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Exam report 2016.1 OSCE

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RACGP Education: Exam report 2016.1 OSCE

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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 semesters. The reliability is a measurement of the consistency of the exam, with values between 0% and 100%. Although The Royal Australian College of General Practitioners' (RACGP) target is 80% or higher, literature suggests that above 75% is adequate.

A candidate must achieve a score 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. 2016.1 psychometrics

Year	2016.1
Mean score (%)	69.86
Standard deviation (%)	7.89
Reliability (%)	81.7
Pass mark (cut score %)	63.53
Pass rate (%)	80.62
Number sat	872

2. Candidate score distribution

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

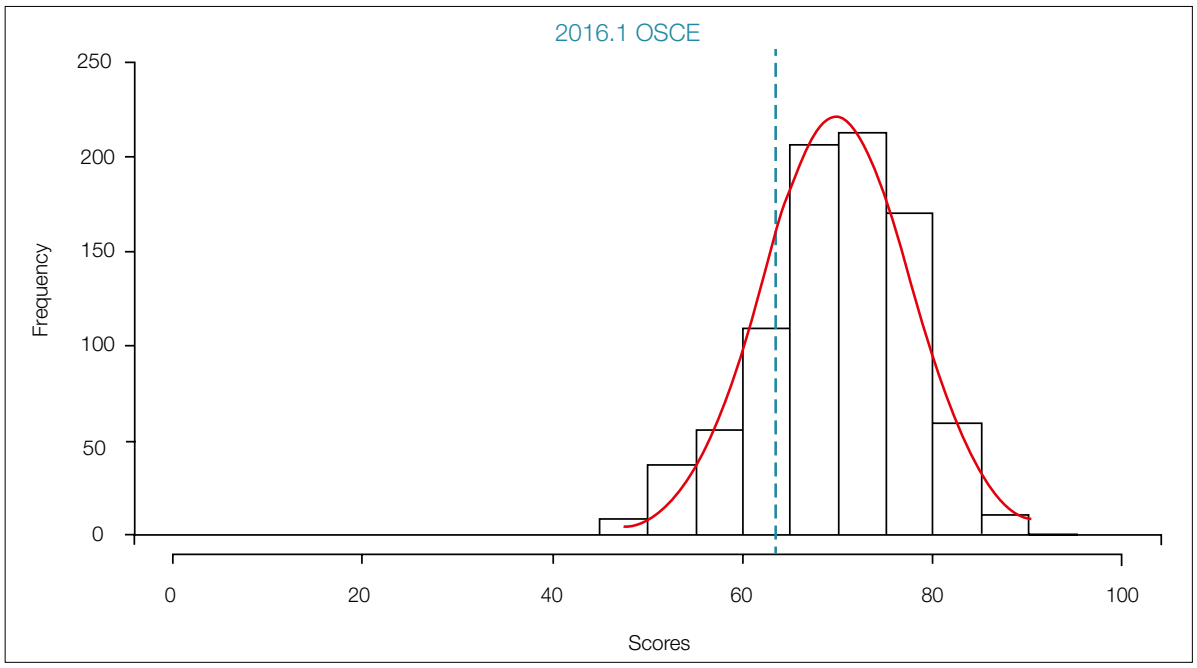

Figure 1. Final 2016.1 OSCE score distribution

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. Pass rates by number of attempts

OSCE 2016.1	
Attempt	Pass rate (%)
First attempt	89.04%
Second attempt	55.56%
Third attempt	64.29%
Fourth and subsequent attempts	32.69%

4. Preparation for the OSCE

Preparation for the OSCE should be focused more on practice rather than study, as well as observation of your performance and case role-play with feedback. Performing well in actual practice makes it easier to translate these behaviours into the exam situations. 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 practice exams ('mock exams'). Practice exams provide a simulated experience in preparation for the real exam. Candidates are provided feedback to complete their experience. Many candidates report feeling more prepared and less nervous in the actual exam, after having completed a practice exam.

5. Feedback report on 2016.1 OSCE

This feedback document has been published in conjunction with candidate results.

It should be noted that OSCE examiners are experienced GPs trained in assessment principles. The OSCE is assessed by 25 or more examiners, whose ratings (marks) make up each candidate's total score.

Candidates were rated on how they assess and manage different clinical situations, ie the components of a consultation:

- Communication and rapport
- History taking
- Physical examination
- Investigations
- Diagnosis
- Management

Examiners at each OSCE station rated the candidates on a selection of areas within the context of the case. Feedback from the examiners noted that it was very important to read the candidate instructions and understand the tasks in each case. Each station has an individualised rating schedule that corresponds to the tasks identified in the candidate instructions. Although the tasks within each case are focused/specific, candidates are expected to exhibit a 'whole-of-patient' approach by demonstrating the core general practice skills found within the *RACGP Curriculum for Australian General Practice 2016*.

The following is a selection of OSCE cases from the 2016.1 exam, illustrating some of the rating areas in which a number of candidates underperformed, highlighting the essential elements of a competent candidate.

Example 1

In this long case, a young adult postgraduate student presents with headache. This is her first consultation for this problem.

The tasks specified in the candidate instructions are to take a history, carry out an appropriate headache examination including cranial nerves, and explain the diagnosis and management to the patient. No results of investigations are available.

Rating is more heavily weighted to physical examination (as is appropriate in a physical examination case) and equally weighted to communication and rapport, history and management.

After taking an empathic history, the candidate should have identified the multiple stressors in the patient's life, asked about work and lifestyle factors, explored for red flags and arrived at a probable diagnosis.

A number of candidates underperformed in the physical examination. A competent candidate should explain the intended examination to the patient, be considerate of the patient's comfort and ensure hand hygiene. A neurological examination should be conducted (cranial nerves having already been specified in the instructions), without overlooking palpation of the lower scalp and upper cervical muscles, while checking for red flags. Some candidates were not able to carry out a systematic and orderly examination. Candidates are expected to report their findings to the observing examiner as they examined.

Although no results of investigations are available, candidates who advised the patient that they would need imaging, or who over-medicated the problem, were rated lower in the area of management.

This case is classified as neurological under the International Classification of Primary Care, second edition (ICPC-2) based on the reason for presentation. The aetiological classification eventually turned out to be psychological.

Example 2

In this short case, a 34-year-old woman presents because she has not fallen pregnant after two years of trying.

The tasks specified in the candidate instructions are to take a history, ask for the physical examination findings and surgery tests (provided on a 'hand-to-candidate' page), outline the diagnostic conclusions and proposed relevant investigations to the patient, and discuss the initial management plan.

History would reveal the problem as secondary infertility in an otherwise normal and healthy couple. From an appropriate sexual history, the frequency and timing of sex can be discounted as a possible contributing cause.

Rating is weighted to investigations, an area in which a number of candidates underperformed. In a competent performance, a candidate should prioritise and group information (as there are a number of investigations to outline) so as not to overwhelm the patient, be able to provide plain-language explanations, and give an indication of staging of investigations.

The key investigations for female infertility at this first presentation are thyroid function, prolactin, tests to ascertain ovulation, and pelvic ultrasound. Most guidelines also include a hysterosalpingogram. The key investigation for male fertility is seminal analysis – count, morphology and motility. Although not essential, there should be time to outline the process of a prenatal work-up.

Example 3

In this short case, an older male patient who has recently experienced a flare-up of chronic leukaemia attends for a flu injection. There are no new symptoms relating to the leukaemia, with the patient philosophical about his condition. However, an empathic history would reveal his concern about a past medical condition that may recur with immunosuppressive drugs, how to keep any such recurrence confidential, and his wish to not have this information recorded in his medical record.

Rating is weighted to communication and rapport, and management. A number of candidates underperformed in both of these areas.

In a competent performance in communication and rapport, a candidate should use open-ended questions, respond empathically to concerns, be non-judgemental, and check the patient's understanding of his problem and management plan.

In a competent performance in management, the candidate should strongly advise disclosure to the treating haematologist, explain the patient confidentiality process, suggest use of appropriate medications in case of recurrence, and also discuss the confidentiality issues insofar as the patient's carer is concerned.

6. Further information

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

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