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Exam report 2018.1 KFP

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Exam report 2018.1 KFP

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The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002 Australia

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

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Exam report 2018.1 KFP

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Contents

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1. Exam psychometrics

Table 1 shows the mean and standard deviation of the entire cohort who sat the exam. These values can vary between exams and semesters. The reliability is a measurement of the internal consistency of the exam, with values between 0 and 1.

A candidate must achieve a score equal to or higher than the pass mark in order to pass the exam. The pass mark for the Applied Knowledge Test (AKT) and Key Feature Problem (KFP) exam is determined by the Modified Angoff standard-setting method. This is a criterion-referenced methodology that is used internationally in high-stakes assessments.

The Objective Structured Clinical Examination (OSCE) pass mark is determined by the borderline group method (refer to the RACGP Education *Examinations guide* for further detail).

The 'pass rate' is the percentage of candidates who achieved the pass mark.

The Royal Australian College of General Practitioners (RACGP) has no quotas on pass rates; there is not a set number or percentage of people who pass the exam.

Table 1. 2018.1 KFP psychometrics

Mean score (%)	57.67
Standard deviation (%)	7.72
Reliability	0.81
Pass mark (%)	56.83
Pass rate (%)	56.55
Number sat	1542

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2. Candidate score distribution histogram

The below histogram (Figure 1) shows the range and frequency of final scores for the KFP exam. The vertical blue line represents the pass mark.

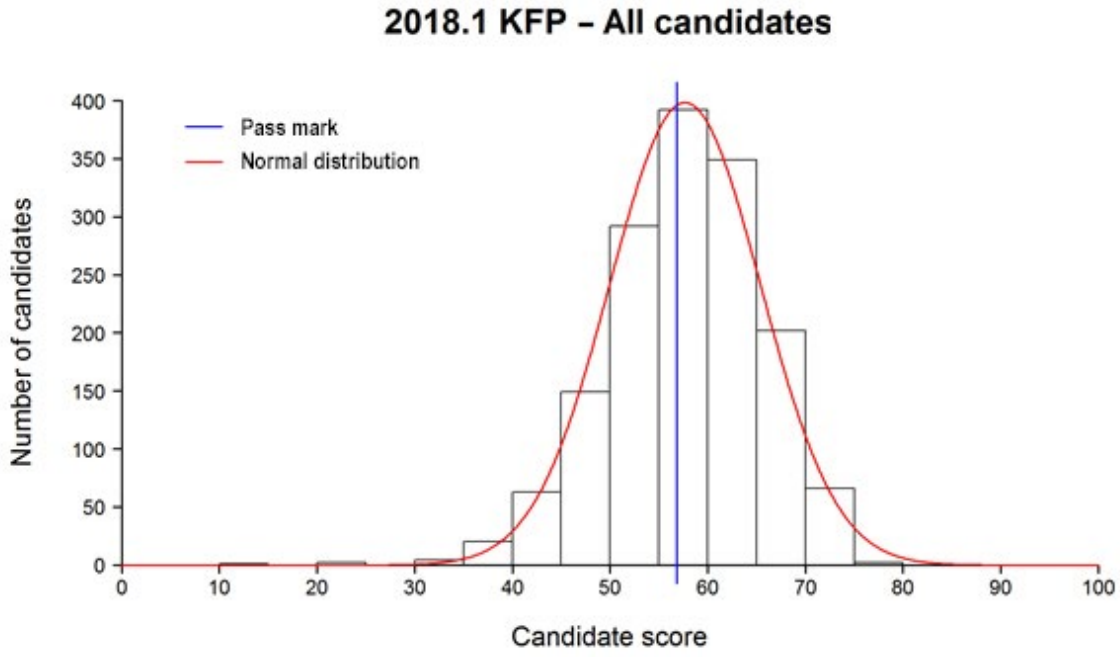

Figure 1. Final 2018.1 KFP score distribution

3. Candidate outcomes by exam attempt

Table 2 provides pass rates (%) displayed by number of attempts. As displayed below, there is a general trend that suggests candidate success diminishes for each subsequent attempt. Preparation and readiness to sit are therefore paramount for candidate success.

Table 2. 2018.1 KFP pass rates by number of attempts

Attempt	Pass rate (%)
First attempt	69.4
Second attempt	42.5
Third attempt	32.0
Fourth or greater attempt	31.8

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4. Preparation – practice exams

An online practice exam is made available to enrolled candidates prior to each AKT and KFP exam. The purpose of this exam is to provide a simulated experience in preparation for the real exam. Candidates are provided with automated feedback to complete their experience.

The practice exam is not designed to provide a mark or grade as an indication of whether or not a candidate will pass.

However, it is evident to the RACGP that those who attempt the online practice exams perform better in the real exam than those who do not (Table 3). Attempting the practice exam is therefore highly recommended.

The RACGP has recently released new Exam Support Online (ESO) modules through *gplearning*. These modules are available to all members and are not linked to exam enrolment. They provide information for all Fellowship assessments, along with sample questions taken from recent exam papers. The modules are suitable for prospective candidates, and those supporting them, as they prepare for the assessments.

Table 3. 2018.1 KFP online practice exam

Attempted practice exam	Total number of candidates	Proportion of candidates (%)	Number passing the real exam	Pass rate (%)
Yes	1,369	89	821	60
No	173	11	51	29
Total	1,542	100	872	

5. Candidate performance – AKT and KFP exam

Table 4 shows the performance of the 1134 candidates who sat both the AKT and the KFP exam in the 2018.1 exam cycle.

Table 4. 2018.1 AKT and KFP exam pass/fail correlation

AKT	KFP	Number	Percentage
Pass	Pass	667	58.8
Pass	Fail	238	21.0
Fail	Pass	17	1.5
Fail	Fail	212	18.7
Total		1,134	100.0

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6. Feedback report on 2018.1 KFP exam cases

This feedback report is published following each KFP exam in conjunction with candidate results. All of the questions within the KFP exam are written and quality assured by experienced general practitioners (GPs) who currently work in clinical practice, and are based on clinical presentations typically seen in an Australian general practice setting. The questions should therefore be answered in the context of Australian general practice.

The KFP exam is designed to assess the clinical reasoning and clinical decision-making of the candidate – a core competency for all clinicians. It is important to remember that the KFP exam paper is not simply a short-answer paper, but requires analysis of the clinical scenario, consideration of the initial information and any evolving information as the cases progress. The candidate is then required to answer focused questions relating to the context of the given clinical scenario.

The paper reflects the breadth of clinical encounters seen in Australian general practice and, as such, the answers should relate to that context. This feedback report is a summary of the information derived from the actual examiners marking the questions. Each examiner marks one question for all candidates, which allows them to offer pertinent information on the common errors, as well as what constituted good answers.

The feedback is provided so all candidates can reflect upon their own performance in each case. It is also being provided so prospective candidates, as well as those assisting them in their preparation, can see the breadth of content in the exam. This feedback report should be read in conjunction with the advice given in the RACGP Education *Examinations guide*.

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Case 1

This case focused on an older male patient presenting with a compression fracture. Candidates were provided with the patient's dual-energy X-ray absorptiometry (DEXA) results demonstrating the patient had osteoporosis. The case required candidates to consider the possible causes of the patient's osteoporosis, appropriate investigations and the medications appropriate for this patient.

The most common errors in this case centred around not answering the case in the context of the question. Candidates provided responses that were wrong for the gender of the patient, providing causes and treatments for a female patient (8% of candidates listed raloxifene as an appropriate treatment).

Candidates provided non-specific answers such as 'alcohol', 'medication' or 'lifestyle' as a cause of the osteoporosis. These answers do not score marks since they provide no insight into a candidate's knowledge. A better answer would include the level of alcohol consumption that would pose a risk, or a medication class that is known to reduce bone density.

Case 2

This case focused on a young female patient presenting with vaginal bleeding in early pregnancy. Candidates were required to consider the differential diagnoses, appropriate investigations and then offer appropriate advice regarding diet in pregnancy.

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The common errors regarding the differential diagnoses were candidates providing answers that relied on history or details not provided in the scenario. It is important to consider the key features in the clinical scenario provided and not to provide answers based on collateral history not included in the scenario.

Case 3

Candidates were presented with a middle-aged diabetic patient who presents for routine diabetic review. They were required to analyse the case information, including results, and consider what complications were demonstrated and how these may be managed.

Although answered well by the majority of candidates, the main error this case demonstrated was failure to read the scenario and the questions. Candidates provided results or investigations as answers, rather than the diagnosis (diabetic nephropathy) as requested in the question. When asked for serious complications of the medication, candidates provided answers focusing on the complication of diabetes rather the medication, or on complications that were not serious. In relation to the management question that specifically asked for non-lifestyle measures, candidates provided lifestyle answers.

It is important to ensure that the case is read fully, all information is considered and that candidates read and re-read the question, and after writing their answer consider reading the question again to ensure their answer matches the actual question asked.

Case 4

This case focused on a middle-aged male patient who presented with two episodes of sudden loss of vision in one eye. Candidates were presented with his past medical history and medications. The initial questions focused on history and differential diagnoses, with a final question considering an incidental skin lesion found on examination.

A common diagnosis given was ‘amaurosis fugax’; this is not a diagnosis, but a term used for a symptom complex. For the history component of the case, common errors were to provide answers that were unfocused and not related to developing a working diagnosis, or that repeated information already in the stem. In the KFP exam, it is important to provide specific answers tailored to the scenario and question.

Candidates were given a clinical photograph of a skin lesion and required to provide the appropriate management. Dermoscopy was a common answer. This is not a management step, but an examination. Another common error was to consider full skin checks or advice on safe sun exposure, neither of which addresses the question, which was about the management of the lesion demonstrated.

Case 5

This case focused on a young female patient presenting with irregular periods. Candidates were required to consider the history and investigations required to develop a diagnosis for the patient’s presentation, then develop an appropriate management plan.

A common error was to only develop the history focused on one diagnosis, such as polycystic ovary syndrome, and not consider a broader list of diagnoses for this presentation. This was repeated in the investigation question as candidates selected investigations that only confirmed a diagnosis of polycystic ovary syndrome rather than, as the question asked, how candidates would investigate the causes of this patient’s symptoms. The initial questions in this case were developed to assess a candidate’s initial approach to a young patient with irregular periods, and provide focused history and investigation.

In the management question, the need for specificity cannot be stressed enough. Providing generic answers such as ‘diet’, ‘exercise’, ‘medication’ or ‘educate’ did not gain marks. Candidates need to expand and show to the examiner that they know what medications or dietary and lifestyle advice they are giving to the patient, and that such advice is both specific and appropriate to the clinical scenario.

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Case 6

This case centred on a male patient presenting with a swollen elbow, and required candidates to provide appropriate diagnosis and management as well as the underlying pathology for the presentation.

This case was generally addressed well, but some candidates did not describe the underlying pathology or cause for the presentation. Instead, they gave further diagnoses or delivered management that was not appropriate and used abbreviations such as 'RICE'. In this presentation, elevation was not appropriate and therefore RICE did not score. Candidates should not use abbreviations in their answers; in this case, if candidates had considered what RICE is an abbreviation for – rest, ice, compression and elevation – they would mostly likely have identified that one element was incorrect.

Case 7

This case presented an elderly man with a complex medical history, including dementia, who attends for his driving licence medical. This question was assessing the ability to consider all the information provided and demonstrate what further information is required to make a decision on the patient's fitness to drive and his subsequent management. The marking grid for this question took into account all the different state-based and territory-based requirements.

Again, it was important to answer the question provided. Common errors were to list all the examination findings for one condition, such as Parkinson's disease, or to list generic examinations such as 'do a full neurological examination'. Such answers did not score.

The question required familiarity with the 'fitness to drive' requirements as well as the forms used in the assessment. In the management question, candidates provided management of his underlying conditions, such as performing investigations and optimising his diabetes control, but not the further management steps required to fully assess the patient's fitness to drive, such as external assessment with occupational therapy or, with consent, a collateral history from relatives.

In the final question, candidates were asked to identify the required management following a decision that the patient was not fit to drive. This is an important component of assessing fitness to drive, and candidates need to be aware of their responsibilities should this be the outcome. The KFP exam can include questions from all five domains of the general practice curriculum, so candidates should include occupational and legal aspects of general practice in their exam preparation.

Common errors were to consider ongoing preventive health measures or assessments, discuss other transport options, or to provide generic answers such as 'reassure', 'refer', 'empathise' or 'educate'. These did not gain marks as they do not give the examiners insight into a candidate's knowledge or ability to manage a patient. It is paramount that answers are specific.

Case 8

This case focused on a young male patient, whose father had recently been diagnosed with symptoms suggestive of Huntington's chorea. The question focused initially on the genetics of Huntington's disease, but then looked at managing requests for genetic screening, as well as the options for in-utero testing, given the patient's wife was in the early stages of pregnancy.

Following the KFP exam, there was significant social media discussion on why there was a question on this condition in the KFP exam. While not a common condition, the scenario provides a route into testing several domains, such as the candidate's understanding of genetic testing requests, appropriate advice to provide, the available methods of antenatal screening and what should actually be screened for. GPs are at the front line for requests for genetic tests and should be able to give appropriate advice on testing and its implications.

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Case 9

Candidates were presented with a young female patient experiencing repeated short-lived episodes of dyspnoea and palpitations. She had a history of well-controlled asthma. Candidates were required to identify appropriate investigations to look for causes of her symptoms, provide differential diagnoses, identify the most likely diagnosis given all investigations were normal, then provide an appropriate management strategy.

A common error for some candidates was to provide answers focused on the patient's asthma, despite it being stated it was well controlled – such answers included spirometry with reversibility as an investigation, and overuse of salbutamol or assorted arrhythmias as a diagnosis, despite normal investigations.

In developing appropriate management strategies, responses such as providing a mental health care plan (which does not actually manage the patient unless it details the specific mental health treatment required) or non-specific referral will not score.

Case 10

Candidates were presented with a young girl who is found to have a hot, tender and swollen knee on a background of a recent sore throat.

The majority of candidates answered this question well. The most common error was in providing responses not appropriate to the age of the patient, providing management that did not respond to the urgency of the presentation or providing investigations based on secondary care.

The final component of the question required candidates to identify from a clinical photograph that the young girl had simple warts on her fingers, and then to provide appropriate management advice

Case 11

This case focused on an Aboriginal middle-aged female patient presenting with abnormal liver investigations and a diagnosis of chronic hepatitis C. Candidates were asked to consider the reasons why the patient may not have accessed care earlier and received appropriate treatment. Candidates had to also identify what investigations they would consider before commencing appropriate GP-based treatment for her hepatitis C.

The majority of candidates answered this question well. The most common errors were choosing investigations that were not essential prior to specifically assessing the appropriateness of providing GP-based hepatitis C treatment programs.

Case 12

This case consisted of a young adult male presenting to a rural hospital with symptoms and vital signs demonstrating evolving anaphylactic shock. Candidates were required to provide a specific diagnosis and specific initial and ongoing management.

Common errors involved not reading the question and identifying that the scenario was a remote rural location, or not identifying the urgency of the situation, so providing answers unrelated to the scenario or the questions asked. Some candidates also managed the patient as a case of envenomation despite no information in the scenario suggesting this.

While candidates knew the principles of managing acute anaphylactic shock, there were issues relating to awareness of dosages or providing medication no longer used in current guidelines. The question required candidates to identify this was a case of anaphylactic shock, evident from the vital signs, and not just anaphylaxis. Candidates should be familiar with managing the range of emergency presentations that may arise in general practice.

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In the KFP exam there may be questions where an answer is either a 'killer answer' where undertaking this action is dangerous (refer to case 25), or an 'important answer' where without a specific management step the patient is at significant risk. In this case, failure to provide adrenaline meant that the candidate scored zero for that question – not for the whole case, but just for the question.

Case 13

Candidates were presented with a three-month-old baby with progressive respiratory signs suggestive of bronchiolitis. Candidates needed to make a correct diagnosis and identify the most likely causative organisms in bronchiolitis, then identify factors in the child's history they would need to enquire about to assess if they are at risk of severe disease.

Common errors centred on not identifying organisms but offering differential diagnoses, and on providing examination or investigation findings when asked specifically about the patient's history. Candidates also provided answers such as prematurity or being unimmunised, which were in conflict with the information in the scenario – the baby was born at term and fully up to date with immunisation.

In the final component of the case, candidates were required to identify a common self-limiting facial rash in young babies and offer appropriate management advice to the parents. This was answered well by the majority of candidates.

Case 14

This case focused on a young male patient who presents with acute onset of increased breathlessness on exertion. There was a history of recent viral infection. Candidates were asked to consider key elements of the history they required in order to formulate a diagnosis, interpret cardiovascular findings to provide a diagnosis, then appropriately manage this acute presentation

Common errors were in only obtaining history centred on one diagnosis – for example, pulmonary embolus/deep venous thrombosis or respiratory infection – rather than exploring more broadly relevant aspects of history. At times, candidates focused on the patient's employment, even though a recent employment medical was normal. Another error was to provide non-specific answers such as 'family history' or 'take respiratory history'.

Some candidates failed to correctly interpret the cardiovascular examination finding in light of the presentation, so did not identify the correct diagnosis or the urgency required for immediate referral or admission.

Case 15

Candidates were presented with an elderly female patient in a residential facility. The patient had a complex history and now presented with signs of a deep venous thrombosis. Candidates were required to identify specific examination findings that they would assess for in order to confirm the diagnosis as well as the subsequent investigation and appropriate management.

Common errors included not correctly synthesising the information within the scenario and developing an appropriate diagnosis, therefore focusing the examination on other diagnoses. When offering investigations, candidates were not specific in their request. The KFP is seeking to assess what candidates do in their day-to-day clinical practice. When requesting a duplex or Doppler scan, it is important to specify what the scan is of and where. Hence, maximum marks were for providing an answer such as venous Doppler/duplex of the deep veins of the left leg. Simply putting duplex or Doppler would not have gained marks.

In managing this particular patient, candidates needed to appreciate the implication of the patient's recent and past medical history and that the patient therefore required urgent input from secondary care in regard to anticoagulation. Initiating GP-based treatments with anticoagulants was not appropriate.

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Case 16

This case focused on an older female patient who presented with collapse. Candidates needed to provide the most likely differential diagnoses and initial investigations in light of relevant past medical history and medications.

While this question was generally answered well, the most common errors were in providing diagnoses not relevant or likely given the information in the scenario. As for some earlier questions, candidates appeared to develop a collateral history and so provided irrelevant diagnoses. The commonest incorrect investigations focused on candidates selecting investigations that would not be considered initial, or investigating those conditions that were not the most likely differential diagnoses.

Case 17

This case focused on an unimmunised eight-month-old baby girl presenting with her mother. The mother wished to enquire about immunisation and possible contraindications given the child's allergies. Candidates were required to identify the contraindications to immunisation as well as manage the request for immunisation in light of the father, who is not present, being opposed to all vaccinations.

The scenario required candidates to identify the complex medico-legal and ethical aspects of this scenario and manage appropriately, and to also provide the limited medical contraindications to vaccination from current guidelines. In terms of the vaccination request, in this scenario, the key response was not to immunise at this point but explain why vaccination cannot proceed, seek to address paternal concerns and obtain appropriate legal advice.

The final component of this case required candidates to identify and appropriately manage a rash on the baby's cheeks that required simple non-pharmacological intervention other than the use of emollients.

Case 18

Candidates were provided with the history of a late middle-aged female patient presenting with a history of persistent productive cough following a significant chest infection 12 months previously. Further medical and social history were provided to enable the candidate to provide the most likely differential diagnosis and initial investigations.

This question was answered well, but common errors centred on not taking the scenario information into account and providing diagnoses that were not the most likely given the patient's demographic or history.

Case 19

This case focused on a patient presenting with progressive fatigue through the day, muscle weakness and being increasingly clumsy over a short, well-defined period. Information on the patient's past medical history and clinical findings were provided. Candidates were required to identify that the most likely presentation was of myasthenia gravis and select from a list the appropriate investigations to confirm the diagnosis.

Although myasthenia gravis is uncommon, it needs to be considered when patients present with the symptom complex and examination findings described in the scenario.

The final part of the question required candidates to provide appropriate management of a suspicious pigmented lesion discovered during the examination.

The case was answered well by the majority of candidates.

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Case 20

Candidates were presented with a post-menopausal female patient wishing to discuss the results of tests requested by her alternative health practitioner. These included a mildly raised CA 125 blood test. Information about the past medical and social history was provided.

Candidates were required to provide a focused history to explore the raised CA 125 and the patient's symptoms and key examination findings that would raise the suspicion of serious underlying disease.

Given the inappropriate use of tumour markers for screening, the final component of the question required candidates to consider other diagnoses that may be the cause of a raised CA 125.

Common errors were either not reading the scenario in full or not synthesising the information provided when responding to the questions. Examples included repeating information given in the scenario; providing examination or investigations in response to the history question; providing diagnoses that would not be appropriate given the patient's age and that she is five years post-menopausal; and providing male causes of a raised CA 125.

Case 21

This case presented candidates with a young female patient attending for follow-up of results. She initially presented with a history of increasing diarrhoea, amenorrhoea, abdominal pain and weight loss. Candidates were provided with her results, including a negative pregnancy test, in order that they should interpret these and provide the most likely diagnosis and key features of the examination they would assess in order to confirm a diagnosis. In the final component of the case the patient collapsed with acute shock, and candidates were required to identify the steps in their immediate management.

The case provided the key features of an evolving adrenal insufficiency/Addison's disease.

Common errors centred on candidates describing the investigation results, giving a list of diagnoses when the question asked for the single most likely diagnosis, or providing diagnoses that focused on only one aspect of the history and not taking all information into account.

Despite the patient denying any eating disorder, some candidates focused their history on signs of an eating disorder or developed a collateral history not provided in the scenario, and so developed other examination findings and diagnoses unrelated to the scenario.

Case 22

Candidates where provided with a clinical scenario and photograph of an older male patient presenting with a facial palsy. Candidates were required to identify key elements of the patient's history they would ask about in order to establish the cause of his presentation and then provide the most likely diagnosis.

While candidates were able to identify the relevant features of the history and the diagnosis, there were issues regarding the initial management of the presentation. Answers were either non-specific, such as stating 'steroids' without appropriate dosing regimens, or generic, stating 'educate', 'reassure', 'refer' or 'analgesia'. These answers give the examiner no insight into a candidate's ability to provide appropriate management or whether they actually know how to manage. Non-specific responses did not score in this question, nor will they in any KFP question.

Case 23

This case focused on an older male presenting in a remote setting with acute desquamation. The history included both his past and recent medical history as well as recent medication change and a clinical photograph. The case required candidates to identify the most likely diagnosis and the urgent nature of both the presentation and need for immediate supportive treatment.

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This question was answered well by candidates. Common errors were in providing further diagnoses rather than providing a cause for the presentation, or being side-tracked by the patient's past medical history and offering management strategies for these.

Case 24

Candidates were presented with a patient identified as having raised intra-ocular pressures by their optometrist. They were required to identify risk factors in the history that may predispose to the diagnosis, and provide appropriate management options.

Common errors included non-specific answers – for example, stating simply 'ethnicity' or 'medication' – providing examination findings rather than relevant elements of the patient's history, or providing risk factors already included in the scenario. In the question focused on topical management, the most common error was to provide non-topical treatments such as oral or intravenous medication, or surgical options.

The last component of this case required candidates to correctly identify a skin lesion opportunistically discovered during the examination.

Case 25

This case presented a middle-aged female patient with a six-month history of both dysmenorrhea and menorrhagia. The scenario contained information about the patient's past medical and social history, including her smoking history. Candidates were required to provide their initial investigation strategy to assess for the underlying cause of her symptoms, and their specific management when the investigations return as normal.

This case contained a 'killer question': given the patient's age and smoking status, there was an absolute contraindication to using the combined oral contraceptive pill. If candidates chose this as one of their answers, their answer scored zero. This is appropriate given the serious complication of using this medication to manage this patient.

In investigation questions, it is important to read each question carefully and ensure answers address the question. A common error was for candidates to select investigations that assessed severity or complications of the condition, such as full blood count or iron studies, but not identify the cause of the patient's abnormal menstruation. Similarly, candidates selected renal and liver function tests that are commonly performed, but did not assess the cause of the problem.

The final component of this case required the candidate to identify the management required for the patient's abnormal cervical screening result. This required candidates to be familiar with the new screening guidelines that came into operation two months before the exam, and which had been widely published in the months prior to this.

It is important that candidates are aware of changes to key guidelines in their approach to the exams. If new guidelines are released in the immediate period before a KFP exam, marking grids will have been adapted to ensure candidates are not penalised. In this case, only the current guidelines were scored given the significant lead-in time and the implementation date.

Case 26

The final case in this paper presented candidates with a young male patient presenting with a severe and protracted cough. He had not responded to a prescribed course of antibiotics. Candidates were required to identify other features in his history to define the diagnosis. A chest X-ray was provided for candidates to interpret.

Common errors in the history component centred on providing aspects already covered in the scenario, and providing questions not relevant for the patient demographics. It is important that candidates only consider the information provided and not develop a collateral history beyond the information provided and asking questions based on this.

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With the normal chest X-ray, a common error was to provide a diagnosis rather than an interpretation or describe abnormal pathology.

The final question required candidates to provide appropriate investigations given the information in the scenario and the normal chest X-ray

7. In conclusion

As outlined above, there are some common themes and key issues to consider when approaching the KFP exam.

- The KFP exam is not a simple, short-answer paper. You must always answer the question in the context of the clinical scenario provided, using all the information provided. Read the scenario at least twice.
- Always read the question at least twice and, after you answer, check that you have answered the actual question asked.
- Keep your answers succinct.
- Only provide the number of answers requested. Review your answer – have you created a list rather than one answer per line? If so, you will be penalised for extra answers.
- Be specific in your answers, whether in the investigations being ordered or the treatment you are prescribing. Non-specific answers will not score.
- Remember that general answers such as 'educate', 'refer', 'reassure' or 'review' do not score without specific detail. They provide the examiner with no information about whether you as a candidate know how to manage the clinical scenario.
- Be aware of clinical guidelines and any important changes or additions to treatments. If guidelines change very close to the exam, the marking keys are adapted to consider the original and the new guidelines so that candidates are not penalised if they have not consulted a guide published close to the exam sitting. Where major guideline changes have been well publicised prior to implementation, such as with cervical screening, only the new guidelines will be accepted.
- Access the practice exams provided after enrolment closes and use the RACGP assessment preparation resources provided, such as the ESO modules accessed via *gplearning*.

8. Further information

Refer to RACGP Education's *Examinations guide* and work through the ESO modules via *gplearning*.

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