

# The Part 3 Membership of the Royal College of Obstetricians and Gynaecologists and Our Journal

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The Part 3 Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) was first introduced in the United Kingdom in September 2016. Its first overseas Part 3 examination was conducted by our College on 13 November 2017. The Part 3 examination is a clinical assessment of knowledge, skills, attitude, and competency and consists of 14 tasks in a circuit, each task based on one of the 14 modules detailed in the MRCOG syllabus. Each module is assessed in the context of five domains: patient safety, communication with patients and their relatives, communication with colleagues, information gathering, and applied clinical knowledge. Each of the 14 tasks assesses three to four of the domains to reflect everyday clinical practice; for example, communicating with patients is associated with applied clinical knowledge, and communicating with colleagues involves aspects of patient safety. Trained clinical examiners score the candidate for each of the tasks, while trained lay examiners are involved in four of the 14 tasks and assess the domains of communication, patient safety, and information gathering from the patient's perspective. In the November examination, our eight local trainees did extremely well, with a pass rate of 100%.

As our next batch of trainees is preparing for this year's Part 2 and Part 3 examinations, it is an appropriate time to discuss what is really required of our candidates and ourselves in current clinical practice. Of the five domains, the Part 3 examination targets traditional training of our residents and focuses on applied clinical knowledge and patient safety. The other three domains, while discrete, are closely related. Information gathering from the patient, family members, and colleagues is closely associated with communication skills. When directly asked, most of us presume that our information gathering skills are excellent, but are they? In a survey, 75% of orthopaedic surgeons considered their communication with patients to be satisfactory, but only 21% of patients reported satisfactory communication with their doctors<sup>1</sup>. Communication skill workshops teach us to greet patients with open-ended questions such as "How can I help you?" This allows the patient to define the conversation. It takes most gynaecology patients 2 minutes to tell their story and explain why they are seeing you, and probably less for obstetric patients to

tell you their pregnancy progress. You then realise that the hardest thing to do is to wait until the patient finishes speaking. It has been reported that the average physician interrupts the patient within 18 to 23 seconds<sup>1</sup>. Avoid this pitfall, listen for 2 minutes, and the patient will tell you 80% of what you need to know. The same probably goes with your residents. When they present their cases in a ward round, how much of the *blah blah blah* do you tolerate before you start jumping on them?

Communication skills are now formally taught in medical schools and residency programmes in many specialties all over the world<sup>2,3</sup>. Evidence from randomised controlled trials has proved that interactive continuing medical education is effective in improving clinical performance. This has stimulated the development of various models of integrated learning, such as the patient pathway tutorial, in which students have to perform a series of tasks that represent the temporal sequence of clinical and communication skills needed for management<sup>4</sup>. Indeed our midwifery colleagues use such models. In their introductory week, our student midwives are asked to pretend to be a pregnant woman or her husband, and to go through all the stages of pregnancy from booking an antenatal visit in our hospital to being discharged from the postnatal ward after delivery.

The ultimate objective of any doctor-patient communication is to improve the patient's health and medical care. The ultimate objective of our Journal is to improve patient health and care by sharing up-to-date research findings, professional knowledge, and state-of-the-art practices. The articles published in each issue are another form of communication that has to be learnt and practised by all our trainees. Our College has one of the most stringent and demanding requirements for research training. I am confident that most trainees will continue to practise their clinical skills after their Exit examination to become specialists, but I am not certain how many will continue to use the knowledge and skills they have acquired to design a research project, conduct a literature search, work out statistical analysis, and write up a scientific article in their post-exit years. It may be argued that the hard work put into acquiring research skills has already paid dividends during

journal reading and critical appraisal of the literature. Well, so be it, but the bliss and enchantment of seeing your ideas or hypotheses proven by science and published under your own name is something you will probably miss for a long time to come.

With an ageing population, pelvic organ prolapse becomes a more common problem encountered in urogynaecology and general gynaecology. Vaginal hysterectomy and laparoscopic-assisted vaginal hysterectomy are common treatment options. In this issue, Cheung et al<sup>5</sup> examine the prevalence of undetected genital tract malignancy and pre-malignancy in women undergoing hysterectomy for pelvic organ prolapse, and offer useful suggestions to reduce such unwanted surprises. Physical exercise is believed to be a key element of good health, but does this apply to pregnancy as well? Chan et al<sup>6</sup> examine the association of physical activity during pregnancy in Hong Kong Chinese women with the mode of delivery and delivery outcomes. Are our babies getting bigger and is maternal obesity the main culprit?

Wong and To<sup>7</sup> examine the predictive risk factors for fetal macrosomia in a large local cohort and confirm the increased risks of maternal and neonatal morbidity. Are our residents overworked, and does working long hours into the night affect their performance? Chan et al<sup>8</sup> examine the association between the time of day of unscheduled Caesarean section and maternal and perinatal outcomes in a public training hospital and conclude that patients are in safe hands around the clock. Kong and To<sup>9</sup> report three cases of haemorrhagic stroke in pregnancy, a rare yet potentially fatal condition, and comprehensively review its pathology and current treatment options. In addition, Choi<sup>10</sup> presents a comprehensive update on developments in minimally invasive surgery in gynaecology. Wong<sup>11</sup> reviews the practicality of ovarian reserve testing before conception. I am confident you will gain something from these articles. Happy reading.

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