MAKING MANDATORY CPD EASIER

In order to help the Fellows of the College meet the requirements of mandatory CPD, the RACP has initiated an online resources portal project.

The online resources portal, called MyResources Gateway, is an online website which will facilitate easy access to a collection of high-quality resources and will be available to Fellows and trainees across the Divisions, Chapters and Faculties of the College.

The MyResources Gateway project will identify educational resources, determine their quality and suitability for CPD, and then provide easy access through the creation of the online MyResources Gateway. The project will also assist the College to identify gaps in resources and to address those gaps through commissioning the development of and/or sourcing of new educational material.

The development of this project will create a centralised and catalogued resource portal which will have the following benefits:

- Provide easy access to relevant educational resources
- Reduce research time of individual Fellows and trainees
- Standardise criteria for assessment and review of content quality and relevance
- Ensure that educational resources are of sufficient quality.

Currently, the sourcing and dissemination of resources has been undertaken by the organisers of individual programs and modules within the narrow scope of their target audience. This project will create a centralised point from which notification and access can be provided through established online College infrastructure.

The MyResources Gateway has an anticipated launch date of June 2010 but is seen as an ongoing project that will require continuing maintenance in identifying and evaluating new resources, while also assessing the relevance of existing content.

Although the primary role of the MyResources Gateway is to provide easy access to College-produced learning modules and support CPD resources, the project has many more exciting possibilities. Initially, the Gateway will be extended to include trainee resources, while a longer term goal is to develop the Gateway in the style of an interactive 'communities of practice' site where Fellows can directly participate in the discussion, creation and evaluation of material that informs site content.

The MyResources Gateway Steering Committee would like to establish lines of communication and cooperation across all Divisions, Faculties and Chapters in order to ensure that the resources identified are suitable and to link any related projects that are being developed with the work of the Resources Gateway. Most Societies, Faculties and Chapters have already been contacted either directly or via a letter of invitation, and although there has been some very positive feedback, we would like to continue to build participation. If you would like to know how your Society, Faculty or Chapter can become involved in the MyResources Gateway, please contact the Project Officer at **Eamon.Vale@racp.edu.au** for more information.

Eamon Vale
CPD Education Resource Officer
Education Deanery

A LATTE WITH THE EXAMINERS THE CLINICAL EXAMINATION 2009

'The usual, thanks John—although Ahmed might be more settled if his coffee was decaffeinated, now that he has passed the Clinical Examination.' We were half-way through our round, taking our usual coffee break. So far things had been going very well and we had seen some interesting patients.

'I'm not sure why Mrs Tankard has got splenomegaly, Ahmed. But I agree, it's definitely palpable when you get her to relax and take a deep breath. You could feel it, couldn't you Mike?'

This was rhetorical—Mike, our medical student, always agreed about signs.

'What do you think the echo will show for Mr Briggs, Anne?' Ahmed had detected a systolic murmur on a patient admitted overnight with falls, with the usual sloppy admission notes. He had raised the possibility of aortic stenosis. 'I'm not entirely sure,' she replied, 'but the way Ahmed is going at present, he's probably right again'. Mike smirked.

'Yes, but the question is, if you think Mr Briggs has aortic stenosis, do you think it is severe enough to be relevant to his falls,' I asked. Anne had been spending a lot of time with her books, preparing for the written examination next year. We needed to make sure she didn't forget her clinical skills.

Ahmed led a useful discussion about the importance of assessing the carotid pulse volume and the relevance of the fourth heart sound, while we waited for the coffee.

'How was your feedback on the cases, Ahmed?' Nothing could really dent his enthusiasm and new confidence since the examination, but I knew that the obsession with detail that would make him a good physician would also have caused him to pour over every item of the examiners' comments.

'Generally, I found it helpful but it was a bit frustrating in parts. I still don't know what they were getting at in the patient with the rheumatoid hands. I made the diagnosis and did a pretty good functional assessment but I

only got a 4 plus,' said Ahmed. 'And yet, in the peripheral neuropathy with the sensory signs that I was sure I had completely bombed, I passed with the same score.'

Experience with trainees since they have been receiving the examiners' reports is that their judgement about their own performance is often more critical than the examiners' and that the examiners' reports are often a surprise. Examiners review the short cases without any prior knowledge and are well aware of the difficulty of individual patients. Sensory examination can be difficult to assess and sometimes made more so by a patient trying hard to contribute to the examination. In such cases, the examiners usually pay more attention to the process of physical examination and whether the technique of sensory examination is well practised. The correct interpretation of muscle wasting and a good technique for assessing reflexes are likely to carry more weight. The examiners will be well satisfied with a diagnosis of 'peripheral neuropathy, both motor and sensory, probably long standing'. A comprehensive list of differential diagnoses, including the rare cause for a specific patient, may not be required.

Conversely, the examiners may require more than a diagnosis in an obvious case like a patient with rheumatoid hands. Was the trainee particularly careful with the examination when told that the patient complained of pain in the hands? Did the trainee search carefully for signs of activity, as opposed to deformity, in any of the joints? Were tests for functional impairment fitted to the patient's deformities—or did they seem to be part of a routine without much thought?

The National Examining Panel has been discussing whether some short cases are intrinsically more difficult for trainees in the Clinical Examination. Is a patient with myotonic dystrophy an easier neurological case than one with a visual field abnormality? What does a trainee have to do to produce a better than expected performance with a patient with limited scleroderma and interstitial fibrosis?

The answers depend on the specific patient being examined. Some patients with myotonic dystrophy are essentially a spot diagnosis; others depend on a specific search for myotonia. Generally, in patients with an obvious spot diagnosis, a good candidate will try to focus more on the information that has been given about the patient, rather than running the routine. The patient with limited scleroderma is introduced as being increasingly short of breath. A good candidate will spend time trying to work out if the shortness of breath is due to interstitial fibrosis or perhaps to primary pulmonary hypertension. The focus will be on the chest, the right ventricle and second heart sound, rather than on the number of fingers than can be inserted into the patient's mouth.

The key to performing well in short cases lies in familiarity with the tasks of physical examination. A candidate who is at ease with patients, clearly and succinctly explains to them what it is they are trying to achieve and moves through the examination tasks smoothly almost always scores well. In contrast, a candidate who is unable to position a patient correctly, struggles to achieve adequate exposure without embarrassing themselves or the patient, and looks blankly at a blood pressure cuff is telling us that these are unfamiliar tasks and that they need another year of preparation.

Following the 2009 Adult Medicine Clinical Examination in July, an audit was performed of the examiners' feedback sheets. These are filled in by the national examiner after the patient's signs have been agreed between examiners. Despite the limited time available to complete the sheets, they are surprisingly thorough in most cases. They contain information about the way the patient was introduced, the system for examination, the diagnosis that was reported for the patient (completed after the signs had been agreed) and the physical signs for the patient. In some cases, examiners also indicate which signs were considered difficult and which signs in particular were thought to be important and should be found by a trainee.

As part of this audit, we established this diagnostic list for Adult Medicine patients used in the Clinical Examination in July 2009.

List of Short Case Diagnoses Adult Medicine Clinical Examination 2009

Cardiovascular	No. of Cases
Mitral Incompetence	27
Aortic Stenosis	18
Aortic Incompetence	15
Hypertrophic Obstructive Cardiomyopathy	14
Mixed Mitral and Aortic Valve disease	13
Pulmonary Hypertension +/– Tricuspid Incompetence	13
Congenital Heart disease	12
VSD	11
Mixed Aortic Valve disease	10
Prosthetic Valve(s)	7
Mitral Valve Prolapse	5
Mitral Stenosis	5
Mixed Mitral Valve disease	4
Pulmonary Incompetence	4
Other	3
TOTAL	161

Neurology	No. of Cases
Polyneuropathy — Others (Pure motor, sensorimotor etc.)	21
Muscular Dystrophy — Myotonic	14
Cranial Nerve lesions including Pituitary Tumours	13
Multiple Sclerosis	12
Myopathy / Myositis	10
Polyneuropathy — Charcot Marie Tooth	7
Motor Neurone Disease	7
Parkinsons Disease / PSN / Huntingdons	7
Cerebrovascular lesions	7
Polyneuropathy — CIDP	6
Muscular Dystrophy — FSH / Bulbospinomuscular	6
Hereditary Spastic Paraparesis	6
Other spinal cord lesions / Syringomyelia	6
Other LMN lesions	6
Neuro Others (electrical injury, Niemann Pick, undefined UMN etc.)	6
Friedrichs Ataxia / Spinocerebellar Ataxia	5
Cerebellar disease	5
Cervical Myelopathy / Other spinal cord lesions	5
Poliomyelitis	3
Brachial Plexus lesion	2
TOTAL	154

Respiratory System	No. of Cases
Interstitial Lung Disease +/– CREST	39
Bronchiectasis	16
Pneumonectomy / Lobectomy	9
Pleural effusion	7
Resp — Others	6
Lung Cancer	4
COAD	4
TOTAL	85

Musculoskeletal System	No. of Cases
Rheumatoid Arthritis	29
Limited Scleroderma / Scleroderma	19
Psoriatic Arthropathy	10
Ankylosing Spondylitis	8
Gout	3
Others (Haemachromatosis, SLE)	2
TOTAL	71

Haematology	No. of Cases
Chronic Lymphocytic Leukaemia / Lymphoma	17
Myelofibrosis / Chronic Myeloid Leukaemia	16
Polycythaemia Rubra Vera	4
Others (HIV, Isolated Splenomegaly, Sarcoidosis)	3
TOTAL	40

Renal	No. of Cases
Polycystic Disease +/– Renal Transplant	32
TOTAL	32

Gastrointestinal System	No. of Cases
Chronic Liver Disease +/– Portal Hypertension	21
Hepatomegaly undefined	3
Splenomegaly (Others)	3
Hepatomegaly Metastatic disease	2
Hepatosplenomegaly (Others)	2
Abdominal mass (Ca Pancreas)	1
TOTAL	32

Endocrine System	No. of Cases
Goitre	10
Acromegaly	4
Others	2
TOTAL	16

The National Examining Panel thought that it would be helpful for trainees to have this information. While individual trainees can expect a random selection of four patients from this list in their examination, it would be sensible to ensure familiarity with the clinical characteristics of the commonly occurring cases. We are now assessing which types of cases have best discrimination as examination cases and what impact there is when patients with spot diagnoses are used in the examination. We are also assessing the variation in performance that exists for individual trainees on specific cases. The audit will provide useful information about the individual components of the examination that contribute to reliability and help with its standardisation.

We examined the list of diagnoses together.

'So, Anne, how do you think you would go with a patient with a right upper lobectomy, or with a patient who has a foot drop?' Anne's eyes widened pensively. Ahmed looked at her encouragingly. Mike finished slurping the froth from his cappuccino and smirked again.

Associate Professor Stephen Judd FRACP

MyCPD APPROVED AS PROTECTED QUALITY ASSURANCE ACTIVITY IN NZ

The Hon. Tony Ryall, the New Zealand Minister of Health, advised on 22 September 2009 that MyCPD has been approved as a Protected Quality Assurance activity under the *Health Practitioners Competence Assurance Act 2003*. Associated with this approval are mandatory annual reporting requirements which will be the responsibility of the New Zealand CPD Committee in conjunction with the New Zealand Joint Executive.