Objective Structured Clinical Examination Introduction

1

Mubashar Hussain Sherazi

Introduction to the Objective Structured Clinical Examination

Since it was described and published in 1975 by Harden and his colleagues, the objective structured clinical examination (OSCE) has evolved into a modern testing tool for evaluation of the clinical skills of physicians and medical students [1].

The OSCE has been integrated into the licensing and evaluating examination systems of medical education and licensing authorities around the world.

In Canada, two important examples of the OSCE are the final licensing exam of the Medical Council of Canada Qualifying Examination Part II (MCCQE II) and National Assessment Collaboration OSCE (NAC OSCE), which has become a mandatory requirement for most of the provisional licensing colleges for international medical graduates (IMG) applying for residency training through the Canadian Residency Matching Service (CaRMS). Similar OSCE examinations are conducted by various colleges for international medical graduates for practice-ready assessments in Canada [2–4].

In the USA, the US Medical Licensing Examination Step 2 Clinical Skills (USMLE Step 2 CS) is one of the required licensing exams and is essentially an OSCE [5].

In the United Kingdom, the Professional and Linguistic Assessment Board (PLAB) Part II and Membership of Royal College of General Practitioners (MRCGP) clinical skill assessment also have a similar OSCE pattern [6, 7].

The Australian Medical Council Clinical Examination is an integrated multidisciplinary structured clinical assessment consisting of a 16-component multi-station assessment. It assesses clinical skills in medicine, surgery, obstetrics, gynecology, pediatrics, and psychiatry. It also assesses the ability to communicate with patients, their families, and other health workers [8].

The OSCE is also widely used all over the world as an important part of clinical clerks/medical students' evaluations in medical schools.

The main advantage of the OSCE is its ability to assess candidates' multiple dimensions of clinical competences:

- History taking
- Physical examination
- Medical knowledge
- Interpersonal skills
- Communication skills
- Professionalism
- Data gathering/information collection
- Understanding about disease processes
- Evidence-based decision-making
- Primary care management/clinical management skills
- Patient-centered care
- Health promotion
- Disease prevention
- Safe and effective practice of medicine

The OSCE uses standardized patients. The examiner either observes in person or the scenarios are recorded for the examiners to later watch the interaction between the candidate and the standardized patients. The candidates will be assessed throughout the station from entering into the room till they finish the station and leave the room.

What to Expect in OSCE?

The OSCE consists of a circuit of a number of stations (10–14), each lasting 5–15 min. Please read and follow the guidelines for your particular OSCE. The candidates are required to rotate through each station. Each station starts with the station's information printed on a piece of paper (candidate's

M. H. Sherazi
Mallacoota Medical Centre, Mallacoota, VIC, Australia

M. H. Sherazi, E. Dixon (eds.), *The Objective Structured Clinical Examination Review*,
https://doi.org/10.1007/978-3-319-95444-8_1

information) placed on the door outside of the respective station. Candidates are given a few minutes to read and prepare notes before entering each station. Candidates are expected to perform one of the following or in some stations more than one:

- Obtain a focused or detailed history.
- Focused or detailed physical examination.
- Assess and address the patient's issues.
- Answer specific questions related to the patient.
- Interpret X-rays, electrocardiograms (ECGs), blood gases, or the results of other investigations.
- Make a diagnosis.
- Write admission orders.
- These examinations include problems mostly in [2]:
  - Medicine
  - Pediatrics
  - Obstetrics and gynecology
  - Preventive medicine and community health
  - Psychiatry
  - Surgery
  - Musculoskeletal system

Each station has an examiner and a simulated patient trained for the particular scenario. The examiner assesses the candidate's skills on a standardized checklist provided by the examining body.

How to Prepare? The OSCE is best prepared by joining a study group or with at least 2–3 study partners. Study groups for the OSCE are invaluable. I remember, when I was preparing for an OSCE in Canada, we use to study twice a week for 4–5 h each day and then practice scenarios once a week. Proper feedback and criticisms are also crucial while practicing OSCE scenarios. Some people feel comfortable to do counseling and history taking on video calls, and they practice mostly on these. Each member can also contribute in making common presentations that they know well and then they can challenge the rest of the group with these. Then the group can also discuss and assess each other.

Make a Study Plan

It is important to make a study plan well ahead of the examination day. Some people prepare for about 6 months, 2–3 months of just individual studying and the rest practicing in a study group. It varies individually, depending on your clinical training, practice experience, clinical knowledge, and understanding of the particular OSCE.

Identifying the objectives that you think you need the most to study is vital. Focus on common and critical patient presentations. Making a list of the most important differential diagnoses, creating checklists, and asking the most relevant questions in a limited time frame are crucial for time management. While practicing, if you think that you are not doing well on a certain topic, then simply spend more time on it and discuss it in your study group.

Develop Your Interview Skills

This is one of the most important components of any OSCE. Clinical knowledge, fluency and grasp of the English language, and practicing before the actual exam are key components of developing interview skills. In the OSCE there is a finite amount of information that one needs to know to get through the exam. It is all about prioritization and strategic thinking. So in any situation, you must remember what checklists or key questions are important and not to be missed.

Are There Books and Courses About the OSCE?

For many OSCE exams, there are not many recommended books or specific reference materials. You can still find recommendations about OSCE study guides in various online study groups and from doctors who have already taken these OSCEs. There are no approved preparatory courses. Some medical faculties offer programs. Some candidates find these courses very helpful, and some do not. In most of these courses, I think you will have an opportunity to become familiar with the OSCE pattern and format.

Day of Examination

Some general tips for your day of OSCE:

- Make sure you get enough sleep before the examination day and you are well rested.
- Examination anxiety is your biggest enemy, so try to remain cool and calm.
- Avoid preparing up to the last minute. I recommend you finish your study and practice about 24 h before the exam.
- Be confident and do your best.
- Do not use a sedative the night before.
- Set multiple alarms and ask someone to check on you to make sure that you wake up on time. Give yourself ample time to get ready for the examination. If your examination is in the morning, make sure you have a good breakfast. If your examination is in the afternoon, then have a good lunch but not too much. If you are in the habit of drinking coffee or tea, do have one as per your normal routine.
- Dress well, business formal dress code. I personally like a suit and tie with an appropriately matched shirt, belt, and shoes. The most important fact about clothing is to *always* try wearing your expected attire before examination day. Check for size, comfort, stains, or difficult to remove

wrinkles. Try not to wear expensive watches or jewelry. Many OSCEs instruct candidates not to wear any perfumes; make sure you follow the instructions. For female colleagues, try to avoid extensive makeup, high heels, sandals, facial piercing, or strange hairstyles.

What to Bring to the OSCE?

- A stethoscope (nonelectronic)
- A reflex hammer
- A plain white lab coat without a university or hospital crest (check size and fitting before the exam)

Registration and Orientation

Follow the examination instructions. Arrive on time and bring any necessary documentation such as a government-issued identification (ID) or admission card. Your personal belongings such as keys, papers, wallets, cell phones, as well as coats will be collected. So try to bring minimum stuff with you to the examination center. These items will be stored until after the examination.

Get your identification badge, stickers, and in most of the examinations a small notebook will be provided. You can write notes while taking the examination. Only one notebook will be provided, and no pages can be added. The notes in the notebook will not be scored. This notebook must be returned intact at sign-out. No pages or parts can be torn or ripped out.

Exam Security

Once the examination starts, candidates are not permitted to talk to other candidates. There should not be any access to any communication devices. Some OSCEs will not permit you to wear watches of any kind during the examination. You can time yourself with clocks placed in each room.

How to Begin Your OSCE Station?

Finally, you are in your OSCE exam. You are standing in front of the first station with your back toward the door with the first station stem pasted on it. You are hearing the instructions and countdown to start the first station.

This is the time to run a *quick checklist:*

- Take few deep breaths and make yourself relax.
- Is your exam *ID badge* attached well on your pocket?
- Is your *pencil* ready to write?
- Have you prepared a new sheet on *your notebook?*
- Do you have *stickers* ready for the station?
- Have you secured the rest of the stickers for the next stations in your lab coat?
- Is your *stethoscope* and *hammer* properly placed in your pockets?

The bell will ring, and you will be asked to turn to the door and then read the stem (Box 1.1). The exam will start. ***READ THE INSTRUCTIONS CAREFULLY.***

Box 1.1 Candidate Information/Doorway Information

A 35-year-old female, Miss XYZ, presented in your clinic with low mood. Obtain a detailed history and address her concerns.

What to remember/write on your notebook from the stem on the door of station?

- Patient name and age
- Chief complaint
- Purpose of visit
- Setting (clinic or emergency room)
- Also if patient was brought by someone else
- What is the station asking for: history only or history and physical examination or history and counseling or physical examination only

I will break down the patient information like this (Box 1.2).

Box 1.2 Make a Plan in Your Mind

A **35-year-old female**, **Miss XYZ**, presented in your **clinic** with **low mood**. Obtain a **detailed history** and address her **concerns**.

How to Plan?

After reading the stem, ask yourself:

- Which system is involved?
- Formulate ~3 differential diagnosis.
- What are three to four important relevant questions that MUST be asked to rule out the differentials?
- Any mnemonics or words you want to go through during the station.
- Quickly review some important questions or sequence you want to use (Box 1.3).

Box 1.3 What to Write in Your Notebook

Miss. XYZ
Age: 35
History and concerns
Setting: clinic
Low Mood
Depression (mnemonic for screening or questions)

Abuse
Hypothyroid
Don't Forget
Safety check
Drug History
Contract to contact

Take a deep breath and tell yourself: "I am ready and I will do this well."

The bell will ring or you will be asked to move to your first station.

Starting the Interview:
Knock on the door. Go into the room with a smile and confident face.

In some of the OSCE, it is required by the candidates to give two name/exam registration number stickers/labels to the examiner before starting the interview. Greet the examiner and hand over the required stickers.

The next thing will be hand-wash or alcohol rub. It is very important for physical examination stations. If using a hand sanitizer, then try not to put too much on your hands. Try to rub it into the palms quickly. Make sure your hands are dry if a patient offers a handshake. If you forget to clean your hands at the start, but remember while starting a physical examination, then ask for sanitizer if you cannot find it or wash your hands.

Patient Interaction
Greet and introduce yourself and state your role/position in the patient's evaluation. Confirm the ID of the patient by asking for the patient's name and age. You can have a quick peek at your page and read the patient's name again before asking. Ask the patient how he or she wants to be addressed? As the history questions start, confirm the source and reliability of the historian.

Mention the purpose for the visit.

Explain to the patient whether you will be taking an interview or will be doing a physical examination or both.

Example Opening the Interview
There are many ways to open the discussion/interview. Here are a few examples for the opening lines. It can be modified according to the station requirements and for adequate time management.

History Station
"Good morning/good afternoon. I am Dr..... I am your attending physician for today.

Are you Mr./Mrs./Miss…? Are you… years old?"

Pattern 1:
In some stations, the stem information might not have a chief complaint, or sometimes there are more than one presenting complaints. If you are not sure how to start, in these situations, the best way to open up the conversation is:

> "What brings you to the *hospital/clinic* today?" (It is very important to remember in which setting you are examining the patient.)
> Or
> "How can I help you today?"

Then allow the patient to talk and listen carefully. The patient will speak about the chief complaint and some vital information about the history of the present illness. The patient may tell about the purpose of the visit or any concern. During this time, one should formulate and rearrange the list of questions and differentials.

Before asking further questions about the details of the chief complaint, I like to ask the patient: "Is it alright if I ask you some questions about it? At the end we will discuss about the treatment plan and if you have any questions or concerns, please feel free to ask during the discussion."

Pattern 2:
If the chief complaint is obvious from the stem, then the usual start should be, for example:

History and Physical Examination Stations:
"Good morning/good afternoon. I am Dr..... I am your attending physician for today. Are you Mr./Mrs./Miss…? And you are…years old?

"I understand you are here because of …"

"Is it alright if I ask you a few questions? I would also like to do a relevant physical examination of…. In the end, we will discuss about the management plan."

"During the history or examination, if you have any questions or you feel any discomfort, please let me know."

For examination stations, have a look around the room. What tools are available? If any tools are there, it is likely that the examiner wants you to use these.

History and Counseling Stations:
"Good morning/good afternoon, I am Dr..... I am your attending physician for today. Are you Mr./Mrs./Miss… ? And you are… years old? I understand you are here because of….. Is it alright if I ask you some questions about it? Then in the end, we will discuss about the management plans and will also discuss if you have any concerns. Do you have any questions?"

If a Patient Asks a Question or Expresses Some Concern Before the Interview Starts:
The interview should always start with an open-ended question. Sometimes the patient may ask a question or reveals

some concern in the start. In this situation, that concern or question should be addressed first before exploring the history of present illness.

Example:
Station: Patient with Fatigue. The patient may ask, "Doc, why I am so tired these days?" This question/concern must be addressed before asking any other question. One way of responding to this question is, "I understand you are here because of fatigue. As I am seeing you for the first time, let me ask you a few questions and let's sort out why you have this fatigue and then we can deal with it accordingly."

How to Build Rapport with the Patients?

Building a good patient rapport is one of the important steps that will determine the overall outcomes of your interaction with this patient.

Following are a few tips that can help you make a quick and better rapport with the patients.

Know Your Patient: The patient's interview starts when you start the introduction, asking patient name, ID, and age. Then ask, "Mr./Miss… how would you like me to address you?" This one question can help during the rest of the interview in making the patient comfortable and relieving anxiety about seeing a new doctor.

Calmness: We must try our best to be in control of the communication, remain calm, and look competent and confident.

Empathy: We should be able to empathize with our patients. We must use sentences such as, "It must be hard for you" or "It must be a frightening experience!" These will make good bridges.

Communication is another integral component of a good doctor–patient relationship. Communication skills help us to understand a patient's needs, concerns, and thoughts. You will be able to find hidden agendas. In almost all the OSCE stations, your communication skills will be assessed. But in some stations, communication skills will be the main skill that will be assessed by the examiner.

The key components of OSCE where communication skills are considered to be important are:

- Getting informed consent
- Decision-making stations
- Breaking bad news
- Dealing with anxious patients or relatives
- Communicating with family members and relatives
- Describing and explaining diagnosis, investigation, and treatment
- Giving advice on lifestyle, health promotion, or risk factors
- Communicating with other healthcare professionals
- Giving instructions on discharge

Communicate Well: Effective communication between a doctor and a patient is the keystone of establishing a trustful relationship. It is important to analyze if the patient is understanding the questions and giving relevant answers. Be a good listener. You must listen carefully while the patient is describing the concerns. You should assess and respond accordingly to verbal and nonverbal body language. Keep good eye contact, respond with appropriate facial expressions, and respond to the patient's verbal and nonverbal cues during the interview.

Anticipate Their Concerns: Try to address the patient's concerns. This will express that you care and you want to provide the best possible care to the patient.

Educate: A doctor should also be a scholar. As stated by the Royal College of Physicians and Surgeons of Canada, "As scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others" [9].

Patients want us to educate them regarding their disease or health issues, and they want to know about the treatment plans. It is important to counsel patient about their diagnoses and treatment plans. Besides having a discussion, we can offer reading material, websites, and community resources.

Follow-Up: To build a long-term relationship with the patient, it is essential to make an appropriate follow-up plan with the patient. It will show that you care.

How to Conduct a Good Interview?

A good interviewer should have the following approach:

- Be professional.
- Mature.
- Be positive.
- Be polite.
- Be understanding.
- Express or offer support.

- Show respect.
- Not being judgmental in approach.
- Patient-centered approach.
- Maintains and offers confidentiality.
- Not be assertive, dominating, or use sarcastic language.
- Maintain good communication skills.
- Ready to educate patient.
- Avoid medical jargon.
- Willingness to discuss patient concerns.
- Take care of patient comfort.
- Show empathy and support.
- Be a good listener and avoid unnecessary interruption.
- Controls temper in difficult situations.
- Respects and interacts positively with colleagues.

Details of History Taking

Quick Recap:

First step was to read and analyze the candidate information.

Second step was starting the interview:

- Knock on the door.
- Enter the station.
- Hand-wash/alcohol rub
- Greet the examiner and the patient.
- Give stickers to the examiner if required or show your ID badge.
- Now sit on the chair or stand on the right side of the patient and start the interview.

Third step:

Opening: "Good morning/good afternoon. I am Dr.…. I am your attending physician for today. Are you Mr.…. And are you… years old?"

Fourth step: Start with the chief complaint and continue with the rest of the history:

- **Chief complaint:** It is the presenting complaint in the patient's own words.
- **History of present illness:** If following pattern 1 (already mentioned), then the interview has already started. While listening carefully, the patient will give initial information. The patient will provide important information, and while listening you should tailor your next questions. Please do not interrupt the patient unless the patient starts talking about something that is not clearly related to the presenting or chief complaint.

If following pattern 2, then the first question should be asked regarding the chief complaint, and usually it is about its ONSET. The first three questions usually related to the chief complaint are its onset, course, and duration. At times the patient may have given answers for these three questions in his/her initial statement. If not, then you can start with onset.

Onset:

- "How did it start?"
- "Did it start suddenly or gradually?"

Course:

- "Did it change since it started or has it stayed the same?"
- "Was it present all the time? Or does it come and go?"

Setting:

- "What were you doing when it started?"

Duration:

- "When did it start? How long have you been feeling sad/tired/fatigued/anxious?"

Character:

- "Can you please explain it more?"

Frequency:

- "How often does this happen?"

Timings:

- "Any particular timings?"

Events Associated:

- "Can you please tell me, is there any particular event that has triggered your symptoms?"

Relevant Associated Symptoms:

- "Did you notice… (name any other symptoms of the same systems or from other systems that may coexist)?"
- Can also ask here about fever, chills, or weight loss.

Relieving Factors:

- "Does anything relieve the symptoms?"

Precipitating Factors or Aggravating Factors:

- "Does anything aggravate the symptoms?"

Functional status or severity or impact on life activities?

Rule Out:

- Differentials

How to Interrupt the Patient if Going Off Track While Giving History:

"Excuse me, Mr./Mrs./Miss…. I understand that these are important issues, but I would like to ask some additional

questions of your current problem so we can come to a management plan."

Review of Systems: It can be done at the end of the present illness questions:

- **Gastrointestinal tract**: Nausea, vomiting, diarrhea, constipation, change in bowel habits, acid reflux, appetite, blood in vomiting or bowel movements, and jaundice
- **Respiratory**: Cough, wheeze, sputum, hemoptysis, and chest pain
- **Genitourinary**: Hematuria, change in color of urine, dysuria, polyuria, change in frequency of urine, nocturia, and anuria
- **Cardiovascular**: Chest pain, palpitations, dyspnea, syncope, orthopnea, and peripheral edema
- **Neurology**: Problems with vision, headache, motor or sensory loss, loss of consciousness, and confusion

Constitutional Symptoms: Fatigue and malaise, night sweat, fever, and weight loss.

Risk Factors

Past Medical and Surgical History:

- "Any medical and surgical illnesses?"
- "Do you have any previous health issues?"
- "Do you have any health issues related to your lung, heart, or kidney?"
- "Previous blood transfusion?"
- "Have you had any previous hospitalization or previous surgery?"
- "Emergency admission history?"

Medication History: "Are you taking any medication prescribed, over the counter or herbal? If so, have there been any side effects?"

Allergic History: "Do you have any known allergies?"

Past Psychiatry History: Previous psychiatric illness, diagnosis, treatments, and hospitalizations.

Social History:

- "Do you smoke? Or does anyone else in your home or close at work smoke?"
- "Do you drink alcohol?"
- If yes, then ask further questions: "How much? Daily? How long?"
- "Have you ever tried any recreational drugs?"
- If yes, "Which ones? How long? When?" Specially ask about intravenous (IV) drug use.

Foreign Travel: "Any recent travel?"

Relationships: "Are you sexually active? Do you have sex with men, women, or both?"

Family History: "Now I am going to ask some questions about your family."

- "How is your family like?"
- Relationship with the family members?
- Any mental illnesses present/past, alcohol, drugs, criminal, suicidal attempts?
- "Do you have family members or friends to discuss your problems?"

Personal History:

- "Please tell me about yourself." (Can be asked in any sequence, marital status, occupation, and religion)
- "Do you have problems at work? How are you doing at work?"
- "Do you have any recent event in the family such as an accident or someone died?"

Self-Care and Living Condition: "What do you do for living? Working status and occupation? Educational status? Who lives with you?"

Support: "Do you have good support from your family and friends?"

Functional status or severity or impact on life activities.

If the patient is a child, add questions about **BINDES** (birth history, immunizations, nutrition, development, environment, and social) here:

Birth History:

Birth history includes prenatal, natal, and postnatal histories. You need to tailor the prenatal, natal, and postnatal questions according to context. If the birth history is not relevant to the presentation of the child, then one general question will be sufficient such as "Any issues with the pregnancy/birth of the child?"

- **Prenatal**:
  - "Was it a planned pregnancy?"
  - "Did you have any regular follow-up?"
  - "Did you have any ultrasound scans? Was it normal or not?"
  - "During your pregnancy did you have any fevers or skin rash?"
  - "Any contact with sick person or cats?"
  - "Any medication, smoking, drugs, or alcohol?"
  - "Screened for human immunodeficiency virus (HIV), syphilis, group B strep (GBS), hepatitis B? Blood group?"
- **Natal (Delivery):**
  - "Term baby or not?"

  - "What was the route?" C-section (C/S), spontaneous vaginal delivery (SVD), or assisted vacuum delivery (AVD)
  - "How long was the labor/delivery?" (18 h is normal for primi, 12 h for multipara)
  - "Early gush of water?" (premature rupture of membranes)
  - "Any need for augmentation/induction?"
  - "What was the Apgar score?" (1 and 5 min)
  - "Did the baby cry immediately?"
  - "Did your baby need any special attention/admission to special care?"
  - "Any bulging or bruising on baby's body?"
  - "When were you sent home?" (C/S 3 days, SVD 1 day).
  - "After delivery did you have any fever, vaginal discharge, or on any medication?"
  - "Were you told that your baby had any congenital deformity?"
- **Natal (Birth):**
  - Vaginal or CS
  - Spontaneous or assisted labor (i.e., forceps delivery)
  - Premature rupture of membranes (PROM) or fever
  - Baby: full term/preterm, weight at birth, Apgar score if known
  - Did the child need any resuscitation at birth?
- **Postnatal or Newborn Period:**
  - Mom: fever, bleeding, or any other complication
  - Baby: jaundice, screening tests, congenital anomalies, suckling, and weight gain

Immunization

If the parent states that the child is not immunized, you need to inquire for the reason. If the child is not vaccinated due to a reason that points toward neglect, then look for child abuse red flags. Inquire further about weight gain and developmental milestones. If it is due to religious beliefs, you do not have to inquire further. Otherwise, move on to nutrition.

Nutrition:

- Mom's medications
- Complications during pregnancy such as diabetes, bleeding, or hypertension
- Multiple pregnancies
- Infections such as TORCH – Toxoplasmosis, Other (syphilis, varicella zoster, parvovirus B19), Rubella, Cytomegalovirus, Herpes
- Mom's age
- Planned or unplanned pregnancy
- Weight:
  - What is the current weight
  - Birth weight
  - Maximum weight
- Is the child breast fed? Or bottle fed?
  - Frequency, amount, supplement, formula fortified, weaning
    If formula, then ask about type/brand.
- Growth charts (height, weight, head circumference)
- Feeding:
  - Formula:
  - "When did you start the formula?"
  - "Was baby ever breast fed?" If yes, then ask, "Why stopped?"
  - "Did you consider breast feeding?"
  - "What type of formula do you use?"
  - "Has there been any change in the feeding? Did you add any solid food or supplements (any fortified serials or iron)?"
- If any diarrhea, when did it start (before the solid food or after)?

Development History:

- Gross motor, fine motor, vision, hearing/speech, and social
- Are they developing according to their milestones? For example:
  - Six months: head control, grasp a toy, generalized reactions, smiles, and babbles
  - Eighteen months: sitting without support; walking/running, good fine motor control (swapping objects/turning pages); 1–15 words and has self-awareness
  - Thirty months: jump, go up/down stairs without assistance, symbolic thought
- Are they growing along growth centiles?
- How do they compare to their siblings?
- Any comments from their teachers at school or daycare?

Environment:

- "With whom does the child live at home?"
- "Any other children?"
- "Relation between your child and others?"
- "Who spends most of the time with the child?"
- "Financially how do you support yourself?"
- "Do you live in your own house?"
- "Does anyone at home drink or use drugs?"
- Building – basement (mold)
- Old houses (lead poisoning)
- Children attending school:
  - School performance: comparing the grades between now and previous

If the patient is a teenager, then add these questions here:

Home:

- "How is your living like?"
- "Who lives with you?"

- "Are your parents married, divorced, or separated?"
- "How long you have been living in your current residence? What does your parent do for work?"

Education:
- "Which grade you are in?"
- "What school do you go to?"
- "How are your grades?"
- "Do you like going to school?"
- "Have you made any future plans in studies?"

Employment:
- "Are you currently working?"
- "What kind of work do you do?"
- "How many hours in a week?"
- "Future career aspirations?"

Activities:
- "Do you have friends?"
- "Do you have a best friend?"
- "What do you do outside of school?"
- "Any hobbies?"

Alcohol:
- "People your age sometimes have problems with excessive drinking. Do you ever have such problems?"
- "Do your friends bring alcohol to the parties you attend?"

Diet:
- "People your age sometimes they have concerns about their body weight, shape, and image? Do you ever have such concerns?"

Drugs:
- "People your age sometimes experiment with street drugs. Have you ever tried street drugs?"
- "Do your friends experiment with street drugs or bring any drugs to school or parties?"

Sexual Activity:
- "Are you in a relationship? Are you sexually active?"
- "Some people your age are uncertain about their sexual orientation. Do you have any concern about it?"
- "Do you know about sexual or physical abuse? Have you ever experienced or had any event that is concerning?"

Suicide:
- "Have you ever thought about harming or killing yourself or others?"
- "Any current plans?"
- "Any previous attempts?"

If the patient is more than 65 years old, add these questions here:

Activities of Daily Living (ADLs):
- **Walking**: Getting around the home or outside. Also labeled as ambulating.
- **Transferring**: Being able to move from one body position to another. This includes being able to move from a bed to a chair or into a wheelchair.
- **Dressing and grooming**: Selecting clothes, putting them on, and managing one's personal appearance.
- **Feeding**: Being able to get food from a plate into one's mouth.
- **Bathing**: Washing one's face and body in the bath or shower.
- **Toileting**: Getting to and from the toilet, using it appropriately, and cleaning oneself.

Instrumental Activities of Daily Living (IADLs)
- **Finances**: Such as paying bills and managing financial assets.
- **Transportation**: Driving or by organizing other means of transport.
- **Shopping and meal preparation**: Getting a meal on the table. It includes shopping for clothing and other items required for daily life.
- **Housecleaning**: Cleaning kitchens after eating and keeping one's living space clean and tidy. Keeping up with home maintenance.
- **Communication**: Using telephone and mail.
- **Medications**: Obtaining medications and taking them as required.

- Any problem with balance?
- Any difficulty in peeing/urination?
- Any issues with sleeping?
- Any change in vision/hearing?
- Any recent change in memory?

Wrap Up:
- Describe the diagnosis.
- Management plan.
- Laboratory tests.
- Possible medical treatment.
- Duration of treatment and side effects.
- Further information: websites/brochures/support groups or societies/toll-free numbers.
- Follow-up.
- Contract for safety.

Tips for a Good Physical Examination

The details of different physical examinations will be discussed later in different chapters. There will be at least one but most of the time two or up to three examination stations in the OSCE. You will be asked to actually examine a simu-

lated patient. Some patients may have positive signs, and it is very important to pick up these signs during the examination.

Here are few tips to improve your physical examination skills:

- Practice, practice, and practice before the actual examination.
- An important thing to practice is explaining and taking consent from a patient about a particular examination. You should be able to answer and describe: Who are you? What examination will you be doing? And why are you doing this examination?
- Proper draping and appropriate positioning.
- Taking care of the patient's comfort throughout the examination.
- Practice well all the major systems and joints (back, hip, knee, foot, shoulder, hand, elbow).
- There are great videos on physical examinations online; use these as guides and quick references. It is recommended to watch these videos multiple times; it will add to your memory and quick reviewing.
- Try to time yourself with a stopwatch and assess how much time you are requiring to complete an examination and how much time you will actually have in the real examination. Then try to practice in time mode and improve your timings for each examination.
- Organize yourself and opt for a systematic approach to save time, for example, in the general physical examination, always start from the hand, check the pulse and blood pressure; face; neck; chest; and so on.
- Do not carry out genital, breast, or rectal examinations. Even in the scenario, if you need to do a particular exam, just mention it and the examiner will give you the findings or will say it is normal.
- If an oral question is required, then it is better to ask the examiner instead of the patient.
- Recognize the manifestations of a disease and then apply your knowledge to look for specific signs of disease manifestations. For example, in acute appendicitis, feel for right iliac fossa tenderness and rebound tenderness.

Navigating Through the Stations During the Examination

In the orientation session, you will be told about navigating through the examination. Usually signs will be posted to help you navigate the exam. There are staff members who can also show you which way will be your next station. Sometimes there will be a rest station. The most important thing not to do in the rest station will be thinking about the previous stations. Try to relax, drink some water, check your tie knot, check your labels, check your tools, and be ready for the next station.

If you finish the patient encounter early, you must wait quietly. If you remember something more that you would like to do, you may re-engage the patient at any time until the final signal/announcement – except in stations with oral questions.

A set amount of time is allowed for moving to the next station and for reading the posted instructions. During this time, remove the bar code identification label from the sheet, to have it ready to give to the examiner. At the sound of the signal, enter the room and proceed with the required task.

Document Writing

Candidate Information:
You have been working as a resident in general surgery. You have just attended a patient with acute diverticulitis, acute appendicitis, or acute cholecystitis. Please write admission notes. Or a patient presents with abdominal pain (RUQ, RLQ, or LLQ), please take a brief history and write admission notes.

The history should be very clear to direct you to a diagnosis, and the examiner may give you positive examination findings or an imaging report, for example, a computed tomography (CT) scan of the abdomen confirming a diagnosis.

Starting the Scenario:
- Knock on the door.
- Enter the station.
- Hand-wash/alcohol rub.
- Greet the examiner and the patient.
- Give stickers to the examiner if required or show your ID badge.
- Sit on the chair or stand on the right side of the patient and start the interview.

Abdominal pain scenarios have been discussed in detail in Chap. 9 on general surgery. Here we shall only focus on admission note or order writing [10].

You will be given a pencil or pen and a blank piece of paper on which you will write the admission note for one of the aforementioned scenarios (see Table 1.1).

Table 1.1 An example of how to write an admission note

DATE:

CHIEF COMPLAINT: Abdominal pain…….. hours/days/months

History of present illness:

Site

Onset

Course

Duration

Character

Radiation

Alleviating factors

Exacerbating factors

Severity

Similar pain before

Nausea

Vomiting

Diarrhea

Constipation

Loss of appetite

Black/bloody stools

Sick contacts, Suspicious food consumed

Fever/chills, SOB, Chest pain, Headache

Dysuria

Past medical history:

Past surgical history:

Medications:

Allergy:

Family history:

Social history:

PHYSICAL EXAMINATION:

Vitals:

General physical examination:

HEENT:

Neck:

Respiratory system:

Cardiovascular:

Abdomen:

Neurology:

Labs ordered:

Imaging results/ordered:

ASSESSMENT/IMPRESSION:

- Abdominal pain due to……

PLAN:

Admit to General Surgery under Dr……

- NPO apart from meds
- IV fluid: D5 0.5% NS at 125 ml/hr x 2 L
- EKG
- Urine C+S
- Morphine 2 mg IV q 2-4 hr PRN pain
- CT abdomen and pelvis with contrast
- GI consult

Signature:

Dr …… *Time and date*

Admission Orders: Acute Diverticulitis

Now let us write an admission orders for a patient with diverticulitis (Table 1.2).

How to Fail the OSCE?

There are more ways to fail than to pass the OSCE. Some are listed here:

- Poor performance through the station
- Poor organization
- Inadequate history taking – miss asking about important parts of history
- Inadequate knowledge
- Could not address patient concerns and problems
- Interrupting patient
- Arguing with the patient
- Giving patient misinformation
- Poor communication skills
- Inadequate physical examination
- Unprofessional behavior

Table 1.2 Admission orders for diverticulitis

Patient Name: Date:
Age:
Admit to: General Surgery
Diagnosis: Acute diverticulitis
Condition: Stable
Vital signs: Stable
Allergies:
Diet: Nothing to eat and drink, beside oral medication
Nursing: Daily weights and intake and output
Activity: as tolerated
Labs: CBC, Electrolyte, urea, creatinine, CRP in the morning.
Imaging: CT abdomen and pelvis with contrast
IV: NS 1L at 125 ml/h
Medication: Metronidazole 500mg IV BID (check with your hospital guidelines)
Ceftriaxone 1G IV daily
Morphine 5 mg IV q 2-4 hr PRN pain
Paracetamol 1000mg q 6 h prn for pain or fever
Signed: dated and time
Position and Name of doctor

- Inability to counsel the patient properly
- Putting patient at harm or risk
- Wasted too much time on history and missed most of the physical examination
- Missing valuable information
- Poor professional judgment
- Looked nervous and rushed through

Best of luck for your OSCE.

References

1. Harden RM, Stevenson M, Downie WW, Wilson GM. Assessment of clinical competence using objective structured examination. Br Med J. 1975;1:447. https://www.bmj.com/content/1/5955/447. Accessed 2 Apr 2018
2. Medical Council of Canada Qualifying Examination Part II. http://mcc.ca/examinations/mccqe-part-ii/. Accessed 2 Apr 2018.
3. Medical Council of Canada. National assessment collaboration examination. http://mcc.ca/examinations/nac-overview/. Accessed 2 Apr 2018.
4. Medical Council of Canada. Practice-ready assessment. http://mcc.ca/projects-collaborations/practice-ready-assessment/. Accessed 2 Apr 2018.
5. USMLE Step 2 CS. http://www.usmle.org/step-2-cs/. Accessed 2 Apr 2018.
6. General Medical Council. What is the PLAB 1 exam? https://www.gmc-uk.org/doctors/plab/23453.asp. Accessed 2 Apr 2018.
7. Membership of Royal College of General Practitioners. MRCGP Clinical Skills Assessment (CSA). http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-clinical-skills-assessment-csa.aspx Accessed 2 Apr 2018.
8. Australian Medical Council Limited. AMC clinical examination. https://www.amc.org.au/assessment/clinical-exam. Accessed 2 Apr 2018.
9. Royal College of Physicians and Surgeons of Canada. Scholar definition. http://www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-scholar-e. Accessed 2 Apr 2018.
10. Wiprud R. Improving patient care. 30 standardized hospital admission orders. Fam Pract Manag. 2001;8(9):49–51. https://www.aafp.org/fpm/2001/1000/p49.html