

August 2009

R E G U L A T I O N S
FOR ADMISSION TO THE DIPLOMA IN OBSTETRICS OF
THE COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS OF
SOUTH AFRICA

Dip Obst(SA)

1. **INSTITUTION** The Colleges of Medicine of South Africa

2. **DIVISION** The College of Obstetricians and Gynaecologists of South Africa

3. **QUALIFICATION** Diploma in Obstetrics of the College of Obstetricians and
TITLE Gynaecologists of South Africa

4. **OFFICIAL** Dip Obst(SA)
DESIGNATION

5. **FIELD** 09 (Health Sciences and Social Services)

6. **SUB-FIELD** Preventive, promotive, curative and rehabilitative

7. **NQF FIELD** 8

8. **BACKGROUND AND MOTIVATION FOR THIS DIPLOMA**
 - 8.1 Perinatal and maternal mortality rates are unacceptably high in South Africa and severe morbidity in neonates and mothers is common. Improving the care of women during delivery and the prenatal and postnatal periods is of primary importance. During pregnancy the majority of women in South Africa receive care from medical officers working in district and regional hospitals. Providing an opportunity for medical officers and primary care physicians to improve their knowledge and skills in obstetrics is an urgent requirement for South Africa. This should be done through supervised experience and appropriate examinations

9. PURPOSE AND AIM OF QUALIFICATION

- 9.1 The purpose of the Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa is to encourage postgraduate training in obstetrics and to raise the standard of obstetrical practice
- 9.2 It is the aim of the College of Obstetricians and Gynaecologists to ensure that the candidates who are awarded the Dip Obst(SA) will have an understanding of modern techniques in diagnosis and treatment; knowledge of the modern literature in the field; and an ability to relate physiological and pathological principles to obstetrics. In addition candidates should understand the principles of organisation, management and audit of primary and secondary obstetric services in health care centres, district and secondary hospitals. Candidates should know the most common causes of maternal and perinatal mortality in South Africa and understand the strategies to improve these

10. THE CAPACITY AND COMPETENCE OF CANDIDATES WILL BE INCREASED BY:

- 10.1 Undertaking obstetrics and gynaecology training in fulfilment of the Dip Obst(SA) examination regulations in:
- 10.1.1 Obstetrics and gynaecology training posts under the supervision of university departments in teaching hospital equivalents or in university satellite departments of non-teaching hospitals. (Information relating to these posts is available from the Heads of university departments of obstetrics and gynaecology)
- 10.1.2 Other posts in regional and larger district hospitals may be suitable for training. These hospitals must be recognised by the College of Obstetricians and Gynaecologists of the CMSA. Such hospitals will be required to have a fulltime or part time obstetrician or an experienced full time medical officer (preferably with a Dip Obst(SA)) as staff members. These hospitals will be required to conduct at least monthly perinatal and maternal mortality and morbidity meetings. Enquiries should be made by prospective candidates as to the acceptability of training posts prior to embarking on training
- 10.1.3 Primary care physicians and medical officers working in small district hospitals will be eligible if the requirements set out for part-time training have been met

11. PATIENT AND COMMUNITY CARE WILL BE IMPROVED BY:

- 11.1 Successful candidates having an understanding of modern techniques in diagnosis and treatment in obstetrics, early pregnancy complications and family planning. Candidates will also understand the principles of organisation, management and audit of primary and secondary obstetric services in health care centres, district and regional hospitals. Finally candidates should be aware of strategies to lower perinatal and maternal mortality

12. TARGET GROUP FOR THIS DIPLOMA:

- 12.1 Medical officers and primary care physicians (general practitioners)

13. ADMISSION CRITERIA**13.1 Qualification:**

- 13.1.1 The candidate must have held for six months a post-internship qualification to practise medicine which is registered or registrable with the Health Professions Council of South Africa
- 13.1.2 The CMSA Senate, through its Examinations and Credentials Committee, will review all applications for admission to the examination, and may also review the professional and ethical standing of candidates

13.2 Education and training (Attached as Appendix A):

13.2.1 Supervised training: A minimum of 6 months of supervised obstetrical training in teaching hospitals or in university satellite departments in non-teaching hospitals and CMSA accredited regional or larger district hospitals. See Appendix A on hospitals acceptable for Dip Obst(SA) training. This may be done in two 3-month periods of training over a maximum of two years. One of the six months of training may be in gynaecology

13.2.2 Part-time training: Certification is required from the chief executive officers, medical superintendents or heads of departments that candidates have fulfilled the requirements as stipulated in Appendix A

13.2.3 Course work:***Recommended reading:***

(i) Cronje, HS. Editor. *Obstetrics in Southern Africa.*, 2003 ed.

(ii) Theron, GB. Editor. *Perinatal Education Programme, Manual 1, Maternal Care.* Cape Town; Perinatal Education Trust; 1998

(iii) Pattinson, RC. Editor. *Saving Mothers, Second Report on Confidential Enquiries into Maternal Deaths in South Africa 1999-2001.* ISBN: 1-875017-80-1. Department of Health, Pretoria

(iv) Pattinson, RC. Editor. *Saving Babies, Second Perinatal Care Survey of South Africa 2001.* ISBN: 0-620-29228-8. MRC Unit for Maternal and Infant Health Care Strategies, University of Pretoria. Available at www.ppip.co.za

13.2.4 Mortality and morbidity meetings: Monthly (at least) perinatal and maternal mortality and morbidity meetings must be conducted in accredited hospitals

13.2.5 Formal rounds and discussions: The obstetrician or senior medical officer should, at least, do a weekly teaching ward round with discussion of appropriate clinical problems

14. CONTENT GUIDELINES**14.1 Syllabus:**

Attached as Appendix B

15. PREPARATION FOR EXAMINATION**15.1 Recommended reading:**

See 13.2.3

15.2 Training programmes:

Attached as Appendix A

16. EXAMINATION STRUCTURE AND OBJECTIVES**16.1 Overall standard expected:**

Importance is attached to the hospital training in obstetrics, the management of complications during early pregnancy and family planning; but candidates will be examined primarily to determine whether as general practitioners or medical officers they have good and practical obstetric skills and whether they will be able to render an obstetric service of adequate standard at primary care level and in district and secondary or regional hospitals

16.2 Written paper:**16.2.1 Structure:**

One 3 hour written examination consisting of 4 forty five minute questions that could be divided into short questions

16.2.2 Objective:

To ascertain whether candidates have an understanding of obstetrics with regards to:

- modern techniques in diagnosis and treatment
- knowledge of the modern literature in the field
- an ability to relate physiological and pathological principles
- the principles of organisation, management and audit of primary and secondary obstetric services in health care centres, district and secondary hospitals
- an understanding of the main causes of maternal and perinatal mortality in South Africa and the strategies to lower these rates
- the management of complications during early pregnancy
- family planning

16.3 Clinical examination:**16.3.1 Structure:**

An Objective Structured Problem-Solving Examination (OSPE) of 120 minutes on 4 clinical problems in obstetrics. The candidate will be given 15 minutes to study the written clinical problem where after there will be a 15 minute oral examination on the specific problem

16.3.2 Objective:

To test the candidates' clinical knowledge in obstetrics and to conduct a fair examination where all candidates get the same questions and examiners as well as a wider range of questions

16.4 OSCE:

The Objective Structured Clinical Examination will include questions on antenatal cards, partograms, cardiotocography and any other topics relevant to the clinical practice of obstetrics

16.4.1 Structure:

A circle of at least 8 questions (stations) lasting 10 minutes each

16.5 Certification:

Candidates must have their supervised or part-time training certification (Appendix A) approved 4 weeks prior to the date of the written examination

16.6 Guidelines for examiners:

See Appendix C

17. APPENDICES

- Appendix A : Training programmes
- Appendix B : Syllabus
- Appendix C : Instructions and guidelines for convenors and examiners

A P P E N D I X A**TRAINING PROGRAMMES****HOSPITALS ACCEPTABLE FOR DIP OBST(SA) TRAINING**

Candidates are informed that obstetric training in fulfilment of the Dip Obst(SA) examination regulations may be undertaken in:

1.0 SUPERVISED TRAINING

A minimum of 6 months of supervised obstetrical training in teaching hospitals or in university satellite departments in non-teaching hospitals. Regional or larger district hospitals accredited by the College of Obstetricians and Gynaecologists of South Africa of the CMSA. This may be done in two 3-month periods of training over a maximum of two years. One of the six months of training may be in gynaecology

2.0 PART-TIME TRAINING**2.1 Requirements for part-time training:****2.2 Primary care physicians in private practice:**

2.2.1 The applicant must have performed at least 15 deliveries annually over a 3-year period, of which at least 15 of the total deliveries are caesarean sections

2.2.2 A list of the names, dates and method of delivery must be provided

2.3 Medical officers working in small district hospitals:

2.3.1 The applicant must have worked for a 2-year period in a hospital that conducts at least 400 deliveries annually, of which at least 40 of these are caesarean sections. At least 20 of these caesarean sections must have been performed by the applicant. A perinatal audit covering at least one year, eg a Perinatal Problem Identification Programme (PIIP) report must also be provided

2.3.2 The medical superintendent must certify that this information is correct

2.4 In addition, applicants from both above-mentioned groups must attend an academic hospital or regional hospital accredited by the College of Obstetricians and Gynaecologist of South Africa of the CMSA for 4 weeks (at least 40 hours per week) spread over a period of not more than 2 years

2.4.1 The aim of this training is to become acquainted with the newer developments regarding:

- Antenatal care including high risk cases
- Intrapartum care including operative obstetrics

2.4.2 In addition the following activities must be attended:

- Antenatal, postpartum and postoperative ward rounds
- Perinatal and maternal mortality and morbidity meetings
- Discussions with the obstetrician or senior medical officer

2.4.3 The CEO of the institution or head of department must certify that the candidate has fulfilled these obligations

3.0 COURSE WORK**3.1 Recommended reading:**

- (i) Cronje, HS. Editor. *Obstetrics in Southern Africa*, 2003 ed.
- (ii) Theron, GB. Editor. *Perinatal Education Programme, Manual 1, Maternal Care*. Cape Town; Perinatal Education Trust; 1998
- (iii) Pattinson, RC. Editor. *Saving Mothers, Second Report on Confidential Enquiries into Maternal Deaths in South Africa 1999-2001*. ISBN: 1-875017-80-1. Department of Health, Pretoria
- (iv) Pattinson, RC. Editor. *Saving Babies, Second Perinatal Care Survey of South Africa 2001*. ISBN: 0-620-29228-8. MRC Unit for Maternal and Infant Health Care Strategies, University of Pretoria. Available at www.ppip.co.za

3.2 Mortality and morbidity meetings:

Monthly (at least) perinatal and maternal mortality and morbidity meetings must be conducted in accredited hospitals

3.3 Formal rounds and discussions:

A weekly formal ward round and discussion must be conducted by the obstetrician or senior medical officer

4.0 ACCREDITATION REQUIREMENTS OF HOSPITALS FOR DIP OBST(SA)

- 4.1 Candidates who wish to obtain the Dip Obst(SA) working in hospitals that have not been approved by the CMSA can ask the CEO or medical superintendent of the hospital to apply to the CMSA for approval. The following hospitals will be considered. It is the responsibility of these hospitals to provide the required information
- 4.2 Hospital with full-time Obstetrician and Gynaecologist consultant (evidence must be provided)
- 4.3 Hospital with part-time Obstetrician and Gynaecologist consultant and Medical Officer (with experience) full-time in a department of Obstetrics and Gynaecology. (Evidence must be provided, including duties of part-time Obstetrician and Gynaecologist consultant and number of years experience of Medical Officer)
- 4.4 Hospital conducting a minimum of 1000 deliveries per year and a full-time doctor on the staff with at least five years of experience in obstetrics, plus:
 - at least six months perinatal mortalities audit data – eg PPIP reports
 - evidence of the protocols as defined by NCCEMD – eg Protocols for hypertension, abortion, puerperal sepsis, HIV/AIDS, VBAC, post-partum haemorrhage
 - clearly described referral routes to the next level of care
 - performs caesarean sections and evidence that the candidate has performed at least 40 caesarean sections. (Certified by CEO of hospital).

5.0 POST-INTERNSHIP OBSTETRIC TRAINING POSTS HAVE BEEN APPROVED IN THE PAST AT THE FOLLOWING HOSPITALS

Addington/Mahatma Gandhi Memorial Hospital Complex	Mapulaneng Hospital
Barberton Hospital	McCord Hospital
Boitumelo Hospital	Mofumahadi Manapo Mopeli Regional /Elizabeth Ross Hospital
Bongani Regional Hospital/Welkom	Mokopane Hospital
Chris Hani/Baragwanath Hospital	Mpilo Hospital
Dihlabeng Regional Hospital/Bethlehem	Natalspruit Hospital
Dora Nginza Hospital; Ciskei	Nelson Mandela Academic Hospital
Dr George Mukhari Hospital	Ngwelezane Hospital/Umphu Health Clinic
Durban Hospital Complex	Odendaal Hospital; Nylstroom
East London Hospital Complex	Paarl Hospital
Eben Dönges Hospital	Pietermaritzburg Hospital Complex
Elim Hospital	Port Elizabeth Hospital Complex
Ermelo Hospital	Potchefstroom Hospital
Eshowe Hospital	Port Shepstone/Murchison Hospital Complex
Far East Rand Hospital	Pretoria Hospital Complex
Free State Hospital Complex	Prince Mshiyeni Hospital
George Hospital	Raleigh Fitkin Memorial Hospital
GF Jooste Trauma Emergency/Lentegeur/Mowbray Hospitals	RK Khan Hospital
Goldfields Hospital/Welkom Provincial	Rob Ferreira/Barberton Hospital Complex
Grey's/Northdale Complex; Pietermaritzburg	Rustenburg Provincial Hospital
Grootehoek Memorial Hospital; Lebowa	SAMHS: # 1 Military Hospital
Groote Schuur Hospital/CHC	SAMHS: # 2 Military Hospital
Harare Group of Hospitals	Sebokeng/Kopanong Hospital Complex
Helen Joseph/Coronation Hospital Complex	Somerset Hospital
Hottentots Holland Hospital	South Rand Hospital
Johannesburg General Hospital	Stanger Hospital
Jubilee Community Hospital; Hammanskraal	Tambo Memorial/Germistion Hospital
Kalafong Hospital	Tembisa Hospital
Karl Bremer/ Tygerberg/Kraaifontein Hospital	Themba Hospital
Kimberly Hospital	Tshepong/Klerksdorp Hospital
Klerksdorp/Tshepong Hospital Complex	Tshilidzini Hospital
Ladysmith Hospital	Tygerberg Academic/Stikland/ Bishop Lavis/Bellville Day & Eerste Rivier Hospitals
Lebowa Kgomo Hospital	Uitenhage Provincial Hospital
Leratong/Dr Yusuf Dadoo Hospital Complex	Victoria Hospital
Letaba Hospital Complex	Vryburg/Taung Hospital complex
Madadeni/Newcastle Hospital Complex	Wambaths Hospital
Mafikeng Provincial Hospital	Windhoek/Katutura Hospital Complex
Mahatma Gandhi Memorial Hospital	Witbank Hospital
Mankweng/Polokwane Hospital Complex	Woodstock Hospital

AND CURRENTLY**5.1 Post-internship obstetrics and gynaecology posts in the following hospitals in Zimbabwe:**

Harare Group of Hospitals
Mpilo Hospital, Bulawayo

Enquiries concerning acceptability of posts should be addressed to:

The Academic Registrar
CMSA
Private Bag X23
BRAAMFONTEIN
2017

JOHANNESBURG
August 2009

APPENDIX B

SYLLABUS

GUIDELINES TO CANDIDATES FOR THE DIP OBST(SA) EXAMINATION

CONTENT

Organised alphabetically and not in order of importance

1.0 ANATOMY AND PHYSIOLOGY

1.1 Anatomy:

- 1.1.1 Anatomy and architecture of the bones, joints and ligaments of the pelvis
- 1.1.2 Anatomy of the abdominal wall and intra-abdominal organs
- 1.1.3 Anatomy of the breast
- 1.1.4 Surgical applied anatomy of the pelvic floor and perineum
- 1.1.5 Surgical applied anatomy of the intrapelvic organs
- 1.1.6 The mature fetus especially fetal skull and circulation
- 1.1.7 The mature placenta: morphology, types, functions

1.2 Physiology:

- 1.2.1 Fertilisation, implantation and early development of the placenta and fetus
- 1.2.2 Ovarian and menstrual cycle
- 1.2.3 Physiological changes during normal pregnancy, normal laboratory values
- 1.2.4 The amniotic fluid formation, composition, functions

2.0 NORMAL PREGNANCY

- 2.1 Antenatal care
- 2.2 Assessment of fetal well-being and diagnostic aids during pregnancy and labour
- 2.3 Diagnosis of intrauterine pregnancy
- 2.4 Fetal growth and maturity tests and assessments including amniocentesis
- 2.5 Minor complaints
- 2.6 Obstetric history and examination
- 2.7 The danger of radiation during pregnancy
- 2.8 The use of drugs during pregnancy and lactation
- 2.9 Knowledge of the use of ultrasound in normal pregnancy
- 2.10 Psychosocial aspects

3.0 NORMAL LABOUR

- 3.1 Episiotomy
- 3.2 Lactation and breastfeeding
- 3.3 Relief of pain during labour
- 3.4 Resuscitation of newborn baby

- 3.5 The initiation of labour, normal uterine function
- 3.6 The management of normal labour
- 3.7 The newborn, normal baby
- 3.8 The normal puerperium
- 3.9 The stages, mechanism and progress of normal labour and the use of the partogram

4.0 ABNORMAL PREGNANCY

- 4.1 Abortion and complications
- 4.2 Anaemia in pregnancy
- 4.3 Antepartum haemorrhage
- 4.4 Blood group incompatibilities
- 4.5 Cardiac disease in pregnancy
- 4.6 Clinical features of advanced abdominal pregnancy
- 4.7 Conditions of the central nervous system and psychiatric conditions
- 4.8 Diabetes mellitus
- 4.9 Drug abuse, alcohol and smoking during pregnancy
- 4.10 Ectopic pregnancy
- 4.11 Hyperemesis gravidarum
- 4.12 Hypertensive states during pregnancy
- 4.13 Immunisations during pregnancy effects on fetus/neonate
- 4.14 Infections in pregnancy
- 4.15 Intrapartum fetal distress
- 4.16 Intrauterine death
- 4.17 Liver disease; jaundice
- 4.18 Placental insufficiency and intrauterine growth restriction
- 4.19 Polyhydramnios; oligohydramnios
- 4.20 Postdatism and the postmaturity syndrome
- 4.21 Preterm and prelabour rupture of membranes
- 4.22 Primary management of gestational trophoblastic disease
- 4.23 Sexually transmitted diseases (including AIDS)
- 4.24 The acute abdomen in pregnancy
- 4.25 The grande multipara and elderly gravida
- 4.26 The pregnant teenager

- 4.27 The thyroid and pregnancy
- 4.28 Thrombo-embolism and clotting defects
- 4.29 Urinary tract disease
- 4.30 Respiratory disease in pregnancy
- 5.0 ABNORMAL LABOUR**
- 5.1 Abnormal uterine function
- 5.2 Congenital fetal abnormality
- 5.3 Birth injuries
- 5.4 Cord presentation and prolapse
- 5.5 Obstructed labour
- 5.6 Malpositions and malpresentations
- 5.7 Management of a patient with a scarred uterus
- 5.8 Multiple pregnancy
- 5.9 Obstetric injuries of the genital tract and repair
- 5.10 Postpartum haemorrhage
- 5.11 Preterm labour
- 5.12 Puerperal sepsis and other complications
- 5.13 Shoulder dystocia
- 5.14 The shocked obstetric patient
- 6.0 OBSTETRIC PROCEDURES**
- 6.1 Caesarean section
- 6.2 Amnioinfusion
- 6.3 Fetal birth injuries due to obstetric procedures
- 6.4 Forceps delivery (outlet)
- 6.5 Induction of labour
- 6.6 Pudendal nerve block and other local anaesthetic techniques
- 6.7 Vacuum extraction
- 6.8 External cephalic version

7.0 OBSTETRIC STATISTICS AND AUDIT

- 7.1 Maternal morbidity and mortality
- 7.2 Perinatal morbidity and mortality
- 7.3 An understanding of strategies to reduce above

8.0 FERTILITY REGULATION

- 8.1 Barrier contraception
- 8.2 Combination oral contraceptives
- 8.3 Contraception during the puerperium
- 8.4 Intrauterine contraceptive devices
- 8.5 Emergency contraception
- 8.6 Progesterone only contraceptives
- 8.7 Sterilisations

9.0 COMMUNITY OBSTETRICS

- 9.1 A management strategy for obstetric services at primary and secondary levels of care
- 9.2 Obstetric services at a primary care level
- 9.3 Obstetric services at a secondary care level

10.0 TERMINATION OF PREGNANCY (TOP)

- 10.1 Choice of termination of pregnancy Act 1996
- 10.2 Counselling for TOP
- 10.3 Methods of TOP

11.0 ETHICS IN OBSTETRICS

12.0 PSYCHOSOCIAL ASPECTS

- 12.1 Support during TOP, pregnancy and labour and counselling for bereavement

A P P E N D I X C

INSTRUCTIONS AND GUIDELINES FOR CONVENORS AND EXAMINERS

CONTENTS:

1. INTRODUCTION

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3. WRITTEN PAPERS

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Explanations

1.0 INTRODUCTION

1.1 The primary function of the College of Obstetricians and Gynaecologists is to establish an objective and fair examination to ensure that high standards of training are maintained

1.2 Convenors and examiners are requested to study the recommendations carefully before organising the examinations

2.0 CERTIFICATION

2.1 Certification is required from the chief executive officers, medical superintendents or heads of departments that candidates have fulfilled the requirements as stipulated in Appendix A for:

2.1 Supervised training

2.2 Part-time training

3.0 WRITTEN PAPERS**3.1 Objectives:**

- 3.1.1 The written papers are aimed to test knowledge at various levels summarised by Bloom as: 1) knowledge; 2) insight; 3) application; 4) analysis and integration; 5) synthesis; 6) evaluation. The lower numbers indicate lower levels of assessment and the higher values indicate better and higher levels of assessment
- 3.1.2 Several skills are thus addressed including factual recall, insight, integration of knowledge, utilisation of knowledge and experience to solve problems, and the skill to communicate the gained knowledge in writing
- 3.1.3 A further objective is that the written papers serve as a screening mechanism for invitation to the clinical part of the examination

3.2 Setting a paper:

- 3.2.1 One 3 hour paper compiled by the examiners of the previous examination. This is purely for practical and security reasons. The paper is marked by the current set of examiners, one question per examiner
- 3.2.2 The large extent of the obstetrics should be reflected in the topics covered. Therefore repetitions of questions in successive papers or within a single year cycle are not acceptable
- 3.2.3 Each full question should not take more than an hour to complete.
- 3.2.4 Dividing the long questions into a number of short questions is encouraged. Each part of the short questions should clearly state what percentage of the whole question is allocated to it

3.3 Memoranda:

- 3.3.1 Memoranda serve as guidelines for marking and are in no way an attempt to reflect the factual contents required in a question. Because different sets of examiners set and mark the paper, these guidelines may indicate what was expected from the question and eliminate some subjectivity on the part of the marker. Memoranda must be compiled by the examiners setting the paper and sent to the CMSA, which at the time of the next examination will send it to the examiners

3.4 Marking a paper:

Questions should be marked using percentages:

- **70-100%** : distinction, exceptional standard
- **65-69%** : more than satisfactory
- **50-64%** : satisfactory; acceptable standard
- **46-49%** : less than satisfactory
- **< 45%** : totally unsatisfactory, unacceptable standard

- 3.5 All marks must be sent to the convenor before the deadline date

3.6 Invitations to clinical examinations:

- 3.6.1 This is based on the combined mark achieved for the paper. The CMSA makes these decisions in conjunction with the convenor of the examination and/or members of the Dip Obst(SA) examination committee. A candidate can fail one question
- 3.6.2 Candidates with a mark < 45% for the paper will not receive an invitation to the clinical examination
- 3.6.3 Convenors will receive the marks of all candidates who are identified by their examination number only. **Convenors must ensure that no marks for the papers are made known to examiners before the final examiners meeting.**

4.0 THE OSCE

- 4.1 The OSCE has become an integral part of clinical examination. It is usually held on the first day of the examination. All examiners should be present and participate actively

4.2 Objectives:

The OSCE tests knowledge and skills at various levels. As its purpose is to present very specific questions (because of the time constraint) in a clinical way, it can be regarded as “short cases”. It also tests the candidates interpretation of special investigations and manual skills to demonstrate procedures on models.

4.3 Setting an OSCE:

- 4.3.1 With the current number of candidates per Dip Obst(SA) examination it may become necessary to do the OSCE in two groups. Allocation into the two groups is done alphabetically. OSCEs need not be very long, as the objective is to address a defined question. A circle of at least 8 or more questions (stations) lasting 10 minutes each is recommended
- 4.3.2 The convenor has the responsibility to set the OSCE. It is essential to consult with other examiners and previous convenors. All examiners should meet before the OSCE to inspect the different stations and to decide on the memoranda that will be used to mark the answers objectively
- 4.3.3 For each station an instruction sheet should be prepared, and for each candidate an answering sheet should be provided at the station. Each question should indicate the total mark at the end of the question. CMSA examination scripts can be used as long as a single page is used per question. The convenor must ensure the OSCE is set out in a convenient venue and that a timekeeper is available
- 4.3.4 The process must be explained to the groups of candidates prior to commencing the OSCE. It is essential to ensure that there is no contact between the two groups when the circle is used for the second time

4.4 Types of questions:

- 4.4.1 The following types of questions are recommended:
- Clinical obstetrical simulations with partograms, cardiotocograms, non-stress tests, Doppler flow velocity waveforms, ultrasound images and antenatal records
 - Interpretation of special tests (pathology reports, etc)
 - Ethical issues posed as clinical problems
- 4.4.2 The convenor must be certain that the defined questions can be answered in the time allocated

4.5 Manned stations:

4.5.1 The 6 examiners of the Dip Obst(SA) examination will be used for the manned stations

4.5.2 Examples of these stations include:

- Obtaining a specific detailed history on a well-defined problem from a patient or mannequin
- Doing a clinical examination on a patient or model
- Testing specific skills such as a forceps or breech delivery on a model
- Obtaining informed consent for a specific procedure
- Answering questions using a mannequin on a specific problem

4.6 Marking an OSCE:

The OSCE questions are marked on the memorandum or checklist by the examiner during the examination. Written questions are marked by the examiners immediately after the examination according to the memorandum for that station. A final numerical mark is then calculated into a percentage. The convenor should take the responsibility to complete the mark sheet but must keep it secret from the other examiners until the final examiners' meeting.

4.7 Value assessment:

The OSCE has been accepted as an important component of the clinical examination and counts one third of the total mark

5.0 OSPE (OBJECTIVE STRUCTURED PROBLEM-SOLVING EXAMINATION)**5.1 Objectives:**

To test the candidates clinical knowledge in obstetrics, early pregnancy complications and family planning and to conduct a fair examination where all candidates get the same questions and examiners as well as a wider range of questions

5.2 Range of questions:

There will be 4 questions on obstetrics, early pregnancy complications and family planning. The questions will address clinical situations generally encountered in obstetrics. It will be put to the candidates in writing. Adequate time will be given to the candidates to study the question before explaining the proposed management to the examiner. All questions will be on medical officer/primary care physician level

5.3 Technical aspects:

At a meeting of all the examiners before the OSPE, all the questions will be selected. Essential knowledge for each question will also be discussed and the marks allocation will be according to a prepared memorandum

5.4 Marking system:

Examiners are requested to give a percentage for each question as this will help difficult decision making in borderline cases. At the end of the OSPE examinations a single percentage should be calculated

5.5 Value assessment:

Each OSPE counts one third of the total mark. Candidates should pass at least 3 of the 4 questions

6.0 DEALING WITH THE MARKS**6.1 Technical aspects:**

All the marks, for the paper, OSPE and the OSCE should be presented by the convenor at the final examiners' meeting. Marks should be given in percentages and the total percentage mark should be calculated. Examiners should not be given any marks of parts of the examination before the final meeting. Examination numbers and not names should be used for the final discussion. Candidates who failed are identified. All marks are confidential and all mark sheets should be kept by the convenor

6.2 Combining symbols:

The examination consists of 3 components: the paper, OSCE and OSPE. The rules of the CMSA state that a candidate failing in some parts of a series of questions need not necessarily fail the component. The final mark of the component is important and should be used on the final mark sheet. Candidates must pass the clinical (OSPE) part

7.0 DEALING WITH THE FINAL RESULTS**7.1 Lists:**

A list of the successful candidates must be faxed to the CMSA at the number indicated on the form sent to convenors. The same list may be displayed at the examination venue after the final examination committee meeting

7.2 Explanations:

No explanations are currently offered to unsuccessful candidates at the time of the examination. Written notes may be made available to the CMSA in such cases to deal with enquiries from candidates