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JOHANNESBURG
ACADEMIC OFFICE

February 2016

THE COLLEGE OF PAEDIATRICIANS OF SOUTH AFRICA

R E G U L A T I O N S

FOR ADMISSION TO THE EXAMINATION FOR THE POST-SPECIALISATION

SUB-SPECIALTY CERTIFICATE

IN

ALLERGOLOGY

Cert Allergology(SA)

1.0 ELIGIBILITY TO TAKE THE EXAMINATION

In order to be eligible to enter for this examination, the candidate:-

1.1 must comply with the requirements for registration as a medical practitioner, as prescribed by the Medical, Dental and Supplementary Health Services Act.

1.2 must be registered as a specialist Paediatrician

2.0 ADMISSION TO THE EXAMINATION

(to be read in conjunction with the Instructions)

The following are the requirements for admission to the examination:

2.1 registration as a specialist Paediatrician

2.2 certification of having completed at least 18 months as a subspecialty trainee in an accredited Allergology unit in a teaching hospital, registered and approved by the Health Professions Council of South Africa

2.3 submission of a written report from the head of the institution/programme in which he or she trained indicating satisfactory completion of all training requirements

2.4 submission of a satisfactorily completed logbook

2.5 presentation or acceptance for presentation of an original first author research poster or paper at a local or international congress OR submission or acceptance for publication of an original first or co-authored manuscript in a peer reviewed journal.

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2.6 Training is valid for a period of three years from the date of completion in a numbered subspecialty training post. Candidates who do not successfully complete the subspecialty examination within the period must motivate with support from their HOD to the College of Paediatricians for a once off extension.

3.0 SYLLABUS AND TRAINING

See Appendix A

4.0 FORMAT AND CONDUCT OF THE EXAMINATION

See Appendix B

A P P E N D I X A

1.0 SYLLABUS/CURRICULUM FOR ALLERGOLOGY SUBSPECIALISATION

1.1 GENERAL CONCEPTS / BASIC SCIENCES

1.1.1 **Definition of Allergy, Atopy, Hypersensitivity, Intolerance.**

1.1.1.1 World Allergy Organisation Guidelines on "What is an Allergist".

1.1.1.2 World Allergy Organisation "Requirements for Physician Training in Allergy 2006"

1.1.2 **The Genetics of Allergic Disease, Asthma and the Allergic March**

Eg Beta2 receptor polymorphisms, genes linked to allergic cytokines, asthma and steroid receptor genes.

1.1.3**. Environmental Factors and Allergic Disease**

1.1.3.1 Allergen Nomenclature (biology, molecular biology of the major allergens [food, drug, aeroallergens], geographical distribution, cross-reactivity).

1.1.3.2 Indigenous allergens in Southern Africa (Environmental Exposure):

a) *Indoor* (eg house dust mites, cockroach, fungal, pets, latex, laboratory animals)
b) *Outdoor* (eg aeroallergens, fungal spores)
c) *Pollutants* (eg sulphur dioxide emissions)
d) Adjuvants
e) Aero biology / Pollen monitoring
f) Allergen sampling (Burkard)

1.1.3.3 Allergen vaccine, production, standardisation, biological units, protocols, routes of administration, potency, shelf life, storage and regulatory approval for importation.

1.1.4. **Immunology and Biochemistry of Allergic Disease**

1.1.4.1 Anatomy and normal physiology and function of the immune system
1.1.4.2 The developing immune system and allergy
1.1.4.3 IgE regulation: Specific IgE responses
1.1.4.4 Cytokine and Chemokine regulation of the immune response (IL4, IL5, IL10, TGFB, IL13, &IFN)
1.1.4.5 T-cells and allergy (TH1, TH2, Modified TH2 response, Regulatory CD25, T cells)
1.1.4.6 Early and late phase reactions
1.1.4.7 The biology of mast cells, secretagogues and mediators
1.1.4.8 Immunoglobulins, IgG, IgM, IgA. Synthesis/half life
1.1.4.9 Complement system (C1 esterase inhibitor, C4)
1.1.4.10 Mouse models of allergens (knock out mice)
1.1.4.11 Biology of histamine
1.1.4.12 Diurnal variations of corticosteroids and C4 positive cholamines
1.1.4.13 Laboratory tests available to measure cytokines, chemokines and mediators.

1.1.5…/

1.1.5. **Pharmacology / Pharmacokinetics**
- 1.1.5.1 Antihistamines
- 1.1.5.2 Corticosteroids (different types: topical, oral, inhaled, intranasal, systemic, new steroids [ciclesonide, Momethazone INH])
- 1.1.5.3 Beta-2 agonists (SABA, LABA, Ultra LABA)
- 1.1.5.4 Anticholinergics
- 1.1.5.5 Leukotriene synthesis modifiers and leukotriene receptor antagonists
- 1.1.5.6 Anti-IgE
- 1.1.5.7 Theophyllines
- 1.1.5.8 Adrenaline (biology, half life, correct usage)
- 1.1.5.9 Combination therapy (corticosteroids + LABA, Corticosteroid + LTRAs)
- 1.1.5.10 Dosing in the young (drugs registered for paediatrics versus off label usage)
- 1.1.5.11 HFA vs CFA / spacers / delivery
- 1.1.5.12 New drugs for allergies (eg recombinant molecules, genetically modified molecules)
- 1.1.5.13 Calcineurin inhibitors (eg Pimecrolimus, Tacrolimus)
- 1.1.5.14 Immunosuppressants (eg cyclosporine, methotrexant)

1.1.6. **Strategies for Prevention of Allergy**
- 1.1.6.1 Identification of high-risk infants
- 1.1.6.2 Primary prevention
- 1.1.6.3 Secondary prevention / Avoidance of exposure
- 1.1.6.4 Allergy in pregnancy

1.1.7. **Immunotherapy**
- 1.1.7.1 History and objectives
- 1.1.7.2 Types of immunotherapy:
  - *a) Subcutaneous injection (SIT)*
  - *b) Sublingual (SLIT)*
  - *c) Peptide*
  - *d) Recombinant*
- 1.1.7.3 Mechanisms: SIT/SLIT
- 1.1.7.4 a) Indications and contra-indications
  b) Available vaccines
  c) Vaccines relevant in the RSA
- 1.1.7.5 a) Practical aspects
  b) Regulatory considerations
  c) Protocols
- 1.1.7.6 Risks and Precautions
- 1.1.7.7 Duration
- 1.1.7.8 a) Follow up
  b) Quality of Life

1.1.8. **Psychosocial effects on allergy**
- 1.1.8.1 Epidemiology of allergic diseases in South Africa
- 1.1.8.2 Hygiene hypothesis
- 1.1.8.3 Effects of affluence
- 1.1.8.4 Family size
- 1.1.8.5 Obesity
- 1.1.8.6 Crèche exposure
- 1.1.8.7 Influence of viral infections

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2.0 CLINICAL DISEASES

2.1 Asthma

2.1.1 Epidemiology:
- a) ISAAC Global
- b) South African Asthma Epidemiology

2.1.2 Aetiology / genetics
2.1.3 Pathophysiology
2.1.4 Allergy investigations
2.1.5 Lung functions / small airways
2.1.6 Diagnosis and clinical manifestations at different ages
2.1.7 Differential diagnosis
2.1.8 Prevention and therapeutic approach
2.1.9 GINA Guidelines and National Guidelines
2.1.10 Asthma control
2.1.11 Prognosis and risk factors for severe asthma
2.1.12 Special situations in asthma:
- a) Occupational
- b) Asthma under the age of 5
- c) Aspirin induced
- d) Immunotherapy and asthma
- e) United airway concept

2.1.13 Approach to chronic cough

2.2 a) Allergic Rhinitis
b) Non Allergic, Vasomotor
c) NARES (non allergic rhinitis with eosinophilia)

2.2.1 Epidemiology
2.2.2 Aetiology / genetics
2.2.3 Pathophysiology
2.2.4 Diagnosis and clinical manifestations and differential diagnosis
2.2.5 Prevention and therapeutic approach (National Guidelines, ARIA Guidelines, monosensitive versus polysensitive, nasal cytology, rhinometry)
2.2.6 Prognosis

2.3 Sinusitis

2.3.1 Epidemiology:
- a) Acute
- b) Chronic

2.3.2 Aetiology / Association with allergy
2.3.3 Pathophysiology and organisms
2.3.4 Diagnosis and clinical manifestations in young children, in older subjects. CT scanning
2.3.5 Prevention and therapeutic approach
- Medical/Surgical referral criteria
- Duration of treatment
- Antibiotic recommendations

2.3.6 Complications

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2.4 **Nasal Polyposis**

2.4.1 Pathophysiology and Aetiology

2.4.3 Diagnosis and clinical manifestations: Association with Aspirin sensitivity

2.4.3 Therapeutic approaches:

- Medical
- Surgical referral indications
- Desensitisation

2.4.4 Prognosis

2.5 **Food Allergy**

2.5.1 Nomenclature and definitions of adverse reactions to food (Allergy, Intolerance, Toxic, Aversion)

2.5.2 Classification:
a) IgE mediated
b) IgE / Non-IgE mediated
c) Non IgE mediated

2.5.3 Epidemiology

2.5.4 Aetiology / Major allergens:

- Stable versus unstable allergens
- Cross reacting allergens
- Major food families
- Profilins

2.5.5 Pathophysiology

2.5.6 Diagnosis and clinical manifestations:

- Anaphylaxis / Angioedema
- Eczema
- Elimination diets
- Skin prick tests
- RASTs
- Cut off values
- Open challenges
- Double blind placebo controlled food challenges

2.5.7 Specific syndromes:

- Eosinophilic oesophagitis
- Oral allergy syndrome
- Latex / Food allergy syndrome

2.5.8 Prevention and therapeutic approaches

2.5.9 Prognosis

2.5.10 When to re-challenge (guided by in vitro or skin prick test cut off values)

2.5.11 Genetically modified foods

2.5.12 Common food additives and preservatives

2.5.13 South African food labelling laws

2.6 **Atopic Eczema (Dermatitis)**

2.6.1 Epidemiology: Prevalence

2.6.2 Aetiology / genetics: Adults vs Children

2.6.3 Pathophysiology:

- Allergic March
- Histology

2.6.4 Diagnosis and clinical manifestations:

- Extensive
- Flexural
- Nummular
- Nerodermatitis

2.6.5 Prevention and therapeutic approaches:
- Role of food/diet
- Topical steroids
- Calcineurin inhibitors

2.6.6 Prognosis

2.7 **Contact Dermatitis**

2.7.1 Epidemiology
2.7.2 Common contact allergens and sensitising agents
2.7.3 Pathophysiology
2.7.4 Diagnosis and clinical manifestations (including differential diagnosis with eczema): Role of patch testing
2.7.5 Prevention and therapeutic approach:
- Wet wraps
- Emolients
- Topical steroids

2.7.6. Prognosis
2.7.7 Referral to a dermatologist (UVB, biopsy, immunosuppressants)

2.8 **Urticaria**

2.8.1 Classification: a) Acute
b) Intermittent
c) Chronic

2.8.2 Aetiology:
- Physical
- Allergic
- Food additive induced
- Autoimmune
- Idiopathic

2.8.3 Pathophysiology
2.8.4 Diagnosis and clinical manifestations (including differential diagnosis):
- Including elimination diet
- Autoantibody to IgE receptor

2.8.5 Prevention and therapeutic approach
2.8.6 Prognosis

2.9 **Papular Urticaria and Other Insect Bites**

2.9.1 Epidemiology
2.9.2 Pathophysiology
2.9.3 Diagnosis and clinical manifestations (including differential diagnosis)
2.9.4 Prevention and therapeutic approach
2.9.5 Prognosis

2.10**.** **Angioedema**

2.10.1 Epidemiology
2.10.2 Classification:
- Hereditary
- Drug induced (eg ACE inhibitors)
- Food additive induced
- Idiopathic

2.10.3 Pathophysiology
2.10.4 Diagnosis and clinical manifestations (including differential diagnosis)
2.10.5 Prevention and therapeutic approach:
- Management of life threatening angioedemas
- Use of Danazol, EACA, use of concentrates (eg Berinert)

2.10.6 Prognosis and long term follow up

2.11 **Allergic Eye Diseases**

2.11.1 Epidemiology

2.11.2 Classification:
- Allergen
- Vernal conjunctivitis
- Contact lens
- Chemical (eg Benzalkonium chloride)

2.11.3 Pathophysiology

2.11.4 Diagnosis and clinical manifestations (including differential diagnosis)

2.11.5 Prevention and therapeutic approach

2.11.6 Prognosis

2.12 **Drug Allergy**

2.12.1 Epidemiology:
- In general population
- In high risk subjects (AIDS, cystic fibrosis)

2.12.2 Aetiology / genetics

2.12.3 Pathophysiology

2.12.4 Diagnosis and clinical manifestations:
- Drug allergy testing (controlled, titrated skin prick testing, and in vitro tests)

2.12.5 Prevention and therapeutic options including desensitization / Medic Alert

2.12.6 Prognosis

2.12.7 Reporting of adverse drug events

2.13 **Latex Allergy**

2.13.1. Epidemiology.

2.13.2 Aetiology:
- care workers
- Spina Bifida cases

2.13.3 Pathophysiology

2.13.4 Diagnosis and clinical manifestations

2.13.5 Prevention

2.13.6 Occupational health aspects and notification

2.13.7 Development of hospital latex policies and latex free environments

2.13.8 Prognosis and containing the epidemic

2.14 **Anaphylaxis**

2.14.1 Epidemiology

2.14.2 Aetiology:
- Allergic, Idiopathic, Exercise induced
- Determination of serum tryptase levels

2.14.3 Pathophysiology

2.14.4 Diagnosis and clinical manifestations

2.14.5 Prevention and therapeutic approach: Correct use of Adrenaline

2.14.6 Education and prognosis

2.14.7 Resuscitation of anaphylaxis

2.15 **Occupational Asthma and Allergies**

2.15.1 Epidemiology

2.15.2 Aetiology: Allergic/Irritant

2.15.3 Diagnosis and monitoring

2.15.4 Notification: The Occupational Health Act / COIDA

2.15.5 Compensation process

2.15.6 Prevention and management

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2.16 **Allergies of the Gastrointestinal Tract**

2.16.1 Oral allergy syndrome
2.16.2 Allergic / eosinophilic oesophagitis
2.16.3 Milk induced enterocolitis
2.16.4 Food intolerances
2.16.5 Allergic colitis
2.16.6 Gastro oesophageal reflux

2.17 **Miscellaneous Allergic / Immunological Diseases**

2.17.1 Mastocytosis
2.17.2 Immune deficiency disorders:

- IgG deficiency
- IgG subclass deficiency
- C1 esterase inhibitor deficiency
- C6 deficiency

2.17.3 Hyper IgE syndrome
2.17.4 Hyper IgM syndrome
2.17.5 Allergy in HIV and AIDS
2.17.6 Allergy to vaccines

2.18 **Special Consideration in Allergy and Asthma**

2.18.1 Pregnancy
2.18.2 Infancy, especially milk allergies, substitutes and natural history

2.19 **Future Therapies**

2.19.1 Therapy directed against mediators
2.19.2 Gene therapy
2.19.3 Immunomodulation

3.0 ALLERGY EVALUATION AND DIAGNOSTIC PROCEDURES

3.1 **History Taking in Allergy**

3.2 **Physical Examination**

3.3 **Pulmonary Function Testing**

3.3.1 Static lung volumes
a) Spirometry
3.3.2 Flows and timed volume
a) Peak expiratory flow
b) Forced expiratory volumes
c) Maximal expiratory flow volume curve
3.3.3 Airway responsiveness
a) Bronchodilator response test
b) Bronchoprovocation (challenge testing)
c) Exercise testing
3.3.4 Interpretation of pulmonary function tests

3.4 **Airway Inflammation**

a) Fractional exhaled nitric oxide
b) Inflammatory markers in induced sputum and serum (ECP, IL-5, Tryptase, etc.)
c) Urinary leukotrienes
d) Determination of leukotrienes in exhaled breath condensity

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3.5 **Nasal Cytological Examination**
- 3.5.1 Examination of nasal cavity (head lamp)
- 3.5.2 Sampling technique and processing of nasal specimens (blowing, swab, lavage, scrapings)
- 3.5.3 Fixation and staining (for eosinophils and neutrophils, eg Hansels stain)
- 3.5.4 Microscopic examination (in collaboration with Haematology laboratory)

3.6 **Laboratory / Diagnostic Studies**
- 3.6.1 Sensitivity, specificity, positive and negative predictive values
- 3.6.2 Phadiatope, Fx5E
- 3.6.3 CAST testing (sulphido leukotriene release assays)
- 3.6.4 Skin-prick testing
- 3.6.5 Atopy patch test
- 3.6.6 Induced sputum
- 3.6.7 Oximetry
- 3.6.8 Audiometry
- 3.6.9 Micro array techniques (new)
- 3.6.10 IgE (Immunocap), Total IgE
- 3.6.11 Serum tryptase
- 3.6.12 Western blotting / dot blotting
- 3.6.13 Basophil histamine release tests
- 3.6.14 Staining for eosinophils and application of eosinophilic cationic protein in nasal smears, sputum
- 3.6.15 C1 esterase inhibitor functional and antigenic assays
- 3.6.16 Reference values, co-efficient of variation, Quality control of the allergy laboratory

3.7 **Elimination – Challenge Testing in Food Allergy**
- 3.7.1 Basic elimination diet
- 3.7.2 Open challenges
- 3.7.3 Single – blind challenges
- 3.7.4 Open challenges
- 3.7.5 Double blind placebo controlled food allergy challenges (DBPCFC)

3.8 **Evaluation of Drug Allergy**
- 3.8.1 Clinical:
  - Allergic (Type I)
  - Other adverse reactions
- 3.8.2 In vitro tests (IgE, CAST, flow CAST)
- 3.8.3 In vivo tests (skin prick titrated tests)
- 3.8.4 Ancillary tests (controlled challenges)

3.9 **Desensitization for Drug Allergy (Protocols)**
- 3.9.1 Antimicrobials (eg Penicillin, Cephalosporin, Trimetropirin)
- 3.9.2 NSAID's (Aspirin)
- 3.9.3 Immunosuppressive agents
- 3.9.4 Insulin
- 3.9.5 Miscellaneous (other drugs)

3.10 **Imaging**
- 3.10.1 X-ray studies
- 3.10.2 Computed tomography (CT scan) and limited CT scans
- 3.10.3 Ultrasonography
- 3.10.4 Nuclear medicine

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3.11 **Quality of life in allergic diseases**

3.11.1 Rhinitis
3.11.2 Atopic eczema
3.11.3 Chronic urticaria
3.11.4 Asthma
3.11.5 Food allergy

The use of validated specific quality of life indices (eg Juniper for Rhinitis or SF36) in assessment and monitoring of allergic interventions in the above diseases

3.12 **RESEARCH METHODS**

3.12.1 Basic statistics: Parametric / Non parametric tests
3.12.2 Research design and computer literacy: Use of medical search engines
3.12.3 Clinical audits / Record keeping / Allergy databases
3.12.4 Clinical trials / GCP
3.12.5 Evidence – based methods / Levels of evidence / Cochrane database
3.12.6 How to write a paper: The candidate would be expected to conduct a literature review, design and conduct a self initiated supervised allergy research project during the 2 year training period, analyse the results, presentation of work at a congress and to submit the research for publication.

3.13 **PLANNING NATURAL AND REGIONAL SERVICES IN ALLERGY**

3.13.1 Primary health care
3.13.2 Secondary or regional hospitals
3.13.3 Tertiary services in allergy
3.13.4 Education in allergy (undergraduate and postgraduate)

3.14 **RESEARCH METHODS**

- Statistics
- Research design
- Clinical trials
- Evidence based methods
- Cochrane and systematic reviews

A P P E N D I X B

1.0 FORMAT AND CONDUCT OF THE EXAMINATION

1.1 **Evaluation of Competence**

1.1.1 Evaluation of overall competence of the trainee will be based on:

a) an appraisal by the Head of Unit/Division/Department of the institution where training was undertaken

b) an examination under the auspices of the Colleges of Medicine of South Africa (CMSA)

2.0 PORTFOLIO

2.1 A portfolio/logbook is a mandatory requirement for entry to the examination

2.2 The portfolio for the sub-specialty is available on the CMSA website

2.3 The portfolio includes six-monthly formative assessments (as a minimum) made by the supervisor/divisional head, which is be signed by both candidate and trainer These assessments should, however, be kept confidential and should not be submitted to the CMSA

2.4 Each candidate will be expected to submit their portfolio/logbook to the CMSA by 15 January or 15 June of each year (for the relevant March or August examination)

2.5 Portfolios are viewed by the HOD and satisfactory performance must be indicated in their letter to the CMSA

3.0 EXAMINATION CONVENORS

3.1 A list of potential convenors will be provided by the College of Paediatricians (hereafter referred to as the "College")

3.2 The College will select convenors for each examination

3.3 In the case of a convenor from each examining centre not being represented on the convenors' list, the College Council may at its discretion appoint a convenor from another centre for a particular examination

4.0 CONVENOR RESPONSIBILITIES

The Convenor will:

4.1 Recommend an examiner's panel from the approved list of examiners supplied by the College

4.2 Be sensitive to the following issues in selecting examiners:

4.2.1 Rotation of examiners (representation from different centres)

4.2.2 Exposure of junior sub-specialists (new examiners)

4.2.3 Representation from different centres in South Africa (must have representation from three different centres, except in exceptional circumstances)

4.2.4 The CMSA's transformation goals

4.3 Forward the recommended examiners'panel to the College for approval

4.4 Recommend a moderator for the examination to the College

4.5 Forward a copy of the draft written paper to the College for review by the moderator

4.6 Submit a written report to the College Council after each examination outlining the conduct of the examination, marks achieved, success rates, problems identified and recommendations for future examinations. This report will also be sent to the Head of each training centre and the CMSA Examinations office

5.0…/

5.0 EXAMINER SELECTION

5.1 Examiners will be appointed by the College following recommendation by the convenor

5.2 A Certificate examiner must be registered with the Health Professional Council of South Africa (HPCSA) as a sub-specialist, and should be at least two years post his or her certification examination or registration as a sub-specialist

5.3 Use of a non-specialist examiner or one from an allied subspecialty must be motivated for in writing to the College

5.4 The examination panel will consist of three examiners, including the convenor. This number of examiners is considered fair to the needs of the candidate and the CMSA

5.5 Any request to alter the examiner numbers for an individual examination must be motivated in writing to the College

5.6 The written and oral/OSCE examinations will be conducted by the same set of examiners

5.7 An examiner will not necessarily be excluded if he/she is the trainer/supervisor of the candidate

5.8 Ideally, no more than one examiner will be chosen from any single centre in South Africa for each examination

5.9 The selection of Certificate examiners will be independent of the FC Paed(SA) Part II examiner selection process

5.10 Whenever possible the same examiner should not be involved in a Certificate examination and a FC Paed(SA) Part II examination simultaneously

5.11 The CMSA Academic Office will be responsible for notifying examiners about their selection for an individual examination

6.0 MODERATORS

6.1 In order to adhere to CMSA standards and for quality assurance, a process of 'moderation' of each examination is considered necessary

6.2 A moderator shall be appointed by the College for the Certificate examination. This individual will ideally be a senior member of the sub-specialty

6.3 Prior to the conduct of the written examination, the moderator will check that the examination questions and marking memorandum reflect a fair spread of the curriculum (reliability), match the curriculum (validity), and that the mark allocation of the questions is fair and appropriate

6.4 The moderator will complete a report and return this to the College and the CMSA at the end of each examination. The College will formally review the report

7.0 STRUCTURE OF THE EXAMINATION

7.1 The Certificate examination has two components:
a) A written component
b) A oral/OSCE/OSPE/clinical component

7.2 Each of the two components contributes 50% to the overall mark

7.3 The pass mark for the overall exam is 50%

7.4 A sub-minimum pass mark of 50% is expected for each of the two (written and the oral/OSCE/clinical) components of the examination

7.5 There is no sub-minima for individual papers, questions or sub-sections of the OSCE/oral/clinical examination

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8.0 EXAMINATION CENTRE

8.1 Ideally the centre/region hosting the FC Paed(SA) Part II examination will be the host centre for each Certificate examination

8.2 The Convenor of the examination will preferably, but not necessarily, originate from that centre/region

8.3 Exceptions may be granted where there is no suitable Convenor based at that centre/region or the sole candidate in an examination is from the host centre

9.0 WRITTEN EXAMINATION

9.1 Certificate examinations will comprise of two three-hour written papers
Paper I will consist of 4 long questions or scenarios (may contain sub-parts), worth 25 marks each (each examiner shall submit 2 such questions to the Convenor)
Paper II will consist of 10-12 short questions, worth 10 marks each (each examiner to submit 5 such questions to the Convenor)

9.2 A marking memorandum – a basic outline to the expected answer - will be provided, by each examiner at the time of question acceptance, including an indication of the allocation of marks for each section/part answer

9.3 The language of written papers will follow College recommendations

10.0 CLINICAL / ORAL / OSCE EXAMINATIONS

10.1 This examination will last NO LONGER THAN 3 hours (the recommended duration is 1–3 hours)

10.2 If the examination is longer than 1½ hours the candidate must be given a 15-minute break with refreshments

10.3 This examination will consist of 5 ‘stations’ and/or 3–5 ‘clinical scenarios. (Ideally, this examination should contain at least 5 ‘stations’ and/or 3–5 ‘clinical scenarios)

10.4 The examination will be structured, balanced and similar for each candidate

10.5 The language of the oral/OSCE/clinical examinations will follow College recommendations

11.0 TIMING OF ORAL/OSCE/CLINICAL EXAMINATIONS

11.1 The examination will be held in the same week as the FC Paed(SA) Part II clinical examination

11.2 Exceptions will be by written motivation to the College

12.0 RESPONSIBILITY OF THE COLLEGE IN THE EXAMINATION PROCESS

12.1 Selection of Convenors, examiners, and moderators

12.2 Monitoring of the conduct of each Certificate examination

12.3 Reviewing all aspects of each examination on completion

12.4 Tracking performance and success rates in individual examinations

13.0 APPEALS PROCESS

13.1 The CMSA has an appeals process that will be followed

JOHANNESBURG
February 2016