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The Art of Writing Exam Answers

5

How to Become a Good Wordsmith so that Your Written Essays, Short Answers and Notes Are Precise, Relevant and Clear to the Reader

Potentilla indica

Writing is its own reward.

(Henry Miller)

5.1 Key Tips

1. Answer all questions
2. Write in a legible style (The RACS Court of Examiners is about to introduce TYPED answers, as the new standard)

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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_5

3. Consider the time allowed for each part of the question—this tells you how much is expected on that topic
4. Draw a diagram only if asked—any mistake would be more obvious

Certain aspects of professional exams in plastic surgery require a level of writing skill that conveys your clinical and scientific thinking. The ability to write concise and accurate answers to written questions is important for exam success. Your written word conveys to the examiner(s) reading it an indication of your thinking as a consultant plastic surgeon, your ability to interpret and understand the topic of the question and how you organise this into a communication that displays commonsense, consideration of the variables and focused patient care. In general terms and perhaps the key to writing competency is clear, logical and selective use of words. The less you write ensures that the reader will be engaged. More is less.

It is always a good idea to construct a plan or an overview for your written response. Over the many years of marking actual or mock written answers, I have observed how a clear and well-organised plan at the beginning heralds a good answer; an answer that is clearly a pass mark. The plan can be in any form including bullet points, headlines or an algorithm-like plan.

As *an example* a question about the management of a patient with inverted nipples would commence with:

> Definition of inverted nipple and a classification for the different grades of inversion.
> Aetiology and differential diagnosis.
> Functional versus aesthetic concerns.
> The context of inverted nipples – congenital, acquired or secondary to underlying pathology.
> Management options – non-surgical versus surgical.
> Your method of choice.
> Technique.
> Complications.
> Patient issues.

A young woman with congenital inversion of her nipples is contrasted with a middle-aged woman who presents with unilateral inversion associated with pain, nipple discharge or nipple bleeding. The first scenario involves a stronger aesthetic, body image and self-confidence set of concerns, whilst the second raises the definite possibility of intraductal carcinoma. The history and examination of both cases requires a comprehensive consideration of the real risk of breast cancer and if this is real then further investigation with breast mammography, high-resolution ultrasound and MRI scanning should be suggested.

For the simple case of congenital nipple inversion, the consideration of management should include the issues of nipple hygiene, recurrent infections and the future of lactation potential with or without surgical correction.

Many different methods of surgical correction have been described. The most reliable is probably that described by Professor Neven Olivari of Cologne, where a small incision is made at the base of the inverted nipple, a skin hook is used to retract the inverted nipple and all the shortened nipple ducts are sharply released [1]. The

resulting soft tissue gap is then closed with a buried purse-string suture. This method is simple, reproducible and reliable. The resulting scars are minimal and the surgery can be performed as an outpatient under local anaesthesia. Future breast feeding is unlikely, but Olivari's published series mentions a small percentage of patients who went on to successfully breast feed their babies. Spontaneous recanalisation is the likely reason in these rare cases. Other methods have been described using microscopic dissection of the nipple to preserve lactation function and various buried areolar flaps designed to support the everted nipple structure. These involve more soft tissue dissection, scarring and complications. The fundamental question is whether or not patients with inverted nipples will ever truly successfully breast feed with or without surgical correction. There has been a growing body of lactation specialist nurses who would argue otherwise but the reality is open to debate.

5.2 Types of Written Questions

1. Multiple choice
2. Short answers
3. Essays

Multiple choice questions are more the trend for the Part 1 FRACS exams. They are a feature of professional anaesthetic exams Part 2, FANZCA. The Part 2 or Final Fellowship exams for FRACS tend to be in a combination of short answer and long answer/essay form. The two written papers that candidates present for about a month before the oral examinations are usually 2 hours long. The questions are carefully constructed by members of the plastic surgery mini-court, several months before and will have indicators for how much time should be allocated by the writer.

5.3 Style of Written Questions

1. Knowledge style; assess the question and decide what knowledge needs to be conveyed: anatomical, pathological, clinical or diagnostic
2. Interpreting a particular clinical context with mature judgement and safe decision-making
3. Contrasting and comparing different approaches to the same clinical problem
4. Situation awareness, risk management
5. Problem solving

5.4 Feedback from 8 Years of Marking Mock (Practice) Written Questions

From a review of the data that we have recorded from successive coaching courses (2012–2018) for groups of presenting candidates, without identifying any of these young surgeons, prognostic indicators have been observed. From a total of 469

mock written responses the overall pass rate has been 60%. The set-up for the Mock Written Questions is this: candidates enrolled for our coaching courses are emailed the mock written questions, one at a time. They are instructed to set aside protected time to complete the answer, in usually 30 or 60 minutes.

Candidates practising the mock written questions in an exam context show a definite improvement in their success rate with practice and constructive feedback. Fifty seven percent of candidates completed 50% of the set mock written questions. The answers are marked with a purposefully high scholarly expectation within 24 hours of them being returned by email. Those candidates who fail or have only a marginal pass receive written feedback with constructive advice on how to improve their answers.

A small percentage of candidates completely misread the question or misdiagnose the clinical case in the question. This was in reference to the difference between the syndromes of hemifacial microsomia and hemifacial atrophy. An obvious disadvantage for some candidates is regurgitating a preconceived answer, which bears little relevance to the question asked. Another glaring fault was the failure to construct a plan at the beginning of the answer. Time management is also a challenge and candidates must learn to allocate enough time to segments of their answer, so that major omissions of knowledge and interpretation are minimised.

A real but occasional problem, given that handwritten answers are still the standard for the RACS final fellowship exams is illegible writing. Some candidates do struggle with this handicap even when counselled about it. The stress of the exam environment does not help this characteristic of illegibility, but it is a fundamental principle that the examinee must construct text and written language that can be read. Philip Carson FRACS, current Chairman of the RACS Court of Examiners revealed at the May 2018 ASC Education Session, that a move to TYPED answers is imminent.

Some other general guidelines for successful exam writing include the following:

1. Practice answering written questions under pressure, so that you become used to the ‘test anxiety’ reality of professional exams.
2. Develop time-use strategies, again under pressure with practice of mock written questions, until your writing skills improve.
3. Avoid guessing an answer, use deductive reasoning and commonsense based on first principles.
4. Don’t try and bluff your answer.
5. Use key words that have clear meaning.

5.5 Previous Mock (Practice) Written Questions

Here are some examples of either real questions from past exams or mock questions designed for our coaching course for FRACS (Plastic & Reconstructive Surgery). *Model answers can be found in Appendix A at the end of the book.*

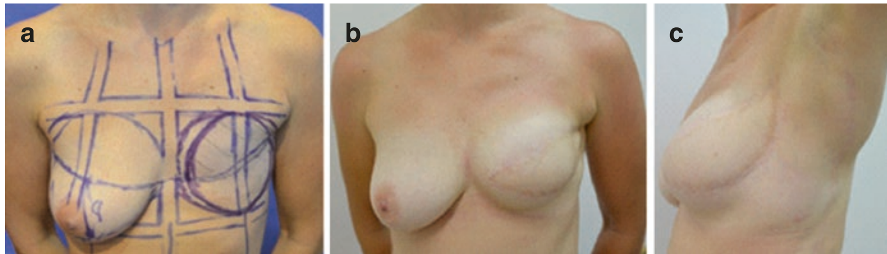

Fig. 5.1 (**a**–**c**) Images of 32-year-old left breast reconstruction case

5.5.1 Mock (Practice) 01 (Fig. 5.1)

A 32-year-old marine biologist is 2 years post left mastectomy for extensive DCIS with foci of invasion. She is nulliparous and has moderate ptosis of her contralateral right breast. After staged reconstruction of a left breast mound with tissue expander covered with a latissimus dorsi myocutaneous flap and definitive matched anatomical permanent submuscular implant ***she is very content with her appearance in clothing and declines further surgery including nipple-areola reconstruction and right mastopexy to give her perfect breast symmetry.*** *Discuss (30 min).*

5.5.2 Mock (Practice) 02

For cutaneous defects of the face post skin cancer excision, a number of repair techniques are available including healing by secondary intention, direct closure, local flaps and skin grafts. Consider different regions of the face, the type of skin cancer prevalent to each and discuss your preferred repair method (60 min).

5.5.3 Mock (Practice) 03

Consider the management of hand fractures, mechanism of injury and methods available for successful outcomes functionally and rehabilitatively (60 min).

5.5.4 Mock (Practice) 04 (Fig. 5.2)

A 57-year-old woman presents with an infiltrating ulcerated BCC of her right conchal fossa. She is aware of ageing changes in her lower face. Discuss a management plan that addresses both the skin cancer and her ageing concerns (60 min).

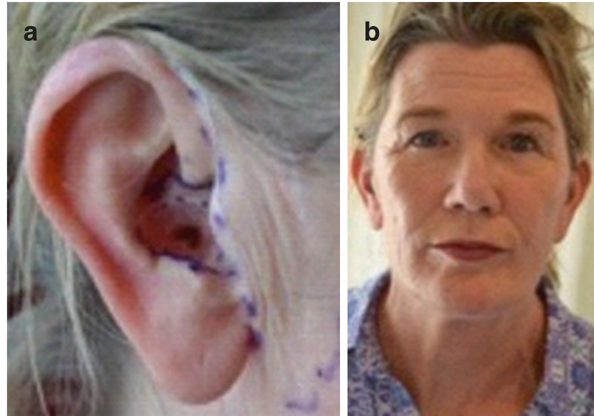

Fig. 5.2 (**a**, **b**) 57-year-old woman with infiltrating BCC of right conchal fossa and lower facial ageing stigmata

5.5.5 Mock (Practice) 05

Compare and contrast the surgical techniques for rhinoplasty including open versus *closed techniques and septoplasty (60 min).*

5.5.6 Mock (Practice) 06

Outline the theory and practice of neonatal ear moulding for auricular deformations (30 min).

5.5.7 Mock (Practice) 07 (Fig. 5.3)

This 20-year-old student suffers from Ehlers-Danlos syndrome and has had previous bilateral first rib resections for thoracic outlet syndrome. She is on significant analgesic medications for chronic pain secondary to her joint instabilities which involve her shoulders and her vertebral column. She requests a bilateral breast reduction for her pendulous breast hypertrophy. Discuss your management strategies including perioperative risk factors (60 min).

5.5.8 Mock (Practice) 08 (Fig. 5.4)

This fit 45-year-old woman requests restoration of breast volume and projection. She is not keen on breast implants and just wants to have a more feminine appearance. Describe the conversation you would have with her and what your recommendation would be. Justify your decision for management (60 min).

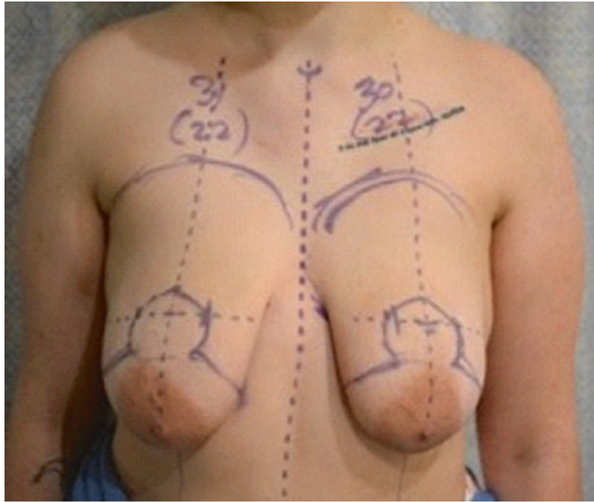

Fig. 5.3 20-year-old woman with Ehlers-Danlos Syndrome and severe grade III bilateral breast ptosis

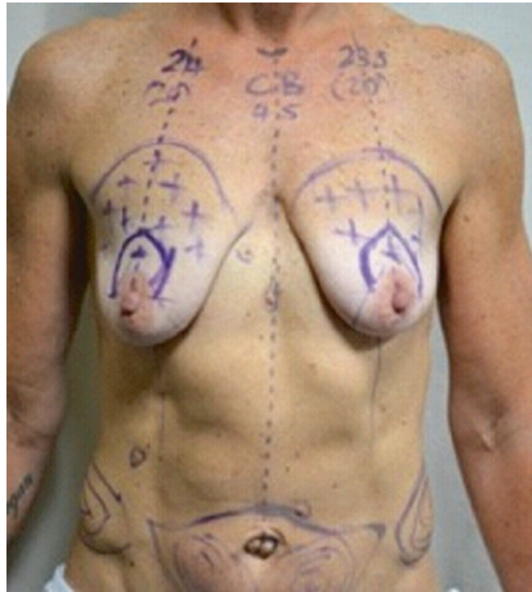

Fig. 5.4 This 45-year-old woman has post-partum breast involution and requests advice about restoration of her breast volume and projection

Reference

1. Olivari N. Practical plastic and reconstructive surgery: an atlas of operations and techniques. Heidelberg: Kaden; 2008. ISBN-10: 3922777848.