COMMITTEE FOR EXAMINATIONS

Report on the September 2016 OSCE Examination

Distribution: (candidates, examiners, EOs, EC, CSIMGE, OTPC, CEO, website)

The Royal Australian & New Zealand College of Psychiatrists

The September 2016 OSCE examination was held in Brisbane, Queensland on Saturday, 10 September 2016. This was the second sitting of the OSCE examination under the 2012 Fellowship Program.

There were 107 candidates sitting the examination, of whom 73 passed, giving a pass rate of about 68%.

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 Kaveh Darabian (The Prince Charles Hospital) and Dr Emile Touma (Royal Brisbane and 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 their time and expertise.

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

The Prince Charles Hospital	**Royal Brisbane and Women's Hospital**
Dr Charana Arachchige	Dr Helen Donaghy
Dr Abhijith Krishna	Dr Peter Huang
Dr Claire McAllister	Dr Naomi Jess
Dr Katherine Moss	Dr Nicholas Lenskyj
Dr Skye Murray	Dr Abigail Lane
Dr Yamini Samy	Dr Leesha Mackie
Dr Lin Lin Thaw	Dr Khine Oo
	Dr David Nguyen
	Dr Arul Ravindran
	Dr Rhys Thomas

In total, there were two streams operating in the morning and afternoon at The Prince Charles Hospital and two streams operating in the morning and one in the afternoon at the Royal Brisbane and 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 'inactive' 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. 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 at the end of Stage 3, it was expected that the candidates' 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 station, candidates were required to demonstrate the capacity to engage an Indigenous patient, a lawyer, and to put him at ease, display respect and a capacity to work with a person of different cultural background and to take a history that recognised the importance of cultural heritage to the individual and incorporate that into the formulation presented to the examiner.

A number of candidates took notice of the available cues that this station was predominantly about cultural aspects and risk assessment and prioritised these accordingly. Some candidates found it difficult to meet some of the cultural competencies and the majority of candidates tended to focus on general history rather than cultural context of the history provided.

Station 2 was the Core Skills station, where candidates were expected to outline the management of a 54-year-old man with treatment-resistant depression, who has been referred to a Community Acute Care Team by a private psychiatrist, against a background of polypharmacy. This was a challenging station for a number of candidates. Better candidates differentiated melancholic/non-melancholic depression. A number of candidates missed or did not consider the ethical issues inherent in polypharmacy prescribing and possible Code of Conduct implications in this station.

Station 3 In this station candidates were to assess a 69-year-old male with a history of depression and concerns regarding decline in his cognition despite an improvement in his depressive symptoms. Candidates were to demonstrate their ability to accurately choose and undertake a series of bedside cognitive tests and incorporate available information to come to a preferred diagnosis of Alzheimer's dementia.

A number of the cohort jumped into performing a frontal lobe assessment only. Some candidates appeared to struggle with providing a running commentary to accompany the cognitive assessment. Some candidates performed their own version of established cognitive tests and a number of candidates were not able to correctly comprehend and interpret the MRI report, with a number not identifying the evident temporal lobe atrophy. In general there was a generic and formulaic management plan which did not meet the standard of a junior consultant.

Station 4 In this Viva station candidates were to discuss an approach to undertaking an audit the monitoring of metabolic syndrome assessment in patients with schizophrenia in a community mental health centre. Candidates were expected to outline the key measures and their overall frequency of assessment. They were then expected to describe the process of audit, including the importance of feedback in any continuous quality improvement activity, and to consider likely barriers to assessing how well health professionals are performing against accepted standards and guidelines. The candidate was also expected to describe their role in conducting an audit within a multidisciplinary team environment.

This was a discriminating station and on the whole and it was poorly done. Feedback from Examiners was that candidates did not read their instructions and only focused on importance of monitoring metabolic syndrome and the importance of managing it. Variation in responses from candidates indicated limited understanding of the differences between a survey, research and audit. Knowledge and application of the audit cycle was poorly demonstrated.

Station 5 In this station candidates were to assess a 69-year-old man with Parkinson's Disease. The candidate was also expected to identify a range of differential diagnoses and specifically consider depressive disorders and apathy. Candidates performed well in this station, though some did have issues with time management. Superior candidates presented a much more focused and appropriate diagnosis.

Station 6 This station involved an outpatient review of a currently stable 34-year-old female with bipolar disorder and a history of severe manic episodes, in the context of her husband being convinced she is relapsing. Candidates were to evaluate the ability to distinguish normal range of mood versus abnormal mood states in bipolar disorder. This station was generally undertaken well by the cohort, with the assessment done very well, though candidates struggled to talk about the home environment, expressed emotion and how to deal with husband's concerns.

Station 7 was a Viva station which expected candidates to demonstrate their knowledge of the negative symptoms of schizophrenia, including historical factors, identification, differential diagnosis and their management. Examiners felt that candidates should be able to demonstrate good understanding of this core content. Overall the differential diagnosis was done well but the history was often read as "how to take a history for negative Schizophrenia" instead of the "historical aspects of the concept of negative symptoms in schizophrenia".

Station 8 relates to an interview with a parent in relation to his concerns about his 8-year-old son who has Autism Spectrum Disorder (ASD) who was being bullied at school. The candidate was expected to demonstrate that they are familiar with common mental health issues caused by bullying through an interview situation that required the candidate to elicit and establish the range and severity of parental concerns in relation to an ASD child. Candidates found this to be a challenging station with many candidates running out time. Some candidates struggled with history taking from a parent and were unsure on how to advise about what to do with regarding to bullying. Very few candidates asked about depression and self-harm, while some candidates focused on sexual abuse and deviated from the tasks at hand.

Station 9 In this station the candidate was asked to meet with the sister of a patient who was admitted to a medical ward with complications related to anorexia nervosa. The candidates tasks were to convey information about anorexia nervosa, provide information about the medical complications of this disorder and answer any questions. Candidates struggled with this station with many delivering a marginal performance. Many candidates were unable to empathically interact with the anxious relative of a patient who is seriously ill, particularly in the context of concerns that the patient may die.

Station 10 required candidates to take a focussed drug and alcohol history from a 25-year-old woman who has taken an accidental overdose of over-the-counter opioids. Examiners were to evaluate the candidate's ability to take a focussed drug and alcohol history, and establish opioid dependence (codeine) based on the findings. Candidates were also expected to outline management options for opioid dependence.

Examiners found this station to be straight forward and clear in its tasks. Most candidates had assessed the history and diagnosis well but failed to elicit the dependence criteria sufficiently. A number of candidates appeared to be unfamiliar with the product '*Nurofen plus*'. Time management was an issue with a number of candidates running out time. Examiners observed that management was poorly handled, with the main outcome being a referral to the local Drug and Alcohol Service as opposed to candidates being able to accurately provide information about interventions. It appears that some candidates may have read the Candidate Instructions incorrectly, directing their focus to the management of insomnia.

Station 11 related to a 40-year-old single female, suffering from generalised anxiety disorder who was attending her first appointment for Cognitive Behavioural Therapy (CBT). The candidate was to review her symptoms and then explain the process of CBT. Examiners found a disconnect between "doctor and patient", as candidates lacked ability to show empathy toward the patient. Few candidates identified the diagnosis of generalised anxiety disorder. Some candidates seemed to have knowledge but struggled to explain the history, which was often covered in breadth rather than depth. A number of candidates achieved the standard for diagnosis, but provided a disorganised or unclear explanation of therapy.

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	25.1	29.8	8.0	72.9%
2	26.3	29.8	7.2	72.9%
3	24.8	27.3	8.0	66.4%
4	23.5	26.2	9.4	58.9%
5	24.8	27.1	6.4	69.2%
6	27.5	31.7	9.0	70.1%
7	23.6	25.5	7.7	60.7%
8	23.8	25.9	8.7	67.3%
9	26.4	25.7	7.1	47.7%
10	26.0	25.6	9.3	53.3%
11	26.9	29.6	7.0	66.4%

The pass rate for the candidates who attempted the OSCE for the first time was approximately 74%

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".

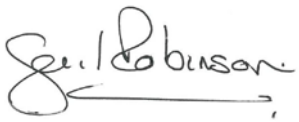
The Committee wishes to clarify the use of "prompts" in the examination. If candidates are to be given a timing prompt, the details will be noted on the "Instructions to Candidates". Candidates will **not** be given prompts unless they have been scripted. Should a candidate already be undertaking the 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.

Exam Delay:

The Committee for Examinations acknowledges the delay in the commencement of the OSCE due to loss of some examination material. The CFE took the decision to delay the examination and reprint and collate the missing documentation. The CFE were aware that delaying the examination would be distressing to the candidates, but the cancellation of the examination may have compromised the integrity of the examination content and inflicted a greater impost on the candidates and the examination infrastructure.

There was a delay of approximately one hour to the start of the examination at The Prince Charles venue from the commencement time published in the Sample Master Timetable for OSCEs. The delay at Royal Brisbane was of approximately 1 hour 40 minutes.

A number of candidates have submitted incident reports relating to the delay of the commencement of OSCEs. As a result of this incident, the Committee carefully reviewed all results and compared them with previous examination held in April 2016. The Committee found no significant difference in candidate performance in the two cohorts. Therefore the Committee has declined to make any compensatory adjustments to marks.



Dr Viki Pascu
Acting Chair,
Committee for Examinations

Assoc. Professor Gail Robinson
Chair,
Objective Structured Clinical Examination Subcommittee.

3 October 2016