Summary and General Advice

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Lapsana Communis II

There is never a second opportunity to give a first impression
(Renato Saltz)

The well-prepared candidate should not fear professional plastic surgery exams.

The candidate who feels ready to present and has this confirmed by his/her supervisors/mentors should do so with quiet confidence.

M. F. Klaassen and E. Brown, *An Examiner's Guide to Professional Plastic Surgery Exams*, https://doi.org/10.1007/978-981-13-0689-1_16

The candidate who doesn't feel confident but is encouraged by their supervisors/mentors needs to read this book and practice, practice, practice for the exam environment and interactions.

Communication is the key. Communicate your knowledge and experience to the examiner. Good communication skills carry you through your professional life, (hopefully keep you out of trouble) and make you a good Doctor.

Overconfidence and brashness can come across negatively and sew doubt into the examiners' minds.

All candidates must be healthy in mind and body to present their best face and performance. Professional Plastic Surgery Exams like the final FRACS, are the mental equivalent of running a marathon. Prepare your brain for a challenging test, that requires physical and mental toughness for success.

Saturation study and cramming just before the exams are due to commence, are always counter-productive to success.

Writing skills may not come naturally and require practice too. This skill can be refined in your clinic dictation notes.

Learn to construct precise, carefully worded prose that is meaningful and will catch the attention of an examiner, faced with many answers to mark. The good candidates stand out like beacons of light. At the beginning, define the exact point of the question and deconstruct this with an answer plan in bullet points, headlines or an algorithm of connected boxes/shapes.

Less is more in writing, and will ensure the reader is engaged. Keep your answers brief, interesting and don't be afraid to use your own style. Underline key words and concepts/principles. As Gillies once wrote, 'A good style in plastic surgery, will get you through'.

Start well and finish well. The intervening body of text should be in harmony with the beginning and the end.

Example: Ulcerated SCC left nasal vestibule (see Chap. 2).

START—'The image illustrates an aggressive looking ulcerated tumour infiltrating the left columella, which has sinister implications for clinical severity and the need for a major resection and staged complex reconstruction of a key facial landmark'.

BODY OF TEXT: 'Workup, imaging, biopsy, MDT, combined chemoradiation/surgery, immediate versus delayed reconstruction, CLEAR versus DRAPE, anaesthetic considerations PACS (Proper Anaesthetic Care & Safety), different stages of reconstruction, anticipated potential complications, prognosis, survival chances, consideration of prosthetic versus autologous reconstruction'.

FINISH—'Non-healing ulcerative lesions involving the aerodigestive tract of chronic smokers should raise the possibility of malignancy early. The earlier these lesions are diagnosed the more successful the potential outcomes. Never underestimate the challenge for the patient and family of disfiguring ablative surgery and complex staged reconstruction in terms of time, energy and mental well-being'.

The good candidate will always consider plastic surgery principles, alternative management options, risks and complications and most importantly the patient's feelings and feedback.

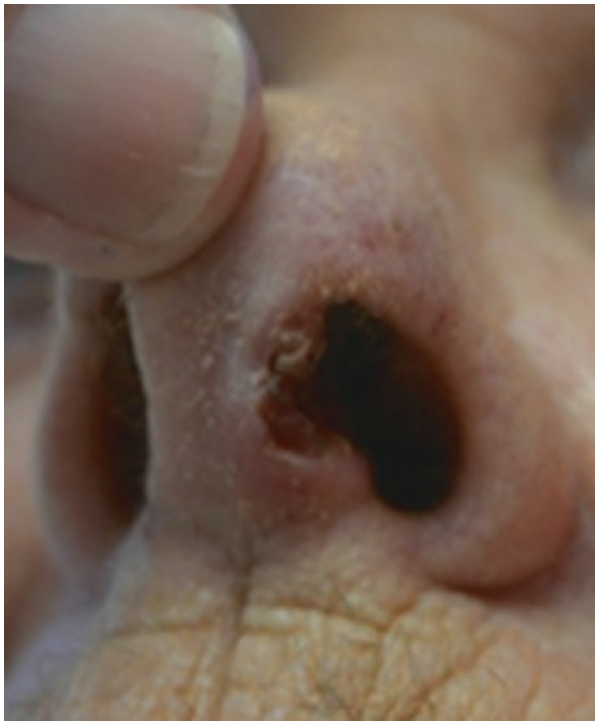

Fig. 16.1 The case from chapter 2 of an ulcerated lesion involving the columellar and caudal septum in a chronic smoker

There is some value in quoting pioneers of a particular branch of plastic surgery. For the nasal cancer case above (Fig. 16.1), the treatment plan was based on the important principles of aesthetic nasal reconstruction as defined by the late Gary Burget and Fred Menick. These Principles were earlier promoted by Ralph Millard based on the Sir Harold Gillies Commandments (Chap. 4) (based on what had been passed down to them via Ralph Millard Jnr and to him by Sir Harold Gillies CBE). It is probably not helpful though to excessively quote the recent medical literature where some novel idea or concept may not yet be broadly tested or accepted by everyone. An appreciation of the historical evolution of techniques and surgical methods, however, shows a maturity of understanding and reflection.

Oral skills of communication are mandatory for a large part of the professional plastic surgery exams. Some candidates are natural orators, confident and good at thinking and articulating on their feet.

Others will have to spend time practising this so that during the exam process, it may come naturally too. There are some basic principles to be remembered here:

Stay calm and friendly, smile occasionally to disarm your examiners.

Make eye contact from time to time.

Show compassion and consideration for the patient you are examining.

Learn to speak slowly with clear articulation and give the impression that you are thinking and speaking like a new surgeon consultant. It can be a challenge to break away from the role model of a trainee, but this is important for overall exam success.

In the marking of hundreds of mock/practice exam answers over the past 5 years my most common feedback was:

> Start thinking and writing like a consultant plastic surgeon, rather than a time-expired trainee. Take ownership and responsibility for the clinical problem before you and based on sound and ageless fundamental principles, make good clinical decisions based on the evidence, the signs and the circumstances for the patient & problem.

A suggested template for this is:

1. What is the problem?
2. Is it simple or complex?
3. Are there extenuating circumstances, patient risk factors, atypical features?
4. Is there tissue missing or displaced? (W M Machester)
5. Diagnose before you treat (H D Gillies)
6. Don't let routine method become your master (H D Gillies)
7. Make a plan and a pattern (H D Gillies)
8. Do something positive (H D Gillies)
9. What could I do here?
10. What do I favour as a method?
11. What should I do after considering 9 & 10.
12. Always have a backup plan and a lifeboat (H D Gillies)
13. Don't be too proud or arrogant to 'cry for help'—consult other specialists (H D Gillies)

Some other variables to consider for every clinical case:

1. Co-morbidities involving the cardiovascular system, lungs, kidneys and liver.
2. Extrinsic factors such as drugs, tobacco and alcohol.
3. Intrinsic factors such as degenerative diseases, immunosuppression, diabetes mellitus, hypertension, anticoagulation, nutrition, cognitive dysfunction (dementia, depression and body dysmorphic syndrome).

Complex discussions with the patient should be managed in supportive, open-minded conversations, about what they understand about the diagnosis, the options for management and their personal wishes.

Complex congenital anomalies should always be managed in an MDT setting, with protocol-based treatment programmes applied with sound strategies over a time scale, from childhood—teenage years—adult years.

Aesthetic problems should always be considered in the context of applied anatomy, the physiology of aging and the breadth of treatment methods from simple to extended. The driving agenda and motivations of the patient contrasted with their personality profile are also essential considerations.