OSCE Exam Preparation Handbook

Created by Jon Dowling, for Monash Health Emergency Education group
Adapted from the Princess Alexandria Hospital OSCE handbook
Written by Jonathon Isoardi and Darren Powrie
Version 1, 2015
Introduction

This manual was adapted from the Princess Alexandria Hospital OSCE preparation handbook, 2014, written by Dr Jonathon Isoardi and Dr Darren Powrie.

Now we have experience with preparing for the real exam, feedback from examiners and candidates and exposure to the actual exam questions, we have been able to update this manual with our best current knowledge of what you may experience on the day. The exam is still in its early days, and as such we expect further evolution of questions, but in general the rough breakdown of question types contained within this handbook should be reasonably accurate.

As a general guide, anything you might see at work may be tested in this exam.

Preparation for this exam should not involve the acquisition of new knowledge, but rather honing the skills you have been developing since you commenced ED training. Now is the time to perform in front of the examiners.

Our experience so far is that this exam is entirely reasonable (albeit challenging), and if you approach it correctly most Advanced trainees should have a pretty decent chance at passing.

Good Luck!
Eligibility (from ACEM)

Candidates for the FEx (Clinical) must meet all of the following criteria:

1. They must be a registered and financial trainee of the College

2. They must hold current registration to practice medicine in Australia or in New Zealand

3. They must have completed at least 36 months of the 48 months of accredited Advanced Training time prior to the relevant examination application closing date (not including any required ED remediation time)

4. They must have satisfied the trainee research requirement

5. They must have successfully completed the FEx (Written)

Candidates must meet these eligibility criteria, as per official College records, by the closing date for the relevant examination sitting.
1. Preparation for the exam

The OSCE exam should be the culmination of years of work in the ED, and therefore you should not be studying new information. Instead you should be practicing your existing skills, while ironing out any bad habits you might have collected over the last few years. If you are still studying, you are probably not ready.

We recommend that when preparing for this exam, you should be working in one of the three Emergency Departments, as this is the best way of ensuring you have the right mindset. Non-ED rotations, while clinical useful, do not necessarily get your head in the right space.

Most people describe this exam as being “like a big day at work”. This means that everything that you may be expected to do in a shift at work can be tested (within reason). Working in the ED, therefore, allow you to practice your skills every time you come to work.

In addition, you are regularly asked to perform WBAs – you should treat these as ideal practice for the real exam, and perform as such with the SMS supervising you. Whenever you receive an ECG/blood gas or other investigation from the nursing staff or junior medical staff, you should practice describing and interpreting it to your junior colleague. You should treat every patient interaction as a way to practice your communication skills.

That way the whole time you are at work, you are practicing for the exam.

You do need to be familiar with the major textbooks, but in general most of the book study will have been done for the written exam. It is important, however, to stay abreast of any recent changes to work practice, as this would be fair game to test. For example, if ILCOR or the ARC has released recent changes to resuscitation guidelines, you probably should know them!
The Study group

Your study group is essential to your success in the exam. A good study group maintains collective enthusiasm, clinical focus and relevance to Emergency Medicine. It also allows you to share the organizational workload. Who you choose greatly depends on the other candidates, but you should aim to have a mix of personality types – everyone has strengths and weaknesses, and your study partners should compliment your skills (and vice versa). There is no point you all being expert in the same area.

We generally recommend small groups, particularly when practicing OSCEs with the SMS. Too many tends to dilute the experience for everyone, so you should aim for only 2-4 in any study group/practice session.

It is your responsibility to arrange time with SMS – most of us will gladly make time for you, but the organization is up to you. If you are unsure as to which SMS will assist you with practice sessions, refer to the educational website (www.gcs16.com) and head to the Fellowship exam tab. With over 40 SMS employed in the network, there generally will always be someone available to assist you.

There are practice OSCEs on our site as well, but we recommend you don’t do these questions except with the SMS. There are a list of recommended sites for resources on the ACEM website, as well as our own.
2. Exam format

The examination takes an OSCE format. There will be up to a total of 18 stations in 180 minutes. It is almost certain that some stations will “double up”. For example, two stations may be combined to run as one 20-minute scenario rather than two separate 10 minute scenarios.

The OSCE exam will be split in to two 90 minute exams held on two consecutive days.

Each single station will go for 10 minutes, with 3 minutes devoted to reading time outside the exam room. This time should be used to try and forget about how you performed in the previous station (good or bad), and to prepare yourself for the expected flow of the next station. Most times, you should be able to predict what will happen once inside the room, based on the clinical stem.

Make sure you read EVERYTHING in the stem. All the information is relevant, so you don’t want to miss something that significantly hampers your performance. The stem also tells you what domains you are being assessed in – if it says you are being tested on scholarship and teaching, you need to teach! The examiners will be assessing you on every domain that is listed on the OSCE stem separately. It is no good performing excellently in one domain while failing at another.

At the appropriate time, you will be instructed to move into the room and begin the OSCE. Make sure you pick up on all cues in the room – there may be results, ECGs, x-rays or other props that may be important. However, not all props will be abnormal – be prepared for a normal x-ray, for instance, as this may be the whole point of the station.

Within each OSCE, you need to ensure you have given appropriate prioritization, particularly when listing differentials or
management. Remember, this is a Consultant level exam – if a patient has chest pain, it would look a bit poor if you don’t prioritize an ECG. Similarly, with the patient with a peaked T waves on an ECG you may want to get an urgent K rather than a D-dimer.

You will be given a 1-minute warning before the end of the station. At the end of the station (a bell will chime), exit the room promptly and move directly to your next assigned station – the 3-minute reading time will start immediately at the end of the previous station.

Don’t be too concerned about rushing – 3 minutes is a long time to prepare!
3. The Examiners

This is not a cross table style SCE: The OSCE format does not involve two-way communication with examiners i.e the examiner will not ask you specific questions, unless they are playing a role in that particular scenario. However, should you be asked to present certain findings, the examiner may be able to ask some questions.

In general, all your cues will be taken from the confederates in the room. Some of these confederates are professional actors, some will be volunteer nurses and some doctors (possibly including SMS you are currently working with).

The examiner(s) will generally be sitting in the corner and not interacting with you.

ACEM uses a complex marking algorithm, which requires substantial post hoc review. In general at each station candidates will be marked as falling into three categories – clear pass, clear fail, or borderline. The pass mark is derived from an analysis for the borderline candidates.

After a candidate is through the exam, there is no quarantine process. The college relies on candidates not to divulge information to others yet to sit. Due to the complex marking process, it is **not in your interest to pass on information to other candidates**, as you may raise the performance of other ‘borderline’ candidates, which can actually raise the overall required pass mark. This means that by helping others, you may in fact ensure that you fail.

In addition, it is not in your interest to receive this information, as evidence shows candidates can perform worse with some prior knowledge (and the questions may have been changed anyway!).
4. The Domains

ACEM recently restructured the training program to divide the program into key Domains, with clearly outlined expected proficiencies within those domains (based on your training level).

It would be very useful to review these domains before you start preparing for the exam, to ensure that you meet the expected level of a Junior Consultant. These can be found on the ACEM website.

Each OSCE station will clearly state what domains are being assessed in that particular station.
5. Types of stations

Examples of OSCE stations have been provided by the College, which can be found on the ACEM website. However, there are only a few examples of these at this stage.

More examples are on the Monash Health education site (www.GCS16.com) with links to other educational sites. Now the exam has been run for real, we expect more scenarios to become available over the next few months.

Paediatric scenarios will comprise approximately 25% of the exam, in some fashion (whether that’s a resus station, or communication to an unhappy parent)

Given the format, just about anything can be asked in this format of the exam. In general, there are six styles of OSCE that will make up most of the exam:

1) History stations
2) Physical examination stations
3) Pure communication stations
4) Simulation scenarios
5) Clinical synthesis
6) Procedure stations
5.1 History stations

This is NOT a long case.

History stations will involve confederates with specific instructions on how to behave and answers to give your questions.

In these stations, the domains tested will generally be: Medical Expertise, Communication, Professionalism, Health Advocacy.

The station stem generally will be a brief scenario, which you should use as a lead in to start. This is comparable to the information you may receive from triage regarding a patient who has presented.

For example, the stem may say:

“Mr Smith is a 60 year old man who has presented with intermittent chest pains for the last 2 weeks.

Please take a history from Mr Smith, and communicate your interim management plan to him.”

So your lead in may be “Hello Mr Smith, my name is …… I understand you’ve been having some chest pain?”

In general you will not be required to examine the patient, and you will probably not present your findings to the examiner. Instead your summation of your history is back to the confederate.

“So Mr Smith, it sounds like this pain you’ve been getting is reflux, which wont require you to be admitted to hospital. However, given your age and risk factors, I’d like to do some tests before we let you go, which will include an ECG, some blood tests looking at your liver, pancreas and blood count. If they are ok, then we will ask your LMO to arrange an Endoscopy”

This type of station should be one of the easier formats. It tests
something you do many times every day. Preparation is self-explanatory. You will be practicing at work every day.

Tips:

• Be thorough (you have 7 minutes)

• Take a history in a methodical fashion, unless directed otherwise

• Be prepared to take cues from the actor

• There are only so many types of presentations that can be included in this type of scenario. It is unlikely your patient will be a complex multisystem presentation (eg renal transplant with c.difficile infection, heart failure and lymphoma!)

• Do not forget a Mental State examination. Examples may be doing a risk assessment for suicide, or assessing a psychotic patient (in this last example, you may be presenting your findings to another confederate playing a Psychiatrist).

Some variations to this style of station may include:

• Possibly being required to give a brief summary to the examiner (who may be playing a role) or list of differentials, investigations or managements priorities

• You may be required undertake a clinical handover to the examiner. This would be at the level of a referral to a receiving unit consultant, and not as a long case

• A double station with the first half being the history component, and the second half being the clinical handover

• A written station, where you may be required to write out discharge instructions for a patient
5.2 Physical examination stations

This is NOT a Short Case.

The Physical examination stations involve a ‘standardized’ patient, so that every candidate will experience roughly the same examination. The level is aimed at the level expected of a SMS at work in an ED. Therefore, you are unlikely to be asked to perform a higher functions neurological assessment, but would be expected to be able to perform a Cranial nerve exam. Things like orthopaedic examinations, or examinations to assess function following an injury are completely fair game.

However, as these patients need to be ‘standardized’ it is unlikely weird and rare diagnoses will come up.

It is possible that the patient is an actor, and the findings are simulated (eg simulating weakness of a certain muscle group, or nerve palsy, tendon injury etc), or that the patient has genuine findings (eg murmurs, lumps, organomegaly etc)

As such, you definitely need to read Tally and O’Connor, so you know the major (and not so major) clinical examinations. You also need to think about how you would approach the assessment of the patient with examinations that may not be contained in Tally and O’Connor (eg the patient with the painful ankle, or with a limp).

You probably have not done a formal clinical exam for some time, and probably have some bad habits. You should do at least a few sessions with your study group going over the main physical exams. Remember, though, this is not a Short Case.

The other major skill you need to practice is presenting your findings in a clear and focused method – this is harder than you might think, and is where many candidates fell apart in the ‘old’
format clinical exam. Depending on the stem, you may be presenting to the examiner directly (who may be playing the part of a colleague) or to the patient. The language you need to use will clearly vary depending on whom you are presenting to.

Do not forget hand hygiene, asepsis or personal protection – anything you would do at work should be done here. If the patient has a (simulated) wound, then you are expected to wear gloves.

Domains assessed in this style of case include: Medical expertise, communication, professionalism, health advocacy, scholarship and teaching.

**Combined Hx and Exam**

It is possible you may be asked to take a history and examine a patient in the same station. An example would be of a patient who presents after falling over and presents with an injury of some sort. If this is the case the stem will clearly state you have to do both.

It is not feasible to have anything complicated in this style of station, so the hx will not be complicated. Think what you would do for someone who presents with a minor injury through Fast Track
5.3 Pure communication stations

Domains being assessed in these stations include: Medical expertise, communication, professionalism and Health Advocacy.

It is obvious which candidates have practiced these types of stations, and those that have not, and is one type of OSCE where prior preparation can quickly and relatively easily modify your approach. One tip is to have your study group film your practicing these skills. You may not realize what message your body language is displaying.

These stations generally fall into two groups:

1. Communicating with patients or relatives

There are many examples of this style of station – ACEM has done this for a number of years during the old style SCE exam, and examples can be found on the ACEM website.

Some examples that have been done in the past include:

- Breaking bad news to a relative of a patient with a catastrophic ICH
- Informing a relative about a complication of a patient’s care (pneumothorax complicating the insertion of a CVC)
- Counseling patients about a diagnosis (febrile convulsion)
- Obtaining consent (e.g., LP for suspected SAH)

Other common stations will involve answering complaints.

It is important with these style of stations that not only do you take an empathetic approach and use jargon free language, but there must be the delivery of some important information to the patient/relative. As an example, in the SCE involving counseling a parent whose child has had a febrile convolution required candidates to actually provide information to the mother, not just
smile and be ‘nice’.

Make sure you introduce yourself and shake hands with the confederate. Use clear and concise language that is free of medical jargon – if you do use medical terminology, make sure you explain what you mean in lay terms. Maintain a calm and professional demeanor, but be empathetic and respond to the confederates’ prompts.

2. Communicating with other health professionals

Again this comes in many forms. Examples include:

- Dealing with inappropriate behavior from an inpatient unit or one of your own staff
- Giving advice to another professional about management of a patient (this may be over the phone and the examiner may be in another room)
- Discussing with a nurse about departmental issues (e.g. the ‘Full department with an incoming resus’ scenario). This has been done in various forms in both the old and new formats of the clinical exam

It is important in this type of station you maintain your calm, and avoid antagonistic behaviors. If the confederate is angry or upset, maybe the crux of the station is to engage with that professional and get them to see your point of view.
5.4 Simulation scenarios

Domains being assessed in these scenarios include: Medical expertise, Teamwork and collaboration, Prioritization and Decision-making, Professionalism, Scholarship and teaching.

You almost certainly will get one or two of these stations (in the first run of the exam, candidates were given two stations). These will be a double station (followed by a rest station). As such you will have the same 3 minutes outside the room as a single station, but the station will run up to 17 minutes long once inside.

It is likely you will be tasked with leading a resuscitation, and have a team of staff (eg one ‘Registrar’ and one ‘nurse’) to assist you. The confederates will be real ED staff, not actors, and so will have some experience. Usually they will have instructions to follow commands, and have certain prompts to keep the station moving (“I cant feel a pulse!”), but will have limited ability to prompt you. They will likely be able to perform certain procedures under your direction, such as cannulation, venipuncture or insertion of IO.

Most of the mannequins will be low to medium fidelity, but can have procedures performed on them. Most of the time you, as team leader, will be directing the confederate to do the procedure (eg talking a registrar through an intubation). Occasionally the confederates will ask you to confirm your instructions – this does not necessarily mean you have made an error, but would be normal practice in a real resus (eg most nurses will be expected to check a dose before it is given).

In this scenario, you will be tested on both how you manage a clinical scenario, but also how you lead a team. Your communication and professionalism may be more important to your success than medical knowledge. It is therefore extremely important you practice this type of scenario – we strongly recommend that you are observed by the SMS doing these stations,
and again a useful exercise is to film yourself as this will identify areas of weakness that you are not aware of (or that your study group is too polite to tell you!). It is highly desirable that you have spent time in the Sim centre prior to this exam, but remember that the Sim centre uses higher fidelity mannequins than are likely to be used in the real exam. Therefore, it is important you are able to place yourself “in the moment” to make this scenario as real as possible, as your performance will greatly improve if you do. Again, practice is the key.

It is possible you may be a team member working under the direction of the Team leader eg being the Airway doctor.

For most people, these type of scenarios represent the culmination of years of training, and as such should not be a great surprise, or hardship. If you feel that you aren’t ready for this type of exam station, perhaps you need to reconsider whether you should be sitting this exam right now.

Domains being tested in this type of scenario include: Medical expertise, Communication, Professionalism, Leadership, Scholarship and teaching, Teamwork.
5.5 Clinical synthesis

This is everyday practice.

These stations will involve some sort of clinical scenario requiring you to interpret information given to you, and then demonstrate your knowledge in some way, either by giving directions or advice.

This is the most likely station that will test your knowledge around pathology, ECGs and radiology.

The ECG OSCE on the ACEM website is a good example of this type of station: a junior doctor presents a patient to the senior doctor (you) and has an ECG for you to interpret. The expected response is to take the appropriate info you are being presented with, formulate what your working diagnosis/problem list is and communicate that back to the junior, along with a management plan.

Again, there are no surprises here – this is what you do every day supervising junior staff (medical and nursing). If you think you will struggle here, perhaps you aren’t ready for the exam (or even to be supervising others!).

The key to success in this style of station is to practice every day at work – think how often a junior colleague asks you for advice and you can understand how much of this practice can be done at work. Every time someone shows you an ECG, take time to ask about the details of the case, interpret the ECG and then explain the ECG back to the nurse (this is what you should be doing anyway!). This type of behavior not only prepares you for the exam but builds great rapport with your team mates.

A variation to this station involves giving phone advice to another health professional.

One key component to these stations is education of the junior staff
member. There are many ways to teach, but in the exam setting you should be very specific about how you go about it. When presented with a set of results by a confederate, it is not acceptable to just ask the confederate what they think of the results (the “well what do you think of this” approach) – this is an exam and you are the one being tested. Instead you should take the “this is what I think of these results, and why” approach.

For example, when given a VBG that is consistent with DKA, don’t ask the confederate whether they know how to calculate the anion gap. Instead, calculate it yourself and explain how you did it.

When given an ECG, don’t ask the confederate whether they know what the rhythm is, point it out to the confederate (along with the ST elevation, long QT and whatever else is abnormal).

Domains being assessed in this station include Medical expertise, Communication, Leadership, Scholarship and teaching and professionalism.
5.6 Procedure stations

This was not tested in the first exam, and there are only so many procedures that are suitable for this type of exam. The College provides a list of expected procedural proficiency – it is important you are familiar with these procedures. Anything that the required level of proficiency is “Mastery” is fair game, but not all can practically be tested.

Most procedures would be done with a part task trainer. Examples include: LP, central access, intubation, surgical airway, chest drain insertion or US guided venous access. It is fair game to be asked to perform a FAST or AAA scan.

You will either be asked to perform the procedure or teach the procedure. Teaching involves the extra step of communication, but you need to be fluent in how you do this – ie you should be talking while you are doing. If you stop to explain things along the way, you may run out of time.

For each procedure, you should deconstruct the steps involved well ahead of time (try explaining it to your partner, child or dog!), so that explanation will come more naturally in the exam. Make sure you verbalize it – there is no point thinking it through without speaking it out loud.

Lastly, don’t forget consent and preparation where appropriate as a first step. And wash your hands!
6. What to Bring

ACEM has clarified what equipment is required of candidates. Essentially you need to feel comfortable in the clothes of your choice. It is entirely acceptable to wear scrubs to the exam. Generally whatever you wear, you need to practice in prior to the day. The official ruling is reprinted below.

<table>
<thead>
<tr>
<th>What to wear and what to bring to the ACEM Fellowship Exam (Clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to wear</strong></td>
</tr>
<tr>
<td>In the OSCE exam, candidates will be expected to perform tasks (including physical examinations and procedures) as you would at work. You should dress appropriately. Wear something that you would feel comfortable in during a clinical shift and that you consider would be acceptable to all patients you might encounter in such a shift in a mixed adult/paediatric department.</td>
</tr>
<tr>
<td>The following guidelines should help you to decide how to dress for the exam:</td>
</tr>
<tr>
<td>. If you elect to wear scrubs you should ensure that they do not have any identifying information on them (e.g. name of trainee or name of hospital)</td>
</tr>
<tr>
<td>. Please note that there are no changing facilities at the exam centre. If you want to wear scrubs you will need to arrive at the exam centre wearing them</td>
</tr>
<tr>
<td>. The most important thing to remember is that you need to be able to perform as you would at work (e.g. able to comfortably examine patients, conduct a resus, perform a procedure etc.)</td>
</tr>
<tr>
<td>. It is considered sensible to follow the following guidelines:</td>
</tr>
<tr>
<td>Wear closed shoes that protect your feet.</td>
</tr>
<tr>
<td>Do not wear high heels.</td>
</tr>
<tr>
<td>Do not wear jeans or ripped /scruffy clothes.</td>
</tr>
</tbody>
</table>

**What should I bring?**

Please bring the stethoscope you use at work to the exam. Any other equipment needed at the exam will be provided for you. No food or drink permitted in the exam room except for water in clear, plastic, non-spill bottles.