

# The Second Clinical Attachment OSCE:

## What to Expect

This document has arisen out of the feedback about the OSCE, which showed that students did not know enough about what to expect in the exam. We have discussed this issue in the Galenicals education committee and also at the curriculum development and co-ordination group (affectionately known as CDCG). In the latter Dr. Roberts suggested that a joint staff-student effort be made to write some notes of guidance for students.

As well as the guidance given below there are plans to include a session about the exam, what to expect and how to prepare as part of the lectures incorporated into the 2<sup>nd</sup> clinical attachment. There may also be a move to encourage consultants to run more OSCE-like sessions as part of their teaching and firm appraisals

The purpose of this document is to give you an idea of what to expect and hopefully an insight into the complexities of the OSCE (i.e. why it is so hard to run). Its purpose is **not** to act as a comprehensive guide to what will be in your OSCE. Part of preparing for this kind of exam is realising that clinical medicine is not an exact science so that it is not really possible to write a precise curriculum in the same way as for many other subjects. In medicine we need to know something about a large number of subjects, rather everything about a few.

## **(a) GENERAL QUESTIONS**

### **· What is an OSCE?**

OSCE stands for OBJECTIVE STRUCTURED CLINICAL EXAMINATION

It is not the same as a traditional style clinical exam in which you are examined on long or short cases. An OSCE is not always an exam, either. It can be more of a learning experience. There is a disability OSCE in the disability week of the curriculum as well as an orthopaedics OSCE, neither are exams.

### **· What is the benefit of an OSCE over a written exam or viva?**

In the past students were examined on long and short cases in a viva setting. These were fairly unstructured – students could encounter very different types of cases, and might come up against examiners who had rather different ideas on marking. It was therefore hard to standardise the exam. The 'objective' and 'structured' part of the OSCE aim to reduce this discrepancy between the experience of different students. This should therefore make the whole process fairer.

An OSCE also allows students to be tested on a much wider range of subjects rather than the small number that usually come up in a viva. Each station in the OSCE contributes only a small amount to the total mark at the end, so it has the advantage that if you are poor in one area you have more of a chance to make up your marks in other areas.

### **· What does the 3<sup>rd</sup> year OSCE aim to test?**

The purpose of the 3<sup>rd</sup> year OSCE is to test you on the overall aims and objectives of the attachment and it is therefore focussed primarily on assessing your clinical skills. There will be some stations to test your knowledge, but these carry much less weight. As outlined in the handbook, you are therefore expected to be able to take a history and examine any body system. This sounds an enormous task but the idea is to test you on common conditions, to ensure you have the correct grounding in the things that you will have come across most frequently. A list is provided for you as a guide in your

handbooks. It's a cliché that common things happen commonly but it is these things that you are expected to know about.

**(b) FORMAT AND CONTENT OF THE OSCE**

**How is the exam set out?**

The precise details of the exam vary from year to year depending on the number of students to be examined, examiners available etc., but the general scheme is as follows. The OSCE is generally held in a clinic or ward which is closed for the few days that the exam runs. There are 16-18 different stations which you have to visit in rotation. Lots of people are recruited to help with the running of the exam so there will always be someone around to tell you when to move on and where to go next. Last year there were four clinical stations (three examination and one history station), eight written stations and a couple of rest stations. These proportions may however vary from year to year.

The table below show the content and format of these stations and how long you have for each one.

No of stations	Type of Station	Time allowed	example
3	<p><b>Clinical Stations (examination)</b></p> <p>You will be faced with a patient and an examiner who will tell you what to do. Normally involves examining a particular system and telling the examiner what you have found. You will not always be asked to examine a whole system – sometimes you might be asked to examine a lump, or a pair of hands or feet.</p>	10 minutes	<p>You might be asked “This patient has been complaining of swollen ankles and shortness of breath. Please examine his cardiovascular system to see whether you can find the cause” You would then be expected to examine the CVS. The examiner would then be watching carefully to make sure you knew how to examine the CVS – everything from the fingers to the heart – and if you, for example, found a murmur, that you were able to describe what you found. If there is time you might be asked what you thought the murmur was, but that would account for only a very small proportion of the marks</p>
1	<p><b>Clinical Station (history)</b></p> <p>You will be conducting a consultation with an actor who is playing the part of a patient. A doctor will also be in the room, to observe and mark your consultation skills.</p> <p>You will first be asked to read a short briefing note, which gives a bit of background information about the patient, and tells you what we would like you to do in the consultation. The focus of the station may vary, but it is likely to test skills such as listening, taking a well-structured history, explaining something to a patient, and arriving at a realistic differential diagnosis.</p>	10 minutes	<p>You might be asked to take a history from a man complaining of shortness of breath. We would expect you to show a well-structured approach to taking a history, including asking about key things e.g. smoking, diurnal variation, reversibility of symptoms with medication to distinguish COPD from asthma. We would expect you to show a ‘whole-person’ approach, which might include thinking and asking about relevant social, psychological, environmental, or employment issues.</p>
8	<p><b>Written Stations</b></p> <p>Each of these stations will have a <b>few questions for you to answer</b>, these are</p>	5 minutes	<p>A chest x ray of an obvious pleural effusion with related questions asking for diagnosis, aetiology and clinical presentation etc</p>

	<p>normally related to an x-ray, instrument, investigation result etc which will be at the station for you to look at.</p> <p>There will be a sheet of paper at each station for you to write your answers on and a space at the top for you to put your exam no. When it is time for you to move to the next station you put your answer sheet face down in the tray that is at each station. About half of these stations will cover surgical topics and half medical. There may also be questions related to A &amp; E and primary care.</p>		
	<p><b>Other stations</b></p> <p>Some of the written stations may be replaced by short practical stations. You could be asked to undertake some very common simple practical procedure or particular aspect of an examination while being observed by an examiner. All of the procedures would be things you should have encountered frequently on the wards.</p>	5 minutes	Taking blood pressure, using an ophthalmoscope, eliciting reflexes, placing ECG leads, testing urine, taking blood etc.

· **If I take my exam after a friend, will I have the same stations as them?**

For each of the clinical stations there are two parallel options, A and B of which you only do one and the patients often change between exams so you won't necessarily have the same patients. There are also several sessions each day and the questions are often changed between sessions. If absolutely identical questions are used in two sessions, the two groups of students doing them may be kept apart during the changeover so they don't mix. This is however probably not strictly necessary since the main emphasis of this exam is on assessing the way you approach a clinical problem, rather than getting a single correct factual answer, and even knowing the questions in advance wouldn't really make any difference.

**(c) THE CLINICAL EXAMINATION STATIONS**

· **What am I expected to be able to do in the clinical stations with a patient?**

The time allowed for these may not seem like long but the task is not impossible (honest). The aim is for you to demonstrate that you are familiar with examining the various systems and can do so in a competent way (eg that you don't hurt the patient). The examiner is really looking to see if you know what to do rather than wanting to know if you can reach a clinical diagnosis on the spot. Students often worry about whether to say what they find on examination as they go along or to save and report at the end of the exam. Feel free to ask the examiner what s/he wants. Try to make sure you listen to what you are asked to do and if you are unsure, clarify it with the examiner. This is equivalent to reading the question in a written exam and this way you will not waste time doing something for which you will not get any marks. This part of the exam is not intended to be an ordeal, if you have seen a good mix of patients during your attachment and been to your teaching etc you will be fine in the OSCE. Examiners can easily tell which students are familiar with examining patients and which have not spent much time on the wards – the former will almost always pass, but latter are likely to have problems!

#### **(d) THE HISTORY TAKING STATION(S)**

This station particularly tests you on the sort of things you will have done in your primary care teaching (although the consultation in the exam might be in a primary care or hospital context). In your primary care teaching you will have practised taking histories and examining patients with a range of common complaints. You will have learnt to integrate questions about physical symptoms, patients' concerns, the effect of an illness on a patients life, and relevant social and behavioural factors (e.g. smoking, drinking, patient's jobs, families etc.). If you have participated fully in your primary care teaching you should have no problem with the history taking station. On the other hand if you have learnt all of your medicine from books, and have not practised talking to real patients, you may come unstuck.

#### **(e) HOW IS THE OSCE MARKED?**

The clinical stations account for 60% of the marks and the written stations for 40%. For each clinical station the examiner is given a structured marking scheme which divides up the available marks into various categories. For example, on a clinical examination station you will be given marks for 'attitude' which includes your approach to the patient, how clear your instructions are etc, for 'examination technique' (matched against a checklist of things we expect you to cover in examination you have been asked to perform), for 'findings' and for 'interpretation'. At this stage in your training the vast majority of the marks are covered by the first two categories. For example, if you were asked to examine a heart, the marking scheme might give you more than 80% of the possible marks for performing an entirely perfect examination even if you didn't even hear the murmur. If you happened to describe the murmur accurately you might get another 12%, and if you were smart enough to know what valve lesion it was likely to be caused by you could get about 3% extra. These proportions are only approximate since they can change according to the patient seen or question asked. Practical skills stations will be marked in a similar way. Each task will have been broken down into its component parts, and the examiner will assign marks according to a checklist based on these. Written stations usually demand several short answers, each of which has been pre-assigned a fixed proportion of the available marks.

#### **(f) THINGS TO REMEMBER**

Knowledge at this stage in the course is assessed by an OSCE because it is felt that this is the best way to do it despite the fact that it is a difficult exam to set up and run. Suffice to say that the logistics of getting 50-60 patients and actors, more than 50 doctors, a couple of dozen helpers and 160 medical students to take part in this exam are daunting. On top of this the course is still new and still changing...there are *bound* to be difficulties and teething problems.

We appreciate that as the first clinical exam you do this is bound to be relatively stressful. We hope that these notes lessen this but would emphasise that they are not intended to be a comprehensive guide as this would be impossible to write. The OSCE, and particularly the clinical stations are a good indicator of how you have spend your second clinical attachment, ie how many patients you have seen etc. Also, you won't be expected to comment on or know about many things which are not common or obvious.

Often students comment that their house officers, SHOs or registrars don't know anything about the exam or what will be in it. This should come as no surprise as the vast majority of them are not involved in the new course in a way which would enable them to know this kind of information. Your consultant will have been sent some guidance regarding this and will have the best idea.

#### **(g) FEEDBACK ON THIS DOCUMENT**

You will be glad to hear this is optional! We would be grateful for any constructive comments about this document and how useful (or not) it is. We would be particularly happy to hear from any students who have already done the OSCE with their thoughts on this.