Australian
Medical Council Limited

Tips from Examiners

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1. Tips from AMC Examiner Observations

As in any examination, it is critical that you read and process all the information provided, noting the tasks and suggested times, and plan your approach accordingly. No marks are given for doing a task that is not requested.

Note that:

- Each scenario will mainly focus on performance in one of four Predominant Assessment Areas (PAAs) - History, Examination, Diagnostic Formulation and Management/Counselling/ Education
- The tasks in any particular case may address a mixture of these Assessment Areas
- The number of tasks and suggested times to allocate to each indicate the predominant focus of the scenario and where marking will be directed.

A general observation is that the approach of some candidates to a particular scenario is as if they are convinced that they know the answer/recognise the case from some element or 'clue' and do not proceed to address the tasks adequately or systematically. Incomplete performance of all the tasks is unlikely to constitute an overall satisfactory performance in that scenario.

Although this is a stressful examination situation, try to place yourself as the clinician you are and respond to the simulated patient as if they are in a real consultation with you and, respond as their doctor, focusing on the clinical scenario and tasks.

The following tips for candidates and commonly observed issues are listed by Predominant Assessment Areas (PAAs).

1.1. History PAA

History scenarios predominantly assess your ability to communicate with your patient/their carer/team member, respond specifically to the presenting problem/s, obtain a relevant, systematic, and appropriately thorough history, and demonstrate your clinical knowledge and reasoning in doing so.

A candidate who performs well may do the following:

- Note any times given for a particular task and plan your performance accordingly. For example, if 5 minutes is allocated to history, you should use all this time to gather information
- Use the information provided in reading time and the patient's initial statements and observed behaviour to focus your questions
- Listen carefully to the patient's answers and respond appropriately
- Probe for more detail as appropriate
- Follow a relevant and organised approach that demonstrates your clinical reasoning.

Things to avoid:

- Not using the given candidate information as a base to frame your data gathering
- Not listening to or responding specifically to the initial statements or concerns of the patient/carer/team member
- Taking a cursory history and jumping to a conclusion about the diagnosis or next step
- Overuse of closed questions
- Using double-barrelled questions seeking a closed yes/no answer – e.g. 'Do you have vomiting and diarrhoea?' This risks gathering inaccurate information
- Phrasing questions with technical terms, incurring inaccurate responses or requests for clarification
- Taking a 'scattergun' or random approach in your line of questioning
- Not demonstrating clinical reasoning or not using previous answers or information to inform the next question.

1.2. Examination PAA

An examination scenario predominantly assesses your ability to perform relevant physical and mental state examinations of common problems, demonstrating appropriate techniques and delivering logically and coherently. It is crucial to accurately identify and interpret physical and mental signs/findings. Areas of assessment may include your choice and technique of examination, the organisation and sequence of your examination, the accuracy of your examination, your commentary or explanation of the procedure and/or familiarity with the equipment.

In-person examination

A candidate who performs well may do the following:

- Will pay close attention to relevant information in the stem
- Can adapt to multiple examination modalities, e.g. role-playing, standardised, simulated, videoed or 'real' patient, or of a model or video recording
- Listen carefully to the patient's opening statement and carefully observe their behaviour
- Identify what is the most important examination focus relevant to the clinical problem when given the task of undertaking a relevant or focused examination. Ask yourself: 'What information do I need from this examination?' For example, suppose the suspected problem is peripheral vascular disease. In that case, you will probably run out of time to perform the expected vascular examination of the lower limb if you start with a neurological examination
- Is familiar with commonly used diagnostic equipment and assessment proforma
- Demonstrates a fluent and accurate technique
- Performs the necessary examination in a respectful way that enables you to elicit the signs while minimising patient discomfort

- Systematically report exactly what you find in your patient/model on that day using appropriate terminology. Be specific about what you have observed
- If the task is to report your findings to the examiner as you proceed, then report all the positive and significant negative findings.

Things to avoid:

- If a history component is part of the station, not doing this in a focused manner and within any given time limit
- Saying to the examiner, 'I would like to...' or 'I am going to examine…' without actually doing the examination carefully
- Presuming any findings in a case
- Taking a scattergun approach to examination
- Not demonstrating familiarity with basic equipment; for example, unable to turn on an otoscope or ophthalmoscope or incorrectly placing a BP cuff
- Lack of correct and appropriate technique of physical or mental state examination. For example:
  - The predominant system or body part selected for examination lacks relevance to the case, such as a neurological examination instead of a musculoskeletal examination for a painful wrist
  - Poor physical examination technique that makes eliciting signs impossible; for example, palpation of the abdomen is so light that no tenderness or organomegaly could possibly be elicited
  - Mental state examination technique that makes eliciting relevant findings impossible; for example, mood/affect are not sought; judgment questions are poorly aligned to patient presentation
  - Not differentiating between judgment and insight in the mental state examination
- Not demonstrating familiarity with basic evaluation frameworks (e.g. Glasgow Coma Scale or Folstein Mini-Mental State proforma) or with standard medication or fluid charts
- Lack of accuracy in the identification of physical and mental state signs (both present and absent). For example:
  - An absent peripheral pulse is identified as present
  - A delusion is identified when it is an hallucination which has been sought
- Where there is a task to report findings to the examiner as you proceed, remember it is the findings the examiner wants to hear, not simply what you are examining for
- Poor time management during the case (including ignoring the time prompts) and running out of time.

Online assessment of examination PAA

These stations are mainly descriptive tasks that describe what examination you would perform, how you would do it, and what you are looking for given the clinical scenario.

You may be directed to use technical language and anatomical landmarks in your description.

A candidate who performs well may do the following:

- Identify what is the most important examination focus relevant to the clinical problem when given the task of describing a relevant or focused examination. Ask yourself: 'What information do I need from this examination?' For example, suppose the suspected problem is peripheral vascular disease. In that case, you will probably run out of time to perform the expected vascular examination of the lower limb if you start with a neurological examination
- Use appropriate language when describing an examination to a patient or appropriate technical and anatomical terms when describing to a medical professional
- Described the examination steps in clear and sufficient detail, e.g. how you would position the patient, how you would palpate, where exactly you would place the stethoscope to listen to the heart
- Describe the relevant positive and negative findings you are looking for given the clinical presentation.

Things to avoid:

- If a history component or description of an image is part of the station, not doing this in a focused manner, and within any given time limit
- An overinclusive approach to the examination – describing the examination of systems or body parts not relevant to the clinical scenario presented
- Lack of clarity and detail in description of technique
- Not reporting the findings you are seeking and their relevance to the clinical scenario
- Poor time management during the case (including ignoring the time prompts) and running out of time.

1.3. Diagnostic Formulation PAA

These scenarios predominantly assess your ability to formulate a reasoned diagnosis based on history and/or physical examination findings and/or investigations. Cases will usually involve some history taking and being given (or asking for) physical examination or investigation findings. You may be asked to tell the patient/carer or team member your diagnosis or possible diagnoses, giving your reasons.

A candidate who performs well may do the following:

- Take note of whether your task is to give your:
  - diagnosis/most likely diagnosis - give one diagnosis only

  - differential diagnoses/likely diagnoses - give a prioritised selection
- Use the specific tasks and any times allocated to guide your data-gathering process
- Seek history, physical and mental state examination findings, or investigations which are prioritised according to relevance. Avoid wasting time on searches of low relevance
- Synthesise the information you have gathered from what you have read in the candidate information, asked and found on examination or investigation results
- Avoid premature closure, 'knowing the answer', without obtaining sufficient data
- Demonstrate your ability to make a reasoned diagnostic conclusion for this particular patient.
- Clearly explain your reasoning in your diagnostic formulation
- Give the reasons for a prioritised differential diagnoses using information gathered specific to this patient
- Avoid using technical language and/or euphemisms when giving the diagnosis/differential diagnoses to the patient/carer.

Things to avoid:

- Using insufficient data/inadequate attention to other tasks (history/physical examination/investigations) to come to a diagnosis
- Not demonstrating logic and clinical reasoning in either gathering the additional data (history, examination findings and investigations) or in the diagnoses made
- Giving a long "textbook" list of possible diagnoses bearing little relationship to the particular features of the scenario
- Using technical language without plain explanation to the patient/carer
- Selecting diagnoses that are mutually exclusive (e.g. upper airway signs versus lower airway signs: tonsillitis vs pneumonia)
- Selected diagnosis is non-specific. For example:
  - "Psychosis" where the features clearly allow a diagnosis of schizophrenia
  - A euphemism e.g. "nasty growth" when a cancer is suspected
- Not providing justification/reasoning for the diagnosis.

1.4. Management/Counselling/Education PAA

These scenarios predominantly assess your ability to develop and communicate an appropriate management plan that may involve patient/carer education and counselling as well as treatment.

A candidate who performs well may do the following:

- Listen carefully to the opening statement of the patient/carer and carefully observe their behaviour and responses
- Pause and check regularly for patient/carer understanding
- Recognise clinical urgency and responds accordingly
- Aim for shared understanding and agreement/decision making
- Prioritise the information given/shared with the patient/carer, to not overwhelm them with a barrage of information
- Provide specific recommendations and advice relevant to the problem and context with reasons for the advice
- Communicate the general management plan, even if you would not be responsible for its delivery.

Things to avoid:

- Not addressing the concerns/questions/presenting problem of the patient/carer/team member
- Not using the context and setting background provided in the candidate information to tailor management advice
- Not demonstrating familiarity with tasks around breaking bad news, including showing empathy, giving time, ensuring patient/carer comfort and safety, ensuring patient understanding, involving significant others, and offering ongoing support
- Not checking for patient/carer/team member understanding of recommendations/advice
- Communicating advice in overwhelming detail
- Reliance on technical language and jargon, lack of provision of explanatory statements
- Reliance on drawing a diagram which is not clearly explained to the patient
- Advice lacks specificity. For example:
  - Too generic (e.g. “antibiotics”, “psychotropics”)
  - Overly inclusive (e.g. simultaneous/indiscriminate use of social services, psychologist, psychiatrist, crisis intervention, community services)
  - A platitude (e.g. “good diet”, “mind-body”)
  - A euphemism (e.g. “bad lump”, avoidance of use of the word “cancer” where appropriate)
- Not demonstrating familiarity with the general principles of management of common conditions:
  - Reliance on simply referring the patient to specialist services (for example “my senior/a specialist/psychologist”) without specifying the expected management is usually not satisfactory.

  - Likewise, just stating “Don’t worry you are in good hands” or “You will be well cared for” or “I will give you some relevant education material” by themselves are generally insufficient

- The treatment plan for this patient with this condition at this time is incorrect/inaccurate.