Slides 2 – 5: Introduction

The AMC is responsible for assessing the knowledge, clinical skills and professional attributes of international medical graduates (IMGs) with limited registration on the standard pathway seeking to practise medicine in Australia.

IMGs on the Standard Pathway can be assessed by an initial multiple choice question (AMC1 MCQ) examination, and a subsequent clinical examination (AMC2 OSCE) or a program of workplace-based assessment (WBA) of clinical skills and knowledge by an AMC accredited authority.

Examination concerns
Concerns raised by a jurisdiction following AMC MCQ and AMC2:
- Communication and cultural issues – 20%-30% of IMGs.
- >50% had performance concerns compared to 3% for Australian-trained graduates.
- Most significant concern was clinical judgement.

Current snapshot of the AMC2 Clinical Exam
- Held mainly in Melbourne, with one or two exams per year in Perth.
- Exam cohort pass rates are usually between 30-40%.
- Pass rate for 305 candidates in October 2016 – average of 35%.
- The results of OSCEs are not a good predictor of performance in a clinical setting.

Millers pyramid of clinical competence:
Miller was an educational psychologist, proposing a framework for assessing clinical competence:
- MCQ written assessments assess candidates at the ‘Knows’ and ‘Knows How’ levels.
- OSCE assessments assess candidates at the ‘Knows How’ and ‘Shows’ levels.
- The WBA clinical assessment program assesses candidates at the ‘Does’ level.
- MCQs, Orals and OSCEs all have a place in medical education for determining candidate strengths and weaknesses.
- The gold standard in ascertaining clinical skills and knowledge is through mini clinical examinations with real patients.
Sources:


Slides 6 – 13: Workplace-based Assessment

The WA Country Health Service (WACHS) identified in its Annual Report 2015-16 that attraction and retention of clinical staff continues to be a challenge. While there has been an increase in numbers of Australian-trained medical graduates, it can be difficult to get the right workforce mix/balance to attract and retain Australian-trained graduates. There continues to be a reliance on IMGs for service delivery.

Accreditation of WBA
The WBA program is an alternative to the AMC2. Seven locations have been accredited by the AMC to become program providers and implement WBA at 15 hospitals, nationwide. Individual hospitals are supported to implement WBA taking into account local circumstances (e.g. workforce – in WA the program varies in size across the three sites and the WA Department of Health has developed a sliding scale of candidate fees to support variations between sites).

Implementation of WBA
Implementation of the WBA program at Bunbury, Geraldton and Kalgoorlie Hospitals has supported recruitment and retention to these locations, with significant interest at each recruitment round. There are approximately 20 candidates selected to the WBA program annually with, on average, a 70% retention rate to rural areas of those that remain employed in WA.

Benefits of WBA
The WBA program is rigorous and has a much higher pass rate than the AMC clinical exam. A total of 84 IMGs presented for WBA in the 2014/15 financial year, with 76 (90%) successfully completing. A total of 1979 clinical examinations were held in this timeframe with 588 (30%) successfully passing.

Significant other benefits have resulted from implementation of the WBA program including:
- Supports integration of candidates into the local community.
- Assists candidates to assimilate into the Australian health workforce including:
  - Appropriate use of effective communication.
  - Respect for patients and colleagues.
  - Working productively within a healthcare team, and
  - Applying risk-management skills.
- Provides consistency of supervision and assessment techniques within the wider hospital community (e.g. professional development of clinicians performing an assessment role, calibrating across all teaching and training interactions).
- Provides opportunity for immediate feedback and supports identification of underperformance and implementation of an appropriate action plan reviewed within an agreed timeframe.
- Recruitment and retention of higher quality medical staff.
- Improved patient care (safety and quality).

What is WBA?
WBA assessments test performance in the everyday clinical practice and to ensure reliability and validity should use:
- A variety of assessment methods.
- Multiple observations in various clinical settings.
- Trained multiple assessors.

WA WBA Program
The program in WA is accredited for 12 months, with assessments typically spanning 9 months and 3 months for consolidation/catch-up. The Medical Board of Australia requires demonstration of 47 weeks of practice as one of the eligibility requirements for general registration.
To join the WBA program candidates must have addressed the requirements of the AMC and must have secured a contract of employment with one of the accredited WACHS hospital.

**Sources:**


**Slides 14 – 22: Assessment considerations**

**Level of assessment**

The assessment level of WBA is that of an Australian intern at the end of the PGY1 year or that which one would expect from a minimally or just competent medical officer at the end of PGY1.

**Purpose of training and calibration of assessors**

- Orient assessors to the specific assessment methods used.
- Explain what each method assesses.
- Advise how each assessment is applied.
- Ensure assessors are aware of their own performance as an assessor.

**Who can assess?**

Assessors should be experienced clinicians who:

- Possess expertise in the clinical tasks being assessed.
- Are trained in WBA for target cohorts (IMGs in this case).
- Available to assess.
- Have agreed to assess according to WBA principles.
- Consultant, registrar, medical practitioner with 4 years of experience in the Australian health care environment or equivalent.
- Nurse educators, nurse practitioners or highly experienced staff who can all assess specific procedures within their individual scope of practice at the discretion of the WBA Program Director (e.g. plaster technician).

**What is the role of assessors?**

- Select the patient/case and assure consent is received.
- Ensure the candidate has undertaken adequate preparation.
- Conduct direct or indirect assessment in a clinical area and provide immediate feedback.
- Undertake a formative assessment and provide feedback if requested.

**Direct assessment requirements**

- General or specialist registrants who have successfully completed 4 years of experience in the Australian health care environment or clinicians with equivalent experience who trained in a designated Competent Authority country.
- DOPS may also be assessed by registered nurses with appropriate clinical assessment experience.
- **Other AMC candidates are not to be included as assessors or patients.**

**Indirect assessment requirements**

- The WBA provider should have clear statements of the expertise and experience required for the appointment of assessors. All assessors must have:
  - Completed the **WBA assessor and supervisor training package**.
  - Signed the declaration that they have completed this training.
- In the case of MSF, the candidate and/or WBA provider may choose to include other members of the health care team.
Conflict of interest
- Need to avoid any biased judgements
- Assessors need to be at ‘arm’s length’
- Always difficult to document unsatisfactory performance when a collegial relationship exists. Conversely a good assessment can be viewed with suspicion if a collegial relationship exists.
- Extremely unlikely that all assessors can be totally free of conflicts of interest.
- Can avoid or reduce conflict of interest through:
  - Objective benchmarks with all assessments.
  - Use multiple assessors some with no supervisory or employment relationship.
  - Training to show assessors how to distance themselves.
- If a conflict is unavoidable assessors can excuse themselves from the assessment process.

Sources:

Slides 23 - 31: Assessment methods and Mini-CEX practice
The WA WBA Program has been accredited by the AMC to deliver an assessment plan using a variety of direct and indirect assessment methods, according to an approved blueprint developed in 2010 and adjusted in 2014.

<table>
<thead>
<tr>
<th>Direct assessments</th>
<th>Indirect assessments</th>
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<tbody>
<tr>
<td>Mini clinical examination (Mini-CEX) x 12</td>
<td>Case-based discussions (CBDs) x 6</td>
</tr>
<tr>
<td>Direct observation of procedural skills (DOPS) x 6</td>
<td>Multi-source feedback x 1</td>
</tr>
<tr>
<td>External assessor report x 1</td>
<td>Supervisor reports x 5 (formative and summative)</td>
</tr>
</tbody>
</table>

Further information on assessment methods is provided in the WBA Assessor Guide.

Role of the assessor in the Mini-CEX
- Totally uninvolved in the encounter/unobtrusive as possible, unless there are risks to patient safety.
- Any issues identified should be followed up after the candidate has completed with the patient.
- All questions should be completed with both effective and ineffective aspects of performance noted.
- The Mini-CEX forms should be returned to the WBA administrative officer for data entry and record keeping.

Slides 32 and 33: AMC feedback and resources
The AMC has provided the following feedback to the Department from the review of candidate results by the AMC Results Panel:
- All boxes/fields must be completed on the assessment forms, including comments in all areas.
- Forms must be signed by candidate and assessor.
- When a task or requirement is not observed the assessor must provide a reason.
- DOPS forms must indicate what is being assessed (i.e., procedure or information).
- The quality of assessments must be readable.
- Suggested minimum observation and feedback times of 10-15 minutes for each.

Resources used to develop this package include:
Scenarios on YouTube: Developing Mini-CEX assessment skills

There are three different candidate performances for three different clinical encounters.

- History taking for a patient with angina complicated by anaemia (scenarios 1-3)
- Physical examination for patient with shortness of breath, fatigue and productive cough (scenarios 4-6)
- Patient counselling encounter - high cholesterol: treatment counselling session (scenarios 7-9)

You can complete the AMC modules without registering, however, if you register and log in you will receive certification that can be used for continuing professional development points.

Assessing clinical performance – what is assessed?

1. Watch scenario 3 – history taking for chest pain.
   - Consider what performance aspects you observed in the encounter
   - Strive to be analytical
   - What was good, what was not so good?
   - Think about how you would rate the candidate.
   - Complete the mini-CEX assessment form for scenario 3.
   - Bring the completed assessment form to the WBA Supervisor and Assessor workshop.

2. Watch scenario 6 – physical examination for SOB, fatigue, cough.
   - Consider what performance aspects you observed in the encounter.
   - Strive to be analytical.
   - What was good, what was not so good?
   - Think about how you would rate the candidate.
   - Complete the mini-CEX assessment form scenario 6.
   - Bring the completed assessment form to the WBA Supervisor and Assessor workshop.

3. Watch scenario 9 – counselling for raised cholesterol.
   - Consider what performance aspects you observed in the encounter.
   - Strive to be analytical.
   - What was good, what was not so good?
   - Think about how you would rate the candidate.
   - Complete the mini-CEX assessment form for scenario 9.
   - Bring the completed assessment form to the WBA Supervisor and Assessor workshop.

Developing a frame-of-reference for your assessments

1. History taking encounters:
   - Watch scenario 1 then rate the candidate using the assessment form provided.
   - Watch scenario 2 then rate the candidate using the assessment form provided.
   - Think about the two candidate performances and your rating then write some comments.
   - Watch the Feedback session for scenario 2.
   - Write down some key points about effective feedback to share with colleagues at the workshop.

2. Physical examination encounters:
   - Watch scenario 4 then rate the candidate using the assessment form provided.
   - Watch scenario 5 then rate the candidate using the assessment form provided.
   - Think about the two candidate performances and your rating then write some comments.
   - Watch the Feedback session for scenario 5.
   - Write down some key points about effective feedback to share with colleagues at the workshop.

3. Counselling encounters:
   - Watch scenario 7 then rate the candidate using the assessment form provided.
   - Watch scenario 8 then rate the candidate using the assessment form provided.
   - Think about the two candidate performances and your rating then write some comments to share at the Assessor Workshop.
   - Watch the Feedback session for scenario 8.
   - Write down some key points about effective feedback to share with colleagues at the workshop.
Write down some overall points on how you can give effective feedback to share with colleagues at the WBA Assessor and Supervisor Workshop.
You can compare your answers with the following information from WBA Online.

1. Preparing for the feedback session:
   - Observe the candidate first hand.
   - Identify the criteria against which performance is assessed.
   - Plan feedback content based on goals and criteria; consider amount of feedback.
   - Choose a suitable environment (privacy/setting).
   - Deliver feedback in a timely manner – as close as possible to the encounter.
   - Plan how you will deliver the feedback. Different techniques include:
     - Describing what went well and what needs improvement.
     - Using the expanded feedback sandwich.

2. Conducting the feedback session using the expanded feedback sandwich:
   - ‘What do you think you did well?’
   - ‘What do you think needs improvement?’ (The candidate is usually on target)
   - ‘This is what I saw that went well.’
   - ‘This is what I saw that needs improvement.’ (Generally there is concurrence)
   - ‘How would you try to improve?’
   - ‘Here are some suggestions you might try’.
   - ‘Which would you like to try first?’

3. After the session:
   - Be reflective of your approach and the strategies you used in giving feedback overall.
   - Seek feedback on your own performance.

The following YouTube scenarios may assist:
   - **Scenario 1a**: mid-term report interview for a PGY1 doctor.
   - **Scenario 1b**: mid-term assessment feedback 2nd interview.
The following analyses of scenarios are designed to help you calibrate your own assessments to ensure all your future WBA assessments remain both valid and reliable.

If you have wide ranging differences in your assessments compared to the following then please discuss the differences with the WBA Program Director and for discussion with your colleagues at the WBA Supervisor and Assessor Workshop.

'I am not sure that I agree with your XCZZHJEU mini-CEX assessment, DOCTOR!'
A 60 year old male retired accountant presents to an outpatient clinic complaining of intermittent chest pain that he has had for some months

Scenario 1

- Poor communication from the candidate throughout the interaction.
- Used closed questions with apparent disinterest in the patient’s responses. The only positive response was replying ‘good’ to exercise.
- Ignored the patient’s specific concern regarding his father’s illness.
- The candidate moved quickly off the reported symptom of indigestion rather than following this up and asking more questions which may have identified melaena.
- Gave a brief and technical explanation of the patient’s condition.
- Failed to establish any rapport with the patient.
- Failed to allow the patient to talk.
- Appeared uncaring and did not respond to the patient’s calls for understanding. This is a situation where empathy is clearly called for.

Because of her ‘shotgun’, rapid fire, closed questions the candidate did not process the information given in an appropriate way to generate and test diagnostic possibilities (or hypotheses). Although the candidate did make the diagnosis of angina there is little else correct in the performance.

Rating:
Overall a very unsatisfactory performance.

Scenario 2

- The candidate was pleasant throughout the interview.
- In some respects the candidate was thorough.
- The candidate asked about:
  1. Risk factors, including family history, hypertension, cholesterol and other vascular disease (eg claudication looking for peripheral vascular disease).
  2. Disease in the distribution of the carotid (asked about visual changes, episodes of weakness).
- The candidate checked for other cardiac symptoms (heart failure, peripheral oedema), then started a mini systems review but used double-barreled or multiple questions such as indigestion, vomiting, bowel problems. The systems review sought a history of joints.
- The candidate did not appear to be thinking in a problem solving mode (if presented with indigestion and melaena the link between joint disease and other symptoms might be non-steroidal anti-inflammatory medication).
- The candidate appeared to be in data gathering mode, collecting data without thinking of its significance (eg after hearing about elbow problems he did not ask about non-steroidal medication).
- When the patient asked for an explanation the candidate avoided responding by saying it was ‘too early’ and spoke of the need for tests even though he appeared to have a good idea of what was happening.

Rating:
Overall borderline unsatisfactory.

Scenario 3

- The candidate uses good open-ended questions and good listening techniques, able to pick up on patient cues (eg indigestion, identifies potential impact of family history particularly the father’s death on his perception of own illness and prognosis).
- The candidate was appropriately empathic in relation to the patient’s concerns.
- Very satisfactory description of likely diagnoses using appropriate lay language.

Rating:
Overall this was a very satisfactory performance.
A 60 year old male presents to clinic with the main complaint SOB, fatigue and productive cough. He is unsure but thinks he has slowly been getting more short of breath over the last year or so. He is a smoker, having consumed 25 a day between the ages of 25 and 55 years. He has noticed some mild ankle oedema in the last 2 months. He is otherwise well and is on no medication.

He was diagnosed with Inflammatory Bowel Disease 20 years ago and this has been stable since an ileostomy 15 years ago.

The doctor has taken his history and the patient has been asked to go into the examination room and strip to the waist prior to being examined.

Scenario 4
- The candidate assessed the cardiovascular system including looking at the JVP and for ankle oedema.
- The candidate listened to several areas of the lung posteriorly.
- It was a fair methodological approach but the observing assessor wasn’t sure what the candidate was looking for and how the findings impacted on her working diagnosis.

Rating:
Physical examination techniques were very satisfactory.

The overall rating was satisfactory but there was uncertainty about her clinical reasoning (this might be good if she was looking for the right things). This would be elicited in the interview and debrief at the end of the physical examination.

Scenario 5:
- The candidate was respectful of the patient and was thorough to such an extent that she was overly inclusive in examination components.
- Given the presentation she did not need to look in his ears or feel glands in his neck. This may indicate that she isn’t testing a working hypothesis.
- Technique: evidence suggests that vocal fremitus is inferior to vocal resonance – applied hand vertically instead of horizontally in rib spaces.
- Examination of the abdomen was satisfactory but not necessary.
- The assessor would want to ask her what she was thinking in the interview afterwards.

Rating:
Technique: satisfactory but overly inclusive

Overall:
Need to have a clear view of diagnostic possibilities and use clinical reasoning to identify those features that should be sought on physical examination.

Scenario 6:
- The candidate’s technique appeared to be very satisfactory.
- The candidate appeared to be generating hypotheses and testing them.
- All aspects of the examination were done appropriately to test hypotheses including recording the peak flow.
- The candidate should have repeated peak flow at least twice more but there is a reasonable assumption that he would refer for detailed lung function tests.

Rating:
Overall very satisfactory
A 46 year old female, returning to clinic for follow-up and counselling, for hyperlipidaemia. She has a strong family history of heart disease. At the last test her LDL cholesterol was 7.2 mmol/l. She is recently divorced and works as an administrative officer in the city.

She smokes about 10 cigarettes a day and has ignored past advice to stop smoking. She has no regular exercise.

Scenario 7
- The candidate demonstrates poor communication skills.
- Did not involve the patient.
- Used short statements with little explanation.
- Did not check understanding.
- Unsettled the patient.
- Use statistics and jargon that the patient didn't understand.
- Had very few pauses to allow the information to be absorbed by the patient.
- Had poor eye contact which allowed him to miss patient cues.
- Told the patient what to do instead of negotiating a plan.
- Grossly inadequate explanation of the side effects.

Rating:
Overall very unsatisfactory

Scenario 8
- The candidate engaged the patient and provided options.
- Smoking and exercise were addressed but not in enough detail.
- Further information and advice would be needed (eg gradually increase fitness level).
- The important side-effect of statins (myositis) was covered.
- The concern about weight gain was inappropriately dismissed by the candidate.
- The candidate approached the encounter in a disorganised way.
- Focused more on the medication and less on lifestyle issues.

Rating:
Interviewing skills: very satisfactory
Organisation: less than satisfactory
Overall: satisfactory

Scenario 9
- The candidate engaged the patient.
- Checked understanding.
- Actively involved the patient in negotiating a plan.
- Acknowledged that lifestyle changes are important.
- Would need further appointment and negotiated a mutual agreement to talk about lifestyle changes at the next appointment.
- Checked understanding again at the end of the interview.
- Offered to see the patient again.
- The candidate addressed risk factors but could have been a little clearer in terms of immediate and long-term risks.

Rating:
Overall very satisfactory.