Conduct of ACP Clinical Exams for 2020

Information for Candidates and Examiners

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Table of Contents

Prior to examinations 4
Introduction of formal Marked Mock Exams (MME) 4
Number of Exam Attempts 4
Examining Committee 5
Examining Panels 5
Number of examiners 5
Diversity of examiner panels 5
Preparing well for the Examination 5
Logistics 6
Professional Indemnity Cover 6
Authorisation to practice at the examination venue 6
Candidate meeting 6
Examiner meeting 6
Candidate orientation session 6
Examination timetables 6
Structure of the examination 6
Timing of the practical examination 7
Outcome measures 7
Patient referrals and imaging 7
Practical examination 8
The nine standards of practice 8
Selection of exam cases 8
Viva Voce (oral examination) 9
Conduct of examinations 9
Exam marking schema 9
Global Rating Scale (GRS) 10
Safety 10
Practical examination procedure 10
Structure of the examination 10
Use of technology during exam 11
Post exam discussions 12
Interaction with relevant others during the examination 12
Patient notes 12
Management of 'close fail' cases 12
Exam panel meeting: summary of feedback 13
Exam records 13
Post examination 14
Post Exam Self-reflection 14

Official ACP 'support person' 14
Awarding of Fellowship 14
Feedback to unsuccessful candidates 14
Appeals 15
Appendix 1: Preparing for ACP specialisation exams 16
Feedback from examiners for facilitators 17
Appendix 2: Viva Voce Questions 18
Musculoskeletal Physiotherapy Viva Voce Questions 18
Women's Men's Pelvic Health Viva Voce Questions 19
Appendix 3: Examination Mark Sheets 20
Appendix 4: Suggested Prompts for the Post-exam Discussion 33
Appendix 5: Post-Exam Self-reflection Template 34
Appendix 5: Appeal Documentation 38
Regulations Governing Appeals 39

AUSTRALIAN COLLEGE of PHYSIOTHERAPISTS

Information for Conduct of ACP Clinical Exams for 2020

Introduction

At the end of 2016 College Council approved appointment of the Exam Review Committee (ERC).
The ERC comprised of Barby Singer (Chair),
Gwen Jull and Kevin Sims (MSK discipline),
Mark Kenna and Keren Faulkner (Sports discipline),
Anne Andrews and Trish Neumann (Women's, men's and pelvic health discipline),
Liz Shannon (Neurology discipline).

The committee met between November 2016 and August 2017. In addition to extensive discussion amongst the ERC, committee members consulted within their discipline, where necessary, to inform the consensus decisions. The ERC presented its final report and recommendations to the College Council in August 2017. All recommendations were accepted and the process of implementing them was proposed to be complete at the close of the 2018 exam round. The work undertaken by this committee was thorough and of high quality. It has led to a substantially improved examination process, achieving more accountability, transparency, consistency and robustness. The College acknowledges and thanks the ERC for their work.

The following information arsing from the review is relevant to the 2019 Specialisation Examination round.

Prior to examinations

Introduction of formal Marked Mock Exams (MME)

A formal MME, comprising *at least* a single session with a new patient and a post exam discussion using the ACP examination mark sheet, will be held:

(a) at the end of the first year of the Training Program (TP) and
(b) between November and the end of February of the second year of the TP.

Data from these marked mock exams will be used to inform Board of Censors decisions about:

(a) a registrar progressing from first to second year of the TP and
(b) readiness to sit the final examinations.

Number of Exam Attempts

A registrar is allowed to attempt the examinations a maximum of twice. The Fellowship Programs Standing Committee, at its sole discretion may approve a third attempt at the examinations. A candidate will be required to apply in writing to the Board of Censors and to submit a Learning Contract (TP format) that clearly addresses all areas of concern raised by examiners as part of their application. The candidate will submit progress reports to the Board of Censors as required. The Fellowship Programs Standing Committee has the right to rescind the offer of a third attempt at the examinations at any time. if the candidate fails to make satisfactory progress towards fulfilling the requirements of the Learning Contract.

Each subsequent attempt at the examinations will occur in the year immediately following the failed attempt. The Fellowship Programs Standing Committee, at its discretion may allow an unsuccessful candidate to defer their next attempt at the examinations for no more than twelve months.

Examining Committee
Great care is taken in the selection of the examination committee for each discipline. Examiners must declare any Conflicts of Interest (CoI) and examination panels for individual candidates are carefully constructed to avoid any Conflicts of Interest (CoI). There are mechanisms in place that enable recognition of issues arising during the exams and, wherever possible, resolution of such issues. Examination committee meetings are held prior to the start of the exams to ensure that all examiners understand the examination process and procedures.

The Chief Examiner's main role is to support the examiners, including answering any queries and identifying and resolving, wherever possible, any issues arising. The ACP Manager, Specialisation and Fellowship Programs, supports the candidates and oversees examination logistics and procedures. The Exam Coordinator has oversight of all examinations and supports the patients. These three individuals form a committee over the course of the examination weekend to ensure any issues arising are dealt with quickly and fairly.

Each examiner awards marks independently, but they can confer about elements of the examination to ensure that the assessment of candidates is well considered and balanced. The exam timetable allows time specifically for examiners to consider the performance of each candidate, on their own, and in discussion with their partner examiner.

Examining Panels
Examining Panels are responsible to the Fellowship Programs Standing Committee (FSPSC) through the Exam Coordinator. Formation of each Panel may involve consultation with the Exam Working Party, (established by the FSPSC to implement the Exam Program) and the Chief Examiner.

Number of examiners
While the benchmark is four member examiner panels, the number of examiners per candidate needs to be flexible to accommodate the needs of different groups. It is acknowledged that disciplines with fewer Fellows may be unlikely to have sufficient numbers of examiners for panels of four.
In the event that insufficient examiners are available from within the discipline, the value of out-of-discipline examiners is recognised.

Diversity of examiner panels
Selection of exam panels takes into account diversity of geography, gender, previous exam experience, and area(s) of clinical expertise.
An examiner should not re-examine a candidate whom they have previously failed. Although it is preferable not to examine a candidate from the same state, there can be exceptions where necessary; however, any examiner must have had limited interaction with the candidate to be examined.
It is preferred that an examiner should not have conducted mock exams with the candidate in the four months immediately prior to the exam round; however it is recognised that flexibility is required within disciplines with fewer potential examiners.

The Examining Panel will examine a candidate in all parts of the final examination, formulate a report on the candidate's performance and make a pass/fail recommendation for the consideration of the Fellowship Programs Standing Committee.

All examiners award marks independently. Marks from each examiner are only revealed at the end of day 2, immediately prior to the examination panel discussion.

Preparing well for the Examination
Feedback from previous exam rounds, including observations and comments from previous examiners may be found in Appendix 1. It is recommended that you read this material to assist your exam preparation.

Logistics

Professional Indemnity Cover
All candidates and examiners must provide documentary evidence of current professional indemnity insurance. Candidates and examiners are advised to check their professional indemnity cover very carefully to ensure their existing cover is not limited to a particular facility.

Authorisation to practice at the examination venue
The venues in which specialisation examinations are conducted may be required to 'authorise' examiners (other than those who normally work at the host facility) to practice physiotherapy at that venue. In order to be 'authorised' to practice at the examination venue, candidates and examiners must supply the following documentation to the College, if requested.

- Copy of registration certificate (certified)
- 100 points of identification documentation (certified)
- Evidence of professional indemnity cover relevant to examination host State/Territory
- Permission to conduct a police check.

College staff will communicate the due date for authorisation documentation via email. Please note that certification by a family member will not be accepted, even if they are an approved certifier. This documentation must be supplied by the specified deadline to give the host facility enough time to ensure candidates and examiners are appropriately authorised. Candidates who fail to provide this documentation by the specified deadline may jeopardise their chance to sit the examinations resulting in postponement of their exam until the next scheduled examinations for their discipline.

Candidate meeting
There will be a candidate teleconference following the circulation of this manual, where candidates can raise any issues, seek clarification and discuss any aspect of the examinations.

Examiner meeting
There will be an examiner teleconference following the circulation of this manual, where examiners can raise any issues, seek clarification and discuss any aspect of the examinations. An examiners meeting will be held directly before the exams (either the night before or morning of). Examiners are expected to be present for this meeting.

Candidate orientation session
There will be an informal orientation session at the examination venue in the afternoon of the day before the final examination commences for candidates. This session will enable candidates to familiarise themselves with the examination venue, equipment, access, security and emergency procedures. More detailed information will be provided to candidates by email closer to the date.

Examination timetables
Individual examination timetables (de-identified) will be forwarded to candidates prior to the final examination. A timetable with case details (name and condition) and examiners will be made available on the morning of Day 1 of examination.

Structure of the examination
The examination will consist of practical exams on two patients (initial assessment and management of each patient) on the first day, with follow up assessment and management on the second day. In accordance with the examination schedule, there will be a 'post assessment' discussion between the candidate and examiners on day two of the exam. Every effort will be made to schedule the oral exam (viva) scheduled within this two day period. Circumstances may arise that require the Viva to be scheduled outside the two day period and to be held virtually.

Timing of the practical examination
Examiners will leave the room at the expiration of the allotted time. The candidate should finish what they are doing with the patient. This will be limited to 5 minutes. As the examiners will not 'see' this additional activity, they cannot take it into account when they make a judgement about the candidate's performance. Candidates are advised to provide advice or education to the patient only when the examiners are in the room. New information gained during the period after the exam time has elapsed will be deemed inadmissible as part of the examination or as part of the post examination discussion.

Outcome measures
All examination and treatment procedures undertaken by the candidate should be performed in the allocated examination time. Use of equipment such as US imaging, video analysis etc. is permitted but must be undertaken in the allotted examination time. It is permissible for patients to complete questionnaires after the initial assessment has concluded. Results will be made available to examiners on Day 2.

Patient referrals and imaging
Examiners will have access to the patient referral documentation prior to the scheduled start time of the initial assessment for each clinical case. Imaging and/or imaging results will be made available where possible. Identical information will be given to the candidate during the 10 minute reading time immediately preceding the Initial Examination.

Practical examination

The nine standards of practice
The candidate will be expected to demonstrate the following standards of practice in all areas of the final examination process of Fellowship by Specialisation:

1. Highly advanced professional behaviours of a specialist physiotherapist
2. Highly advanced communication skills of a specialist physiotherapist
3. Highly advanced knowledge in the field of the physiotherapy specialty and related sciences, advanced skills in information retrieval and analysis, highly advanced skills in the application of evidence based practice
4. Highly advanced skills in physiotherapy assessment
5. Highly advanced skills in clinical reasoning
6. Highly advanced skills in development and application of an optimal physiotherapy intervention and prevention plan
7. Highly advanced skills in the evaluation of effectiveness, efficiency and cost effectiveness of physiotherapy interventions
8. Ability to contribute to multidisciplinary and heath care team management at a specialist level
9. Highly developed skills in service delivery and quality improvement processes. Candidates will also be expected to demonstrate highly advanced clinical practice within treatment records and communication with other health professionals in the form of referral letters or reports.

Selection of exam cases
The TP is designed to reflect specialist practice, with a broad base of expertise in a discipline, as well as the potential for recognition of some sub-specialisation within that clinical area.

The Chief examiner in each discipline should work with the clinician(s) responsible for identifying potential examination cases and will be consulted in relation to the final selection of examination cases. The selection is based on the 'primary presenting disorder' with the understanding that sometimes the focus of assessment and treatment can change during the actual examination.

In selecting cases, the following considerations are taken into account:

- The patient is known to be reliable (will present for the exam or communicate lack of availability in a timely manner)
- The patient is able to communicate effectively (that is, if the person has communication deficits, or English as a second language, an adequate communication strategy is established)
- The patient has a complex presenting condition relevant to the discipline and is representative of the kinds of cases which a specialist in that discipline might typically see
- Wherever possible, basic referral information is available including (at least) imaging report(s), where relevant, and information from the treating health professional, if appropriate.

In selecting cases for MSK exams, at least one case will be a 'spinal' presentation. Any peripheral case should not require specialist knowledge fundamental to another field (eg. an athlete with a 'thrower's shoulder') should not be selected for MSK exams.
In selecting cases for the SPEX exams, no areas of sub-specialty are nominated.
In selecting cases for the 2020 WMPH exams, male patients will not be included.
In selecting cases for other disciplines, the Chief examiner will ensure that at least one of the selected cases reflects a 'core' area of specialist practice in that discipline (eg. stroke for neurology, cerebral palsy for paediatrics).

Viva Voce (oral examination)

The Viva Voce is 60 minutes in duration and will be scheduled within the two day examination period. Two of the candidate's examiners will conduct this exam. The oral examination is designed to assess:

- Advanced knowledge in basic, applied and medical sciences relating to the specialty field.
- Advanced knowledge relating to specific conditions, clinical situations or settings relevant to the area of specialisation.
- Advanced knowledge of the role of the physiotherapist within the multidisciplinary and/or multiservice construct of management and prevention for the field of specialty.
- Attributes of professional leadership and responsibility.
- Attributes of professional, ethical and socially responsible conduct.

Current Viva questions for MSK and WMPH disciplines may be found in Appendix 2.

Conduct of examinations

All examiners award marks independently. Marks from each examiner are only revealed at the end of day 2, immediately prior to the examination panel discussion.

Exam marking schema

The Assessment of Physiotherapy Practice (APP) tool is used for all MMEs and Exams. This marking schema includes all current performance elements, with some minor wording revision.
The APP was developed by Megan Dalton, in conjunction with Jenny Keating and Megan Davidson, and the psychometric properties of the tool have been extensively evaluated.
Ref: Dalton M., Keating J., Davidson M. (2009) Development of the Assessment of Physiotherapy Practice (APP): A standardised and valid approach to assessment of clinical competence in physiotherapy. [Australian Learning and Teaching Council (ALTC) Final report PP6-28]. Brisbane: Griffith University. Available online at: www.altc.edu.au

The APP schema effectively has two 'fail' grades and then a 'pass' can be graded as adequate, good or excellent, allowing higher quality performance to be acknowledged. The normative reference for the scoring system will be the performance (skills, knowledge and professional behaviours) expected of an 'entry level specialist'. These marking sheets are included in Appendix 3.

The APP rating schema is as follows:
0 = Infrequently/rarely demonstrates performance indicators (fail)
1 = Demonstrates few performance indicators to an adequate standard (fail)
2 = Demonstrates most performance indicators to an adequate standard (pass)
3 = Demonstrates most performance indicators to a good standard ('credit' pass)
4 = Demonstrates most performance indicators to an excellent standard ('distinction' pass)
Not assessed = item was not assessed.

Examiners must record marks as whole numbers. Half marks (.5), ranges (2-3) and other variations must not be used. N/A or the numbers 0, 1, 2, 3, 4, are the only marks that should appear on the mark sheets.

It is expected that all performance elements in the marking schema will be assessed over the two days of the examination, but if this is not the case, the item is scored as 'not assessed' (N/A). For example, it is possible that the day 2 criterion: 'Able to identify domains of presentation that are outside scope of practice and recommend referral to relevant expert(s)' is not appropriate to the particular case, and so the examiner may choose the N/A mark allocation. In this event, an adjustment is made so that the score allocated is a percentage of the total number of items assessed. ie. the maximum total mark over all three sections of the clinical case examination (25 criteria) is usually 100, but if one criterion is N/A the exam would be marked out of 96.

Examiners need to be certain about when it is appropriate for a 'not assessed' score to be allocated (that is, when the behavior was not seen, but this was appropriate to the circumstance) or whether the behavior was rarely/infrequently seen and this was not the expected level of performance, in which case a zero score should be allocated.

Global Rating Scale (GRS)
Examiners should complete the four point GRS **before they add up their marks** at the end of the post exam discussion for each case or after the viva (where relevant) on Day 2 of the examinations. The GRS is based on the overall impression of the performance of the candidate for that case/viva (not adequate, adequate, good, or excellent). The GRS facilitates examiners' review of the overall performance of the candidate **prior to focussing on** the individual marks allocated for each section and is not used to determine pass or fail for the candidate. If there is a discrepancy between the GRS and the final mark for that case, this will be discussed in the meeting of examiners following the conclusion of day 2.

Safety
Examiners have the right to intervene or stop the examination if they consider the performance of the candidate to be unsafe for the patient. Subsequent action is taken based on immediate discussion between examiners and the Candidate if required. If necessary the Chief Examiner (if available) or the Exam Coordinator may be consulted. Time taken for such deliberation is not included in the examination time. If a patient safety issue becomes obvious following an examination, examiners can take it into consideration in determining the candidate's final mark and pass/ fail.

There will be no mark allocation for the 'safety' criteria. This is a dichotomous category, with a section for comments. If a 'no' is allocated, examiners must determine whether the issue was sufficiently serious to constitute an overall fail, or whether it is a matter that they will discuss with the candidate to inform their future practice. It is likely that a concern with the safety and risk criterion will be reflected in other criteria related to clinical reasoning, and this may contribute to the decision whether or not to allocate an overall 'inadequate' score.

A range of circumstances can result in a 'no' grade for the safety and risk criterion. They must all relate to actual harm/risk of harm to the patient, the candidate, the examiners, the College, APA or the profession. A distinction needs to made between immediate risk of harm versus anticipation of a future risk. An example of the former might be unsafe infection control practices for intimate examination or treatment. Some examples of the latter might include: if a patient is given an inappropriate home exercise program which could be harmful; where failure to establish consent or undertake risk assessment for a procedure could expose the candidate (and, indirectly, the examiners and organisation) to a negligence claim; or where the candidate's inattention to serious physical or mental health flags means that the patient may not receive the most appropriate holistic management including preventative steps to promote their safety. The examination mark sheet safety considerations in assessment states 'Predictive ability ensures safe and wise *conduct of assessment*, execution of intervention(s) and appropriate anticipatory planning'.

Practical examination procedure
The Fellowship Programs Standing Committee, through the exam coordinator, will be responsible for all examinations and the appointment of the Examination Committee and Examining Panels.

Structure of the examination
The examination will consist of practical exams on two patients (initial assessment and management of each patient) on the first day, with follow up assessment and management on the second day. According the examination schedule and following the follow up assessment, there will be a 'post exam discussion' between the candidate and examiners. There will also be an oral exam (viva), 60 minutes in duration, scheduled within this two day period. Circumstances may arise that require the Viva to be scheduled outside the two day period and to be held virtually.

Examination Duration

Reading time: 10 minutes	All disciplines
Initial Assessment: 60 minutes	CRP, MSK, Pain, SPEX, OHPA, WMPH
Initial Assessment: 90 minutes	Gero, Neuro, Paeds
Follow up Assessment: 30 minutes	CRP, MSK, SPEX, WMPH
Follow up Assessment: 45 minutes	Gero, Neuro, Paeds, Pain
Break: minimum of 15 mins or as scheduled	All disciplines
Post Discussion Assessment: 15 minutes	All disciplines
Viva Voce (Oral examination): 60 minutes	All disciplines

No examination will extend over the allotted time. Examiners leave at the designated conclusion of the examination.

10 minutes is allocated for reading time immediately prior to the initial assessment of each case on day 1.
60 minutes is allocated for the initial assessment and management on Day 1.
30 minutes is allocated for the subsequent consultation or presentation of intervention on Day 2.
15 minutes is allocated for questioning after the subsequent consultation on Day 2 for each case.

Following the second day consultations with the same two patients there will be post exam discussion with the examiners where the candidate will be offered the opportunity to answer any questions which the examiners may have and to elaborate their reasoning for the assessment and management of that case. Questions will vary according to the circumstances, but may include the following:

- Candidate's diagnosis and analysis of the patient's main problem(s)
- Relevant background from biological, medical and behavioural sciences
- Rationale and evidence base for assessment and management undertaken in initial assessment
- Rationale for Outcome measures used
- Management plan in the short and long terms
- Likely prognosis
- Psychosocial or environmental factors that might impact on management or outcome
- Role of others in the management of the case (e.g. other health professionals, family, sporting personnel, employers, insurance companies) where appropriate
- Any specific education that may be relevant including self-management and preventive measures/health promotion.

Use of technology during exam
Recording of the examination, by either the candidate or the examiner, for the purpose of reviewing the candidate's performance is disallowed and a breach will be considered an ethical and exam process violation that will be reviewed by the FSPSC and potentially, referred to appropriate professional regulatory authorities. The patient will also be informed regarding the privacy breach according to legislative requirements. The use of technology to augment the assessment process is allowed (eg. RTUS imaging, video of a movement task). This must be undertaken in the allotted examination time, although allowance for brief 'travel' can be made if the equipment to be used for the assessment (eg. treadmill) is at some distance from the location of the rest of the examination.

Verbal consent must be gained from the patient and noted by the examiners. If the video recording is for feedback to the patient or for educational purposes (eg. a home exercise program), then it should be on the patient's mobile device where possible, unless appropriate consenting procedures for the exam venue have been completed. If the video is obtained on the candidate's mobile device, the file must be deleted in the presence of the examiners and preferably the patient, at the end of day 2 of the examination weekend.

Post exam discussions (with candidate at the end of day 2)
The post exam discussion should not be viewed as a 'defence' but rather as an opportunity for the candidate to elaborate their reasoning with regard to their assessment /management choices, to clarify any areas that the examiners wish to explore and to provide further evidence, if required, that they have the knowledge base expected at a entry level specialist level. Some prompts for the post exam discussion are included in Appendix 3.

Interaction with relevant others during the examination (ie: patient's family members/guardian)
Currently, in many disciplines, registrars are encouraged to focus exclusively on the interaction with the patient/client, but there are circumstances (eg. where the client is a minor) when it is appropriate and, indeed important, to include a 'relevant other' in assessment/intervention and discussion about post examination management to ensure that appropriate data are obtained and advice about management is communicated clearly. Assessors should score the relevant criteria according to the clinical scenario.

Patient notes
At the completion of the second consultation, candidates will be asked to complete their notes for each patient. These summaries should be completed outside the official examination conditions. They form part of the examination record and must be handed to College staff prior to leaving the exam venue. The exam coordinator will provide more information in the pre-examination meeting with regard to these documents. Any letters written on behalf of the patient to the referring physiotherapist, medical officer or other relevant health professional must be included with the treatment notes. Post examination documentation must be completed in a timely fashion according to the examination schedule and if not, could be considered incomplete and marked accordingly.

Management of 'close fail' cases
All examiners award marks independently. Marks for all sections of the exam, and the total mark for that candidate, is only revealed at the end of day 2, immediately prior to the examination panel discussion.

Candidates must pass the viva and achieve an overall pass mark for the clinical cases. This is based on three of the four (or two of three) examiners assessing their performance as being satisfactory (adequate, good or excellent) on the GRS and supported by an overall mark that is 50% (or greater) of the maximum possible mark for the criteria assessed. If a candidate passes the viva, but fails to achieve an overall pass mark on the two clinical cases, they are not required to re-sit the viva.

Two scenarios are relevant to the 'close fail'.
(a) A significant discrepancy in marks between examiners (the 'variant marker') leading to a pass/fail within a case.
(b) A discrepancy in performance (and therefore variance in marks) across the two cases.

The situation of discrepant performance across cases is more common. In this situation, a strong performance on one case may lead to an overall pass. If the successful case is only just at the adequate level, and the other case is close to a pass, the candidate may be a 'close fail'. All unsuccessful candidates and 'close fail' scenarios are discussed in detail.

Discussions between **all members** of the discipline examination panel for that candidate occur in the situation of the 'close fail'. The discussion is chaired by the Chief examiner or the Exam coordinator if the Chief examiner has been involved in examining the candidate. The GRS may be used to determine each examiner's intention with regard to that assessment (pass/fail). Documentation written by the candidate after the session with the patient has finished (which is part of the examination record) may be considered in the discussion of 'close fail' cases.

A majority agreement regarding pass/fail (2/3 or 3/4 examiners in that panel) will determine the final outcome. In the event of an ongoing split decision amongst examiners (2/4) with regard to overall pass/fail outcome, the Chief examiner (or their nominee if the Chief examiner has been involved in examining the candidate) has the casting vote to determine the final outcome for the examination.

Exam panel meeting: summary of feedback
The performance of every unsuccessful candidate is discussed in detail by the candidate's examination panel. Each examiner then writes an individual report, or detailed comments on the exam mark sheets, which informs the summary that is eventually sent to the unsuccessful candidate and also informs the verbal feedback session, where this is undertaken. Feedback needs to highlight the main areas of deficit and identify what the candidate would need to do to achieve the required standard.

Ideally the individual examiner reports and the summary are completed on the final day of the exam. There may be occasions where this is not possible, such as during virtual/F2F examinations, or further reflection is required. Final individual examiner reports, if these are additional to comments included in the examination mark sheets, must be submitted within seven days from the completion of the exam. If required, the examiners may meet via teleconference to finalise the report provided to the Candidate. The Chief examiner is responsible for appointing a panel member to oversee the report writing and its submission to the ACP Manager Specialisation and Fellowship Programs in a timely fashion.

Exam records
The exam record comprises: the examiners' original mark sheets, the Examination coordinator's results summary, the candidate's notes about the patient, any information provided *to* the patient, letters to the referring doctor/therapist, and any written information supplied *by* the patient (self-report questionnaires etc.). The ACP Manager Specialisation and Fellowship Programs is responsible for the security of the exam record at the end of the examination weekend.

In addition, other documents which will become part of the exam record and will inform the provision of feedback to unsuccessful candidates include: the candidate's self-reflection on the exam (which is returned to the ACP Manager Specialisation and Fellowship Programs within two weeks of the examination weekend, but remains confidential until results are released), any individual examiner reports, and the overall examiners' summary which is provided as a report to the unsuccessful candidate.

Post examination

Post Exam Self-reflection
All candidates are required to prepare a reflection on both cases, to be written as soon as possible after the exam and submitted to the ACP Manager, Specialisation and Fellowship Programs within two weeks of the examination. This is intended to act as an aide de memoir in the event that a feedback session is required. This self-reflection remains confidential until results are provided to candidates and a feedback panel has been formed for any unsuccessful candidates. At that time it is released to the feedback panel, to be used in addition to case notes and the examiners' report, to guide the feedback session.

The Fellowship Programs Standing Committee approves the examination results and makes recommendations to College Council with regard to exam outcomes. In the case of any internal review of a case, the Fellowship Programs Standing Committee will take into account the recommendation of the reviewer with respect to the recommendation made to College Council.

Chief examiners will provide a brief report to the exam coordinator giving general information about behaviours that were seen during the exam round that were 'helpful' or 'less helpful'. This will be made available to facilitators and future candidates to assist their exam preparation.

Official ACP 'support person'
Each year, the College will appoint a person who is very familiar with the post exam processes and timelines and the grounds and procedures for an appeal in a support role to candidates while they wait for results. Immediately after the examinations have finished, and before the results are released, s/he will contact all candidates and offer them general support and an opportunity to de-brief.

There is no expectation that this person has discipline specific knowledge, and it is not their role to provide any commentary on the candidate's performance. While some candidates will talk to their facilitator, and many contact the ACP Manager Specialisation and Fellowship Programs during this period of waiting for results, it is considered that appointing a senior FACP to this role may allow candidates to feel better supported and may prevent/reduce feelings of dissatisfaction and alienation in some unsuccessful candidates.

Awarding of Fellowship
The Examining Panel will provide a result for each candidate, via the Exam coordinator, to the Fellowship Programs Standing Committee of the Australian College of Physiotherapists.
The Fellowship Programs Standing Committee will consider the advice of the Examining Panel and will make a pass/fail recommendation to the College Council.
The College Council will make the final determination as to whether or not a candidate shall be awarded a Fellowship. Each candidate will receive an email with an official letter of notification attached from the Chief Censor.
Successful candidates who are financial members of the College are entitled to use the letters FACP and to call themselves Specialist (Discipline) Physiotherapist (as awarded by the Australian College of Physiotherapists in XXX Year). It is essential this exact wording is used. Variations are not permitted under AHPRA regulations.

Feedback to unsuccessful candidates
Each unsuccessful candidate is offered the opportunity to participate in a feedback session. This session will be scheduled no sooner than two months after the appeals period has concluded (notification of an appeal must be received 28 days from the day results are released). The feedback session may take the form of virtual meeting (eg. skype/zoom), teleconference, or a face to face meeting and will be arranged at a time of mutual convenience to all parties. It will be attended by the candidate, and the feedback panel - consisting of one Fellowship Programs Standing Committee appointed representative (who could be from another

discipline), and one representative of the examination panel (Chief examiner, or one of the candidate's examiners). The candidate has the option to invite their facilitator to attend. The session will generally take no more than one hour.

The aim of the feedback session is to provide advice about where the candidate did, or did not, meet the standard expected of an entry level specialist; to identify what behaviours (skills, knowledge etc.) expected at specialist level were not seen; and to give the unsuccessful candidate direction on how to prepare for any subsequent attempt at the examination. It is not the intention of the feedback session to provide a justification or detailed breakdown of the assessment and management of the clinical case(s), although examples of behaviours observed during the examination may be provided, to illustrate where the expected standard was not met.

Appeals

Candidates have the right to appeal against a decision of the College. Appeals must be submitted within 28 days of the College's decision being communicated to a candidate. Appeals may be requested on the sole ground that the procedure set out in this and other procedural documents of the Australian College of Physiotherapists has not been followed.

Appendix 1: Preparing for ACP specialisation exams

Make sure that you undertake some mock exams with ACP experienced examiners.

Ensure that your mock examiners are using the 2019 College marking sheet and that they go through it with you afterwards. Ask about any scores that were not at the 'adequate' level (2). Try to get specific information about how you could you do better.

Seek feedback that is honest and as objective as possible. This requires you to be open to critical review as it is part of the learning process. Reflect deeply on all examination feedback, not just thinking about it, but writing down the key points that you gained from the experience, in relation to the patient, your performance and the encounter overall.

Be self-critical and reflective. 'What did I do well' and 'what could I have done better' are helpful questions to ask yourself at the end of a mock exam.

Aim to practice 1 patient/week, if possible, as an 'exam scenario' in your own clinic. Stop and write down your reasoning after 'Day 1', ideally discuss the reasoning with someone else (eg. Your facilitator or co-registrar or both) as the ensuing discussion can be very enlightening.

Use clinical reasoning forms and practice ways to help the examiner follow your reasoning process (eg. 'reasoning aloud' techniques).

The examination time provided is sufficient to demonstrate expertise. Avoid running out of time to cover all aspects of the examination – it is not acceptable to miss priority areas. Use a 20/20/20 rule and stick to it. Time management is crucial. Try to hone in on the main problem and the patient's goals/ perception of the problem.

Although you may do well on the subjective examination, if you run out of time for management or perform very rushed management, you cannot achieve a pass overall. Pointless objective tests demonstrate a lack of clear clinical reasoning and prioritisation. There is no need to 'cover yourself' by doing lots of tests when you can clearly justify well targeted assessment choices. Use effective clinical reasoning to justify doing fewer tests, but perform them with a high level of expertise. Use every opportunity to demonstrate to the examiners that the assessment procedures that you have used were targeted well.

Any chance to perform hands-on assessment or manual handling is an opportunity to demonstrate your expertise. Poorly performed hands-on assessment can be a source of lost marks. Practice the routine physical examination process on colleagues in a constrained timeframe for a variety of different body regions and different scenarios, so that these procedures become more automatic.

Video is not a substitute for effective assessment or reasoning. There is no evidence that assessment of a 2D image is reliable or valid. Video could be used (with permission) to provide feedback or for comparison but it is not always valid for biomechanical assessment.

Candidates who can think on their feet and be responsive to the patient are demonstrating good reasoning.

Establish patient goals early and respond to these by the end of day 2 – wrap it up well.

Feedback from examiners for facilitators

1. In history taking – facilitators need to help registrars to develop pattern recognition skills, rather than using stereotyped questioning of the patient. Candidates seemed to be fearful of the consequences if they did not ask every routine question. Histories tended to be too long, probably because candidates were asking questions from a schema rather than pursuing a diagnostic hypothesis from the emerging clinical pattern. Examiners like to see candidates who have well developed listening skills, rather than applying stereotypical questioning schemas.

2. Examiners would like to see 'who' the candidates are as clinicians, rather than seeing what the candidates think the examiners want them to be. There were many examples of tests being done or questionnaires being completed which, on questioning, candidates said they would be unlikely to use on the first examination of the patient (which was the more appropriate position). In other words, much of the time, candidates admitted in the post exam discussion to behaving differently than they actually would in practice. For instance, candidates tended to use expressions like 'in this artificial environment'…. Examiners want to see what candidates would really do, rather than (as above), doing what they think examiners want them to do. Much of the time, they seemed to be 'second guessing' what the examiners wanted to see.

3. Facilitators need to reassure candidates that they do not have to do everything. In the discussion after the examination, candidates can say that they chose not to do 'so and so' for the following reasons. In other words, examiners would like to see candidates follow a line of clinical reasoning throughout the examination, rather than feel they will be penalised for not doing all tests that could possibly be done on the patient. Candidates should consider that statistically, the more physical tests undertaken, the more likely it will be that chance findings (read "positive findings") will be found that must be differentiated from "real and relevant findings" of clinical significance.

4. Candidates need to remember that the exam is a 2-day process, and that they will not be penalised for leaving some of the examination to day 2, or if they do forget to do something on day 1, they can do it on day 2.

5. Rather than doing 'everything', examiners would like to see candidates develop expert skills in 'prioritising' their assessment and matching that to a meaningful treatment/intervention/management approach.

6. On reflecting more about common shortcomings amongst candidates, it was evident that consideration of patient activity and exercise programs was applied at a very low key level – candidates need to take care to utilise collaborative SMART goals in activity and exercise programs. For instance, these form the basis of CBT approaches that have good evidence in facilitating compliance and improving outcomes in persistent pain states.

Appendix 2: Viva Voce Questions

Musculoskeletal Physiotherapy Viva Voce Questions

The viva voce examination will include questions related to any of the topics listed below:

1. Contemporary issues in pain: Discuss physiological and behavioural drivers of pain and how they might interact in a pain state. Discuss how such features are recognised clinically in the assessment and management of patients with musculoskeletal conditions and what guides treatment decisions. Relate particularly to the field of low back and neck pain.

2. Discuss the evidence for physical, behavioural and functional alterations in the motor system in relation to either a cervical, lumbar or extremity musculoskeletal disorder. Discuss how this evidence will influence assessment and exercise prescription in patients with these disorders?

3. Discuss the evidence base for manipulative therapy and therapeutic exercise for either neck or low back pain.

4. Discuss the evidence for the mechanisms of action of manipulative / musculoskeletal physiotherapy.

5. Discuss the need, methods and evidence for sub-grouping within the non-specific diagnosis of mechanical back and/or neck pain.

6. Discuss the differential diagnosis and evidence base for the management of headache by physical therapies.

7. Discuss conditions that may masquerade as musculoskeletal pain states and their clinical recognition.

8. Discuss potential red flag musculoskeletal conditions and their clinical recognition.

9. Choose either an overuse injury of the shoulder or knee - discuss the evidence for contemporary diagnosis and management

10. The differential diagnosis of dizziness: consider vertebrobasilar insufficiency, cervical vertigo and vestibular dysfunction.

11. Nominate and discuss major professional and/or ethical issues relating to contemporary musculoskeletal physiotherapy therapy practice.

AUSTRALIAN COLLEGE of PHYSIOTHERAPISTS

Women's Men's Pelvic Health Viva Voce Questions

The viva voce examination will include questions related to any of the topics listed below:

1. Choose a gynaecological or urological condition and illustrate the clinical reasoning framework you use for assessment and intervention in clinical practice and the evidence to substantiate this approach.

2. Choose an ano-rectal condition and illustrate the clinical reasoning framework you use for assessment and intervention in clinical practice and the evidence to substantiate this approach.

3. Discuss the evidence for physiotherapy management (assessment, diagnosis, treatment and prevention) in one of the following conditions:
   a) Lactation disorders
   b) Low back pain in pregnancy
   c) 3rd/4th degree perineal tear following childbirth
   d) Gestational diabetes mellitus

4. Discuss the barriers to implementation of evidence based physiotherapy in Women's Men's Pelvic Health Physiotherapy practice and strategies to address these.

5. Discuss the role of exercise during either the:
   a) childbearing year OR
   b) menopause
   and the evidence which supports this. Include a discussion of the risks, precautions, physiological and psycho-social benefits of exercise during this period.

6. Discuss the role of the physiotherapist in the management of either:
   a) osteoporosis across the lifespan, and the evidence which supports this.
   b) lymphoedema and other complications of breast and/or pelvic oncology surgery.

7. Discuss the rationale and evidence for physiotherapy management (assessment, diagnosis, treatment and prevention) in two (2) of the following conditions:

   a. Nocturia
   b. Dyspareunia
   c. Dysfunctional elimination syndrome in children
   d. Overactive bladder
   e. Intrinsic sphincter deficiency (ISD) of bladder OR internal anal sphincter (IAS) deficiency
   f. Post-prostatectomy incontinence

8. Critically evaluate the outcome measures used in practice as a Women's Men's Pelvic Health Physiotherapist.

9. Contemporary issues in pain: discuss physiological and behavioural drivers of pain and how they interact in a pain state. Discuss how such features are recognised clinically in the assessment and management of patients with pelvic pain and what guides treatment decisions. Relate particularly to the field of pelvic girdle pain and persistent pelvic pain.

10. Nominate and discuss major professional, political and ethical issues relating to contemporary Women's Men's Pelvic Health Physiotherapy practice.

Appendix 3: Examination Mark Sheets

INITIAL ASSESSMENT - Examination Mark Sheet

Examiner:				**Candidate:**	
Date:				**Patient initials; Condition:**	
Time:		**Room:**		**Case:**	

Scoring rules:

- Evaluate the performance against the **minimum** competency level expected for an **entry level specialist.**
- **Score only one number for each criterion**. Half marks (0.5, ½) and ranges (1-2) **must not be used**.
- If a score falls between numbers on the scale **the higher number** should be allocated.
- **Not assessed** – a criterion should only be scored as 'not assessed' when there is a credible reason that the criterion was not seen during the examination. If a criterion is 'not assessed' the total potential score is adjusted for the missed criterion.

Rating scale

0 = Infrequently/rarely demonstrates the performance indicators (inadequate)

1 = Demonstrates few performance indicators to an adequate standard (inadequate)

2 = Demonstrates most performance indicators to an adequate standard at the level of an **entry level specialist** (pass)

3 = Demonstrates most performance indicators to a good standard (credit pass)

4 = Demonstrates most performance indicators to an excellent standard (distinction pass)

Not assessed – it is acceptable that the criterion was not able to be evaluated.

PATIENT /CLIENT INTERVIEW (Reference Standards 1-5)	**Rating**
Questions patient/client selectively, thoroughly, efficiently and appropriately.	
Is able to pursue assessment according to a highly advanced line of reasoning, which incorporates available medical, radiological or other (including psychosocial), information.	
Identifies most relevant problems including patient/client goals Identifies appropriate screening tools / outcome measures that will form the basis for examination, management and reassessment.	
Comments:	

PHYSICAL EXAMINATION (Reference Standards 1-5)	Rating
Is able to pursue a physical examination according to a highly advanced line of reasoning which extends from the patient/client interview.	
Demonstrates highly advanced assessment skills.	
Uses a range of appropriate assessment domains. Is able to modify assessments as appropriate. Gains targeted information on which to proceed.	
Comments:	

OUTCOME OF EXAMINATION (Reference Standards 2, 3, 5, 6)	Rating
Clearly demonstrates an advanced understanding of the patient/client's presenting problem.	
Comments:	

MANAGEMENT PLANNING (Reference Standards 2,3, 5 & 8)	Rating
Identifies intervention options according to a highly advanced line of reasoning which extends from the outcomes of the examination.	
Clearly outlines intervention options to the patient /client and considers their values and preferences in deciding how to proceed.	
Constructs a management plan that is collaborative, comprehensive and targeted towards the individual's goals, needs, and capacity.	
Comments:	

INTERVENTION (Reference Standards 5, 6 & 7)	Rating
Demonstrates highly skilled execution of chosen intervention(s) in an efficient and effective manner. Is highly responsive to changes and patient/client responses concurrent with the intervention implementation.	
Comments:	

ONGOING ASSESSMENT - RESPONSE TO PATIENT /CLIENT (Reference Standards 2-5, & 7)	Rating
Demonstrates the ability to be flexible, adaptable and rapidly responsive to patient/client's expectations, their understanding of the management approach, and reactions to the intervention(s). Notices subtle changes in patient/client's response and introduces new assessment procedures or interventions appropriately in response to findings.	
Comments:	

COMMUNICATION AND PROFESSIONALISM (Reference Standards 1 & 2)	Rating
Consistently seeks patient/client's input, listens reflectively and responds appropriately. Explains the source(s), contributing and causative factors, and mechanisms underpinning impairments, activity limitations, or participation restrictions as required Explains ongoing management and any program to be undertaken by the patient /client clearly and succinctly, ensuring there is complete understanding and acceptance by the patient/client. Displays professional and empathetic consultation and goal setting with patient/client. Demonstrates high level documentation skills including all relevant information and provision of informed consent.	
Comments:	

SAFETY (Reference Standard 1-5, 7)	YES/NO
Predictive ability ensures safe and wise conduct of assessment, execution of intervention(s) and appropriate anticipatory planning. Demonstrates consideration of issues related to obtaining informed consent. Implements measures to ensure patient/client safety at all times.	

Additional Comments:

Total Number of marks awarded | |

Examiner's Signature: _____ Date: _____

Australian College of Physiotherapists

FOLLOW-UP ASSESSMENT – Examination Mark Sheet

Examiner:				**Candidate:**	
Date:				**Patient's initials; Condition:**	
Time:		**Room:**		**Case:**	

Scoring rules:

- Evaluate the performance against the **minimum** competency level expected for an **entry level specialist.**
- **Score only one number for each criterion**. Half marks (0.5, ½) and ranges (1-2) **must not be used**.
- If a score falls between numbers on the scale **the higher number** should be allocated.
- **Not assessed** – a criterion should only be scored as 'not assessed' when there is a credible reason that the criterion was not seen during the examination. If a criterion is 'not assessed' the total potential score is adjusted for the missed criterion.

Rating scale

0 = Infrequently/rarely demonstrates the performance indicators (inadequate)

1 = Demonstrates few performance indicators to an adequate standard (inadequate)

2 = Demonstrates most performance indicators to an adequate standard at the level of an **entry level specialist** (pass)

3 = Demonstrates most performance indicators to a good standard (credit pass)

4 = Demonstrates most performance indicators to an excellent standard (distinction pass)

Not assessed – it is acceptable that the criterion was not able to be evaluated.

ASSESSMENT: PATIENT /CLIENT INTERVIEW (Reference Standards 1-5)	**Rating**
Questions selectively, thoroughly, efficiently and appropriately. Is able to pursue assessment according to an advanced line of reasoning. Assesses response to previous intervention(s) against findings and goals. Clarifies any factors from the initial interview. Uses the most appropriate outcome measures.	
PHYSICAL EXAMINATION (Reference Standards 1-5)	**Rating**
Uses advanced skills of re-assessment to interpret response to previous intervention(s). Uses appropriate assessment domains relevant to the patient/client's main problem and goals.	
Gains targeted information on which to proceed. Is able to modify assessment or add additional assessments if necessary, Shows sensitivity and flexibility in re-assessing the patient/client, including modifying and adapting the assessment according to response to previous intervention(s).	
Comments:	

INTERVENTION /MANAGEMENT PLAN (Reference Standards 2,3, 5 & 8)	Rating
Develops a collaborative, targeted and comprehensive management plan that is evidence based, highly relevant, and specific to patient/client's problems and achievement of goals. Selects optimum interventions/management relevant to re-assessment findings. Progresses, modifies or adapts intervention(s) based on patient/client's previous response.	
Comments:	

INTERVENTION (Reference Standards 5, 6 & 7)	Rating
Demonstrates highly skilled execution of intervention(s) in an efficient manner. Is highly responsive to changes concurrent with the intervention implementation.	
Comments:	

ONGOING ASSESSMENT AND RESPONSE TO PATIENT/CLIENT (Reference Standards 2-5, & 7)	Rating
Demonstrates the ability to be flexible, adaptable and rapidly responsive to patient/client's expectations, their understanding of the management approach, and reactions to the intervention(s). Notices subtle changes in patient/client's response and introduces new assessment procedures or interventions appropriately in response to findings.	
Comments:	

COMMUNICATION AND ONGOING MANAGEMENT (Reference Standards 1, 2 & 8)	Rating
Communicates future management plan & implications to patient/client, accurately, clearly & succinctly.	

Is able to identify domains of presentation that are outside scope of practice and recommend referral to relevant expert(s).	
Comments:	

SAFETY (Reference Standard 1-5, 7)	**Y/N**
Predictive ability ensures safe and wise conduct of assessment, execution of intervention(s) and appropriate anticipatory planning. Implements measures to ensure patient/client safety at all times.	

Additional Comments:

Total Number of marks awarded | |

Examiner's Signature: _____ Date: _____

Australian College of Physiotherapists

POST EXAM DISCUSSION – Examination Mark Sheet

Examiner:		**Candidate:**	
Date:		**Patient initials; Condition:**	
Time:		**Case:**	

GLOBAL RATING SCALE

Please complete this section BEFORE you add up /finalise your detailed marks for this case.

In your opinion as an ACP examiner, the overall performance of this Candidate in this clinical exam against the **minimum** competency level expected for an **entry level specialist** was:

☐ Not adequate ☐ Adequate ☐ Good ☐ Excellent

Examiner's Signature: _____ **Date:** _____

Australian College of Physiotherapists
POST EXAM DISCUSSION – Examination Mark Sheet

Examiner:	
Date:	
Time:	

Candidate:	
Patient initials; Condition:	
Case:	

Scoring rules:

- Evaluate the performance against the **minimum** competency level expected for an **entry level specialist.**
- **Score only one number for each criterion**. Half marks (0.5, ½) and ranges (1-2) must not be used.
- If a score falls between numbers on the scale **the higher number** should be allocated.
- **Not assessed** – a criterion should only be scored as 'not assessed' when there is a credible reason that the criterion was not seen during the examination. If a criterion is 'not assessed' the total potential score is adjusted for the missed criterion.

Rating scale

0 = Infrequently/rarely demonstrates the performance indicators (inadequate)

1 = Demonstrates few performance indicators to an adequate standard (inadequate)

s3 = Demonstrates most performance indicators to a good standard (credit pass)

4 = Demonstrates most performance indicators to an excellent standard (distinction pass)

Not assessed – it is acceptable that the criterion was not able to be evaluated.

CLINICAL REASONING IN ASSESSMENT (Reference Standards 1-5)	Rating
Able to provide a succinct, accurate summary of patient/client's problems. Clinical reasoning process is well articulated and reflects a substantial, well organized, knowledge base. Able to link patient/client's problems to pathophysiology and function and to identify the impact of environmental and personal factors at an advanced level.	

CLINICAL REASONING IN MANAGEMENT (Reference Standards 2, 3, 5, 6 & 8)	Rating
Demonstrates an innovative and broad range of actual and possible management approaches. Able to support management decisions with well targeted problem solving and appropriate theoretical background. Decision making reflects a personal model of practice developed from clinical experience and is well integrated with research evidence.	
Comments:	

CRITICAL REFLECTION ON OUTCOMES (Reference Standards 2- 5)	Rating
Understands and is able to discuss the reliability and validity of measurement tools used, including normative values if available. Is able to interpret and critique patient/client outcomes against assessment findings and goals of the intervention. Reflectively critiques own reasoning process in relation to assessment and intervention.	

FUTURE MANAGEMENT PLANNING (Reference Standards 2, 3, 5-8)	Rating
Understands and is able to discuss prognosis. Is able to develop a collaborative, comprehensive, appropriate plan for progression of patient /client management, based on excellent theory & evidence, as well as taking into account the patient/client's values, preference and capacity. Outlines comprehensive and well developed plans for ongoing management (if appropriate).	
Comments:	

Additional Comments:

Total number of marks awarded ☐

If the Global Rating Scale score awarded on page 1 is not congruent with the Total number of marks awarded, please provide a brief explanation:

Examiner's Signature: _____ **Date:** _____

Australian College of Physiotherapists
VIVA VOCE ASSESSMENT

Candidate:			
Date:			
Time:		**Room:**	
Examiner:			

GLOBAL RATING SCALE

Please complete this section BEFORE you add up /finalise your detailed Viva Voce marks.

In your opinion as an ACP examiner, the overall performance of this Candidate in this Viva Voce Exam against the **minimum** competency level expected for an **entry level specialist** was:

☐ Not adequate ☐ Adequate ☐ Good ☐ Excellent

Examiner's Signature: _____ **Date:** _____

Australian College of Physiotherapists

VIVA VOCE ASSESSMENT Examination Mark Sheet

Candidate:			
Date:			
Time:		**Room:**	
Examiner:			

Scoring rules:

- Evaluate the performance against the **minimum** competency level expected for an **entry level specialist.**
- **Score only one number for each criterion**. Half marks (0.5, ½) and ranges (1-2) must not be used.
- If a score falls between numbers on the scale **the higher number** should be allocated.
- **Not assessed** – a criterion should only be scored as 'not assessed' when there is a credible reason that the criterion was not seen during the examination. If a criterion is 'not assessed' the total potential score is adjusted for the missed criterion.

Rating scale

0 = Infrequently/rarely demonstrates the performance indicators (inadequate)

1 = Demonstrates few performance indicators to an adequate standard (inadequate)

2 = Demonstrates most performance indicators to an adequate standard at the level of an **entry level specialist** (pass)

3 = Demonstrates most performance indicators to a good standard (credit pass)

4 = Demonstrates most performance indicators to an excellent standard (distinction pass)

Not assessed – it is acceptable that the criterion was not able to be evaluated.

CRITERIA	Rating
Advanced knowledge in basic, applied and medical sciences relating to the specialty field.	
Advanced knowledge relating to specific conditions, situations or settings relevant to the area of specialisation.	
Advanced knowledge of the role of the physiotherapist within the multidisciplinary and/or multiservice construct of management and prevention for the field of specialty.	
Attributes of professional leadership and responsibility.	
Attributes of ethical and socially responsible conduct.	

Comments

Total number of marks awarded | |

If the Global Rating Scale score awarded on page 1 is not congruent with the Total number of marks awarded, please provide a brief explanation:

Examiner's Signature: _____ **Date:** _____

Appendix 4: Suggested Prompts for the Post-exam Discussion (15 minutes)

This discussion should provide the registrar with an opportunity to demonstrate their understanding of the patient's presentation and elaborate their clinical reasoning process and the evidence base for their choices of assessment and management.

Keep in mind that the questions should seek to recognise the priorities, reasoning and evidence guiding decisions. There are situations in which very open or highly focussed questions are appropriate. It is important to consider the marking guide and focus on areas in which the registrar has not scored highly – it may be necessary to go to these areas first in the question time.

The language used below might be useful as a guide.

- 'Thank you. There are a few questions we have in order to understand your decision making more clearly. Can you please elaborate…'
- 'Can you tell us what the main issues were in this case?'
- 'What do you feel were the perspectives of this patient in regard to the impairment(s)?'
- 'Can you discuss the pain/dysfunction mechanisms involved?' / 'What do you think was the main source of symptoms?'
- 'How did you prioritise the relevance of the symptoms'
- 'Can you please outline the reasoning behind your choice of intervention(s)? Which information from the examination led you to select this approach? Is there particular evidence which supports this intervention?'
- 'Can you elaborate the ongoing management plan for this patient?'
- 'Are there any other investigations / objective assessment tests / interventions that you'd like to consider in the future for this patient?'
- 'How will the outcome be measured in this case?'
- 'What guides you to expect that your management plan will work?'
- 'What do you think the prognosis is in this case? Do you think the patient understands their prognosis?'
- 'What were the patient's goals for the session? Do you feel these were addressed?'

Appendix 5: Post-Exam Self-reflection Template

Candidate Self-reflection on Specialisation Exams

As part of the examination process you are required to complete this self reflection. The purpose of this exercise is to capture and document details of the cases that you were examined on, and your initial perceptions about your exam performance. *You will retain this self reflection until after exam results are available.* If required, this will assist with preparation for your feedback session.

When documenting your reflections, incorporate *keywords* which will prompt your recall in the future.

CASE ONE

The patient/client – write a concise summary including their presenting condition, relevant history and demographics.

Use the following headings to identify areas of the assessment and management of this case where you were satisfied with your performance (where you felt that it met the standard expected of a beginner specialist) AND where you were less satisfied / unsatisfied with your performance (where you felt that it DID NOT meet the standard expected of a beginner specialist).

DAY 1: Patient/client Interview

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 1: Physical examination

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 1: Intervention

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 1: Post intervention management and advice

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Re-assessment: Interview

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Re-assessment: Physical examination

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Intervention

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Post intervention management and advice

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Post examination discussion with examiners

Satisfied with performance	Less satisfied / dissatisfied with performance

Viva Voce

Satisfied with performance	Less satisfied / dissatisfied with performance

CASE TWO

The patient/client – write a concise summary including their presenting condition, relevant history and demographics.

Use the following headings to identify areas of this case where you were satisfied with your performance (where you felt that it met the standard expected of a beginner specialist) AND where you were less satisfied / unsatisfied with your performance (where you felt that it DID NOT meet the standard expected of a beginner specialist).

DAY 1: Patient/client Interview

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 1: Physical examination

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 1: Intervention

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 1: Post intervention management and advice

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Re-assessment: Interview

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Re-assessment: Physical Examination

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Intervention

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Post intervention management and advice

Satisfied with performance	Less satisfied / dissatisfied with performance

DAY 2: Post examination discussion with examiners

Satisfied with performance	Less satisfied / dissatisfied with performance

Appendix 5: Appeal Documentation

Notice of Appeal

Candidates have the right to appeal against a decision of the College with regard to their examination results. Appeals must be submitted within 28 days of the College's decision being communicated to a candidate and should be in the prescribed format (Notice of Appeal). Appeals may be requested on the sole ground that the procedure set out in procedural documents of the Australian College of Physiotherapists has not been followed.

On completion, a signed copy of this form should be sent to the ACP Manager, Specialisation and Fellowship Programs
Email: college@australian.physio; post PO box 437 Hawthorn BC Vic 3214.

Name of Candidate: _____

Date of decision being appealed against: _____

Brief description of decision being appealed against:

Procedural grounds for appeal:

Evidence for appeal:

Signature of Candidate: _____ Date: _____

Regulations Governing Appeals

11. Appeals

11.1 Candidates shall have the right to appeal against a decision of the Council regarding the awarding of a Fellowship in accordance with Regulation 11.2.

11.2 A person who is aggrieved by a Council decision may request an appeal in respect of that decision on the sole ground that the procedure set out in these Regulations has not been followed. A person is not entitled to appeal a Council decision on the basis that the correct or preferable decision was not made on the material before the decision-maker.

11.3 An application for appeal (Notice of Appeal) must be made in the form prescribed by the Council and shall be made within 28 days of the Council's original decision being communicated to the appellant. An appeal must outline the grounds and evidence on which the appeal is based.

11.4 The Council shall establish an Appeals Committee to consider a written appeal submitted by a candidate. This Committee shall comprise a representative of an Examining Panel, a representative of the Board of Censors and one other person nominated by the Board of Directors. Such representatives shall not have been a party to the original decision of the College to which the appeal relates. The Council shall appoint the Chair of the Appeals Committee from the members of the Appeals Committee.

11.5 An appellant shall have the option of presenting their appeal personally to the Appeals Committee and shall advise on the Notice of Appeal whether they wish to take up this option.

11.6 The Chief Executive Officer or his or her nominee shall give an appellant at least 28 days prior notice of the date, time and place that the Appeal Committee shall be convened.

11.7 Where an appellant elects to present their appeal personally at the Appeals Committee meeting, the appellant may:

11.7.1 present his or her Notice of Appeal but shall not be permitted to introduce grounds of appeal or evidence not previously raised in his or her Notice of Appeal

11.7.2 be accompanied by another person, who must not be a legal representative, but is not entitled to be represented as the appeal must be presented personally and

11.7.3 attend the meeting in person or by teleconference but if attending in person shall be responsible for their own costs of attendance.

11.8 Appeal hearings shall involve as little formality and technicality as the proper consideration of the appeal permits.

11.9 The Appeals Committee may make inquiries and obtain any information it needs to decide a matter before it. However, where an appellant admits, or does not dispute a matter, the Appeals Committee may make a decision without the need to inquire into that particular matter. As a guide this information may include but shall not be limited to:

11.9.1 the personal presentation of the Notice of Appeal by the appellant;

11.9.2 the Examiners' Summary Report;

11.9.3 these Regulations of the College.

11.10 In order for an appeal to be successful an appellant will need to establish one or more grounds as specified in Regulation 11.2.

11.11 Decisions of an Appeal Committee are decisions about which a majority of the Committee agrees.

11.12 After considering an appeal, the Appeals Committee may either:

11.12.1 **uphold** the original decision of the College and dismiss the appeal in which case the original decision of the College will stand or;
11.12.2 **overturn** the original decision of the College and grant the appeal in which case the Appeals Committee may substitute its decision for the original decision and such substitute decisions may include, without limitation, granting the appellant a full pass in the final examination for Specialisation or granting the appellant a partial pass in the final examination for Specialisation or;
11.12.3 **set aside** the original decision of the College in which case the Appeals Committee may, without limitation, allow the appellant to resit the final examination for Specialisation without the payment of additional examination fees or allow the appellant to resubmit original work for a thesis with corrections for consideration by an Examining Panel that will comprise members who were not part of the original Examining Panel or the Appeals Committee or allow the appellant to resubmit a published textbook with justifications for consideration by an Examining Panel that will comprise members who were not part of the original Examining Panel or the Appeals Committee or allow the appellant to re-complete or resubmit any other aspect of a Fellowship by Specialisation or Fellowship by Original Contribution as the Appeals Committee at its discretion sees fit.

11.13 The Chief Executive Officer or his or her nominee shall minute the outcome of the appeal and communicate the decision of the Appeals Committee to the appellant and the College Council in writing no later than 14 days after the date the appeal was decided by the Appeals Committee.

11.14 The decision of the Appeals Committee shall be final and binding on the College and the appellant.

11.15 Where an appeal is dismissed the candidate may be required to pay a fixed amount of $2000 towards the costs incurred.