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Exam report 2016.2 OSCE

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The Royal Australian College of General Practitioners
100 Wellington Parade
East Melbourne, Victoria 3002 Australia

Tel 03 8699 0510
Fax 03 9696 7511
www.racgp.org.au

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We recognise the traditional custodians of the land and sea on which we work and live.

1. Exam psychometrics

Table 1 shows the mean and standard deviation of the entire cohort that sat the exam. These values can vary between exams and cycle. The reliability is a measurement of the consistency of the exam, with values between 0% and 100%.

A candidate must achieve a score equal to or higher than the pass mark (or 'cut score') in order to pass the exam. The Objective Structured Clinical Examination (OSCE) pass mark is determined by the accepted borderline group method (refer to the *RACGP Education: Examinations guide* for further details).

The 'pass rate' is the percentage of candidates who achieved the pass mark.

The RACGP has no quotas on pass rates – that is, there is no set number or percentage of people who pass the exam. Fluctuations in pass rates can be attributed to various factors. The number of candidates who sat the exam is the number of people present on the day. Enrolment figures may be higher due to withdrawals.

Table 1. 2016.2 psychometrics

Mean score (%)	70.67
Standard deviation (%)	6.85
Reliability (%)	74.90
Pass mark (cut score %)	64.07
Pass rate (%)	83.41
Number sat	1025

2. Candidate score distribution

Figure 1 shows the range and frequency of final scores for this exam. The vertical blue line is the cut score.

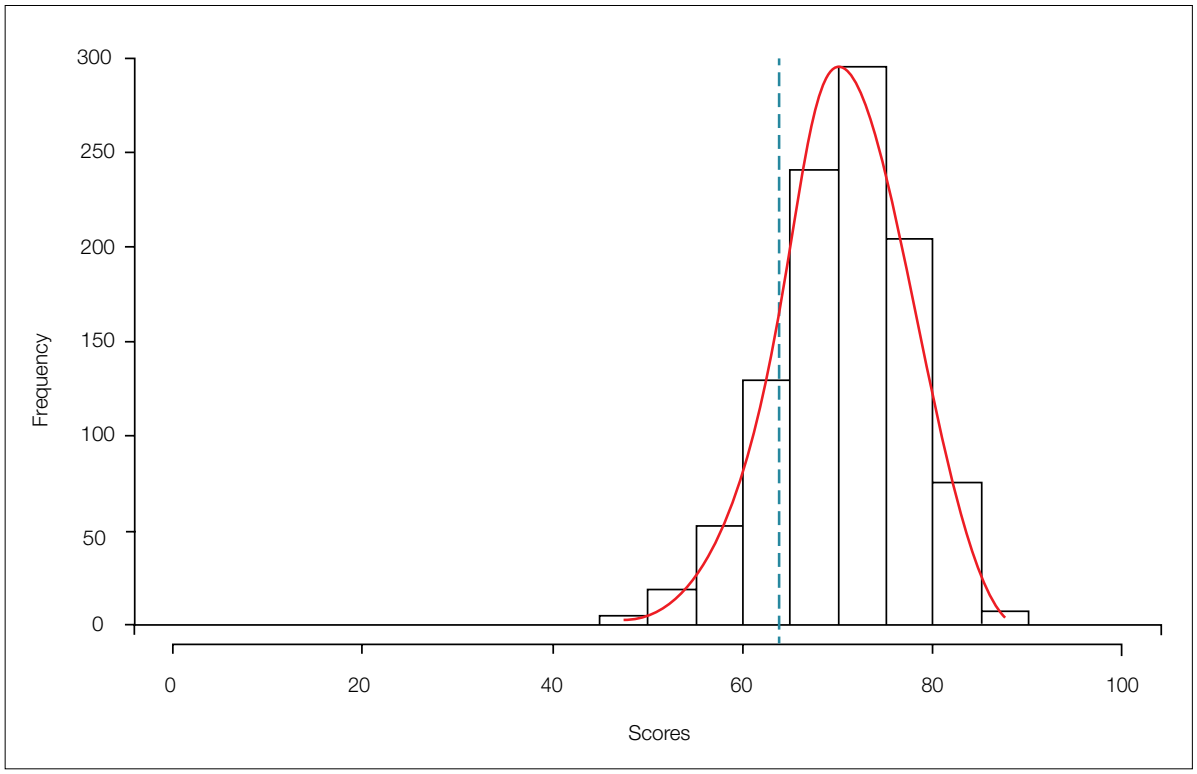

Figure 1. Final 2016.2 OSCE score distribution

3. Candidate outcomes by exam attempt

Table 2 provides pass rates displayed by number of attempts. A general trend suggests candidate success diminishes with each subsequent attempt. Preparation and readiness to sit the exam are paramount for candidate success.

Table 2. OSCE 2016.2 pass rates by number of attempts

Attempt	Pass rate (%)
First attempt	87.00
Second attempt	65.43
Third attempt	71.05
Fourth and subsequent attempts	54.05

4. Preparation for the OSCE

Preparation for the OSCE should be focused more on practice, with candidate performance being observed and feedback being provided. Performing well in actual practice makes it easier to translate this performance into the exam situation. Strategies for preparation are covered in the *RACGP Education: Examinations guide* and in the open letters to candidates.

Specific activities available through RACGP state faculties include candidate preparation workshops and OSCE practice exams ('polish up'/'mock exams'). In the practice or mock exam, candidates are provided with feedback on their performance, although a practice exam is not designed to provide a mark/grade as an indication of whether or not a candidate will pass. Based on candidate feedback, we highly recommend attendance at an RACGP exam preparation workshop and practice exam.

5. Feedback report on 2016.2 OSCE

This feedback document will be published following each OSCE, in conjunction with candidate results.

OSCE examiners are experienced GPs who are trained in assessment principles. One of the strengths of the OSCE is that candidates are assessed by 25 or more examiners, whose ratings (marks) make up the total score.

Candidates are rated on how they assess and manage different clinical situations – that is, the components (rating areas) of different consultations. It is very important to read the candidate instructions carefully and understand what the tasks are in each case. Every OSCE station has an individualised rating schedule that corresponds to the tasks identified in the 'Candidate instructions', and examiners rate candidates on these rating schedules.

Although the tasks within each case are specific, candidates are expected to exhibit a 'whole-patient' approach by demonstrating the core general practice skills found within the RACGP curriculum.

In the 2016.2 examination, the rating areas where a number of candidates underperformed were Diagnosis, Management, and Ethical and Medico-legal issues. Diagnosis is dependent on History and Examination. Management is one rating area where study can improve a candidate's performance. In Management, a good structure consists of:

- explaining the problem(s)
- checking the patient's understanding of the problem(s) and of the general practitioner's (GP's) explanation
- prioritising the information to be shared with the patient (what is important, what needs to be done initially, what needs to be done subsequently)
- checking for any obstacles to the management plan
- safety netting, summarising and structuring follow-up.

As in other OSCE exams, 'Hand to candidate' pages are used where the observing examiner has a moderate amount of information (eg physical examination finding, investigation result) to provide to the candidate.

A handout makes it less likely that a candidate will forget or misinterpret what they heard. It also saves time as it is faster to read than to present a finding orally. However, in 2016.2, examiners noted that a number of candidates either overlooked or ignored the information that was in their hands on the 'Hand to candidate' pages.

Candidates must read any handout carefully, just as they do the candidate instructions. One candidate explained it this way: 'I try to make sure I don't miss anything when I read by running my finger under the sentence as I read it. It works for me, just as it works for my six-year-old!'

Here are some examples of areas of candidate underperformance in the 2016.2 exam.

Example 1

In this viva, the patient forged the GP's signature on a prescription for narcotics. A number of candidates did not adequately address the ethical and medico-legal considerations, which include:

- arranging to meet with the patient, accompanied by another staff member
- reporting the forgery to police (requirements vary in different states)
- advising drug addiction services (requirements vary in different states)
- if ending the professional relationship is contemplated, determining how this would be done, how the patient can be informed, and what alternative arrangements can be put in place for the patient's healthcare.

This viva also requires consideration of the particular circumstances that would warrant a GP to consider terminating the doctor–patient relationship.

Example 2

The diagnostic conclusion in this case of a child, aged five years, is iron-deficiency anaemia due to inadequate iron intake, which relates to the eating behaviour of the child. In this case, Management was an area of underperformance. Management should adequately cover:

- explaining the problem
- advising on iron-rich heme and non-heme foods, giving examples
- advising on iron supplements (calculated based on weight) and safe storage of iron supplements
- providing a structure for follow-up retesting.

Additional management points include:

- encouraging intake of food rich in vitamin C and of fresh vegetables to promote iron absorption
- providing eating advice to assist the parent in managing the child's eating behaviour
- involving dietitian as required
- managing inter-current infections.

Example 3

In this case, a male, aged 51 years, fainted while exercising in the gym. Although this was his first syncope episode, a careful history reveals episodes of feeling faint, lightheaded and nearly passing out – all related to strenuous exercises. The physical examination handout shows systems examination (except cardiovascular system [CVS]) to be normal. Specific enquiry regarding the cardiovascular system reveals enlarged heart and a murmur. Interpretation of the ECG tracing shows an LVH. This means an aortic stenosis has to be considered, with hypertrophic obstructive cardiomyopathy in the list of differential diagnosis.

A number of candidates did not consider symptomatic aortic stenosis. Therefore, their management did not reflect the urgency of the situation – that is, they did not provide for cardiologist assessment, nor provide interim advice to avoid exercise, physical exertion and stimulant medicines/food.

Example 4

In this case, a male, aged 55 years, presents with a two-day history of a painful belly that has been getting worse. In this short case, history should cover adequate exploration of the presenting symptom, changes in bowel actions, fever and generalised symptoms, and exclude red flags. The diagnostic conclusion turns out to be acute diverticulitis.

Management thus should cover explaining what the problem is, appropriate antibiotics (type and dosing), pain relief, and safety netting (ie what to do if the pain does not settle down). Some candidates also gave advice on diet, likely investigation and a follow-up plan – these additional points are rewarded.

6. Further information

Refer to the *RACGP Education: Examinations guide* for further exam-related information.

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