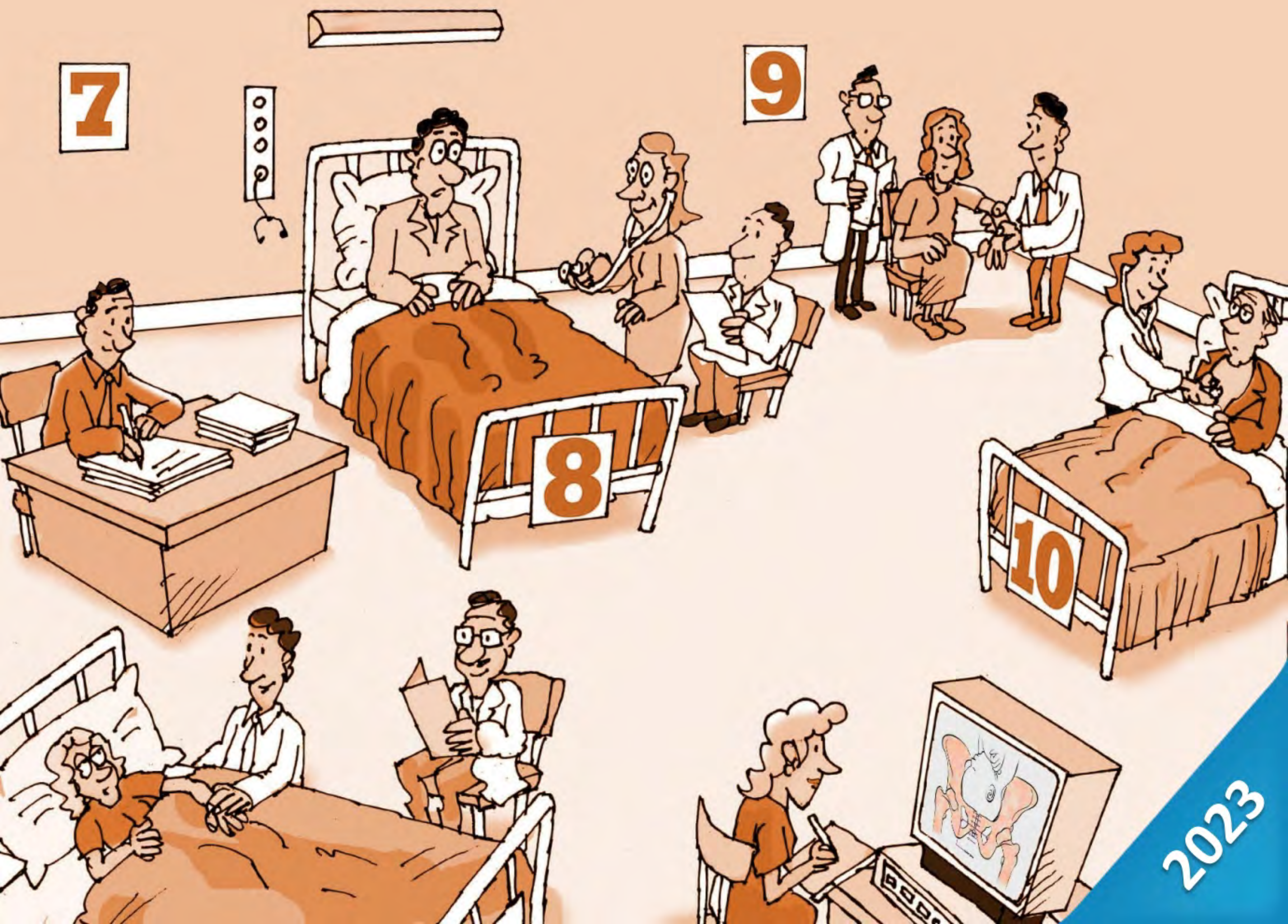
Ahmed Khairi Mshari

How To Pass Your...

OSCE

A practical guideline



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How To Pass Your

OSCE

A practical guideline

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PREFACE

The paramount goal of a curriculum for training in the medical professions is to graduate competent and knowledgeable doctors with the right attitude to practice the profession. To be satisfied that the trainee has achieved the intended and expected outcomes of learning, he has to be put to the test. This process is often referred to as assessment, more popularly known as examination.

Traditional formats of clinical examination, the long case and short case examinations, have been criticized on the grounds that they are subjective in nature, and because of their inability to evaluate clinical competencies in a valid and reliable manner. The objective structured clinical examination (OSCE) has been introduced by some medical schools as a more objective measure of clinical performance than a conventional clinical examination.

The purpose of this booklet is to present an outline on how to prepare, approach, and behave during clinical and practical examinations in the settings of OSCE. It is not a substitute for standard books on the diagnosis or management of medical disorders. The candidates must study standard texts and acquire the necessary clinical competencies through training, and then apply the techniques and advice adopted in this booklet to guide them to a respectable performance in the clinical and practical examination.

DEFINITION OF OSCE

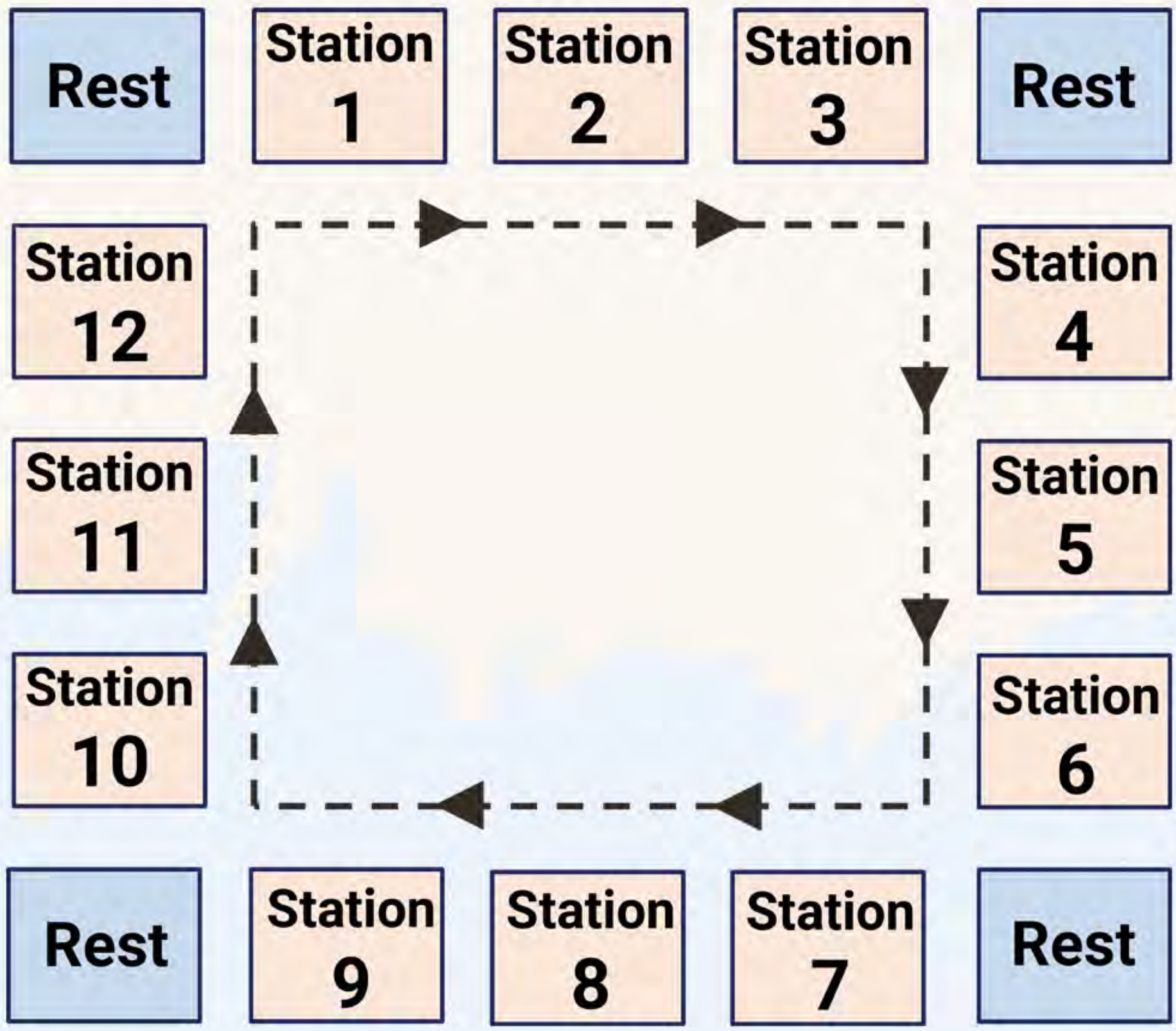
The **OSCE** can be defined as:

"An approach to the assessment of clinical competence in which the components are assessed in a planned or structured way with attention being paid to the objectivity of the examination".

An OSCE is a well-established, performance-based test that allows for the standardized assessment of clinical skills, including problem-solving, critical thinking, and communication skills. This provides a more **valid** and more **reliable** (Annex A) examination permitting the move away from testing factual knowledge to testing a wide range of skills. The OSCE is particularly suited to situations where a pass/fail decision has to be taken and where a decision has to be made as to whether a student has reached a prescribed standard.

THE STRUCTURE OF OSCE

An OSCE consists of a complete circuit of timed stations connected in series. Each station is devoted to the assessment of a specific component of clinical competence or a combination of different elements of competence. All candidates begin simultaneously moving from one station to another in the same sequence. The performance of a student is evaluated independently at each station.



The majority of stations involve examiners, examiners' checklists, candidates' instructions, and standardized or simulated patients. Here is a short explanation of each of these subjects:

The Examination Station

The total number of stations is variable. For most clerkships or courses, the total will vary from 10 to 25. The competency being assessed in a particular station will define how much time should be allotted per station. The length of time will range from 5 to 20 minutes. However, the time per station is constrained by the total duration of the examination.

The time allocated per station should be as uniform as possible thus facilitating the smooth movement of candidates from station to station. Transit time must be built into the total time allocated for each station. For example, a 10-minute station, 9 minutes is allocated for the task and one minute transit time to the next station. The examiner must complete the checklist before the entry of the next candidate.

The Examiner

Most stations will require an examiner (assessor), especially when clinical skills (e.g., history-taking, physical examination, patient interview, or communication skills) are intended to be assessed. The examiner observes and assesses the candidate at each station using a predetermined standardized checklist. The examiner gives the candidate credit for the questions asked and skills and interventions performed that are on the checklist.

Examiners will have instructions outlining the purpose of the station and the task to be carried out. They will also have read the candidate and patient instructions. The examiners will not interact with the candidates except in the following circumstances:

1. An examiner may redirect the candidate if he believes that the candidate has misunderstood the station instructions. For example, if the candidate trying to obtain a history in a physical examination station, the examiner might alert him to re-read the instructions.
2. In a physical examination scenario, the examiner may remind the candidate to explain what he is doing and describe his findings. The examiner may provide pertinent findings once the candidate has initiated specific examination maneuvers.
3. The examiner will intervene if there is a concern about the safety of the patient.
4. Occasionally, an examiner may ask the candidate one or more oral questions during a scenario. If this is the case, it will be indicated on the candidate instructions.

The Checklist

OSCE examiners have a standard printed marking sheet (checklist) for each station that they have to fill out while observing the candidates. Checklists will vary depending on the type of station and skill being assessed, but each task will be marked against explicit criteria. This will be in the format of a checklist of actions the candidate needs to perform.

The checklist is a rating scale that is constructed of items that the candidate should carry out at the station. It is standardized to reduce examiner's bias. Direct or indirect observations, as well as checklists and rating scales, measure the performance against predetermined standards resulting in a more objective examination than with traditional methods. Moreover, the candidates may be examined by an individual or pair of examiners (who should mark independently). In this case, once the station is completed an individual mark can be scored following an agreement by the examiners.

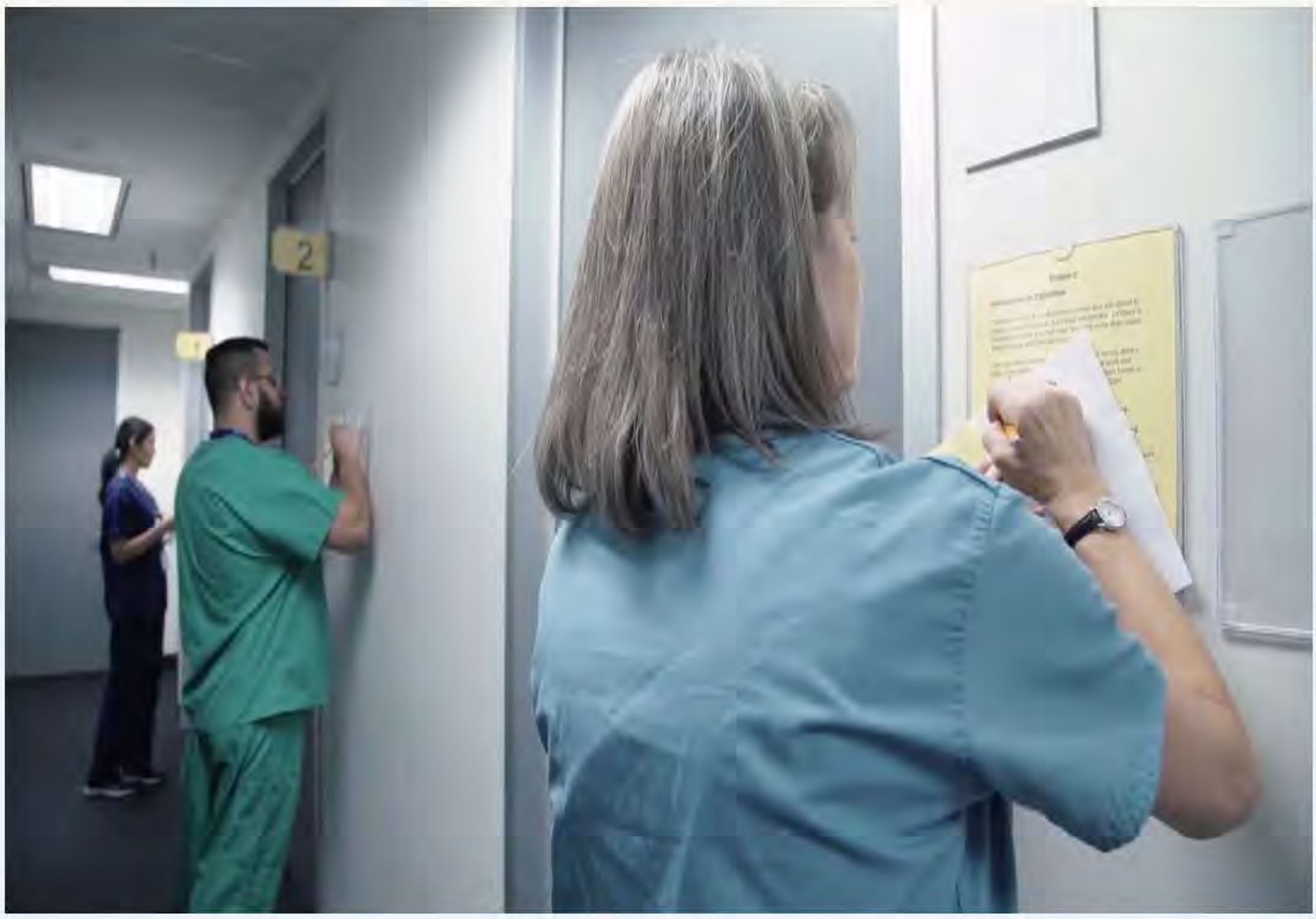
The Candidate Instructions

The candidate instructions provide the information to candidates before entering an OSCE station. These instructions always include the patient's name, gender, and age, as well as their presenting complaint or reason for referral. It should also include the 'clinical task' that must be performed by the candidate, as well as the time allotted for the task. The instructions are posted beside the door to the station room.

For example: *Sudad Aziz is a 63-year-old woman who visits the emergency ward because of chest pain and nausea. In the next 5 minutes, take a focused history and address her concerns.*

In some stations, additional information (e.g., history documentation, clinical information, physical examination findings, laboratory results, or other diagnostic test results) may be posted with the instructions for a candidate. The candidate is not required to memorize any documentation that is provided in this manner. The instructions for the candidate and any additional information are also available in the encounter room with the patient.

If the candidate needs to refer to the documentation inside the station and does not see it, the examiner can point it out to him. The instructions pages need to be laminated to prevent anyone from writing on or marking the documentation. Any notes that the candidate wishes to make should be made in his notebook. The candidate can also use the notebook to highlight his task and jot down any tips that might assist him in his designated task.

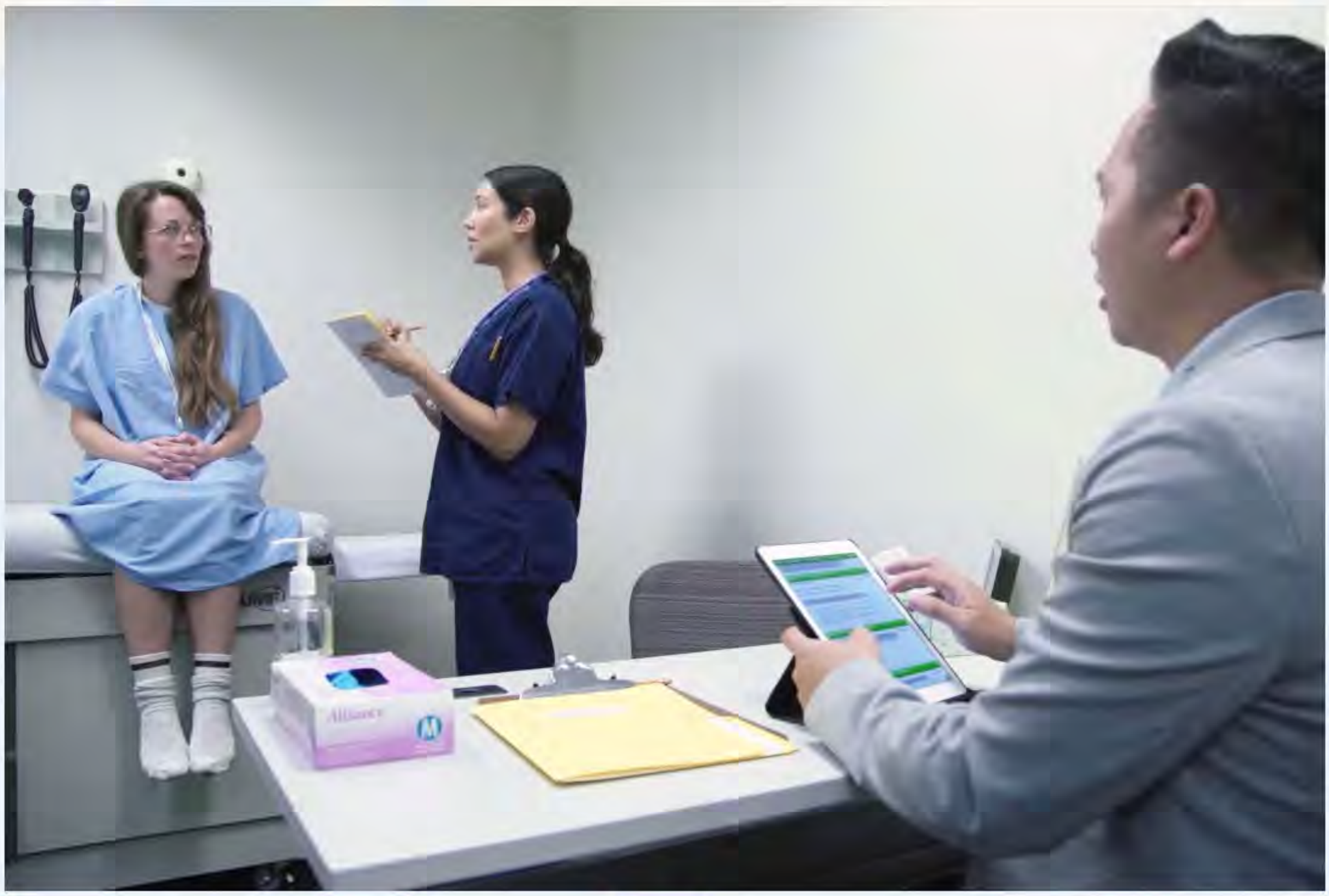


The Standardized Patient

The OSCE cases cover common and important situations that a physician is likely to encounter in common medical practice (e.g., a clinic, emergency department, or hospital setting). Thus, the candidates are evaluated as if it is a real-life practice. A standardized or simulated patient (SP) is an individual trained to portray real patients.

The SP follows a certain script to play with a candidate during the encounter. The script is written in detail, including the patient's general look, clothes, gestures, emotions, and all negative and positive answers. It also includes any unexpected behaviors, such as the SP turns agitated, upset, violent, restless, impolite, or leaves the room during the encounter.

The candidate should treat each SP as a real patient, he should answer any questions the patient may have, tell the patient what diagnosis is being considered, and advise the patient on what tests and studies the candidate plans to order to clarify the diagnoses.



OSCE FORMAT

Almost, any skill or competency in medical education can be assessed in an OSCE exercise. The possibilities for individual OSCE stations are huge but generally, they are organized into five different categories.

1. History-Taking Stations

History-taking is one of the most vital competencies a health professional must acquire. Data gathering through history-taking probably accounts for over 70% of what is needed to make a diagnosis of most disorders. Often, these stations would invariably be focused upon in any OSCE exercise.

The history-taking station often consists of an SP with the examiner. These stations involve a brief description of the patient's presenting complaint. At the end of the station, the candidate will usually be asked to summarize, and will often be asked to discuss differential diagnoses and initial management.

At the history-taking station, an organized approach to history-taking is recommended. The candidate must explore the chief complaint(s) using the history of presenting illness, past medical and surgical history, medications and allergies. In a non-emergency situation, he should also obtain the details about the family, social, occupational, and sexual histories relevant to the case scenario.

Given the limited time available in OSCE, the emphasis must be on focused history-taking and only relevant systems should be tackled to avoid time-wasting. The 'focused history' requires judgment about what to explore and what to set aside. Judgment is based mainly on knowledge and experience. For example, vaccination history is not as important in the case of a child with a large head, but very important in a child with fever or rash. On the other hand, developmental history is important in any neurological case, but not as important for a child with abdominal pain.

In history-taking stations, in addition to assessing the candidate's data gathering approach, his medical knowledge and communication skills are also assessed. This will be an important part of the station's final mark. Some history-taking OSCEs would have some difficulty dealing with a patient or an ethical issue to be assessed too, such as a depressed patient who is unwilling to talk or a failure to thrive child with hidden child abuse.

Importantly, at stations that involve an infant, toddler, pre-school or school-aged patient less than 10 years old, the candidate may be interacting with the parent or caregiver for the patient. If the patient is a 10-year-old or older, the candidate is expected to interact directly with the child patient.

2. Physical Examination Stations

These stations mostly use SPs to assess a candidate's physical examination skills. On some occasions, SPs are trained to demonstrate certain findings on physical examination (e.g., weakness or ataxia). A checklist is developed to assess whether the candidate performs the essential components of the physical examination. In some OSCE formats, audiovisual or video stations demonstrating clinical findings might be used to assess a candidate's observational skills.

Oftentimes, candidates would not have enough time to do a complete physical examination of the patient, nor would it be necessary to do so. They should pursue the relevant parts of the examination, based on the patient's problems and other information obtained during the history-taking. Clues from the presented history should guide the focused examination.

Before starting the physical examination, the candidate should explain what he will do to the patient and take the necessary permission before proceeding. Similarly, the candidate must explain everything he is doing and describe all normal and

abnormal findings to the examiner. Credit cannot be given for positive or negative findings unless the candidate reports what he has found. Sometimes, the examiner may be directed to provide the candidate with information (e.g., clinical findings or results). However, the examiner cannot do so until the candidate has initiated a specific maneuver.

Often, the candidate would be given the necessary equipment that is needed to perform a specific task (e.g., a reflex hammer, cotton wisps, or tuning fork for examination of the central nervous system). If the candidate feels that there is a piece of equipment missing, he must tell the examiner what equipment he wants and what he would use it for.

Aim:	To test your physical examination skills.
Data:	A 35-year-old female presented to your clinic with vertigo.
Tasks:	Perform a relevant physical examination. Explain the rationale of each test to the examiner.

No.	Expected Answers	Student Performance			
		Good	Adequate	Wrong/ Not attempted	Mark
1	**General:**				
	• Introduce yourself	2	1	0	
	• Identify patient	2	1	0	
	• Gain consent	2	1	0	
	• Wash your hands	2	1	0	
2	**Check ears for:**				
	• Look in ears	2	1	0	
	• Rinne test	2	1	0	
	• Weber test	2	1	0	
3	**Check eyes for:**				
	• Spontaneous nystagmus	2	1	0	
	• Positional nystagmus	2	1	0	
	• Gaze-evoked nystagmus	2	1	0	
4	**Check CVS for:**				
	• Cardiac exam	4	3/2/1	0	
	• Listen to carotid	2	1	0	
	• Pulse	2	1	0	
	• Orthostatic BP/Pulse	2	1	0	
5	**Neurologic exam:**				
	• Cranial nerves	4	3/2/1	0	
	• Motor power	2	1	0	
	• Sensations	4	3/2/1	0	
	• Reflexes	4	3/2/1	0	
	• Cerebellar signs	3	2/1	0	
	• Gait	2	1	0	
6	• Thank the patient	1		0	

An example of physical examination station case scenario and checklist

3. Communication Skills Stations

Good communication skills are central to OSCEs and are likely to be tested in the majority of stations. For instance, a candidate would not be assessed as competent in performing a physical examination or practical procedure if he cannot explain to the patient the process and gain consent. The emphasis on assessing medical students' communication and attitudinal behaviors has increased dramatically in recent years.

Communication skills can easily be assessed in an OSCE environment. The candidate would be observed interacting with a patient, a patient's relative, or a fellow health professional (who will always be played by an actor). Although communication skills are the main skill being tested in some stations, a candidate will be marked on his communication skills in almost all stations involving a patient. Examples of what a communication station might include:

- Explanation of a diagnosis, prognosis, laboratory or medical imaging test results, drug interaction or side effects, treatment, procedure, or any patient concerns.
- Obtaining consent for a procedure or treatment.
- Breaking bad news.
- Disclosing a medical error.
- Dealing with a difficult or angry patient or relative.
- Patient education or counseling.

4. Emergency Stations

An emergency OSCE is an important station to assess a candidate's ability to manage acutely ill patients safely and effectively. This station frequently worries medical students as it is perceived to be unpredictable, demanding on the spot decision-making. However, candidates can pass any station by taking a systematic approach.

Emergency OSCE designs vary; in some examinations, a candidate may be asked to undertake all the steps to managing a critically unwell patient came to the emergency room, whereas in others he may be given a specific clinical scenario and asked only about certain parts of the process.

If the candidate is asked to take a history, he must consider how much time ha has to complete this task and prioritize his questions appropriately. If he is asked to take a brief focused history, he must concentrate on the presenting complaint. Sometimes, high-fidelity simulation mannequins might be used to test the ability to examine patients, recognize specific clinical signs (e.g., tachycardia, altered breath and heart sounds), or provide immediate life support.

Regarding investigations, the candidate should start with basic investigations. Then, he can proceed to more invasive tests. A candidate must make sure he can justify the tests he orders and explain how the investigation will aid his management plan. For example, the management of acute abdominal pain is drastically altered if a patient has a positive pregnancy test.

Similarly, a candidate should avoid skipping the basic tests and go straight on to specialist tests. For example, it is unacceptable to order only a computed tomography pulmonary angiography in a patient presenting with chest pain even if the candidate thinks that a pulmonary embolism is the most likely diagnosis. He must also request basic blood tests, a chest X-ray, and an ECG.

The candidate should be well-practiced at interpreting the results of basic investigations (e.g., complete blood count, urinalysis, chest and abdominal X-rays, ECGs) and some specialist tests (e.g., cerebrospinal fluid analysis and cardiac biomarkers). It would be a big mistake for the candidate to just simply read the values without commenting on whether and how these results will influence his differential diagnosis.

Importantly, if the candidate does not get the diagnosis straight away, he should not be panic. It is better for him to focus on common and important differentials rather than rare diagnoses. He should first make it clear which diagnosis he thinks is most likely and why followed by high-risk alternatives that need to be excluded. If the candidate is completely unsure of what is happening, it is better to admit it: the examiner might guide him back on track.

Upon reaching the management stage, it is good practice for the candidate to say that he would resuscitate the patient first. This may be required from the beginning of the station if the patient is critically unwell. Overall, the management plan should aim to stabilize the patient and control his symptoms, but a candidate may also need to initiate definitive treatment. Thus, the candidate should familiarize himself with common emergencies, such as acute coronary syndromes, asthma attack, stroke, acute abdomen, ruptured ectopic pregnancy, testicular torsion, splenic rupture, etc.

Example of an Emergency Station:

- You are called to see the patient; Wasan Hadi, a 35-year-old female who presents with shortness of breath and chest pain for 2 hours.
- You have 10 minutes to do the following:
  - Obtain a brief relevant history.
  - Perform a focused physical examination.
  - Discuss the most important investigations.
  - Discuss the most probable diagnosis based on findings provided.
  - Explain the different options for management to the patient.

5. Procedural Skills Stations

Procedure stations are designed to assess the candidate's technical skills required to execute a range of important diagnostic or therapeutic procedures, such as basic life support procedures, tracheal intubation, urethral catheterization, intravenous drug administration, peripheral venous cannulation, simple skin suturing, venepuncture, lumbar puncture, nasogastric tube insertion, performing ECGs.

At a procedure station, a candidate is given a technical task relevant to clinical practice to perform while the examiner observes and rates his performance. SPs, instruments, mannequins, or anatomical models may be made use of to carry out the tasks at these stations. If appropriate, SP will have received a copy of the scenario and advice regarding the standardized manner in which the patient is to be portrayed.

For a non-painful procedure, the candidate would be asked to perform the skill on an actual or simulated patient, such as in an ECG station. Alternatively, for a potentially harmful or invasive procedure, there may be an SP with a mannequin or an anatomical model nearby. In these situations, the mannequin may be draped and in an appropriate position, to simulate 'real-life'.

For example, a venepuncture mannequin arm draped next to the patient with their arm hidden, or a piece of fake skin draped over a patient's leg for a suturing station. If the candidate is performing the procedure on a mannequin, he must still talk to the SP as though he is performing it on the patient himself (e.g., explain the procedure and gain consent). However, within reason, the candidate does not need to talk to a mannequin.

Finally, if a candidate aspires to do well at a procedure station, he should practice the common diagnostic and therapeutic procedures several times and be familiar with the commonly available equipment and instruments needed to execute the tasks.

Occasionally, in long OSCEs, a combination of the above formats is common, such as a history-taking and a physical examination station, or a history-taking and a communication station. Additionally, few other modified formats fall into one of the aforementioned five main types, such as:

- **Consult over the phone** with a patient.
- **Patient write-ups**, such as admission, discharge, follow-up, pre/post-operative notes, prescription, referral letters, etc.
- **Interpretation of diagnostic materials**, such as laboratory reports, ECG recordings, X-ray/CT scan images, etc.

Example of interpretation of diagnostic materials station:

Students Instructions	
Aims:	To evaluate your ability to interpret X-ray.
Data:	Miss Ahlam Rashid is a 54-year-old woman who visits your clinic due to right wrist swelling and pain. Her PA and lateral right hand X-rays are shown on negatoscope.
Task:	In the next 10 minutes, explain to the examiner abnormal findings in her X-rays and address her concerns.

OSCE PROCESS AND PROCEDURES

The OSCE testing area consists of many examination rooms, which containing standard examination tables and commonly used diagnostic instruments, such as sphygmomanometers, stethoscope, otoscopes, and ophthalmoscopes, non-latex gloves, etc. Examination rooms are equipped with cameras. Recordings are used for quality assurance and are not intended to provide a mechanism for review.

Although OSCEs are performed in many settings regarding the examination purpose, the organizing institution, and available facilities, they all share similar procedures. On the examination day, the candidate will go through the following steps in sequence:

1. Registration: In this step, the candidate will:

- Show his examination invitation card and identification.
- Be reminded about the examination rules.
- Be checked for things that are allowed and not allowed.
- Receive the examination envelope, which contains an identification badge, a clipboard, blank papers for taking notes, and a pen, etc.

2. Orientation: In this step:

- Examination format, procedures, and policies would be reviewed.
- The candidate will be introduced to his team and team leader.
- The candidate will be instructed about his starting station and how to proceed.
- The candidate's questions will be answered (and not allowed beyond this step).
- An orientation video might be shown.

3. Escorting to examination position: The candidate would be escorted to his starting station. He would stop by the assigned room door until a certain signal (e.g. a buzzer or a bell) announces the start of the examination.

4. Station instruction time: This is 1-2 minutes to read the instructions about the station situation, patient, and required tasks. The candidate must read them carefully. At the next buzzer, he should enter the examination room.

5. The encounter: This is a 5-20 minute encounter. Often, the interactive station has an examiner who assesses how the candidate performs the required tasks. The candidate has to start the encounter and then stop at the next buzzer.

6. Post-encounter period: Some stations end with 1-2 minutes assigned to oral questions asked by the examiner inside the examination room. The examiner will ask the candidate 2-4 standard questions relate directly to the encounter that the candidate has just had with the patient. In these questions, the candidate may be expected to determine a diagnosis, identify diagnostic tests, interpret diagnostic results, develop a management plan, write an appropriate prescription or a referral letter, or answer other questions pertinent to the scenario.

Some stations alternate with a period of written questions covering the same aforementioned questions. During the post-encounter period, the candidate is not allowed to talk to the patient but only the examiner.

At the next long buzzer, the first station ended and the next station has started. The candidate has to proceed to the next station quickly as it is the same long buzzer at step 4.

7. Repeat steps 4 to 6: Steps 4 to 6 would be repeated until the candidate has been in all the stations. Some OSCEs will offer 1-2 short rest stations.

8. End of examination: When the examination is over, the candidate will be escorted back to the dismissal area for signing out. The candidate will be asked to handle back all that he had received on signing in; the identification badge, the clipboard, blank papers, the pen, etc.

APPROACH TO OSCE STATIONS

During an OSCE, candidates are expected to perform a variety of clinical tasks in a simulated setting while being assessed by examiners using standardized rating instruments. It is impossible to cover all the possible conditions that could appear in OSCEs. However, this book covers some of the more frequent encounters and also provides a candidate key skills to improve his general technique so that he can better adapt to different situations.

General Approach

The following generic points could apply to almost every clinical encounter, whatever their format:

- Carefully read and follow the instructions provided outside each station.
- Do not be tempted to do more than what the station instructions require.
- Feel free to take notes during the encounter.
- Be relax, take a deep breath, smile, knock the door and enter the examination room with confidence.
- Quickly survey the room for the patient, equipment, and materials provided.

- Stick to time, but do not appear rushed.
- Be calm and appear warm and confident to the patient.
- Greet the patient and introduce yourself, shake hands, smile, even joke if it seems appropriate.
- Explain your task to the patient.
- Use clear language and avoid medical jargon.
- Notify the examiner of any problem.
- Elicit the **patient's perspective** (Annex B).
- Maintain an attentive behavior by using the **SOLER method** (Annex C).
- Minimize distractions, including writing down notes extensively.
- Give the patient the time to answer in his own words, then facilitate and clarify.
- Avoid asking the examiner for assistance or guidance. Such inquiry may be misunderstood as a lack of understanding or knowledge of the problem.

- If the instructions are not clear, you could ask for clarification regarding the requested task or question.
- The examiner is listening always; you do not need to communicate with him.
- Maintain an organized way of thinking and approach to the presented clinical problem.
- At the end of the interview:
  - Schedule a follow-up appointment in the near future if needed.
  - Summarize what has been said, and give the patient the opportunity to respond.
  - Conclude with instructions about what will happen next.
  - Give the patient your contact information so he can reach you by phone (or email).
  - Make clear to the patient that you are there to answer questions at any time.
- If you do not finish by the first bell, simply tell the examiner what else needs to be said or done, or tell the examiner indirectly by telling the patient, for example, "*Can we make another appointment to give us more time to go through your treatment options?*".
- Lastly, forget the station, especially if it went badly, and focus on the next station.

Communication Station Approach

- Introduce yourself to the patient by name and position.
- Confirm the patient's name. Remember the patient's name and use it.

- Sit when the patient is sitting and remain at the same eye level as your patient.
- Avoid being too close, but not too far either.
- Show **empathy** (Annex D) and support to the patient.
- Ensure the patient's comfort and privacy.
- Explain and ask permission for your task.
- Use a 'patient-centered' approach and work in partnership with the patient.
- Encourage the patient to speak, e.g., by asking open rather than closed questions and by prompting him on.
- Acknowledge and respond to the patient's 'cues'.
- Elicit and respond to the patient's perspective and any '**hidden agenda**' (Annex E).
- Explore and acknowledge the patient's emotional state, e.g., "*You seem to be very upset*".

- Explore the patient's feelings, e.g., "*What's making you so upset?*". Validate these feelings, e.g., "*I think that most people would feel that way in your situation*".
- Remain non-judgmental and encourage a positive approach.
- Respect the patient's need for autonomy.
- Use simple and appropriate language and short sentences.
- Avoid using jargon. If using a medical or technical term, explain it in layman's terms.
- Listen carefully and use verbal and non-verbal cues to show that you are listening; good eye contact, silence, and appropriate body posture.
- Avoid interrupting the patient's answers.
- Use non-verbal communication skills effectively; maintain appropriate voice tone, good eye contact, and adjust your body posture.
- Speak calmly and do not raise your voice.
- Avoid dismissive or threatening body language.
- Use physical contact if this feels natural to the patient.
- Provide honest and accurate information.
- Avoid giving false reassurance.

- Check that you have understood the patient's problem(s).
- Check patient's understanding at regular intervals.
- Repeat and clarify.
- Explore possible solutions, and agree on a mutually satisfactory course of action.
- Give the patient time to think about, and weigh up, the information you have given him.
- Offer praise if appropriate, e.g., "*You seem to be coping well…*".
- Use signposting appropriately.
- Acknowledge any gaps in the patient's knowledge and offer to discuss these areas with seniors.
- Provide the patient with an information leaflet and website addresses for further references.
- Invite questions and ask the patient to write down any questions to answer later.
- Provide your contact details in case further questions arise.
- Summarize the consultation and check the patient's understanding.
- Arrange follow-up if needed.
- Thank the patient.

An example of communication station case scenario and checklist:

Students Instructions	
Aims:	To evaluate your communication skills in disclosing a medical error.
Data:	Mr. Ali Hassan, a known case of diabetes type 2, is followed regularly by you. You added recently Metformin to Glibenclamide as his blood sugar is not controlled. On the follow up visit, you noted that his Creatinine was 3, and recognized that you should not have prescribed him metformin.
Task:	Explain to the patient what has happened and what are the next steps.

OSCE Station Scoring Sheet / Check list					
No	**Expected Answers**	**A**	**B**	**C**	**Mark**
1.	**General**				
	Greet the patient and Introduces yourself	2	1	0	
	Establish rapport, put the patient at ease	2	1	0	
	Assess the patient's ideas, concerns and expectations	2	1	0	
2.	**Discloses Medical Error**				
	Give a warning statement	2	1	0	
	States the error in simple words avoiding medical jargon	2	1	0	
	Pause awaiting the reaction of the patient	1	0	0	
	Showed empathy by responding to the patient's emotions	2	1	0	
3.	**Accountability**				
	Personally apologizes	3	1	0	
	Avoids excuses and blaming others	3	2	0	
	Remain calm and avoids the display of feelings of anger, and argumentation	2	1	0	
4.	**Establishes a plan**				
	State how the harm will be remedied	1	0	0	
	Reassure the patient that this error will not occur in the future with him or any other patient	1	0	0	
	State possible actions to avoid this error in the future	2	1	0	

History-Taking Station Approach

A candidate gets 1-2 minutes outside the station to read the clinical case scenario (instructions for a candidate) on the door before entering. It is essential to get yourself organized in these 2 minutes.

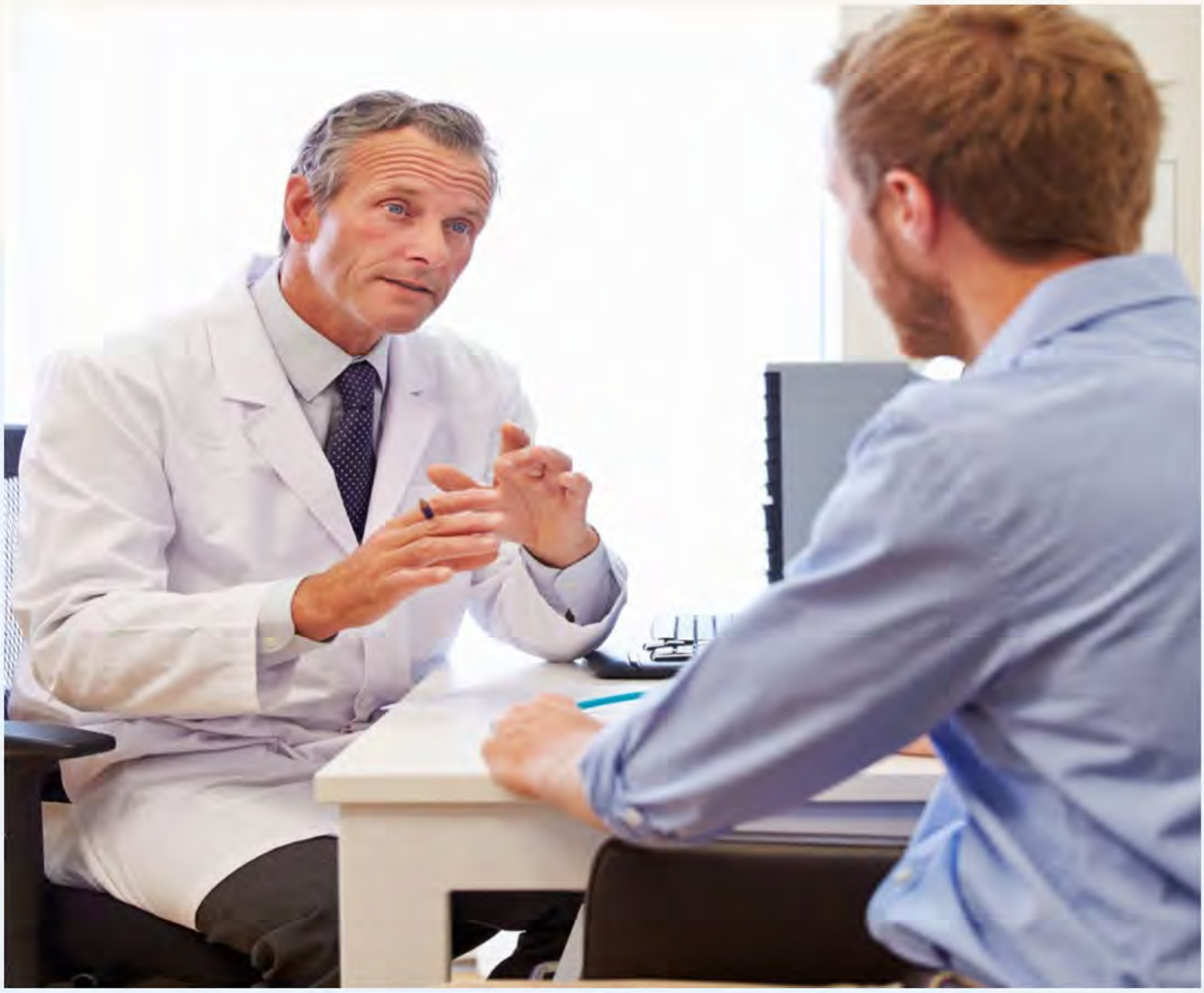
- Knock the door before entering the examination room.
- Approach the patient while smiling and relaxed.
- Greet the patient.
- Identify the patient, e.g., "*Mr./Ms. ...?*" in a questionable tone.
- Introduce yourself confidently, softly, friendly, comfortably, e.g., "*Hi, I am Dr. Tariq*". Shake hands, if appropriate.
- Mention your position, e.g., "*I am covering for Dr. Widad today*" or "*I am the physician on duty here today*".
- Ask the patient about how he would like to be addressed, e.g., "*Ms. Najat, how would you like me to address you?*".

- Ask the patient to sit down (pointing where)–if he is not already sitting or lying on a stretcher.
- Ensure the patient is sitting comfortably, alongside and not behind a desk.
- Sit approximately one meter away from the patient and in a narrow-angle.
- Confirm the reason for the interview, e.g., "*So, Mr. Ayad, what complaint has brought you here today?*".
- Begin with broad questions and then focus your inquiries. Always, start with open-ended questions.
- Do not interrupt the patient's answers off with another question.
- Show empathy, e.g., "*Oh! I am sorry to hear that, I shall try my best to help you*".
- Use non-verbal encouragement and pauses and give the patient time to answer.
- Repeat your question in different terms if necessary.
- Avoid asking questions too quickly or interrogate the patient.
- Phrase closed questions as open ones, e.g., rather than "*Were there coffee grounds in your vomit?*" try "*Was there anything different you noticed about your vomit?*".
- Ask follow-up questions, e.g., "*You said you don't drink alcohol, did you ever drink alcohol?*".

- Take a focused history based on the presenting problem:
  - History of presenting illness: relevant positives and negatives only.
  - Past medical history.
  - Medications and allergies.
  - Family history.
  - Social History–especially smoking and alcohol.
- Consider the following:
  - What organ system are you dealing with?
  - What are the likely causes?
  - What risk factors may have contributed?
  - What are the possible complications?
- Address the patient's ideas about his condition, and explore his concerns and expectations.
- If the patient dries up:
  - Repeat his last statement.
  - Don not rush, silence is good.
- In the end, if you have time:
  - Summarize back to the patient.
  - Ask if the patient has any questions or anything else that he would like to tell you.
- Thank the patient.
- At the end of the station, provide the examiner with a summary of the patient's history, including:
  - Name and age of the patient.
  - Chief complaint.
  - Relevant medical history (positives and negatives).
  - Suggest likely diagnoses and discuss further investigations and management.

Physical Examination Station Approach

- Knock the door and enter the examination room.
- Quickly screen the room: where is the patient, your chair, stretcher, and tools. Tools in the room are more likely meant to be used.
- Approach the patient while smiling and relaxed.
- Greet the patient, introduce yourself, and mention your position.
- Identify the patient.
- Wash your hands before beginning the physical examination.
- Explain to the patient what you are going to do and ask his permission.
- Tell the patient when you are going to begin the examination.
- Throughout the examination, you have to explain every step to the patient before you start.



- If the examiner is present, tell the patient: "*I'm going to explain what I'm doing to my colleague there, okay?*".
- Stand in a way that avoids obstructing the examiner's point of view as much as possible.
- Do a focused examination based on the patient's complaint or what you are asked to do.
- Always use the patient's gowns and drapes appropriately to maintain patient modesty and comfort, but never examine through the gown.
- Keep patient draped–ask permission before removing clothing. Get the patient to do as much as possible. Uncover only the needed areas and cover it back when you finish. Pay attention throughout the interview to keep unneeded body parts covered.
- Invite the patient to get dressed.
- Help the patient on and off the examination bed.

- Show consideration for pain; ask the patient if there is any pain now and where, to keep this area the last to be examined.
- If the patient is in pain or asking for a painkiller: acknowledge and say: "*I can see you are in pain. I'm going to give you some medication for the pain later if needed as I need first to examine you to figure out the cause, okay?*".
- Do not repeat painful maneuvers and apologize to the patient.
- While performing the examination, tell the examiner your findings (without looking at him).
- Try to use any given equipment if appropriate.
- If you remember something that you should have done earlier then go back and do this.
- When appropriate, tell the patient your initial impression and your plan for the diagnostic work-up.
- Educate the patient in short explanatory periods about the findings.
- Negotiate with the patient an agreed-upon plan of action.
- Arrange a follow-up meeting.
- When appropriate, ask for, and answer any additional questions.
- Thank the patient and the examiner politely.

Procedure Station Approach

Before the procedure

Generally, with any procedure, preparation of the patient (or the clinical mannequin), the environment, and the equipment has to be considered.

The patient

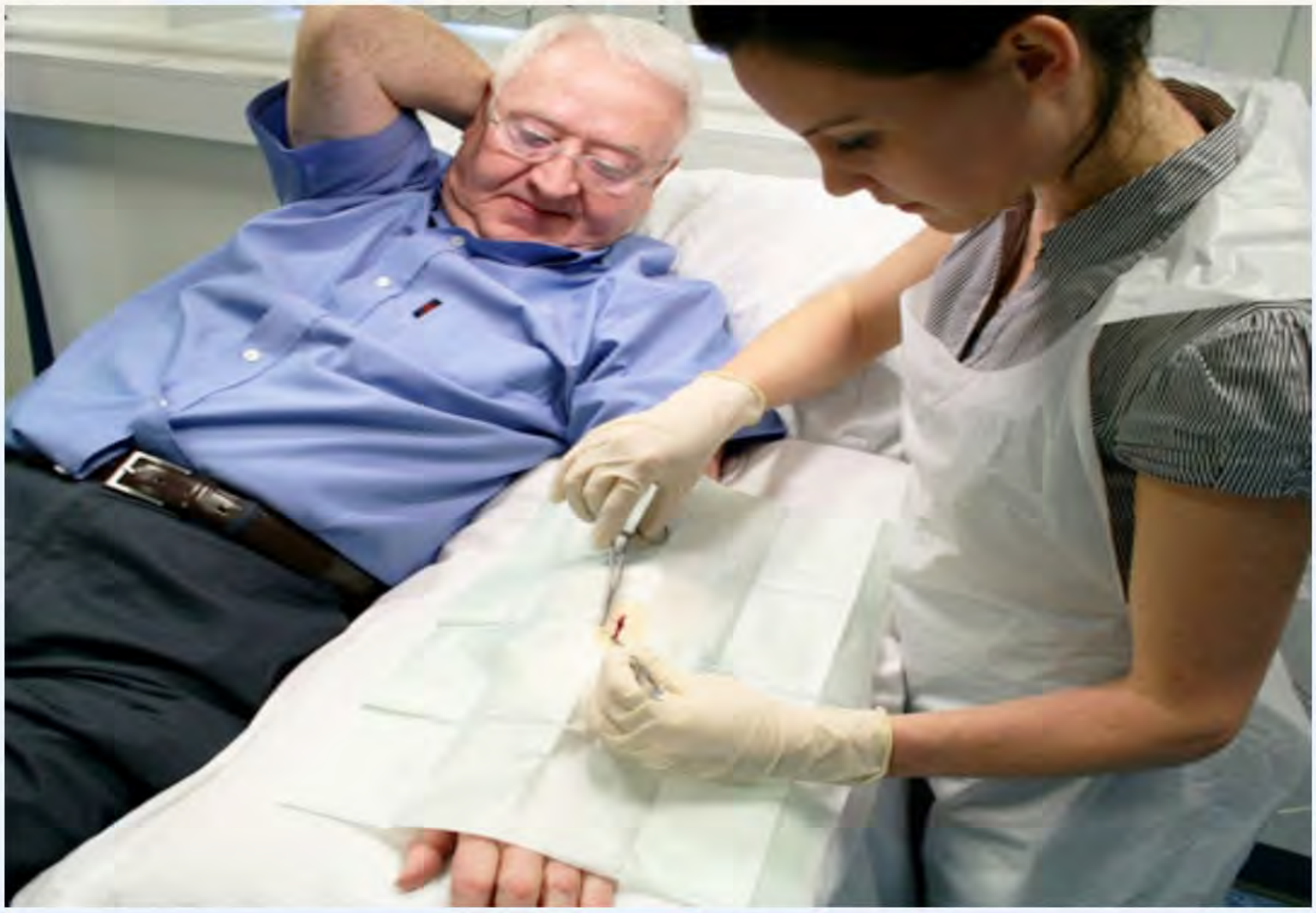
- Appear confident and introduce yourself to the patient.
- Verify the patient's identity.
- Take a very brief history from the patient if appropriate.
- Demonstrate good communication skills.
- Be empathetic and kind.
- Ask for consent to carry out the procedure.
- Explain the procedure, including why it is being done and the risk of any complications.
- Ensure there are no contraindications to the procedure or any drug being given, including allergies.
- Be organized and methodical in approach.
- Appropriately position and expose the patient (or the clinical mannequin) to access the relevant site for the procedure.
- Ensure the patient's privacy and dignity are maintained.
- Answer the patient's questions.
- Always, explain what you are doing to the examiner (step by step).

The environment

- Wash hands carefully.
- Wear appropriate personal protective equipment.
- Ensure adequate privacy and lighting.
- Ensure the cleanliness of the procedure theater.
- Ensure you have an assistant who can help you, or who you can call on for help when things go wrong.
- Ensure you are doing the procedure in an appropriate setting.

The equipment

- Read instructions carefully, understand the task from the scenario that is given.
- Ensure you have all the equipment needed to perform the procedure.
- Lay the equipment out in an easily accessible manner. It is helpful to place it in the order you are going to use it.
- Where drugs are involved, check the prescription, dose, and timing, and also check the ampoule well, including the drug name, dose, and expiry date.



After the procedure

- Clean up after the procedure and discard any rubbish.
- Safe disposal of sharps and appropriate disposal of clinical waste.
- Ensure the patient is comfortable.
- Give feedback to the patient and the examiner.
- Thank the patient.

A checklist of a blood pressure measurement station

Before the procedure		
	Wash your hands	
	Greet the patient and introduce yourself	
	Establish rapport, put the patient at ease	
	Explain the procedure to the patient and ask for his consent to carry it out	
The procedure		
	Position the patient sitting on a chair, with his arm comfortably placed at heart level	
	Ask the patient to expose his upper arm on the relevant side by rolling up sleeve	
	Locate the brachial artery at about 2 cm above the antecubital fossa	
	Wrap the blood pressure cuff around the patient's upper arm	
	Palpate the patient's radial pulse, inflate the blood pressure cuff until you can no longer feel the patient's radial pulse (estimated systolic blood pressure)	
	Place the stethoscope over the brachial artery pulse, ensuring that it does not touch the cuff	
	Re-inflate the cuff 20-30 mmHg above the estimated systolic blood pressure	
	Slowly deflate the cuff at around 2-3 mmHg per second	
	Identify the first consistent Korotkoff sounds as the systolic blood pressure	
	Identify the muffling and disappearance of the Korotkoff sounds as the diastolic blood pressure	
	Record the blood pressure as the systolic reading over the diastolic reading	
	If the blood pressure is higher than 140/90, indicate that you might take a second reading after giving the patient a one-minute rest	
	Once a blood pressure has been obtained, remove the blood pressure cuff	
After the procedure		
	Explain to the patient that the procedure is now complete	
	Ensure that the patient is comfortable	
	Discuss the blood pressure results with the patient	
	Thank the patient	
	Wash your hands	

OBJECTIVE STRUCTURED PRACTICAL EXAMINATION

Objective Structured Practical Examination (OSPE) is a new pattern of practical examination, which is derived from OSCE. It is a multipurpose evaluation tool that is widely used in the assessment of medical students in preclinical and basic medical sciences (e.g., physiology, pharmacology, biochemistry, anatomy, and the pathological sciences). The main clinical areas of medicine may also find it useful to incorporate OSPE-type stations into their OSCEs. OSPE is particularly applicable where a patient encounter is not much needed.

The reasons that necessitated the introduction of OSCE in the clinical sciences also informed the birth of OSPE, especially in the basic medical sciences. Both assessment tools are based on the principles of objectivity and standardization, which allows the assessment of the candidate's performance against standardized scoring schemes by trained assessors. The only variable in a candidate assessment exercise should be his performance and not any other confounding factors.

Several cognitive and psychomotor skills can be examined in an OSPE exercise, such as identification and interpretation of histological slides, anatomical and pathological specimens, X-ray and CT scan images, and laboratory reports. Like OSCE, the main purpose of an OSPE approach is to assess the basic practical skills of the students and to overcome the disadvantages of testing practical skills in the traditional way. OSPE emphasis on the assessment of practical abilities while the candidate is directly observed by an examiner rather than just testing theoretical knowledge. Also, OSPE has the ability to cover a large area of the curriculum and to treat all candidates in a similar manner.

Finally...

OSCE is usually considered a difficult part of medical school and board examinations. However, careful preparation will hopefully improve the likelihood of a successful outcome. It is better for the candidate to study several possible case scenarios and system examinations, and then to summarize in cards the key points for revision in a systematic and organized way.

Candidates need to practice repeatedly with fellow students, as such practice is the key to adequate performance and the best outcome. The performance of students and their time management will improve if such practice examination is observed by a trained physician who is then able to provide immediate feedback. Such practice and rehearsals should be intensified a few weeks before the examination date.

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ANNEXES

Annex A: Validity and Reliability

Validity and Reliability are considered the two most important characteristics of a well-designed assessment procedure.

Validity refers to the degree to which a method assesses what it claims or intends to assess.

Reliability refers to the extent to which an assessment method measures consistently the performance of the student, producing the same outcomes, with consistent standards over time and between different learners and examiners. It is just like a balance scale.

Annex B: The Patient's Perspective

Concepts of 'health and illness' have a strong individual component and rely on a patient's own perspective and frame of reference. That is one of the reasons when consulting a patient, the views on what the patient may consider as 'being ill' may diverge.

To the consultation, the patient brings **ideas**, **concerns**, and **expectations** (**the ICE triad**) related to his health problem. Embedded in the ICE triad are the patient's **feelings** and **emotions**, as well as the effects of the problem on his life. These areas are often grouped together and called the "**Patent's Agenda**".

The ICE triad

I: **I**deas: These are what a patient thinks and feels about his health problem, its causes, its effects, and its management.

C: **C**oncerns: These are worries and fears about the problem, its implications, and its effects on the patient's personal, family, and occupational life.

E: **E**xpectations: These are the information, the involvement, and the care that a patient expects, hopes, or wishes for and how he feels about these expectations.

The doctor must understand the patient's unique experience of illness and the personal meaning it entails. Therefore, the doctor may explicitly ask patients about their perspective.

Examples of questions about patient's perspective:

- **Ideas:**
  - What do you think is causing your health problem?
  - Why do you think that is happening?
- **Concerns:**
  - What are you worried that it might be?
  - What was the worst thing you were thinking it might be?
- **Expectations:**
  - What are you hoping we might be able to do for this?
  - How best might I help you with this?

Annex C: The SOLER method

One researcher (Gerard Egan) describes what he refers to as 'micro skills', which doctors can use when listening to their clients. These skills are summarized by Egan in SOLER method. This method shows how active listening can be demonstrated to others. SOLER method is not hard and fast rules that must always be obeyed but it encourages more open communication.

The SOLER method

S: **S**it squarely in relation to the patient. This sends a message that the doctor is ready to listen.

O: **O**pen posture. Open body language indicates more attentive listening. This means not folding arms, etc.

L: **L**ean forward towards the patient. This indicates an interest in the patient's words.

E: **E**ye contact. The doctor must maintain good eye contact with the patient.

R: **R**elax. A relaxed posture of the doctor puts the patient at ease.

Annex D: Showing Empathy

Empathy' is the ability to see the world through another person's eyes and perceive his emotions. It means that the doctor understands how the patient feels and understands problems from a patient's perspective. The patient will almost always tell the doctor how he is feeling, even when he is trying not to. Either through verbal or non-verbal means, the patient will communicate. Thus, the doctor must be an effective listener and observer.

Empathy is a two-stage process: First, clarifying and gaining both a clear understanding and appreciation of another person's situation or feelings. Second, communicating that understanding back to the patient in a visible and supportive way. Many doctors go halfway. They may acknowledge and be sensitive to a patient's situation, but they often do not visibly show it. The real key to empathy is the overt demonstration and expression of sensitivity to the patient in a way that the patient perceives the doctor's support.

Once a doctor has identified his patient's feelings, he must respond with understanding and acceptance. Responses may be as simple as "I understand", "That sounds upsetting", or "You seem sad". Empathy may also be non-verbal. For example, when a doctor offers a tissue to a crying patient or gently placing his hand on a patient's arm to show understanding. Importantly, the doctor must learn and then integrate the use of empathetic statements into his own natural style so that it is genuine.

Annex E: The Patient's Hidden Agenda

The 'Hidden Agenda' may be defined as "*the covert conscious or unconscious ideas, concerns, expectations, and feelings that underlie a patient's request for a medical consultation*". Every patient who seeks help from a doctor has some expectations of his doctor and feelings and fears about his problem. Some of these emotional concerns may be explicit but a large part may not be.

An important objective of a medical consultation is to understand as much as possible these emotions, in particular, the hidden ones. Unless the doctor is able to fathom these, the patient may only be left with therapy that will treat his most obvious symptoms but not resolve the underlying problems.

Thus, an important objective of a consultation is to go beyond the physical diagnosis of the patient's illness and to make a comprehensive biopsychosocial diagnosis of his problems to eventually uncover the patient's hidden agenda.

Importantly, mastering communication skills, especially Attentive listening, may enable the doctor to recognize and address the hidden agenda of his patients. Appropriate use of these skills can help both doctors and patients to gain more from the interview without increasing the length of the visit.

How To Pass Your OSCE

Ahmed Khairi Mshari, MD

The OSCE has been introduced by some medical schools as a more objective measure of clinical performance than a conventional clinical examination. During an OSCE, candidates are expected to perform a variety of clinical tasks in a simulated setting while being assessed by examiners using standardized rating instruments.

Almost, any skill or competency in medical education can be assessed in an OSCE exercise. However, it is impossible to cover all the possible conditions that could appear in OSCEs. Thus, this booklet covers some of the more frequent encounters and also provides a candidate key skills to improve his general technique so that he can better adapt to different situations.