

AI-ASSISTED AMC CLINICAL OSCE PREP · FREE GUIDE FOR IMG DOCTORS

Why Good Doctors Fail the AMC Clinical — and how to pass.

The exam technique, communication, and timing that separate a pass from a fail. Sourced from examiner feedback and the AMC's own specifications — not more medicine to memorise.

13

DOMAINS ASSESSED

9 / 14

STATIONS NEEDED (SINCE 2024)

2 + 8

MIN READ + PERFORM, PER STATION

Written by a senior Emergency Medicine physician & IMG

Clinical educator · has sat the AMC Clinical Exam · Australia

Start here

If you've failed the AMC Clinical, or you're afraid you will, read this next line carefully — it reframes your entire preparation.

Candidates overwhelmingly fail not from a lack of medical knowledge, but from errors in exam technique, communication, and clinical safety. You almost certainly know enough medicine. You're losing marks on the things the exam is actually built to test — and the things almost nobody deliberately practises.

THE CORE IDEA

The Clinical is a **timed performance** scored against defined domains — not a viva. It rewards the doctor who is structured, safe, and clear over the one who simply knows the most. Once you see it this way, it becomes learnable and trainable.

This guide breaks down the seven failure patterns examiners see most — and the exact frameworks that fix each one. Everything here is drawn from AMC examiner feedback and the official examination specifications.

What's inside

1 · The 2-minute trap — and the 5-Step Reading Strategy	p.2
2 · Running out of time — the Two-Four-Two framework	p.2
3 · How you're actually scored (13 domains, and the one that's everywhere)	p.3
4 · Communication: the real reason IMGs fail	p.3
5 · Red flags & safety-netting — the safety marks	p.4
6 · The Australian-context trap	p.4
7 · How to actually practise (and build stamina)	p.5
The exact words that score marks (communication scripts)	p.6
Breaking bad news, step by step (SPIKES + NURSE)	p.7
Your 12-week preparation roadmap	p.8

1 The 2-minute trap — and how to beat it

A frequent critical error is skimming the door note and misreading the task. **No marks are awarded for tasks that weren't requested** — candidates routinely burn all 8 minutes on a physical examination when the prompt asked only for a focused history.

Use the two minutes outside the room to plan, not panic. Apply the **5-Step Reading Strategy** to the door note:

- 1 **Setting** — GP clinic, ED, or ward? It dictates your resources and management pathways.
- 2 **Demographics** — age and gender immediately narrow your differentials and risk factors.
- 3 **Presenting complaint** — pinpoint the core problem; prioritise ruling out life-threatening causes.
- 4 **Your task** — read this section *twice*. It's exactly what you're scored on. Misreading it is a top cause of failure.
- 5 **Additional information** — hidden cues: vital signs (an acute emergency?), "anxious mother" (a communication demand), investigation results.

Then write a brief plan on your scrap paper: your **opening statement, top three differentials, key questions, and safety-netting plan**. Walk in with a roadmap.

2 Never run out of time again

Nerves make candidates ramble, or spend six minutes on history and cram management into the last thirty seconds. The fix is a fixed rhythm for your 8 minutes: **Two-Four-Two**.

First 2 min	Middle 4 min	Final 2 min
Rapport & opening. Introduce yourself, confirm identity, open question, build rapport.	Core task. History or exam, using frameworks (e.g. SOCRATES). Breadth over depth.	Closure & safety net. Summarise, management plan, warning signs.

EXAM-DAY CUE

If a prompt or bell sounds at the 6-minute mark, it's your signal to **start wrapping up and move to management** — regardless of where you are. And finishing early isn't failing; it means you were efficient.

3 How you're actually scored

Examiners grade you across **13 assessment domains**, though any one station assesses only 3-5 of them. Each is scored on a **7-point scale** (1 = very poor, 7 = outstanding), where **4 is a borderline pass**. To pass a station, you generally need a 4 or higher in every domain assessed there.

Domain 1 is assessed at every single manned station.

"Approach to the Patient" — empathy, respect, and clear communication — is the most heavily weighted element of the entire exam. It's not a soft add-on. It's the through-line that decides borderline stations.

Your clinical skills are tested across four core areas: **history, examination, diagnostic formulation, and management/counselling**. Each rewards a focused, reasoned approach and punishes a "scattergun" one — random, unfocused questioning or examination that isn't driven by the clinical clues in front of you.

4 Communication: the real reason IMGs fail

Inadequate communication is a primary cause of failure — and it's scored continuously, at every station, under Domain 1. The specific pitfalls examiners name:

- **The interrogation style** — rapid, closed, double-barrelled questions ("vomiting and diarrhoea?") with no rapport.
- **Jargon and euphemisms** — technical terms patients can't follow, or vague euphemisms for serious news (calling cancer a "nasty growth").
- **Ignoring ICE** — failing to ask the patient's *Ideas, Concerns, and Expectations*. Simulated patients often withhold key information until you ask what worries them.
- **The silent performance** — jumping between tasks without signposting or narrating your thinking.

30 SECONDS THAT LIFTS YOUR SCORE

Weaving **ICE** into the consultation takes about half a minute and directly boosts Domain 1 — the domain assessed everywhere. Add "chunk and check": deliver information in small pieces, confirm understanding, then continue.

5 Red flags & safety-netting

Examiners prioritise safe practice above almost everything. Two failures recur:

- **Missing red flags** — failing to rule out life-threatening causes early (e.g. not considering ectopic pregnancy in lower abdominal pain) is scored as unsafe, incomplete practice.
- **Omitting the safety net** — closing without telling the patient what warning signs to watch for and when to seek urgent care. This single omission fails stations candidates otherwise performed well.

NEVER CLOSE WITHOUT THIS

End every consultation with an explicit safety net: *what* to watch for, *what to do* if it worsens ("call 000"), and *when* to return for review. It takes fifteen seconds and it's a reliable, scored mark.

6 The Australian-context trap

The exam tests your ability to practise at **intern level within the Australian system**. A frequent cause of IMG failure is transplanting guidelines and habits from home.

- Base management on **Australian sources** — Therapeutic Guidelines (eTG), RACGP, the Heart Foundation, John Murtagh.
- "Speak Australian" — approved drug names (*paracetamol*, not acetaminophen), and understand Medicare and the PBS.
- Observe Australian etiquette — explicit verbal consent, offer a chaperone for sensitive exams, visible hand hygiene, cultural safety. Missing these heavily penalises your score.

COMMON MISTAKE

Prescribing a drug that isn't on the PBS, or reaching for a US guideline. Correct medicine, wrong system — and it costs marks.

7 How to actually practise

Here's the honest part. Reading stations silently feels productive and changes almost nothing. The exam is **spoken, timed, and watched** — so your practice must be too. The gap between knowing an answer and delivering it fluently under a clock, in front of an examiner, is exactly where marks are won and lost.

- **Practise out loud, always** — say every station start to finish, even alone.
- **Use a timer, always** — strict 2-minute read, 8-minute performance. Train your internal clock.
- **Get watched, and get honest feedback** — on completeness, differentials, safety-netting, and clarity. Avoid partners who ignore the clock or go easy on you.
- **Rehearse openings to reflex** — the first 20 seconds of each station type should be automatic.
- **Build stamina** — the real circuit is 16 assessed stations over 4-5 hours. Many who ace isolated cases fail on fatigue. Run full mock circuits before the day.

THE ONE MISTAKE TO AVOID

Sitting the exam underprepared to beat a deadline. A rushed attempt is an expensive way to learn what a proper mock would have told you for free.

Everything above is trainable. The candidates who pass aren't smarter — they turned these behaviours into reflexes through repetition, feedback, and reps under realistic pressure.

WANT THIS ASSESSED IN 3 MINUTES INSTEAD?

Take the free AMC Clinical Readiness Audit

A short self-assessment that names your single biggest exam risk right now, so your practice time goes on the thing that's actually costing you marks.

-> clinexia.org/audit

The exact words that score marks

Communication is scored at every station, yet most candidates improvise it. These are ready-made phrases you can drill until they're automatic — the difference between sounding structured and sounding lost.

Signposting & transitions

Transitional statements keep the interview organised and stop the patient wondering why you're asking. Move between sections out loud:

- *"Now I'd like to ask some questions about things that may or may not be linked to your [complaint] — is that okay?"*
- *"I'm now going to ask some routine health questions I ask all my patients."*
- *"Thank you for that. I'd now like to examine you, then we'll talk through what I find."*

For sensitive topics

Normalise before you ask — it lowers defensiveness and scores in Domain 1:

- *"I include questions about sexual health in my routine history because they're so common — is it okay to ask a few?"*
- *"Many people in a situation like yours notice a change in this area. Have you noticed anything?"*

ICE — in the patient's own words

Eliciting Ideas, Concerns and Expectations takes 30 seconds and lifts the domain assessed everywhere. Standardised patients often withhold key information until you ask:

- **Ideas:** *"What do you think might be causing this?"*
- **Concerns:** *"Was there anything in particular you were worried it might be?"*
- **Expectations:** *"What were you hoping we could do for you today?"*

CHUNK AND CHECK

When explaining, give information in small pieces and confirm understanding before moving on: *"Does that make sense so far?"* It's a named, scored behaviour — not a filler phrase.

Breaking bad news, step by step

Breaking-bad-news and counselling stations frighten candidates because they feel unstructured. They aren't. The **SPIKES** protocol turns them into six ordered, scoreable steps.

- 1 **S — Setting up.** Privacy, enough time, sit down, minimise interruptions. Plan what you'll say.
- 2 **P — Perception.** Before you tell, ask. *"What have you been told about your condition so far?"* Correct misunderstandings and pitch the news to what they know.
- 3 **I — Invitation.** Check how much they want to know. *"Are you the kind of person who likes all the details, or the broad picture?"*
- 4 **K — Knowledge.** Fire a warning shot, then deliver plainly. *"I'm sorry, I have some difficult news."* Use plain words — "spread," not "metastasised." Avoid bluntness and avoid "there's nothing more we can do."
- 5 **E — Emotions.** Respond to the reaction with empathy before facts (see NURSE below). This is the step candidates skip — and the one that carries the station.
- 6 **S — Strategy & summary.** Agree the next steps, summarise, and safety-net. The patient should leave knowing what happens now.

When the emotion comes, use NURSE.

Name it · Understand it · Respect it · Support them · Explore further. For example: *"It looks as though this news has hit you hard — that's completely understandable. I'm here, and we'll work through this together. What's worrying you most right now?"*

THE MISTAKE THAT FAILS THE STATION

Rushing to fill the silence after bad news with more facts. When the patient goes quiet or tears up, **stop, acknowledge the emotion, and wait.** The pause is the empathy, and it's scored.

Your 12-week preparation roadmap

Most successful candidates dedicate 3-6 months and around 100 hours of active, scenario-based practice — not passive reading. A phased structure examiners and successful candidates recommend:

Phase	Focus
Weeks 1-2 Foundation	Review the AMC Clinical Blueprint and the 13 domains so you know what's graded. Form a study group of 3-5. Take a baseline mock to find your weak areas.
Weeks 3-4 Communication	Drill ICE until automatic. Record yourself; review body language, empathy, and signposting. This is where IMGs gain the most ground.
Weeks 5-8 Station mastery	Systematically drill each type — history, then counselling & breaking bad news (SPIKES), then examinations and procedures.
Weeks 9-12 Integration	Practise mixed stations (history → exam → management in 8 min). Prioritise full, strictly-timed mock exams to build stamina.

Frameworks to make automatic

- **5-Step Reading** — Setting, Demographics, Complaint, Task, Additional info.
- **Two-Four-Two** — your 8-minute time structure.
- **ICE** — Ideas, Concerns, Expectations, in every consultation.
- **SOCRATES** for pain · **SPIKES** for breaking bad news.
- **Safety net** — what, what-if, when — to close every station.

THE HARDEST RESOURCE TO FIND

Every strategy here depends on one thing: **realistic, timed practice with honest feedback**. A study partner at 11pm after a shift, an examiner's eye on your blind spots, enough varied stations to drill — that access is what most candidates simply can't get enough of. It's the exact gap the next page is about.

Where Clinexia comes in

Realistic practice, an examiner's feedback, unlimited reps — on demand, built for IMGs.

Clinexia is AI-assisted AMC Clinical OSCE coaching, created by an IMG who has sat this exam. It's built to close the one gap this guide keeps returning to: access to realistic, timed practice with feedback that tells you exactly where the mark slipped.

1

AI role-player simulation

Realistic Australian patients with natural conversation, emotion, and interruptions — practise like the real station.

2

AI examiner feedback

Detailed marking, domain scores, critical-error flags, and a performance summary — know exactly where you stand.

3

AI tutor / clinical coach

Explains what you missed, why it matters, the ideal phrasing, and the clinical reasoning behind it.

4

Personalised repetition & progress tracking

Smart repetition of your weak areas, with dashboards showing strengths, gaps, and readiness.



Smart coaching. Realistic practice. Confident performance.

Clinexia is launching soon.

While you wait, take the free AMC Clinical Readiness Audit -> clinexia.org/audit

This guide is educational and reflects publicly available AMC information and examiner commentary at the time of writing; it is general information, not individual clinical or exam advice, and does not use any confidential examination material. Exam format, fees, and pass requirements change — always confirm current details with the AMC. Clinexia is an independent preparation resource and is not affiliated with or endorsed by the Australian Medical Council. © Clinexia.

Sources: Australian Medical Council, Clinical Examination Specifications and Tips from Examiners (amc.org.au). SPIKES protocol - Baile WF et al., The Oncologist 2000;5(4):302-311. NURSE framework - VitalTalk / Back AL et al. ICE model - Pendleton D et al., The Consultation, 1984.