a lot of direct exposure to in your training. Don't forget to keep track of whom to share your good

news with when you pass!

Advice for Part 2 Vivas

Your four 30-minute vivas will be spread across a whole day. Decide how you will prefer to spend the very long gaps in between. Each session covers one of the four subspecialties (head and neck, otology, rhinology and facial plastics, paediatric ENT). Within each you will typically have six 5-minute topics. The vivas all take place in one large hall with around 20 candidates being examined at a time – lots of background noise! At each station you will sit opposite the two examiners who usually take it in turn to ask questions whilst the other takes notes.

Five minutes per topic passes very quickly and it is important to succinctly respond to the initial question to move the examiners on to more challenging areas. The initial question will typically be designed to get you going e.g. describe this photograph; explain how you would assess a patient with a 2-year history of swallowing difficulties; describe this audiogram, etc. This may then lead onto a more pass/fail level question before the examiners have the freedom to push you in different areas for higher marks. Be prepared to draw if asked. You will read that quoting key papers and classifications is needed to score top marks, however, the questions are rarely designed to allow for this. The key is to do the basics well but relatively quickly, showing clear and sensible reasoning before demonstrating the ability to handle more niche areas. Be wary, your desire to steer a conversation towards a specific journal article must not distract you from being comprehensive with the initial questioning where the majority of marks will be scored.

For example, when questioned on a child who has failed ABR testing during neonatal hearing screening, one could be armed with every last detail on the further subjective, objective, genetic and radiological tests – but if you fail to suggest initially that the first step is to refer to paediatric audiology and repeat the ABR, the examiner may not even let you advance to the next question! Five minutes can pass very quickly.

If you reach a point in any viva where you are stuck, try and at least express your thought process logically. Aim to do this in a mature confident way, filling the shoes of a new consultant having a discussion with a senior colleague. Even for the best candidates some stations will go better than others. You may even do better in topics that you normally wouldn't favour. What's crucial is to be able to move on from a bad question. With so many different marking points across the exam, there are many opportunities to make up for one low score, but you can't afford to collapse in your first question of the 30-minute viva and consequently underperform on the other five. This is even more true of the clinical stations, where the potential to be humbled in front of your patient can be very off-putting.

Advice for Part 2 Clinical Stations

Another crucial piece of advice: The clinical stations are very much vivas in their own

right, only with real patients rather than photographs. You will typically be asked to perform an observed history and/or specific examination with a genuine patient and this will be followed by several viva-style questions. This may include being asked to interpret radiological images. There is a temptation to spend all your Part 2 preparation practising vivas based on photographs and overlook this section. However, these are far more than just choreographed examination rituals and if this is forgotten candidates can easily be caught out.

You will have two 30-minute stations, taking place in hospital clinic rooms. In one station will be 15 minutes with an otology patient and 15 minutes with a head and neck patient. In the other will be 15 minutes of rhinology or facial plastics and 15 minutes of paediatric ENT (typically a child with a parent). You will have two examiners in the room with you. There may be further examiners observing. Each may move around you during examinations to see exactly what you are doing. You should be ready for this and not be unnerved!

Be ready to take a thorough history from a patient with any sort of ENT problem. Your examination technique must be rehearsed thoroughly so that you can perform them fluently. Listen carefully to what is asked though and if you are only asked to perform a specific portion of an examination (e.g. perform tuning fork tests) then do just that.

In junior-level exams performing the examination routine was all that was required. At this level you need to be able to confidently interpret and explain your findings to the examiner, in front of your patient. In reality this is exactly what you do in clinic all the time but doing it confidently in the exam setting is helped with some practice! Are you sure you can describe the post-operative ear? Are you absolutely confident those tuning fork tests are what you expected for this patient? Be prepared for patients who have had some form of historical, unrecognisable operation, for you now have to rapidly figure out what have been done and why they have these anatomical and functional abnormalities! Don't forget the alcohol gel. We were asked to bring our own headlight but in the end any piece of equipment we needed was provided.

These are abnormal scenarios disguised as normal scenarios. You may be asked to perform a seemingly simple examination and explain your findings with a patient for whom you have neither taken the history, nor importantly established rapport with. This can put you off your stride for example when describing someone's nose! Try and break the ice before you do anything else – introduce yourself with a smile, thank the patient for coming in today and perhaps ask them if they mind you speaking to the examiner about them. You will find your own particular version of this but putting yourself and the patient at ease makes a big difference to the rest of the encounter. This is even more true in the paediatric station with children and their parents. Have they found it tiring being asked the same questions by some many doctors in one day? Have they had a day off school? Remember that they are still patients. Remind them that you are a compassionate human being both inside and outside of the examination room – your examiners will appreciate it.

Advice for Part 2 Communication Skills

This station also takes place in a hospital clinic room and lasts 20 minutes with two examiners and an actor playing the role of a patient or family member. You will typically be given a written scenario to read prior to the encounter and the plot will usually consist of history taking, some time spent giving information back based on that history, and possibly a twist in the story – for example a scan that shows a cancer when your original conversation was about a benign condition.

You will be judged on your etiquette, rapport, verbal and non-verbal skills. Though not necessarily the focus of the assessment, you will still be required to exercise sensible clinical judgement and interpretation within the context of the scenario. Thoroughness, sympathy, safety-netting and MDT involvement should be remembered. If you can foresee a potential twist in the scenario then it may help to counsel the patient more thoroughly to begin with and soften any challenging emotions later in the conversation. Ultimately, if you do what you usually do in clinic – safely and thoroughly, with clear language and good rapport, this station should not be an obstacle. Those for whom English isn't their first language perhaps may find it helpful to spend a little more preparation time on this station and seek feedback from mentors. The history and communication skills sections of our MasterPass series textbook '*ENT OSCEs*' are equally relevant for this part.