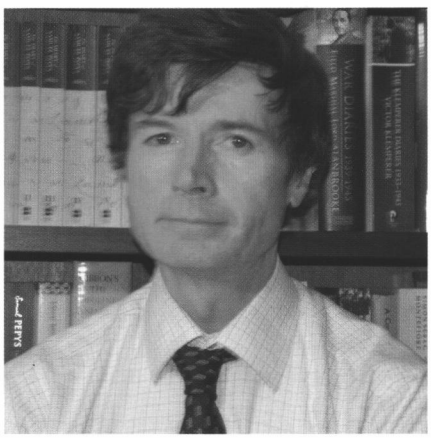
THE PART ONE FRACP EXAMINATION 2011: OBSERVATIONS FROM TWO EXAMINERS



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The FRACP clinical examination still has the ability to strike terror into many if not all who have to face this ordeal, including we suspect numerous examiners (and certainly us). In 2011, we had the privilege of examining candidates (in Newcastle and in various parts of the country, respectively), and we thought it would be helpful to share our thoughts and experiences from an examiner's perspective, as this may help those preparing for next time. We can't pretend to be totally objective or evidence based here but we hope this article will provide some guidance and reassurance if nothing else.

We are often asked if we think the examination is fair. One could argue that luck (both good and bad) can affect a candidate's chances. The lengthening of the exam (double the number of cases from the good old days) has certainly made this less of a player. Anecdotally we all hear of deserving candidates who repeatedly fail and of others who appear to pass unexpectedly, but it is clear the College has gone to enormous efforts to make the exam less subjective than used to be the case. The personality of the examiner definitely intrudes less into the process than it could in the past; the 'smiling death' examiners whom we faced have all but disappeared.

A calibration exercise is required for all examiners and we attended them. Here a video is shown of a long and short case; these are marked individually and then discussed in groups and then by everyone in the room. Members of the National Examining Panel (NEP) spend a whole day on calibration and discussion about the exam. The fact that this is the largest annual group meeting of physicians within the College shows how important Fellows consider the exam to be. Many physicians are prepared to give up their time during the calibration day and repeatedly at their own hospitals to take candidates through cases. Although there is variation in examiners' scores during formal calibration, with a bell-shaped curve, most cluster closely in our experience (within a point). As one of the quality control measures, the College analyses the difference in marks in the actual exam awarded by the toughest NEP examiners (hawks) and the softest (doves), but these are reassuringly small.

The examiners are often worried and nervous too, and although they are much less anxious than the candidates, many say memories of their own clinical exams are very vivid during this period (which demonstrates doing this exam is truly a major life event). On the day of the examination, the examining team is required to see each patient with no information first (just like the candidates), to ensure the case is fair and to confirm the symptoms and signs. By design, one examiner takes up the gauntlet and does the case while the others watch. Fear of embarrassing oneself in front of peers in this setting is very real. There is perhaps nothing more sweat inducing than doing a neurological examination under the watchful eye of a critical colleague who is an expert neurologist. Even for an experienced examiner this is a character building experience.

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Occasionally the case involves an unusual or rare disease one knows little about. There is then the opportunity to learn from the other examiner or indeed from the candidates themselves (who often know more than the examiners in areas outside the examiners' subspecialty). Rarely lack of knowledge trips up candidates at this stage; it's excellent technique, clinical experience (refined by seeing and presenting lots of cases) and sometimes flair that count. An overall below-average candidate who is asked to see long cases where he or she has particular expertise can be lucky enough to get over the line, so exam success (or failure) can arguably be context specific. However, experienced examiners require far more of a candidate than theoretical knowledge. They are looking for a mature approach to the holistic management of all the patient's clinical problems. This is harder for below-average candidates to demonstrate.

There is no prescribed way of approaching the exam although many do find the guidance of senior colleagues useful, and a number of books provide very useful advice. It has certainly been our impression, when examining, that successful candidates can have very different examination techniques. Regardless, passing the clinical exam in our opinion requires doing many cases under exam-like conditions (and plugging any

obvious gaps based on the experience) rather than reading any book.

Candidates continue to make classic avoidable mistakes. In one case a candidate presented the cardiac findings and his summary, but the synthesis was not totally correct. The examiner asked him if it could be a different valve lesion (which would have led to very different signs). The candidate then changed his mind about the signs present and the diagnosis, even when shown the X-ray, and led himself down the garden path to failing the case (avoidably). Another heard signs in a very simple case that could not have been present and were not there on the examiners' evaluation, presumably because she expected it to be complex in the test. The lesson? *Never make anything up—it spells doom!* More basic advice concerns the candidates' bags—often their pride and joy. Placing his new bag on the desk and preparing to take out his neurological equipment, an unfortunate candidate found he had forgotten the combination number for the lock. The lesson? *Practise with the equipment you are going to use on the day.*

Although tests can be very useful, diagnoses are still made largely based on the history and sometimes on the physical examination. There has been talk about the value of continuing to include short cases in the examination. Indeed, in this age of inexpensive portable ultrasonography at the bedside (now available through one's mobile phone), it could be argued that many of the clinical skills required in the past (like examining for hepatosplenomegaly, or carefully assessing heart sounds) are no longer essential, and physicians would be better placed learning and being examined in relevant clinical bedside imaging which is more accurate! An observed long case would be an alternative strategy to ensure candidates can examine well and build rapport, but we would continue to argue that by requiring a short case examination the College ensures that candidates learn and demonstrate other skills (such as the rapid ability to observe and expertly synthesise clinical data, as well as the ability to elicit signs in the absence of historical clues, all of which can be important in practice). Short cases also give candidates an opportunity to mess up; it is amazing that some still refuse to do what the examiners direct be done, are allowed to proceed, and wonder why they fail that particular case. Overall, we hope that the short cases (or at least a variant) will continue to be a part of the assessment in the 21st century.

Our impression as examiners is that colossal and largely successful efforts have been made by the College to improve the clinical exam. Candidates are now better informed and prepared, the examiners are more objective and the marking system has improved. The cases are often interesting, sometimes challenging, but usually appropriate. It is a privilege to examine and learn from candidates and colleagues as well as patients, and we deeply appreciate the opportunity.

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