

# HOW TO Pass



## The Insider's Guide to the RACP Examinations

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# 1 The 10 commandments for starting out in the Written Exam

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1. **Form a study group.** From our observation, this will increase your chance of passing.
2. Introduce yourself to the **Director of Physician Training** at your hospital.
3. Join the **Royal Australasian College of Physicians (RACP)**. A form is available online from their website: [www.racp.edu.au](http://www.racp.edu.au)
4. Book into a **2-week exam preparation course** (Dunedin, Sydney, Melbourne). Consider a DeltaMed “last minute exam revision course”.
5. Organise **study leave** (as much as you can get!). We found that about 4 to 5 single weeks, plus 2 weeks off for a revision course, worked well. Any more time off and you’ll end up renovating the house or walking your dog tds.
6. Do your best to get an **“exam friendly” job** from November (i.e. a job where you can actually take study leave and doesn’t have too many weekends/nights/long days). Lots of people at our hospital opted for a 0.7 reliever job. It makes a huge difference having some time off, both to your stress levels and your ability to study.
7. Start explaining to your house officer that you will not be around on **days when there are registrar teaching sessions**. They will understand.
8. Find someone friendly from the **previous year** from whom to cadge lecture notes/old exams/material from course/tips.
9. Go to a **stationery shop** and buy a sturdy hole-punch, stapler, and a big bunch of folders, lots of highlighters, dividers, and memory cards ...
10. Explain to your family and friends that you are becoming a self-imposed **hermit**. This is not because you are a bad person. This is a tough exam that will require a lot of your time and energy.

# Introduction to the RACP Clinical Exam

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*"Knowledge comes, but wisdom lingers"*

Alfred, Lord Tennyson 1809–92

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Passing the RACP Written Exam gave us a wonderful feeling of bewildering, euphoric disbelief. We spent a few days in the pub comforting our unsuccessful colleagues and congratulating our successful ones. This glorious feeling lasted for a few days and then it slowly began to dawn on us — we were only halfway through. There was still the Clinical Exam to go!

Our happy cloud quickly dissolved into fear and despair. We realised we didn't even know what a long case was! To make matters worse, there were no comforting words from our seniors — they gleefully let us in on the worst/best kept secret in medicine:

## **The Clinical is worse than the Written**

Then, the truth became apparent.

- Knowledge evaporates in an exponential fashion as soon as the Written Exam is over. By the end of the first week, we could barely remember our own names let alone the difference between pANCA and cANCA.
- We were completely and utterly exhausted after the Written Exam. Mentally, physically and emotionally. To start working towards another exam was an horrendous proposition that made us woefully depressed.
- We'd trained our brains to work in multi-choice format, which is the exact opposite way to approach the Clinical Exam (we've decided that multi-choice doesn't work too well for life generally after an incident at the supermarket thinking "Which of the following is the least most likely yoghurt flavour to prevent hunger? A strawberry, B apricot", etc).
- Much of the preparation involves ritual humiliation in front of respected colleagues and seniors. We got used to seeing faces filled with shock and disbelief at how useless we were. At one point, we wondered if anonymous phone calls might be made to the Medical Council about our competence to practice.

Don't freak out yet! Despite all this doom and gloom, we also discovered:

- Somehow, you become desensitised to the humiliation and learn not to take the

criticism personally. We are now perfectly trained to compete on a range of reality TV shows.

- A mixture of humility, confidence, knowledge and experience is what separates the girls/boys from the women/men; both on the day and in real life (in other words, it was probably good for us!).

Now we don't want to imply in any way that the Written Exam was a pushover. No way! There's no doubt that memorising renal histology is a soul destroying and tedious process which no-one should have to live through. That said, on the day of the Written Exam, you could rock up in comfy tracky daks, 2B pencil in hand, and get to work making the best guesses you can. If you make some shocking mistakes, no-one will ever know. It's a stressful day to be sure, but not humiliating. The Clinical Exam is a whole different beast. The enemy is very real and he is standing in front of you asking nasty questions and looking bemused at your answers. Suddenly, passing seems to hinge on hiding that quivering mess of insecurity and pretending like you are a confident and all-knowing doctor.

The Clinical Exam is a game. You need to train, get yourself in shape, have the right attitude, and know as much about the opposition as you can. Athletes train for years for the Olympics — they look forward to their competing event with nervous excitement and determination to win. Think of yourself as an Olympic athlete.

## Getting your timing right: When to sit the Clinical Exam

The College will send you a pile of information (or get it on their website) about eligibility to sit the Clinical Exam. Some young, brilliant registrars pass the Written early in their careers and therefore have to wait until the following year before attempting the Clinical. The vast majority of registrars who successfully pass the Written Exam in March are eligible to sit the Clinical Exam in June (New Zealand) or July (Australia) of the same year. This gives you 12 – 16 weeks to prepare.

In the Bad Old Days, a successful Written Exam candidate had two attempts at the Clinical. If he or she failed both these attempts, the candidate would have to study for the Written Exam all over again. Now, you are allowed five attempts. We implore you, for your own sake, do not take these five attempts lightly! Do your best to pass the Clinical Exam the first time you sit. Maximise your chances of success.

# An Introduction to the Long Case

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*"It's the Long Case where the money is, there's gold in them thar hills."*

*"For God's sake, do more long cases!"*

*"You need to wow the socks off those examiners with your long cases."*

*"You can fail all your shorts but never a long."*

Anyone who has ever sat the Clinical Exam 1933–2006

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## What is a Long Case anyway?

A Long Case is where you are given 60 minutes with a patient in which to:

- Take a history
- Examine the patient
- Formulate a problem list based on your findings

You are then given 10 minutes preparation time sitting by yourself in the corridor. After this, you enter a room with two examiners and present your case for around 10 minutes. Your case presentation is followed by about 20 minutes of "question and answer time" with the examiners.

## Points to prove in the Long Case

In an ideal world, our patients would come to clinic on time, know why they were there and know all their medications by heart. They would listen carefully to our advice and then go home to religiously take their tablets/dialyse three times a week/adopt a graduated exercise programme. They would thank you for your efforts, bake you some ANZAC cookies and send you a card at Christmas.

The College knows that this is a complete fantasy. They have developed the Long Case as a test of how well you perform in the Real World.

The Long Case is about real people with social issues, shoddy compliance, incredible disabilities and complex interrelated medical problems. The patients selected are nice enough to give up day of their lives so you can (hopefully!) demonstrate to the College

that you are a confident, competent practitioner of medicine who deserves to progress to Advanced Training.

Some candidates have an uncanny ability to see through the pitfalls and get to the crux of the issue — they probably don't need to practice Long Cases at all. The rest of us can present heaps better if we have thought about which questions to ask beforehand and already have a template on how to approach common conditions.

It can be quite hard to work out how to do a Long Case if you've never seen one presented before. Our first cases were described as "a complete mess and a clear fail, Zoë, but there is hope" and "well, Ingrid, that was a bit of a dog's breakfast I'm afraid. The only way is up". Ask your Director of Physician Training if a "mock Long Case" could be performed by some consultants to get you all on the right track for practising. If nothing like this can be organised, just get on and give it your best shot. The consultant examining your first practice case will soon give you some pointers to get it together.

We reckon that there are **five areas** that get you brownie points in the Long Case. The emphasis is on keeping things simple, logical and safe. The standard you are expected to achieve is that of a junior general medical consultant, not a sub-specialist. You will be forgiven for not knowing what the chemotherapy is for T-cell lymphoma. You won't be forgiven if you forget to ask if the patient needs home help or not.



**"I can't help you unless you're more specific.  
Now are you feeling 'yucky' or are you feeling 'icky'?"**