

الهيئة السعودية للتخصصات الصحية
Saudi Commission For Health Specialties



PEDIATRICS SAUDI BOARD PROGRAM

**SAUDI BOARD FINAL CLINICAL EXAMINATION OF PEDIATRICS
(2017)**

I Objectives

- Determine the ability of the candidate to practice as a specialist and provide consultation in the general domain of his/her specialty for other health care professionals or other bodies that may seek assistance and advice.
- Ensure that the candidate has the necessary clinical competencies relevant to his/her specialty including but not limited to history taking, physical examination, documentation, procedural skills, communication skills, bioethics, diagnosis, management, investigation and data interpretation.
- All competencies contained within the specialty core curriculum are subject to be included in the examination.

II Eligibility

- Passing Saudi Board Part II (final) written examination.
- Candidates are allowed a maximum of three attempts to pass final specialty clinical examination within a period of 5 years provided that evidence of continuing clinical practice is presented and approved by the specialty scientific council.
- If the candidate did not pass the three attempts, an exceptional attempt may be granted upon the approval of the scientific and executive councils, provided evidence of continuing clinical practice is presented.
- A candidate who failed to pass the clinical examination including the exceptional attempt has to pass Part II written examination again, after which he/she is allowed to sit the final specialty clinical examination only once provided that evidence of continuing clinical practice is presented and approved by the scientific council.
- After exhausting above attempts candidate is not permitted to sit the Saudi board final specialty clinical examination.

III General Rules

- Saudi board final specialty clinical examination will be held once each year within 4-8 weeks after Part II written examination.
- If the percentage of failure in the clinical examination are 50% or more the examination shall be repeated after 6 months.
- Specialty clinical examinations shall be held on the same day and time in all centers, however if multiple consecutive sessions are used, suitable quarantine arrangements must be in place.
- If examination is conducted on different days, more than one exam version must be used.

IV Exam Format

- The Pediatrics final clinical examination shall consist of **10** graded stations each with **10** minute encounters.
- The **10** stations consist of **7** Objective Structured Clinical Exam (OSCE) stations with **1** examiner each and **3** Structured Oral Exam (SOE) stations with **2** examiners each.
- All stations shall be designed to assess integrated clinical encounters.
- SOE stations are designed with preset questions and ideal answers.
- Each OSCE station is assessed with a predetermined performance checklist. A scoring rubric for post-encounter questions is also set in advance.

Final Clinical Exam Blueprint

		DIMENSIONS OF CARE				
		Health Promotion & Illness Prevention 2±1 Station(s)	Acute 5±2 Station(s)	Chronic 3±1 Station(s)	Psychosocial Aspects 1±1 Station(s)	# Stations
DOMAINS FOR INTEGRATED CLINICAL ENCOUNTER	Patient Care 7±2 Station(s)		4	2	1	7±2
	Patient Safety & Procedural Skills 2±1 Station(s)		1	1		2±1
	Communication & Interpersonal Skills 1±1 Station(s)	1				1±1
	Professional Behaviors 1±1 Station(s)	1				1±1
	Total Stations	2±1	5±2	3±1	1±1	10±2

VI Definitions

Dimensions of Care	Focus of care for the patient, family, community, and/or population
Health Promotion & Illness Prevention	The process of enabling people to increase control over their health & its determinants, & thereby improve their health. Illness prevention covers measures not only to prevent the occurrence of illness such as risk factor reduction but also arrest its progress & reduce its consequences once established. This includes but is not limited to screening, periodic health exam, health maintenance, patient education & advocacy, & community & population health.
Acute	Brief episode of illness, within the time span defined by initial presentation through to transition of care. This dimension includes but is not limited to urgent, emergent, & life-threatening conditions, new conditions, & exacerbation of underlying conditions.
Chronic	Illness of long duration that includes but is not limited to illnesses with slow progression.
Psychosocial Aspects	Presentations rooted in the social & psychological determinants of health that include but are not limited to life challenges, income, culture, & the impact of the patient's social & physical environment.

Domains	Reflects the scope of practice & behaviors of a practicing clinician
Patient Care	Exploration of illness & disease through gathering, interpreting & synthesizing relevant information that includes but is not limited to history taking, physical examination & investigation. Management is a process that includes but is not limited to generating, planning, organizing care in collaboration with patients, families, communities, populations, & health care professionals (e.g. finding common ground, agreeing on problems & goals of care, time & resource management, roles to arrive at mutual decisions for treatment)
Patient Safety & Procedural Skills	Patient safety emphasizes the reporting, analysis, and prevention of medical error that often leads to adverse healthcare events. Procedural skills encompass the areas of clinical care that require physical and practical skills of the clinician integrated with other clinical competencies in order to accomplish a specific and well characterized technical task or procedure.
Communication & Interpersonal Skills	Interactions with patients, families, caregivers, other professionals, communities, & populations. Elements include but are not limited to active listening, relationship development, education, verbal, non-verbal & written communication (e.g. patient centered interview, disclosure of error, informed consent).
Professional Behaviors	Attitudes, knowledge, and skills based on clinical &/or medical administrative competence, ethics, societal, & legal duties resulting in the wise application of behaviors that demonstrate a commitment to excellence, respect, integrity, accountability & altruism (e.g. self-awareness, reflection, life-long learning, scholarly habits, & physician health for sustainable practice).

VII Passing Score

- a. The pass/fail cut off for each OSCE/SOE station is determined by the exam committee prior to conducting the exam using a Minimum Performance Level (MPL) Scoring System.
- b. Each station shall be assigned a MPL based on the expected performance of a minimally competent candidate. The specialty exam committee shall approve station MPLs.
- c. At least one examiner marks each OSCE station and two examiners independently mark each part of the SOE.
- d. To pass the examination, a candidate must attain a score \geq MPL in at least 70% of the total stations with 60% on each component (OSCE & SOE).

VIII Score Report

- a. All score reports shall be issued by the SCFHS after approval of the Specialty Examination Committee.

IX Exemptions

- a. SCFHS at present has no reciprocal arrangement with respect to this examination or qualification by any other college or board, in any specialty.

Internal Medicine Clinical Exam	Station 1 Instructions to Resident
--	---

Scene: Emergency Room

You are called to see the patient; Ali Saeed, a 35-year-old who presents with shortness of breath and chest pain for 4 weeks.

YOU HAVE 10 MINUTES TO DO THE FOLLOWING:

- 1) OBTAIN BRIEF RELEVANT HISTORY.
- 2) PERFORM A FOCUSED PHYSICAL EXAMINATION.
 - a. *think aloud during the physical examination.*
 - b. *before performing any maneuver or intervention, inform the patient of your intentions.*
- 3) DISCUSS THE MOST IMPORTANT INVESTIGATIONS.
- 4) DISCUSS THE MOST PROBABLE DIAGNOSIS BASED ON FINDINGS PROVIDED.
- 5) EXPLAIN THE DIFFERENT OPTIONS FOR MANAGEMENT TO THE PATIENT.

Performance Evaluation: Station 1

0 = not done, 1 = attempted but not done correctly/completely, & 2 = done correctly/completely

Patient Care/Assessment	0	1	2
1. Obtains a focused history: (if mentions 5 give full mark). <ul style="list-style-type: none"> • SOB (severity; NYHA class, orthopnea, PND) • Chest pain (Site, severity; CCC, character, radiation, aggravating and relieving factors) • Other cardiac symptoms (palpitations, intermittent claudication and syncope). • Fever (diurnal variation, severity, associated sweating). • Loss of appetite and weight • Past history of TB or TB contact, joint pain and skin rash. • Social history (Smoking, illegal sex) 			
2. Performs focused cardiovascular examination: <ul style="list-style-type: none"> • Requests vital signs and attempts to check for "pulsus paradoxus" • Examine JVP (position at 45^o, proper position of the neck, uses light, confirms JVP). • Attempted to examine the precordium examination. • Attempted to examine for hepatomegaly, auscultation of the base of the lungs and for lower limbs edema). 			
3. Mentions the most probable diagnosis: <ul style="list-style-type: none"> • Cardiac tamponade 			
4. Mentions the most important immediate investigations: <ul style="list-style-type: none"> • CBC, ESR, Renal functions, ANA and RF. • ECG • CXR • Echocardiogram 			
5. Interpretation of ECG: electrical alternans			
6. Interpretation of CXR: Flask like cardiomegaly and clear lung fields.			
7. Mentions the common causes: (if mentions 4 give full mark) <ul style="list-style-type: none"> • Viral/ idiopathic • TB • Uremic/ dialysis associated pericarditis • Malignancy • Pericardial empyema • Post MI • Autoimmune • Others 			
Management			
8. Discusses the immediate management: <ul style="list-style-type: none"> • IVF resuscitation • Diagnostic and therapeutic pericardiocentesis 			
9. Further management: <ul style="list-style-type: none"> • Depends on the cause: <ul style="list-style-type: none"> - NSAID ± colchicine ± steroids for idiopathic and autoimmune diseases - Antibiotics for empyema - Anti-TB for TB - Dialysis for uremic pericarditis - Radio/ chemotherapy for malignancy - Pericardial window for recurrent pericardial effusion 			
Total marks:			

Questioning Skills (ONE choice only)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awkward, exclusive use of closed-ended or leading questions and jargon	Somewhat awkward; inappropriate terms; minimal use of open-ended questions	Borderline unsatisfactory; moderately at ease; appropriate language; uses different types of questions	Borderline satisfactory; moderately at ease; appropriate language; uses different types of questions	At ease; clear questions; appropriate use of open and closed-ended questions	Confident; skillful questioning

Professional Behavior with Patient (ONE choice only)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offensive or aggressive; frank exhibition of unprofessional conduct	Negative attitude toward patient	Borderline unsatisfactory; does not truly instill confidence	Borderline satisfactory; manner inoffensive, but does not necessarily instill confidence	Attempts professional manner with some success	Overall demeanor of a professional; caring, listens, communicates effectively

Overall Organization of Patient Encounter (ONE choice only)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No logical flow; scattered, inattentive to patient's agenda	Counsels patient before taking history or doing physical	Minimal organization; scattered approach	Appropriate approach to patient	Skillful approach to patient	Skillful, professional approach to patient and effective use of time

Facilitation of Informed Decision Making (ONE choice only)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No attempt or inappropriate attempt at information sharing (e.g., deception, slanting of facts, incorrect information)	Incomplete and / or biased information; overuses jargon; does not ensure understanding of issues	Attempts to share information; omits some critical facts; uses some jargon; attempts to ensure understanding	Gives some information on most important facts; may use jargon; attempts to ensure understanding	Gives clear information; supports patient decision making (e.g., alternatives, risks / benefits); appropriate language; ensures understanding	Organized; optimizes patient decision making; significant effort to make information relevant; clear language; attentive to patient understanding

ABHA MEDICAL CENTER

Patient name: Ali Saedd

Age : 35 years

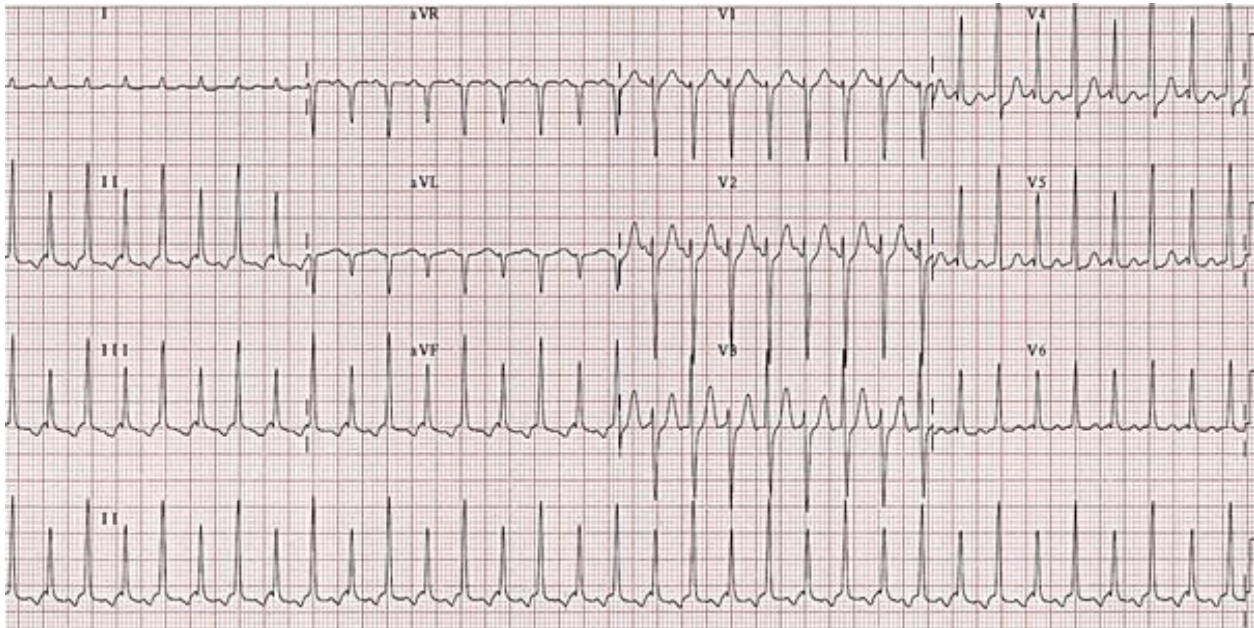
Test	Results	Normal values
Hb	105	123- 157g/L
WBC	6.5	4.0-10.5 X 10 ⁹ /L
MCV	82	80 – 96 fl
MCH	33	28-33 pg/cell
Platelet	280	150 – 400 X 10 ⁹ /L
ESR	70	3-15 mm/hr

ABHA MEDICAL CENTER

Patient name: Ali Saedd

Age : 35 years

ECG



ABHA MEDICAL CENTER

Patient name: Ali Saedd

Age : 35 years

CXR



ABHA MEDICAL CENTER

Patient name: Ali Saedd

Age : 35 years

Echo-Doppler Report:

- Massive pericardial effusion
- Right ventricular diastolic collapse
- Dilated uncompressable inferior venacava
- Normal left ventricular dimentions and functions

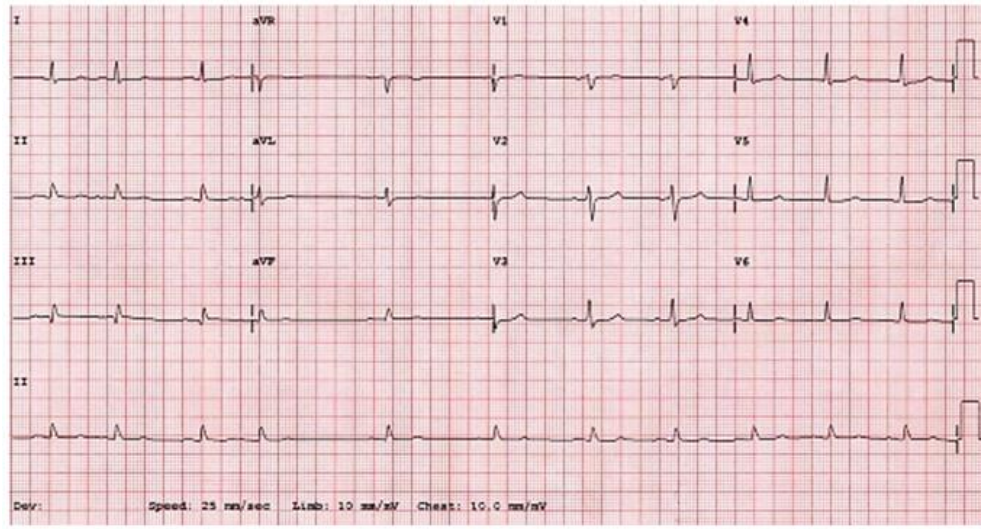
XI SOE Station Sample**

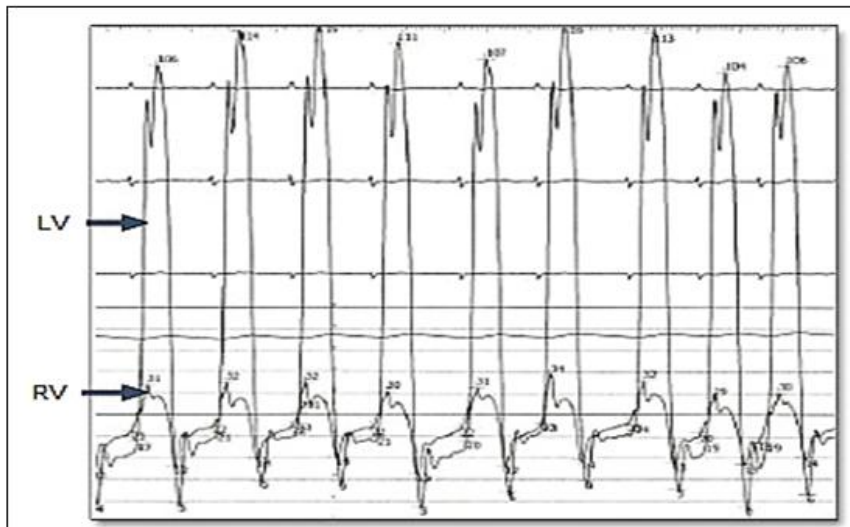
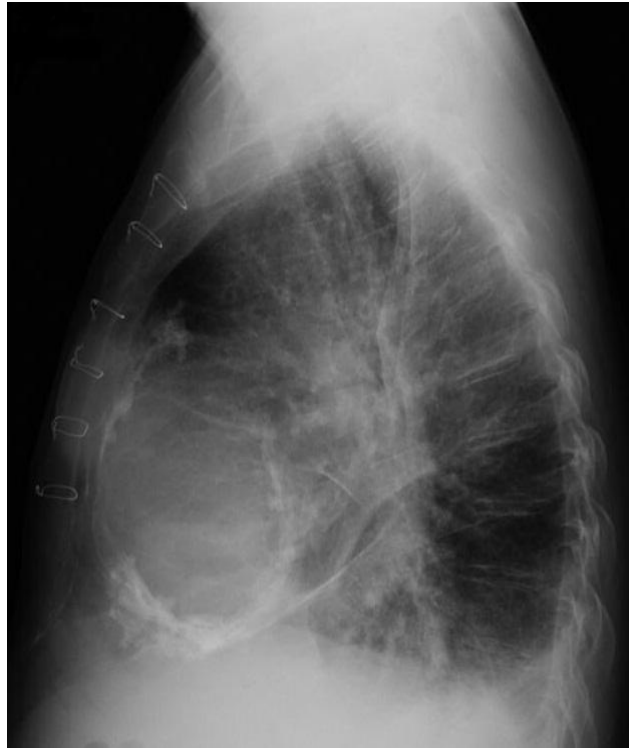
STATION 2

Instructions to candidate:

A 60 year old man is referred to the cardiology clinic for further evaluation of chronic shortness of breath. The patient is under the gastroenterology follow up for ascites with high SAAG for which there is no clear cause.

Question/Ideal Answers	Mark
How would you approach this patient?	
Focused History: Details of SOB (NYHA class, orthopnea, PND) Other cardiovascular symptoms (chest pain, palpitations, syncope, lower limb swelling) Past history of pericarditis, hemopericardium, TB, renal impairment and chest radiotherapy	/6
Relevant Physical Examination: Blood pressure JVP Examine for Pericardial knock. Examine abdomen for Pulsating hepatomegaly and ascites. Examine Chest for pleural effusion Examine for lower limbs edema	/12
The patient has progressive SOB NYHA class III with orthopnea and PND over a 6months period. His past history is significant for CABG 2 years ago which was complicated by hemopericardium and received blood transfusion. He noticed progressive abdominal distention for 2 months. Lately he developed lower limb swellings in both sides. Hepatitis screening, Bilharzia serology, s. ferritin and ANA are negative. U/S abdomen showed hepatomegaly, dilated hepatic veins and IVC. No focal lesions. Physical examination: Pulse is irregular, BP 90/60 mmHg, elevated JVP which increases during inspiration. There is a loud sound shortly after S2. Abdominal examination showed pulsating hepatomegaly and positive shifting dullness. Chest examination: fine basal crepitations. Has bilateral lower limb pitting edema.	
What is the differential diagnosis in this case?	
Constrictive pericarditis Restrictive cardiomyopathy Cardiac tamponade Advanced dilated cardiomyopathy	/12
What investigations would you like to conduct?	
<ul style="list-style-type: none"> ▪ Serum BNP level ▪ ECG ▪ CXR ▪ Echo-Doppler ▪ Cardiac CT or MRI ▪ Left and right heart catheterization 	/6
What are the positive findings of the given investigations?	
<ul style="list-style-type: none"> ▪ ECG: Show the ECG (Low voltage QRS complexes, atrial fibrillation) ▪ CXR: Show the CXR (pericardial calcification) ▪ Echo-Doppler: Biatrial dilatation, normal ventricular systolic function and diastolic dysfunction with restrictive physiology ▪ Serum BNP level: normal ▪ Cardiac CT or MRI: Biatrial enlargement, thickened pericardium with/ without calcification. ▪ Left and right heart catheterization: Show the pressure tracing (Elevated right atrial pressure with prominent X & Y descent, square root sign in LV and RV diastolic pressure tracing and equalization in LV and RV diastolic pressure. Mirror image discordance between the LV & RV peak systolic pressures) 	/6
What is the most likely diagnosis?	
<ul style="list-style-type: none"> • Constrictive pericarditis 	/10
What pathophysiological abnormality is responsible for heart failure in constrictive pericarditis?	
<ul style="list-style-type: none"> ▪ Diastolic dysfunction. 	/10
Mention 4 common causes of constrictive pericarditis?	
<ul style="list-style-type: none"> ▪ Post viral pericarditis ▪ Post cardiac surgery ▪ Post radiotherapy ▪ Post infectious (TB, purulent) ▪ Connective tissue disorders ▪ Miscellaneous causes (uremia, sarcoidosis, drug induced, asbestosis). 	/8
What is the definitive treatment of constrictive pericarditis?	
<ul style="list-style-type: none"> ▪ Pericardiectomy 	/10
Total	/80





**Examples are shown to clarify station structure regardless of case details.