The FRACP Paediatric Clinical Exam

Testing whether laughter is the best medicine

Adapted from the previous handbooks with thanks to previous Chief Registrars and Gen Med Fellows

Royal Children’s Hospital & Monash Medical Centre
THE LONG CASE

- 60 minutes to take a history, examine and develop a management plan for the patient.
- 10 minutes to prepare your discussion/move to the examiners' room
- 25 minutes discussing the patient with one team of examiners
  - Usually 10-15 minutes of presentation and 10-15 minutes of discussion

The examiners are instructed to place emphasis on the accuracy of the history and findings on examination, attitudes to clinical problems, possible diagnosis, investigations required and their appropriateness, overall interpretation / identification of main issues, and approaches to management.

Your goal is to get an overall perspective of the medical and psychosocial issues important in care of the patient both as you see them and as the family sees them. You then need to have an approach for how you would manage these issues as the paediatrician responsible for the patient’s care.

In the immortal words of uncle Hugo after a long:

“At the end of hearing your long case, there’s just one question I need to answer; did these parents get their $120 worth of consultant opinion?”

GENERAL TIPS

Practising:

- Everyone will feel differently about how many longs they need to do in preparation. Given the large number of candidates each year and the difficulties there can be in finding cases, try to maximise the learning opportunities with each case you do - quality is better than quantity. One per week is usually a realistic aim.
- Try to do practice long cases in an hour – your first few cases will be far from perfect, but it is important to practise good time management skills from the beginning.
- Try to spend only 10 minutes sorting out your case before you first present it to someone. If you’re not doing the practice case “hot” then present to a pretend examiner or a friend first in this way. Reworking your presentation again with more time is also useful, getting as much benefit as you can from each patient you see.
- If you are admitting patients or seeing them in emergency or clinic, approach it as a long case and consider even presenting the “issues” to your friends who can ask appropriate investigation/management questions.
- Get a trusted study buddy to tell you if you have any annoying habits such as saying “um” every second word, fiddling with your hands or hair or anything else that could be off-putting to an examiner.
- Practice presenting with non-medical people, or record yourself on video. This allows you to examine your general style, eye contact, body language, talking pace etc.

**Use of time:**
- Organise your time – you have one hour with the patient and their family, so you might use it as follows:
  - 5 minutes of intro questions / demographics
  - 25 minutes of history taking
  - 15 minutes to examine the patient
  - 15 minutes to pause and think about what you may have forgotten! This is a good time to begin your write-up – especially an introduction and/or summary which may help identify any gaps whilst you still have the patient there to ask more questions.
- You will then have an additional ten minutes to organise how you want to present the case, during which time you will probably construct your introduction and summary (if you haven't done so already) and a management plan.

**On the day (with the patient):**
- Explain about exam requirements to the family and the patient and the importance of the exam itself. (e.g. to 'become a Paediatrician or not'). Let them know your plan in advance (e.g. the need for separate time with an adolescent patient, writing on manila folder as you go).
- It's a good idea to explain to the family how nervous you are and that you may seem rude and rush them through some of the history. Apologise in advance and explain that you will need to ask a lot of questions, some of which involve potentially sensitive information, in a short period of time.
- It may also help to tell the parents that it is OK for them to tell you everything and that they are not meant to hide things or trick you. It can help to ask towards the end whether there was anything significant that they discussed with the examiners that you haven’t covered with them.
- Use your bulldog if you need to – to knock on the door to give you a warning at a specified time (e.g. halfway through), even to play with the child outside if they are running wild!

**On the day (presenting the case):**
- It's a summary – there is no need to present all the information you gleaned during the hour.
- You are a doctor – make it a medical summary! Asking lots of questions and repeating back the information is one thing, but interpreting the information and putting it into a logical context shows that you have clinical judgment and perspective.
- You have 25 minutes with the examiners – much of the money is in the discussion time rather than your presentation of the case.
• If you have highlighted or mentioned areas without fleshing out detail, then the examiners can ask you about them. This will give you more control in question and discussion time.

• Try to think about your presentation style as well as content. Speak clearly, at a normal pace, make eye contact, and make your voice sound interesting rather than monotone. You certainly don’t want to bore the examiner and find that they have missed half of what you have said.

• Try to ‘signpost’ the main segments of your presentation with extra emphasis and eye contact, conveying a structured approach.

• Remember Hugo’s newspaper metaphor, “you need the headings and the pictures to keep you interested in the text”.

Responding to Questions

• This is your opportunity to demonstrate your synthesis and analytical skills. Have a structured approach to replying to questions:
  o Anticipate questions when you are writing up
  o Listen carefully to the question and make sure you have understood what is being asked
  o Take a brief moment to reflect and think about the question
  o You may consider starting with a general statement about the issue but progress quickly to the key points of your answer
  o Relate your answer back to the case where possible
  o Stick to the question being asked
  o Form an opinion and be decisive where possible (be prepared to justify your answers!)
  o If you don’t have a lot to say about an issue, try to move on and get to a question that you can

• Maintain good eye contact, looking at all the examiners while you answer.
STRUCTURE OF A LONG CASE: “MODIFIED KELLY SYSTEM”
(Modified just a little from Greg Kelly’s notes, 2011)

“The examiners are instructed to place emphasis on the accuracy of the history and findings on examination, attitudes to clinical problems, possible diagnosis, investigations required and their appropriateness, overall interpretation, and approaches to management. Your assessment should therefore be directed accordingly.”

R.A.C.P

- As though you are a general paediatrician taking over the care of a patient and seeing them for the first time (a nice line for long-case-naive parent(s) too!)
- Marking criteria (don’t forget to look at the appendices!)
  - History
  - Examination
  - Synthesis and priorities
  - Impact of illness on patient and family
  - Management plan

General pointers
- You need to get a huge amount of information out of the carer really quickly: think critically about it and make a plan!
- Carers are highly variable in how well they will give you the history
- Try hard to cover the “one-percenter” you just can’t forget (e.g.: vaccine status). They may not gain you big marks, but if you miss them, it will reflect poorly on you.
- The best approach is to have a really rigid “checklist”-type structure in your head.
- After introductions, write out your checklist on your manila folder. Then you won’t have to worry about structure (or whether you’ll remember vaccine status!) leaving you free to relax and concentrate on thinking.
- The structure below looks complicated but the idea is that you do the history and exam in the same order that you present it. This will convey clear thinking to the examiners
- Signposting: Provide really clear “verbal headings” or in your presentation to the examiners

Taking the history
- Get things moving - quickly
- Introduce yourself and explain the time constraint, apologise for guiding the conversation
- “Firstly, can you tell me your child’s diagnosis and then list all of their medical problems and which doctors and allied health people they see?” Write all of the issues in a little box right bottom corner of front page and connect them to professionals.
- “What medications are they on?” Write this now in your medication space. Are there new issues/conditions that are now apparent but
which the carer did not mention? (e.g.: frusemide-CCF, baclofen-spasticity, anticoagulation-clot, bactrim-urinary or PJP prophylaxis...)

- Take a minute and decide now what issues to focus on, number your issues in the little box you drew earlier. The five top issues will be the same five that you present in your introduction, in your history, and in your conclusion.
- Launch into your detailed history (see below)
- Don’t forget these final questions:
  - Which issues have the treating doctors/examiners been focusing on the most?
  - Was there anything that the previous doctors have asked about that I haven’t?
  - Did they make any particular comments that you remembered?
  - When they examined Johnny what did they seem most interested in?
  - Is there anything you told me that you didn’t tell the examiners?

**Suggested timing**
- History – 30 minutes
- Examination – 10-15 minutes
- Write-up and discussion preparation – 20 minutes

**DETAILED STRUCTURE**
After introductions, prepare your folder, with whatever mnemonics you choose (see Greg Kelly’s below)

**Stem/Introduction**
Name, age, sex, seen with, presenting complaining, main issues
PRESENT THESE IN THE SAME ORDER IN THE INTRODUCTION, BODY, AND CONCLUSION, CLEAR STRUCTURE IS CRITICAL

This is your chance to make a great first impression! Breathe, make eye contact, remember you are a doctor who knows this patient...and hit them with your best shot!

Before the exam, rewrite all your long case introductions and present just the introductions to your study buddies. Do they hit the spot? Are you transmitting an appropriate air of serious enthusiasm, of genuine interest, of considered confidence? If it were a job interview, would you get the job?

**Presenting complaint (if applicable)**
Should be very brief

**Main issues/active problems (D.S.T.C.I.C C!)**
Diagnosis
Symptoms when diagnosed
Treatment (DNA PACS)
  - Drugs (doses only if relevant, eg: steroids)
  - Non-drug therapies
  - Alternative therapies
  - Past treatments and treatment changes
**Administration**
**Compliance**
**Side effects**
Future treatments (planned, considered, discussed...)

**Control / Current status**

**Investigations – last index investigations**

**Complications** - list then discuss separately if necessary (eg: steroids)

**CRITICAL!**

**STOP!** Think critically about what you have written. Does it make sense? Are there important gaps? Are there therapies you would have expected them to have tried? Are there complications you might expect that you haven’t covered?

Consider cleverly summarising a long history to avoid a long and boring list of events punctuated by “and then...and then...and then...”. “NO ‘AND THEN!’” (Dude Where’s My Car {2000}). Sometimes pictures/graphs even help! :

“Over a period of four years, Julia’s disease has followed a relapsing and remitting pattern with approximately 10 discrete relapses leading to hospital admission and a gradual decline in function from independent ambulation and oral feeding to her current state...”

“It is most useful to consider Timothy’s illness in two parts: the initial and dramatic impact of pneumococcal meningitis and then the ongoing chronic sequelae...”

**Past history**

**Non-active issues**

**Pregnancy, birth, neonatal history**

Depending on the case, these may be more appropriately discussed at an earlier stage

Level of detail depends on relevance. Often “Johnny had an uncomplicated perinatal course” will suffice.

Relevant details might include: planned pregnancy, pregnancy details (eg: infections, pre-eclampsia, diabetes, drugs, bleeding, ultrasounds...), IVF, gestation, birth weight, hospital, SCN/NICU, resuscitation,

**Development**

This may or may not be an active problem for your patient, which will affect where you present it. In either case, remember to show your maturity and perspective by summarising rather than just listing...

**In taking the history:**

Main developmental milestones (Gross motor, fine motor, language, personal/social)

Are they delayed? If so, is it global or particular to a domain?

Current functional level or schooling level – have they had extra help at school (or do they need it)? Do they have an aide?

Have they had Early Intervention/do they need it?
DO NOT PRESENT YOUR EXAMINATION FINDINGS IN YOUR HISTORY

When presenting:
If developmental is delayed, it may be useful to match their development to the appropriate age, eg: 3yo child who has just started to utter single words may have expressive language equivalent to around 15-18 months.

DON'T FORGET: S.H.E.T.F.I.B.P
Be sure to tick off this list if you haven’t already, they’re often areas that are considered the domain of a general paediatrician dealing with the kind of very complex patients who are typically chosen for long cases.

Sleep
Hearing
Eyes
Teeth
Feeding/growth/nutrition
Incontinence/toilet training
Bones
Puberty

Drugs and therapies (D.N.A P.A.C.S F.A.I)
You’ll have covered many drugs and other therapies as you present each relevant condition but a drug list recorded here is useful
Confirm that the list given to you is correct
Drugs
Non-drug therapies
Alternative therapies
Past treatments, reasons for changing
Administration
Compliance
Side effects
Future treatment
Allergies
Immunisations

As a nice “one-percenter” remember to think about newer or extra vaccines such as influenza vaccination, palivizumab

Family history
A family tree recorded on a separate sheet with names and ages for siblings and parents can be handed to the examiners, circle the family unit/household
Include extended family members and mention consanguinity especially for genetic diseases and when they provide significant assistance to the patient and family
How are siblings coping? It can be nice to have a brief detail you can mention about each sibling and best if that detail somehow relates to either its impact on your patient or how your patient’s illness impacts upon the sibling.
How are the parents coping? Marital stress, depression, anxiety – do they have appropriate emotional support?
Family meals? Last family holiday?
**Social history**


Normal day

**H.E.A.D.S.S**

Effect of illness on patient and family
- Supports: financial, emotional, carers, community, GP
- Custody
- Accommodation
- Transport – how far to the hospital, how many cars, who can drive, taxi card
- Ambulance – membership, access to home
- Finances – employment, mortgage, rent,
- Respite and support
- Understanding of illness
- Palliative care
- Transition

**When presenting:** try to highlight the family’s strengths and vulnerabilities across biological, psychological and social domains.

**Normal day**

In discussing a typical day for the child, try to convey their personality.

What do they do? What are they actually like?

**H.E.A.D.S.S**

Cover the HEADSS elements in all adolescent cases where appropriate (and it only rarely isn’t appropriate), and spend time alone with the adolescent

Having covered the history, ask yourself, “Do I know this patient and their family?”

Ask the carer +/- patient, “What are the big priorities at the moment and for the upcoming years?” – something like this might get you very little but it just might deliver a killer line or two that show the examiners that you connected deeply with the patient’s and family’s reality.

**Examination**

“If I saw this patient in my outpatient clinic, what would I want to include in my examination?” **Mike South**

General features
- What is the child actually like? Focus on function. Can you usefully comment on their communication abilities, attention, their personality, presentation, how they interact with or move in their environment?
- Height, weight, head circumference, vital signs, Tanner stage (present examiner with chart), nutritional state
- Dysmorphism
- Signs of underlying disease
- Severity of underlying disease (eg: severity of hemiplegia, contractures...)
- Complications of underlying disease or treatment
- Relevant positives or negatives
Especially for adolescents, say the words “Mental State Examination” and you’ll look great. Sound like you know what it means and you’ll look better.

**Summary/Issues**
Organised in the same numerical order as in the stem and in the presentation of main issues – NO surprises!
Don’t sound bored – be concise and direct
Categorise. Do your 15 issues actually just boil down to a few headings?
Present your list and then enter into your discussion
Things to think about and questions to anticipate:
  - In what ways do the patient’s many problems threaten their healthy biological, psychological and social development?
  - What will the future bring for the patient and family?
  - What are the big challenges in their future?
  - What will be the big challenges for his or her doctors?
  - What investigations might be discussed?
  - What interventions (biological, psychological, social) might be useful in improving things for your patient and their family?
Own the issues – don’t “outsource” too early, before you’ve had a chance to show what you know (ie: try not to say you’d refer the patient before you’ve shown what you actually do know...)
Show your maturity by outlining treatment goals
Show your perspective by discussing barriers to achieving these goals

**Practicing**
There are plenty of long lists of suggested approaches to various issues available on the intranet or from past exam candidates. You might find them quite useful in building your own “approach to X...Y...Z”.
In the weeks before the exam, when your study group is doing little else but cooking for each other and bitching about balancing work-study-marriage-children etc... throw the “big questions” at each other to practice your scripts.
REMEMBER...you can’t just ‘cut and paste’ your scripted answers. For the biggest impact, you should demonstrate an ability to tailor the textbook approach to your patient’s circumstances.

**Nice words, good lines**
- The diagnosis was made some time ago and I would like to revisit the basis on which it was made...
- Other considerations...
- There is a discrepancy between the patient’s/parent’s understanding of his illness and my clinical findings...
- I find little evidence that he needs to be on...
- Family centred practice
- Advocacy
- Advanced Directives
- Trajectory of illness
- Cohesive and caring family
- Psychologically-minded, emotional intelligence
- When you’re thinking Ohh $#@! I forgot to ask that... try this:
“Thank you, I didn’t get a good feeling for/we didn't cover that...in the medium to long term it is an important factor...in a subsequent visit I would explore...”
If you can, rolling straight into a discussion of the general topic as it applies to patients who are similar to your patient can work in your favour.
**Approaches to the Short Case**

Shorts last 15 minutes, usually 7-8 minutes examination and 7-8 minutes discussion.

Shorts test your technique of physical examination, your ability to elicit signs, and your ability to interpret and place appropriate significance upon your findings.

Many shorts will require you to ask for and interpret relevant diagnostic tests (eg: x-rays, ECGs, MRI...).

**Practicing**

- You WILL be nervous. Stock statements about hand washing, making introductions and repeating the stem help to settle nerves. Then STEP AWAY FROM THE PATIENT! A good general inspection alone might score you a “good fail” (ie: a 3+) so give it a good crack, and remember to make comments about growth and nutrition before asking for charts.
- Learn the dance then “dance the dance”. There are certain examinations where a hands-to-head-to-toes examination will not quite cut it. For instance, in the short- and tall-stature examinations, remember to dance!
- Lose your ego! – Very hard but the short case is a performance and you need to commit to succeed.
- Practice with your study group, be strict with time and “assess” each other. Practice thinking like an examiner. Look at the marking sheet.
- As well as all the books, sit down with your study group and throw stems at each other, challenging the “candidate” to run through their examination, give them findings, ask them to interpret them, and then throw questions or tests at them...
- Remember the patient and parent! While a short case is a contrived interaction, your performance should reassure the examiners that they could and would leave their own patients/children in your care.
- Most paediatric candidates talk while they examine. A minority examine and summarise only at the end. There are advantages and disadvantages in both methods but if the examiners indicate a preference, LISTEN to them!
- Your approach can and should be different for different examinations. For a developmental examination, talk until you drop. For a cardiac examination, you will really lose yourself in a horrible web of contradictory findings if you just talk talk talk – wait for your observations and auscultation to align in your head and make a concise and confident statement on your findings – even if your examination findings don’t make sense, be confident in saying that!
- Look for scars and then look again, and sometimes, look again if required. Remember, if you didn’t find a shunt and then see an unexplained transverse abdominal incision, go back and look for that shunt! Remember your blind spot: you will never see a scar from a PDA repair or other left thoracotomy unless you look deliberately!
- If you say something stooped or just incorrect, there’s no shame in correcting yourself!
Approach 1:

**ROSSCO SSS** (Courtesy of Andrew Steer and Mike Forrester)

Repeat name and remember stem. Thank/greet patient and guardian/s.

**Observations** – Don’t touch anything but your chin in the first 30secs. Observe equipment, lines etc, vitals, appearance, growth parameters (?chart and ?birth weight), and specific observations pertaining to stem. Make sure the patient is where you want them, appropriately lit and undressed. Gather your gear and your wits.

*Give intro summary and declare intentions to examiners “ On initial observation x is a .........”*

**System exam considering differential as you go**

**Signs of severity and relevant negatives**

**Complications (of disease and management)**

**Other systems etc that may be relevant**

*Think (Am I ready to shoot or do I want to see some investigations first?)*

**Stand straight, feet together, hands behind the back, looking straight at the examiner at all times. (ie not looking at the patient trying to remember what you did...)**

**Speak slowly and reasonably loudly. Say it clearly, or don’t say it.**

**Sound confident and compassionate and professional.**
Approach 2: “I HUG VIDEP then QQ CCC”

Start with I HUG VIDEP to avoid any of the “instant fails” but don’t cover clearly irrelevant things or that will drive your examiners nuts! (ie: hug Videp by all means, just do it without letting everyone know you’re hugging Videp...)

- Introduce
- Hands
- Unwell or well
- Growth and Dev
- Vital signs including urinalysis and stool
- Iatrogenic
- Dysmorphism
- Exposure
- Pain

Then move on to QQ CCC - the essential approach to any short case and if you do all of it you’ll get at least a “5”.

- **Qualify** - demonstrate what they’ve told you – e.g if they say that Johnny walks differently to the other children in his class then get him to walk before anything else
- **Quantify** – how bad is his walking? So walk him, then on his heels, toes, get him to run, walk like a duck, get up from the ground
- **Cause** – look for the cause of his walking problem, is it muscles, nerves, local to his leg? This requires formulation of ddx list and exclusion.
- **Check in.** This is a good time to “check in” with the examiners. E.g., say “I’ve been asked to examine Johnny’s walking and it appears that he has a problem with his walking that is related to his muscles. I’d like to go on and examine him for evidence of this and also any complications of his disease or treatment.”
- **Complications** - look for complications of the disease or treatment
SUMMARISING THE SHORT CASE

PUNCHY intro summarising the overall impression.

If you are confident, begin with the diagnosis and describe your findings to justify your diagnosis. Highlight signs of severity, complications, drug effects. It may still be good to give other differentials at the end.

If you are less confident with a particular case, describe your findings and list possible diagnoses with pros and cons.

Lead on to relevant investigations (and perhaps management)

TIPS:
- Start doing short cases when you start doing long cases.
- Leave each practice case you do on a winner. Go back and make sure you can now find the signs you missed.
- Practice presenting your formulation – develop an opening that you are comfortable with and use it for all your shorts. Tape yourself presenting, present practice cases (and even imaginary cases) to yourself and your group over and over again so you get used to the phrases and sound confident.
- Leave the last case in the room. Begin the next case without thinking about the last case – don’t dwell.
- If you don’t know the diagnosis of your case, it doesn’t matter. There have been many examples of cases used in the exam where the diagnosis is not known by the treating physicians. Using a systemic approach to examination and ordering of and interpretation of investigations, and the ability to discuss the potential differentials is important and can be enough to pass. Know your examinations well so that you can depend on your skills and use these to get you through your hard cases. You do this everyday at work – the examiners just want to see you do it.
DON’T STRESS – GETTING HELP

WHAT IF I CAN’T GET TO EVERYTHING?

You won’t!

The reality of working and training is that it is not possible to get to every training session/practice short or long. Be realistic about what you can achieve and don’t place undue extra pressures on youself.

You don’t need to!

The whole idea of this program of training for the clinical exam is to provide as many opportunities as possible for trainees, so that people can get to whichever fits in with their work and the rest of their life. Not everything arranged will suit your personality and learning style.

Work out what things you find most useful and ditch the rest. Be careful if you are job-sharing or not working as you could easily fill the days mindlessly seeing patients, without self-reflection on your progress. Balance is important! Take a break if you are just seeing cases because you feel you should or other people seem to be, rather than being efficient and effective with your time.

You don’t need to see every possible long case type. The aim is to see enough to have a general approach, and to think about your approach for the cases you haven’t been able to see, so you can deal with whatever crops up. You just need to be flexible and adaptable.

Don’t stress about things that you can’t change!

If you can’t make it to a practice exam, or to the amazing tute by such and such, or the cardiology shorts day, or anything at all, let it go. You do not need them to pass.

Take things at your own pace

This is your exam, no one else’s. Make the conditions ideal for you. Try to help each other out as a group and in turn, that will help support you.

No one can tell you how to pass, they can only tell you how they passed. What was fantastic for one person may be bad advice for the next. Be critical. Be selective. You know yourself best. Take time out and relax – you have to survive to this exam and beyond with your sanity, partnerships, friendships still intact. Avoid people who continually “stress you out”!
Many people need some extra psychological help while preparing for the clinical exam. There are a number of different ways to deal with this. You could speak to your study buddies, your GP, your friends and contacts in and outside of the hospital system. Trainees a year or two ahead of you may have had similar problems during the exam period. You could speak to your mentor or consultant.

**You can also speak to:**

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<td>Phone 1300 360 364</td>
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**Don’t feel you have to handle it on your own! We’ve been there and we know who can help!**
PSYCHING YOU UP!

Know your enemy and know yourself; in a hundred battles, you will never be defeated. When you are ignorant of the enemy but know yourself, your chances of winning or losing are equal. If ignorant both of your enemy and of yourself, you are sure to be defeated in every battle.

Sun Tzu, The Art of War

1. Know your enemy

The clinical exam is one of the biggest ‘performances’ of your life. It is akin to going on stage, or giving a presentation to a huge audience. Like any performance it takes careful, thoughtful, repetitive rehearsal. Find out as much as you can from examiners, and from previous candidates about what it will be like on the day. The closer your rehearsals can be to what will happen on the day, the better prepared you will be. Plan to do difficult cases in exam conditions i.e. ‘hot’ cases, to examiners who make you feel anxious.

2. Identify your strengths and weaknesses

Self reflection and thoughtful self-analysis is one of the keys to your preparation. Identify the things that you are most uncomfortable with (eg a “please examine this child’s development”, or “an adolescent diabetic”) – these are the things that you must practise the most. The more you hate the idea of doing it – the more you should be practising that very thing. Similarly, if you are strong in respiratory cases – don’t waste valuable preparation time doing 4 children with CF. Look at your records, and identify the things that come up repeatedly.

3. Disaster planning

Think in advance about what you will do if things go wrong. Have a plan for dealing with them eg the poor-historian or overly-talkative parent, the child with a million problems, the child who screams throughout the interview. Adverse circumstances in the exam can weigh in your favour as it gives you an opportunity to shine! Remember the examiners have had to see the child as well so may have had the same difficulties. If things happen in the exam (eg your child goes blue or there is a MET call) let the examiners know- they will ask you if anything impaired your exam. Don’t whinge – but let them know!

4. Attitude

Think consciously about how you project yourself to the examiners. They are asked to judge you on your clinical skills, **attitudes and interpersonal skills**. At the end of the day they want to know if they will be happy to work with you as a peer, so it helps for you to think of yourself and behave like a
consultant paediatrician. At the same time beware of arrogance – know your limitations.

Your aim is to appear as an advanced trainee - respectful, knowledgeable with the appearance of perspective!! (yes, this is hard)

5. Put it in perspective

The exam does not need to be stressful and unpleasant. It is not the be-all and end-all. Large number of excellent paediatricians in this hospital took more than one go to pass. You need to walk in to the exam as confident as you can, but you also need to have thought beforehand and have a plan for what to do if you are not successful this time. Life goes on. As one former candidate said: “It is far better to do a long case (no matter how crap), than to be a long case.”

And the most important point (and the most easy to forget)....... 

6. Take time out

Spend some time with your partners and family, eat well and exercise. **Support each other through this process**, and take advantage of the large number of people both inside and outside the hospital who are available to help you.
SITTING THE EXAM THE SECOND TIME AROUND (FROM A FORMER CANDIDATE WITH PERSONAL PERSPECTIVE)

This is the page you don’t want to be relevant to you. However, it is relevant to many. If you have failed previously, welcome to the club. You are a veteran; you have endured, suffered, battled and most likely have scars to show for it. Like people in any field, you are respected for suffering through adversity.

There are plenty of us who have failed, and no one thinks worse of you. Except possibly you yourself. For many, this is the first exam you have ever failed and it comes as a jolt. You would be very surprised at the number of consultant paediatricians who have failed the written or clinical exams at least once. The college statistics published each year are revealing:

- 66% of all national candidates get through the written (that’s how the pass mark is set)
- Of those candidates who pass the written, ~75% pass first time, 40% the second, and it gets worse thereafter.
- NB – each year RCH gets different results – and it is not obvious what makes the results different.

How do you approach the exam a second or subsequent time? My suggestions are:

1. Make a decision about whether or not to continue trying. You have permission to not keep going. There are plenty who have decided that enough is enough, and they have gone on to enjoyable careers in other (more lucrative!) fields of medicine. I could not have sat the clinical any more than the twice I did. There are also others who have battled on, eventually got through and are happy they did. Think about this carefully.

2. If you do want to come back for more, **work out what you are going to do differently.** Anyone can fail the exam and yes, you may have had bad luck on the day. However, anyone can also increase their probability of passing. It is remarkable how many people think that if they just do more of the same, they will pass. They might, of course. However, don’t just see more cases. Maximise the range of approaches to which you are exposed. Present to a social worker, psychologist, or speech pathologist, your partner, a video, a nurse. Get critique on all aspects of cases - clinical, communication, body language...I’m getting away from the core topic here. What I am saying is that I recommend you spend time working out a strategy for improving your chances of getting through - it is likely to be different from the first time around.
   - Finding a good exam mentor or speaking in detail with helpful consultants may be useful.
   - Often short case preparation can be improved – see lots of signs!

3. Be forgiving of yourself – don’t focus on your negatives or shortcomings but try to keep a positive attitude. Sometimes you need to take feedback with a ‘grain of salt’. Interpret it in the context of your own opinion re your performance overall.
4. Consider working together with the others who are sitting for the second time – venting to each other can be really helpful for emotional support.

5. Remember not only do you have scars, but you have advantages over your colleagues who are approaching the clinical for the first time. You know what is involved, what it is like to do cases in front of other people, and you are not afraid of it. Well, not as much as the others. Consolidate this advantage early on. See your first long before the next year’s written, volunteer to be among the first to do “public” cases. You can be running while the new kids on the block are warming up. These advantages are not huge, but make them work for you to overcome the wounds you bring with you from your first experience!

Strangely enough, I enjoyed the camaraderie and increase in knowledge and skills of exam preparation. It is unfortunate that this particular exam is at the end of it.

Rob Roseby March 2003
Updated by Rebecca Mitchell and Monika Hasnat 2006
FROM THE HORSE’S MOUTH!!..... SURVEY OF EXAMINERS

A small group of the consultants who examine regularly for the FRACP clinical exam were sent the following survey in March 2003. Thank you to those who replied and gave such great (and interestingly very variable) comments.

1. **What do you ask the parents in your long case preparation time with them?**

   - What is the most important issue for them.
   - I ask, that both for myself and for the candidates, that the parents pretend that they have recently moved to a new town, and that they are meeting the paediatrician who is going to take over their child’s long-term care. I ask them to tell about everything that is relevant to their child’s problems, and not to withhold any information. I tell them that is OK to reveal the diagnosis and anything else that either the candidates or I might ask.
   - Obviously I work through all the standard parts of medical history, but at the end I say “is there anything else of importance that you have forgotten to tell me? -please think about this while I now go on and examine your child. Try and think if there is anything that has concerned your other doctors recently. What are the biggest problems at the moment for you?
   - Anything else that you think I should know/have asked about?
   - Of all the problems we have talked about, which is the biggest? And the next?
   - If the doctors could attend to one aspect of his/her care, which would you pick?
   - Explain we are under exam conditions so the situation is contrived and rushed.
   - List the three most important issues/problems they see their child has (in order), then take rest of history and do examination bearing these in mind
   - Current concerns, how do they cope, perception of illness, impact on life, finances, rest of family
   - Who is primary paediatrician, ancilliary sub-specialists
   - If I was the paediatrician managing child what would you want me to do or concentrate on to improve things
   - Family supports
   - ...to name a few!
2. Why do you think people fail in their preparation?

- Not developing perspective (often long term) with patient management.
- Not enough long case practice. Not fully understanding what the examiners are looking for.
- Do not learn from their mistakes.
- Lack of practice under time pressure.
- Do not use criticism constructively.
- Don't separate active and inactive problems and emphasise such and concentrate on giving a long history on inactive problems in the long case.
- Poor idea of common sense management of problems in long case, look for esoteric uncommon differential diagnoses.
- In the short case - poor differentials, sit on the fence for diagnosis rather than go for it!
- Either go in too quickly and miss obvious signs, or spend ages on routine exam and "missing the bacon" due to time constraints.
- A synthesis at the end shows up good candidates in the shorts.

3. Why do you think people fail on the day?

- Being too concerned about individual illnesses but not thinking how they fit together. Not thinking about the impact of the disease on the patient and his/her family.
- Inability to see the wood among the trees, and to focus on the investigation and management of the really important issues. Inability to understand the impact of the child's illness on him/her and the family.
- On the day prior to seeing the examiners? If so –
  - Having lost track of time during history and examination
  - Lack of organisation of notes
  - Failure to think about the priorities and following on from this the likely questions that will be asked – the better candidates know what is coming. You don’t want to be surprised by a line of questioning. You need to have developed an opinion about contentious issues prior to meeting with examiner (and to have evidence to back this up)
- Not having thought about a wide range of cases.
- Bad luck (occasionally).
- Overwhelmed and nervous.
- Do not go for it because deep down they do not think that they deserve to get it.
- Anxiety- we all suffer from it and candidates should realise and be comforted that examiners go in blind as well beforehand and have their strengths and weaknesses as well; additionally sub-specialists can be quite devoid of skills/knowledge in certain areas- be comforted by this; also worry about failing a case which then affects performance in others; the longs are critical only. A louder authoritative voice if you are a soft speaker helps cover this.
• Not listening to examiners prompts - you are allowed to ask clarification much the same as if you are having a conversation with a colleague.

4. What are the things that impress you on the day?
• I often learn new facts!
• Being well organised, focused on important issues, and able to impart a feeling of confidence. If I come away feeling that I would be happy for this person to be my senior registrar/fellow next year - then they have passed.
• Organisation.
• Perspective.
• Knowledge of own limitations.
• Being prepared for the questions (i.e. thinking quickly when the question is asked).
• Professional attitude and attire.
• Calm and organised candidate and in control.
• Logical clear presentation & mature discussion.
• Make me feel I could trust my child in their care.
• Candidates that take the initiative in cases.
• Discussion of cases as if you are talking to a colleague.
• Good introduction and conclusions in long and latter for shorts (often helps cover poorer techniques).
• Introduce themselves to parents in a not flustered way and make them feel at ease also.

5. What are the things candidates do or don't do that drive you crazy or cause you to mark down?
• Failure to listen carefully to the questions that are being asked.
• Forgetting the child’s name or age! -I do not mark them down for this but inevitably it gets the case off to a bad start.
• Nothing specific.
• Running overtime.
• Being too verbose (not knowing when to stop talking).
• Candidates should behave professionally.
• Too much paper shuffling.
• Suggest tests without explaining why.
• Arrogance.
• Arguing with the examiners (it happens).
• Failing to listen to and answer the question asked.
• In short cases – the major reasons for failure is poor examination technique.
• Lack maturity and perspective in their discussion.
• Say things like they rote learnt them.
• Not listen, not clarify questions.
• A detailed history without direction.
• A very average technique but picks cardinal signs and good summary allows a good pass in shorts. If you get there then technique is not so important in passing shorts.

6. **Please add anything else you think would be helpful for candidates.....**

• Don’t take “Examination Paediatrics” too seriously.
• Mostly the exam test requires lots of practice and common sense.
• Some golden questions:
  o Anything that the examiners asked about that I didn’t?
  o Anything that I asked about that the examiners didn’t?
• Focus on learning and improving each time you do a case, do not think of it as a pass/fail situation.
• Forget about your ego!