COMMITTEE FOR EXAMINATIONS

Report on the April 2016 OSCE Examination

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The Royal Australian & New Zealand College of Psychiatrists

The April 2016 OSCE examination was held in Melbourne, Victoria on Saturday, 16 April 2016. This was the first sitting of the OSCE examination under the 2012 Fellowship Program. We would like to acknowledge the OSCE Subcommittee's work over the past 18 months – the alignment of the OSCE examination to the competency-based program, developing new CanMEDs descriptors, developing and trialing a new marking proforma, and writing new stations.

There were 88 candidates sitting the examination, of whom 67 passed, giving a pass rate of about 76%.

The Committee for Examinations wishes to thank the volunteers, examiners and College staff for all their work preparing and conducting these examinations. Of special mention, we are particularly grateful for the efforts of the Clinical Examination Coordinators, Dr Sanmuganatham Sujeeve and Dr Titus Mohan, and the Local Hospital Coordinators, Dr Adele Storch (Royal Melbourne Hospital) and Dr Angela Anson (Royal Women's Hospital). The Committee for Examinations would also like to thank the hospitals/services for volunteering their facilities and staff, and the examiners for generously giving of their time and expertise.

We are especially grateful to the Examination Assistants who assisted in the running of these exams. They are:

Royal Melbourne Hospital	**Royal Women's Hospital**
Christopher Cunningham	Dr Abayomi Adeniyi
Misha Dagan	Dr Romi Goldschlager
Dr Kate Egan	Dr Emeka Ike
Melissa Garwood	Matthew Krelle
Dr Navita Mysore	Dr Emily Moriarty
Dr Jerome Nicholapillai	John Mascarenhas
Dr Daithi O'Mathuna	
Dr Thinzar Phyo	
Ashleigh Sellar	
Dr Rowena Sycamnias	
Dr Bharat Visa	

In total, there were two streams operating in the morning and afternoon at Royal Melbourne Hospital and one stream operating in the morning and afternoon at Royal Women's Hospital.

The examination comprised three long stations (stations 1, 2 and 3) and 8 short stations (stations 4 - 11), as well as one 'active' Bye long station.

All stations were referenced to the CanMEDS framework, the RANZCP OSCE Blueprint Primary Descriptor Categories, Areas of Practice and the RANZCP 2012 Fellowship Program Learning Outcomes.

The OSCE examination was assessed at the level of a Junior Consultant Psychiatrist. All OSCE station templates refer to the junior consultant standard in section 3.3 (https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Exam-Centre/April-2016-OSCE-Stations1-11.aspx). In order to maintain the integrity of the standard, on the day prior to the examination the Examiners were trained to the OSCE standard and role players were trained to play the role consistently.

At the level of a Junior Consultant Psychiatrist it was expected that the candidate's performance would display experience beyond that of a trainee ready to proceed to advanced training (the previous OSCE standard), particularly with respect to greater systemic and governance understanding, and preparedness to make decisions and accept clinical responsibility. The marking schedules reflected these requirements.

Station Summary:

Station 1 In this Viva station, candidates were required to review and assimilate a written clinical handover in order to develop a biopsychosocial management plan from the information from obtained in the preceding Bye Station. Many of the candidates struggled to achieve the junior consultant standard in developing & presenting a management plan.

Station 2 Candidates were to undertake an interview with a mother with borderline personality disorder to discuss her concerns about her parenting and the effect of her disorder on her children, 48 hours post overdose. Examiners again reported that many candidates did not address the requirements clearly described in the Instructions to Candidate, with many candidates not fully completing the required tasks. Many candidates also failed to follow the cues provided by the role player.

Station 3 In this station, candidates were examined on their ability to empathically conduct part of a psychotherapy session addressing the issue of being given a gift by a patient. Candidates were to demonstrate ethical conduct and practice in relation to a long term psychotherapy patient during feedback to the examiners. In general candidates did better than expected, despite it being a challenging station. Most candidates managed timing in this station well. Some candidates struggled to deal with the complex psychotherapy issues and may not have had the relevant clinical experience. It was noted that very few candidates made reference to the RANZCP Code of Ethics.

Station 4 required the candidate to accurately confirm the diagnoses of agoraphobia and panic disorder including the severity and impact of the presentation. Candidates were required to demonstrate their knowledge of the non-pharmacological management of agoraphobia with the best evidence base. Examiners noted that most candidates found this station straightforward, with history and diagnosis being handled well. However many candidates did not detail the impact of the disability associated with agoraphobia. The management plan was not well covered as it was often left to the last minute.

Station 5 In this station, the candidate was expected to demonstrate the ability to perform cardiopulmonary resuscitation (CPR) while providing a commentary to the examiner. They were also to evidence skills on how to use an automated external defibrillator (AED), contraindications for the use of AED, knowledge of when to stop CPR and the difference between adult CPR and that in children and infants. The Committee for Examinations and the Examiners of the day were extremely disappointed on the generally poor performance of the cohort on this station. There was a clear lack of knowledge and expertise in what is a mandatory training requirement for all doctors.

Station 6 tested the ability of the candidate to conduct a psychiatric assessment of a young man with a preoccupation with hair loss and his appearance which is having a significant impact on his personal and professional life. This station assessed capacity to take an empathic psychological history and reach a diagnosis of Body Dysmorphic Disorder (BDD). A surprising number of candidates did not seek to look under the patient/role player's hat, i.e. matching concerns with evidence. Some candidates made a correct diagnosis but did not provide evidence of empathy.

Station 7 concerned Sri Lankan female who has been accepted as a refugee and who has been referred by her GP for confirmation of a diagnosis of depression. In this station, the candidate was required to perform a brief diagnostic assessment (history and MSE) focussed on confirming the diagnosis of major depression, assessing its severity, and identifying an additional diagnosis of PTSD. The candidate was also required to explain the findings to the patient in a culturally sensitive and individually tailored manner. Many candidates focussed on PTSD and missed the diagnosis of depression.

Station 8 In this station the candidate was to assess and manage nicotine addiction in a 35-year-old man who suffers from schizophrenia and requires an extended hospitalisation for an orthopaedic procedure and subsequent rehabilitation. The candidate was required to take a relevant history and explain treatment options and assist the patient in making a decision about his treatment. A number of candidates appeared not well versed on the contraindications of bupropion and many did not focus on nicotine in substance use history.

Station 9 was a Viva station, set in a forensic setting, and required the candidate to teach a junior doctor about assessing risk of future violent behaviour incorporating static and dynamic factors; formulate a management plan taking into account the risk factors of future violence and consider the ethical issues pertaining to breach of confidentiality in the context of future risk. Examiners noted that the management plan was not well done by candidates and that a number focussed too much on medical ethics and not the duty to warn potential victims.

Station 10 required candidates to undertake an assessment with the spouse of a 70-year-old man suffering from Alzheimer's disease, who had displayed a recent episode of verbal aggression. The candidate was to present their understanding of the situation and outline the general principles of early management to the spouse. Examiners noted poor time management skills by a number of candidates in this station: Candidates did not allocate enough time to take an adequate history and often asked questions for which answers were in the given information. Examiners hypothesise that poor performance in this station may be due to a lack of experience in older persons mental health services.

Station 11 In this station the candidate was expected to take a history from a 27-year-old man who is at risk of losing his residential rehabilitation placement due to his lack of motivation and poor self-care. The candidate was to differentiate negative symptoms of schizophrenia from other differential diagnoses. The Examiners considered this station to be “bread and butter” psychiatry and lamented the generally poor interview skills in evidence for the cohort as a whole. A number of candidates missed clues given by the role-player and did not address the requirements of the Instructions to Candidates. It was noted that candidates tended to focus on cannabis use at the expense of other factors.

Results Summary:

The table below shows a range of descriptive statistics pertaining to each of the stations.

Station	Cut Score	Mean Score	Standard Deviation	% who scored > cut score for that station
1	24.8	26.7	6.6	59.1%
2	23.9	28.8	7.6	70.5%
3	24.6	26.7	8.2	64.8%
4	30.3	34.9	5.0	83.0%
5	23.7	24.1	9.5	53.4%
6	25.8	28.6	8.3	68.2%
7	26.6	30.9	7.8	72.8%
8	24.2	28.4	8.1	64.8%
9	25.1	27.0	7.2	62.5%
10	23.4	23.4	8.4	52.3%
11	24.5	23.3	6.3	29.5%

The pass rate for the candidates who attempted the OSCE was approximately 76%.

General Feedback:

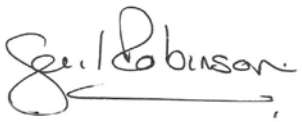
The examiners again wish to remind candidates that it is important to read the instructions for each station carefully, take particular note of the tasks of each station and perform the tasks that are specified. It is important to note that no detail in the instructions provided should be considered redundant. Equally, the candidate is not required to focus on information that is already provided, unless directly instructed to do so (e.g. ‘confirm’, ‘explore’ etc.). Candidates should be especially careful to identify whom they are to address if there is a communication component: will it be the ‘patient’, a ‘mental health professional’, a ‘doctor’ or the examiner? It is critical to target communications appropriately. It is also critical with respect to time management to get into role quickly and to begin to perform the required tasks promptly. It is not necessary to knock on the door prior to entering the examination room or to introduce yourself to the examiner.

Candidates who performed well demonstrated their ability to prioritise and identify key issues quickly, but at the same time avoided too narrow a focus. They also demonstrated a good ability to synthesise information and communicate clearly, and they addressed the requirements specified in the "Instructions to Candidates".

The Committee wishes to clarify the use of "prompts" in the examination. If candidates are to be given a timing prompt, the details will be noted on the "Instructions to Candidates". Candidates will **not** be given prompts unless they have been scripted. Should a candidate already be undertaking the prescribed task, they will **not** receive a timing prompt, as this may impede the activities of the candidate. Therefore, candidates are not recommended to rely on prompts for their timing of task performance.

There were a number of candidate incident reports lodged concerning the issue of MET calls. The Committee for Examinations makes every effort to provide a standardized examination experience, and is aware of the high levels of candidate anxiety on the day, but simply cannot control every internal and external factor that may affect the running of the examination. Given that the examinations are held in hospitals, MET calls are unavoidable. Candidates are advised in their examination preparation to include some strategies for coping with unexpected changes or minor problems, and in particular to expect various types of emergency announcements.

The Committee for Examinations undertakes training of examination assistants in timing and other procedures related to the conduct of examinations. Nevertheless, the Committee for Examinations is aware that the bell was rung about a minute early on one short station at the Royal Melbourne Hospital. In response to this event, the performance of all streams was reviewed to ensure overall comparability of streams. The Committee wishes to advise that no systematic effects were evident either on the affected station or in the overall performance of candidates in the affected vs the unaffected streams. For this reason the CFE did not make any adjustment to marks. The CFE also carefully considered the recommendations of a number of candidates regarding timing procedures, and will make some changes in an effort to reduce the likelihood of future similar events.



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9 May 2016