

2024.1 Rural Generalist Anaesthesia (RGA) SSSA Examination Report

The RGA-SSSA exam was held on 29 June 2024 and conducted online, via the Zoom platform and coordinated from Clifton's, Collins St Melbourne. Candidates were based at their location with examiners onsite in Melbourne.

The exam consisted of eight 13-minute cases and 2 minutes reading time, with 2 minutes to move candidates between Zoom rooms. Exam scenarios are mapped to ensure alignment and coverage of the RGA curriculum areas, RGA Roles in Practice, Clinical Fundamentals and Specialised Study Units

Candidates were assessed on a range of clinical scenarios, with an emphasis on their clinical management, their approach to evolving clinical situations, resource management, quality and safety and the application of their knowledge to a rural or remote context.

A total of 7 candidates sat the exam, with examiners and quality assurance examiners drawn from the panel of examiners which consist of Fellows of all three colleges.

Grading and Scoring System

Candidate performance is graded against a moderated rubric on a 4-point linear scale. Each scenario offers the candidate the opportunity to earn up to 4 points on 6 items, which are scored independently. This results in a maximum possible score of 192.

1. Clinical Knowledge and its application – component 1
2. Clinical Knowledge and its application – component 2
3. Clinical Knowledge and its application – component 3
4. Quality and Safety
5. Approach to scenario/rural context
6. Structured approach and response to changing clinical situation

There is no adjustment, scaling or weighting to the scores given and overall pass/fail outcome is determined on the simple sum of scores. Examiner Overall Impression of whether the candidate is at RGA standard is used as a Quality Assurance measure.

General comments

The RGA-SSSA is intended to assess clinical judgment in anaesthetic practice and as such takes into account that there are multiple different approaches to patients and scenarios that are safe and appropriate. Candidates are therefore encouraged to answer the question by outlining what you would normally do in a given situation.



Better answers were applied to the patient context and maintain focus on the fact that there is a patient involved. Good candidates could maintain situational awareness of the clinical scenario, allowing for a patient-appropriate response rather than a scripted response.

Candidates who structured their answers were able to cover more ground in their answers and tended to remember to include safety aspects of practice such as ensuring adequate monitoring whilst avoiding repetition. Scaffolding answers can help to improve answer structure if the appropriate scaffold is selected, but trying to force an answer into an irrelevant scaffold is unhelpful and can lead to wasted time describing something that was not asked for.

Candidates can ask for a question or information given by the examiner to be repeated if they are unclear about what was asked or stated.

Trainees may find it useful to practise answering viva questions over an online video link such as Zoom to allow you to engage with the mock examiner and practice reading non-verbal cues across this medium.

Notes

Technical issues such as loss of audio during the exam should be reported as soon as possible so that there is the opportunity to address these promptly. It is recommended candidates adhere to venue/audio/internet instructions. Attending the exam from non-standard / compliant venues (for example operating theatre) not only creates audio issues for the examiners, but also has a distracting background.

It is recommended that candidates source a location that has good internet facilities, audio/headphones are connected properly, and devices are properly charged. Candidates should ensure all computers/devices are plugged in/charged/charging and have sufficient familiarity with device to enable prompt troubleshooting (for example in the event of accidental muting, Bluetooth disconnection).

RGA-SSSA 2024.1 (Saturday 29th June 2024)

Viva 1

CANDIDATE INSTRUCTIONS

You are assessing a patient on your list for the next day. He is a 55-year-old man who is to have an excision of a 3cm x 3cm superficial swelling over the postero-lateral aspect of the neck. The surgical assessment is that this is possibly a lymph node that can be excised in the Supine position with the head tilted away. The expected surgical duration of 30 minutes. The patient has no known allergies, and he is not on any regular medications. He does admit to snoring and has a bushy beard but is otherwise fit and well. He weighs 88 Kgs (BMI = 29).

How would you do an airway assessment on this patient?

Candidates were required to outline their airway assessment and plan taking into account features suggestive of increased airway difficulty and shared access to the airway with the surgeon. The scenario then progressed with the development of respiratory distress in PACU, asking about differential diagnosis and management of this. The third component of the scenario asked about management of an airway crisis during a difficult reintubation (in PACU) and progress to FONA in CICO situation.

This question was generally well answered with good plans. Better answers took into account the scenario context with focus on airway assessment and rationalised the use of an ETT in the plan. Better candidates discussed differential diagnoses for respiratory distress including surgical causes and outlined a clear progression of management.

Common mistakes were not detailing assessment of obstructive sleep apnoea, not identifying a surgical cause for respiratory distress and acting to release a neck haematoma, and not outlining use of ETCO₂ to confirm surgical airway.

Viva 2

CANDIDATE INSTRUCTIONS

You are asked to provide analgesia for a primigravida on labour ward, who is in early labour. Her pregnancy has been uncomplicated to date. She is currently 38 weeks gestation and her bloods and ultrasound are unremarkable. Her BMI is 34. She is otherwise well, takes no medications and has no known allergies.

Please outline your consent discussion, including the potential risks and complications you will discuss with her.

Component 1 was generally answered well, focusing on consent for labour analgesia and expecting candidates to subsequently provide a description of how they would establish a labour epidural block.

Component 2 asked for assessment and management of an existing labour analgesia epidural for the patient who now requires a prompt but not immediate Caesarean section, including specifically asking the candidate how to improve a neuraxial block that is mostly unilateral.

In Component 3 the Caesarean operation has commenced under epidural top-up but the patient complains of pain at surgical entry to the peritoneum. Better candidates demonstrated situational awareness by quickly recognising the need for conversion to GA and could confidently direct a team in this process.

Viva 3

CANDIDATE INSTRUCTIONS

A 62-year-old female has presented to the anaesthetic clinic for review. She is scheduled for a laparoscopic assisted vaginal hysterectomy in 1 month. The clinic nurse tells you she has rheumatoid arthritis and has requested her medication list be faxed from the local GP.

What specific features from history and exam would you elicit from this patient?

Candidates were expected to outline areas of history and examination that they would focus on when assessing a patient with rheumatoid arthritis in the pre-anaesthetic clinic setting in preparation for hysterectomy and were then asked about what investigations they would order for this patient. A common mistake was to ignore the indication for surgery which could affect haematinics (if there was bleeding) and could have bearing on the urgency of surgery.

The question is intended to reflect a real-world situation in that the initial information is sparse, which is a common scenario when a patient first presents for anaesthetic assessment. During the course of the viva, more information is then provided to the candidate, in this case in the form of a short medication list that included steroid medication, methotrexate and infliximab. Good candidates could appreciate the medication profile as an indicator of disease severity and were able to discuss the medical and anaesthetic implications of these medications and an approach to their perioperative management.

A common error was taking an over investigative or ‘scattergun’ approach. Some candidates were very quick to refer the patient elsewhere rather than undertaking a nuanced risk stratification. Better candidates had thought through the medical management of the patient’s comorbidities and gave more specific/tailored answers.

The third component of this viva asks about the risks of patient injury due to the positioning required for laparoscopic assisted hysterectomy and candidates were expected to be able to outline standard risks of positioning under general anaesthesia as well as the specific risks of steep Trendelenberg positioning that is often required for this type of surgery. Candidates were also asked to discuss the risk and prevention of inadvertent intraoperative awareness.

Viva 4

CANDIDATE INSTRUCTIONS

You have been called by the on-shift Emergency Department (ED) Medical Officer to attend the ED to assist with the resuscitation of a 50-year with known alcoholic liver cirrhosis and bleeding oesophageal varices. He had presented with coffee ground vomitus but is now vomiting frank fresh blood. His heart rate is 130 beats per minute, blood pressure 75/40 mmHg and oxygen saturations of 92% on room air. He is cool, clammy and peripherally shut down. He weighs 70 kilograms.

You have been tasked with gaining vascular access by the Emergency Department Medical Officer, what do you do?

In this scenario the patient is hemodynamically compromised with active upper gastrointestinal bleeding. The initial question asks about options for vascular access.

Candidates were then asked how they would manage the patient's haemodynamic state and were expected to outline their approach to fluid and blood resuscitation of a shocked patient including laboratory investigations. Good candidates were able to focus and answer this initial part of the question really well, then naturally progress through the scenario.

Candidates were asked to outline how they would secure the patient's airway to allow for balloon tamponade of upper gastrointestinal bleeding in a shocked patient, and then describe ongoing safe transfusion practice, as well as specific questions about arterial line access and potential complications of central venous line insertion.

In the final part of this question, candidates were expected to discuss their approach to the surgeon who wishes to proceed with a gastroscopy on the patient and weigh up the factors that would influence their decision to proceed or await transfer of the patient to a higher-level centre, implementing graded assertiveness as appropriate.

At times candidates showed lack of familiarity with Scenarioville – for example, although platelets are not available in Scenarioville, some candidates mentioned giving platelets as part of their transfusion strategy.

Viva 5

CANDIDATE INSTRUCTIONS

A 64-year-old woman is having an elective left total knee replacement (TKR) in 2 weeks. You are seeing her in the pre-admission clinic. She has a background history of hypertension, COPD and Type 2 diabetes mellitus. She takes metformin, dapagliflozin, salmeterol / fluticasone (Seretide), tiotropium (Spiriva) and ramipril. She is 95kg and 160cm tall (BMI = 37). She had a previous right TKR under spinal + sedation which worked well, and she is keen for the same anaesthetic again.

How would you assess this patient for this procedure?

Candidates were expected to outline their preop assessment of the scenario patient for joint replacement under a planned spinal anaesthetic, including their approach to communication and consent for this. They were then asked to describe their practice in providing neuraxial block and sedation for this hypothetical patient. Better candidates were able to move through the descriptions of their practice fluently giving more time to answer the remainder of the question. Minute detail was not required, rather a succinct answer giving an outline of risks, positioning and technique, equipment and drug selection and endpoints for items such as recognition of intrathecal placement.

The patient becomes hypotensive and bradycardic in the scenario, with tingling in her hands - the diagnosis in the scenario was a high spinal requiring conversion to a general anaesthetic. Common mistakes were not administering a fluid bolus in response to this clinical picture, and not discussing differentials and ways to discern which diagnosis was the most likely. There was tendency to underdose resus drugs stated. Candidates are encouraged to mention the use of a cognitive aid such as the Anaesthetic Crisis Handbook.

Candidates were also asked for their management of this once stabilised, which aside from documentation and open disclosure could take into account evaluation of whether to proceed with the surgery, and whether there was a need to transfer the patient out.

Viva 6

CANDIDATE INSTRUCTIONS

The patient you have asleep on the table is a 60-year-old man who is having a bilateral laparoscopic inguinal hernia repair. Past medical history: Transient Ischaemic Attack – 2 years ago; Diet-controlled Type 2 diabetes. Medications: Aspirin 100mg mane, Perindopril 5mg mane, Atorvastatin 40mg nocte. Allergies – Nil. Prior to the operation, the patient reported he took a long time to wake from a previous anaesthetic for shoulder surgery.

Please discuss the intraoperative monitoring you will use for this patient?

Candidates were expected to outline what monitoring they would use for a patient undergoing elective laparoscopic inguinal hernia repair. The question then asks about management of severe intraoperative bradycardia secondary to pneumoperitoneum. The scenario then evolved to a situation of failure to wake due to inadvertent drug error. Candidates were expected to list potential causes of failure to wake and are subsequently advised that it is due to accidental muscle relaxant administration instead of reversal agent. There was a section of the question that stated the patient was apnoeic and unresponsive prior to extubation. Some candidates focused on the words “apnoeic and unresponsive” as opposed to putting this phrase into context based on the question.

It is important to recognise that a patient who was re-paralysed during the emergence phase of anaesthesia will be experiencing awareness. This requires the patient to be re-anaesthetised while you assess the level of neuromuscular blockade and provide reversal. The patient needs to be re-assured, and appropriately followed up. Some candidates were unable to link the depth of block indicated by a neuromuscular monitor to the dose of reversal agent given.

The final part of this question asked about criteria for discharge of the day surgery patient. A general outline of discharge criteria was expected but better candidates were able to contextualise the information that was provided, and adjust their answer as a consequence, taking into account factors such as adverse intraoperative events.

Viva 7

CANDIDATE INSTRUCTIONS

A 25kg, 5-year-old girl presents to your anaesthetic clinic for review prior to adenotonsillectomy in 2 weeks' time. She has a history of mild asthma. She is on no regular medication. She has recently completed a course of amoxicillin for an upper respiratory tract infection. The patient's mother says that her child is shy and is anxious about the procedure.

What features of your pre anaesthetic assessment are relevant to you proceeding with this case in Scenarioville?

Candidates were expected to outline their preoperative assessment of a child, and to indicate the features in the question scenario which affect the perioperative risk profile for this patient. Candidates mostly described a reasonable assessment process for a generalised paediatric patient, but few candidates demonstrated a good understanding of the factors that increased perioperative risk for the child in the scenario. Obstructive sleep apnoea which is an indication for adenotonsillectomy surgery and obesity were generally not considered by most candidates and consideration was often not given to deferring the surgery in the context of the recent upper respiratory tract infection requiring antibiotics.

Errors in premed dosing were often noted in the part of the question that asked about management of preoperative anxiety.

The second component asked about paediatric airway equipment and progression of the scenario involved a halving of the tidal volume during the surgery. Better candidates made use of the reading time to prepare some calculations on dosing and sizing based on the information in the stem. Candidates tended not to answer systematically in response to the clinical deterioration of a significant drop in tidal volume and only a few knew about the surgical gag as a likely cause.

The third component asked candidates about assessment and management of perioperative analgesia for this 5-year-old having adenotonsillectomy and about safe discharge planning. There was a wide variation between candidates in analgesic plans, but most had appropriate dosing.

Overall, this viva was answered by the cohort less well than expected for what should be core paediatric anaesthesia practice. There was a general unfamiliarity with paediatric equipment and conduct of anaesthesia – possibility suggesting limited paediatric anaesthesia experience prior to the viva. Limited consideration of the Scenarioville context in both preop assessment and post-op/discharge planning led to lower scoring answers.

Detailed understanding of paediatric dosing, equipment, and available rural resources would improve answers, as would more consideration to the implications of being in Scenarioville for paediatric practice.

Viva 8

CANDIDATE INSTRUCTIONS

A 26-year-old male presents to the Emergency Department with a closed fracture of the left tibia and fibula with deformity, after a fall from a ladder. He is a smoker, with occasional recreational drug use. He is 80kg and 180cm tall. The patient has had a FULL trauma assessment showing some minor grazes but NO other injuries. He is complaining of severe pain at the fracture site.

What will you do to treat his pain?

This viva began with the initial (ED) management of a young patient with severe pain from a long bone fracture before moving on to ask the candidate about assessment of pain on history and for features of vascular compromise and neuropathic pain. The second component required the candidate to outline how they would manage the patient's pain in the intraoperative and post-operative setting before asking for a list of differentials for intraoperative tachycardia in a trauma patient undergoing orthopaedic surgery, and to outline

their management of this. The final component of the viva asked about risk factors for chronic post-surgical pain and measures to prevent this in the scenario patient.

Most candidates were able to list some risk factors and treatment modalities for acute, chronic and neuropathic pain. Better answers came from candidates who contextualised their answer to the patient scenario and gave examples of the medications they would administer, which was an effective way to demonstrate a good ability to apply their pain medicine knowledge beyond basic recall. Opioid doses described by candidates tended to be quite conservative for a young patient who was not opioid-naïve. There seemed to be some initial reluctance to administer opioids even though they would be very appropriate initially. Some candidates misinterpreted the question asking how pain is assessed on history to mean only the patient's past history of pain problems and did not include the features of the current pain presentation.

Some candidates opted for cardioversion as their initial management of haemodynamically compromised supraventricular tachycardia under general anaesthesia but did not outline other useful initial measures such as vasopressors or anti-arrhythmic drugs.

Final comments

The Court wishes to pass on its congratulations to all successful candidates.

In addition, we hope that this valuable resource is used by candidates preparing for future attempts at the RGA SSSA Examination.

Dr Min-Qi Lee

Chair, RGA Examination