



**Objectively Structured Clinical Examination
(OSCE)
Guidelines and Instructions
AY 15-16**

- Most cases are specifically designed to elicit a process of history taking and physical examination that demonstrates the examinee's ability to list and pursue various plausible diagnoses.*
- Courses are welcome to include multiple components in their exams, but the stations utilizing Standardized Patients (SPs) should focus on communication and information gathering skills.
- Technical skills, including physical examination skills, should be assessed via technical skill stations graded by physician graders; which can be set up before or after the SP stations. Grading of these skills can be done live or remotely by a physician grader via recording.
- Knowledge-based portions of the exam such as multiple choice questions or identification stations should be completed before or after the SP/OSCE stations. (Ability to have students complete this portion of the exam in the computer may be available but material must be available six weeks prior to the exam.)
- It is recommended that an OSCE examination include no more than five patient encounters per student.
- OSCE cases will be submitted in a standardized case format no less than six weeks prior to the exam.
- OSCE schedules, including room, supply, and SP needs, will be confirmed by clerkship, SP, and Simulation staff no less than two weeks prior to the exam.

EQUIPMENT AND EXAMINEE INSTRUCTIONS

- The testing area of the clinical skills evaluation center consists of examination rooms equipped with standard examination tables, commonly used diagnostic instruments (blood pressure cuffs, otoscopes, and ophthalmoscopes), non-latex gloves.*
- Outside each examination room is a station equipped with a computer, where you will compose the patient note.*
- Rooms are equipped with cameras. Recordings are used for quality assurance and are not intended to provide a mechanism for review.
- Before the first patient encounter, students will be provided with a clipboard, blank paper for taking notes, and a pen. There will be an announcement at the beginning of each patient encounter. When the student hears the announcement they may review the patient information posted on the examination room door (examinee instructions). The student may also make notes at this time. They **MAY NOT** write on the paper before the announcement that the patient encounter has begun.*
- The examinee instruction sheet gives the student specific instructions and includes the patient's name, age, gender, and reason for visiting the doctor. It also indicates his or her vital signs, including heart rate, blood pressure, temperature (Celsius and Fahrenheit), and respiratory rate, unless instructions indicate otherwise. Students can accept the vital signs on the examinee instruction sheet as accurate, and do not necessarily need to repeat them unless the student believes the case specifically requires it. For instance, students may encounter patient problems or conditions that suggest the need to confirm or re-check the recorded vital

signs and/or perform specific maneuvers in measuring the vital signs. However, if the student does repeat the vital signs, with or without additional maneuvers, they should consider the vital signs that were originally listed as accurate when developing their differential diagnosis and work-up plan. *

- Students may encounter a case in which the examinee instructions include the results of a lab test. In this type of patient encounter the patient is returning for a follow-up appointment after undergoing testing. *

THE PATIENT ENCOUNTER

- Students will have 15 minutes for each patient encounter.*
- When students enter the room, they will usually encounter a standardized patient (if not, they will be asked to communicate with a standardized patient over the telephone). By asking the patient relevant questions and performing a focused physical examination, students will be able to gather enough information to develop a preliminary differential diagnosis and a diagnostic work-up plan. *
- Student's role during the examination should be that of at least a first-year postgraduate resident physician with primary responsibility for the care of each patient. Students should treat each patient as a real patient. Communicate in a professional and empathetic manner, being responsive to the patient's needs. Do not defer decision-making to others. *
- As they would when encountering real patients, students should answer any questions the patient may have, tell the patient what diagnoses is being considered, and advise the patient on what tests and studies the student plans to order to clarify the diagnoses. It may be helpful to think of the student as working in a setting where they are the only provider present. *
- Students may introduce themselves however they wish, as either a medical student or as a doctor. Students may introduce themselves using their real name.*
- The elements of medical history students need to obtain in each case will be determined by the nature of the patient's problems. Not every part of the history needs to be taken for every patient. Some patients may have acute problems, while others may have chronic ones.*
- Students will not have time to do a complete physical examination on every patient, nor will 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.*
- The cases are developed to present in a manner that simulates how patients present in real clinical settings. Therefore, most cases are designed realistically to present more than one diagnostic possibility. Based on the patient's presenting complaint and the additional information obtained taking the history, students should consider all possible diagnoses and explore the relevant ones as time permits.*
- If students are unsuccessful in the OSCE and must repeat the examination, it is possible that during your repeat examination students will see similarities to cases or patients that they encountered on their prior attempt. Students should NOT assume that the underlying problems are the same or that the encounter will unfold in exactly the same way. Students should approach each encounter, whether it seems familiar or not, with an open mind, responding appropriately to the information provided, the history gathered, and the results of the physical examination.

PHYSICAL EXAMINATION

- Students should perform physical examination maneuvers correctly and expect that there will be positive physical findings in some instances. Some may be simulated, but students should accept them as real and factor them into their evolving differential diagnoses.*
- Students should attend to appropriate hygiene and to patient comfort and modesty, as they would in the care of real patients. Female patients will be wearing bras, which students may ask them to loosen or move if necessary for a proper examination.*
- With real patients in a normal clinical setting, it is possible to obtain meaningful information during the physical examination without being unnecessarily forceful in palpating, percussing, or carrying out other maneuvers that involve touching. Students approach to examining standardized patients should be no different. Standardized patients are subjected to repeated physical examinations during the OSCE exams; **it is critical that students apply no more than the amount of pressure that is appropriate** during maneuvers such as abdominal examination, examination of the gall bladder and liver, eliciting CVA tenderness, examination of the ears with an otoscope, and examination of the throat with a tongue depressor.*
- Students should interact with the standardized patients as they would with any patients they may see with similar problems. The only exception is that certain parts of the physical examination **MUST NOT BE DONE**: rectal, pelvic, genitourinary, inguinal hernia, female breast, or corneal reflex examinations. If students believe one or more of these examinations are indicated, they should include them in the proposed diagnostic work-up. All other examination maneuvers are completely acceptable, including femoral pulse exam, inguinal node exam, and axillary exam.*
- Another exception is that students should not swab the standardized patient's throat for a throat culture. If students believe that this diagnostic/laboratory test is indicated, include it on the proposed diagnostic workup.*
- Excluding the restricted physical examination maneuvers, students should assume that they have consent to do a physical examination on all standardized patients, **unless they are explicitly told not to do so** as part of the examinee instructions for that case.*
- Announcements will tell students when to begin the patient encounter, when there are 5 minutes remaining, and when the patient encounter is over. In some cases students may complete the patient encounter in fewer than 15 minutes. If so, they may leave the examination room early, but they are not permitted to re-enter. **Students should be certain that they have obtained all necessary information before leaving the examination room.** Re-entering an examination room after leaving will be considered misconduct.*

TELEPHONE PATIENT ENCOUNTERS (if applicable)

- Telephone patient encounters begin like all encounters; students will read a doorway instruction sheet that provides specific information about the patient. As with all patient encounters, as soon as the student hears the announcement that the encounter has begun, they may make notes about the case before entering the examination room. *

- When students enter the room, they are to sit at the desk in front of the telephone.*
 - Students should not dial any numbers.
 - To place the call, _____ (details may be campus specific)
 - Students will be permitted to make only one phone call.
 - Student should not touch any buttons on the phone until they are ready to end the call – touching any buttons may disconnect the call.
 - To end the call, _____ (details may be campus specific)
 - Students will not be allowed to call back after the call is ended.
- Obviously, physical examination of the patient is not possible for telephone encounters, and will not be required. However, for these cases, as for all others, students will have relevant information and instructions and will be able to take a history and ask questions.*
- As with other cases, students will write a patient note after the encounter. Because no physical examination is possible for telephone cases, leave that section of the patient note blank.*

PATIENT NOTE

- Immediately after each patient encounter, students will have 10 minutes to complete a patient note. **If students leave the patient encounter early, they may use the additional time for the note.** Students will be asked to type (on a computer) a patient note similar to the medical record they would compose after seeing a patient in a clinic, office, or emergency department. *
- Patient notes are written using a standard word processing format. Examinees will not be permitted to handwrite the note, unless technical difficulties on the test day make the patient note typing program unavailable.*
- Students should record pertinent medical history and physical examination findings obtained during the encounter, as well as their initial differential diagnoses (maximum of three). The diagnoses should be listed in order of likelihood. Students should also indicate the pertinent positive and negative findings obtained from the history and physical examination to support each potential diagnosis.*
- Finally, students will list the diagnostic studies they would order next for that particular patient. If students think a rectal, pelvic, inguinal hernia, genitourinary, female breast, or corneal reflex examination, or a throat swab, would have been indicated in the encounter, they should list it as part of the diagnostic studies. **Treatment, consultations, or referrals should not be included.***
- Occasionally, due to technical or administration problems, students will not be able to type the patient note for one or more patient encounters. When this happens, examinees will be required to write their patient notes by hand. All examinees should be prepared for the possibility that they may have to write one or more patient notes by hand.*
- If students have a case for which they think no diagnostic studies are necessary, they are to write "No studies indicated" rather than leaving that section blank.*
- Students will not receive credit for listing examination procedures they WOULD have done or questions they WOULD have asked had the encounter been longer. Students should write

ONLY the information they elicited from the patient through either physical examination or history taking.*

- When students hear the announcement to stop typing, they will click "Submit" on the computer, or put down their pen. Continuing to type or write after the announcement to stop will be considered misconduct. They will remain seated and wait for further instructions.*
- In some instances students may be instructed to perform a physical examination that relates to a specific medical condition, life circumstance, or occupation. Synthetic models, mannequins, or simulators provide an appropriate format for assessment of sensitive examination skills such as genital or rectal examination, and may be used for these cases. In such cases, specific instructions regarding the use of these devices will be provided. If students encounter any case for which they decide no physical examination is necessary, leave that section of the patient note blank.*

SCORING

- OSCE cases will use the standardized SP checklist that includes COM standardized communication questions. Courses may add up to five questions to the checklist.
- During your physical examination of the standardized patient, students should attempt to elicit important positive and negative signs. Students should make sure to discuss with the patient their initial diagnostic impression and the diagnostic studies they will order. The patients may ask questions, and students will see a range of personalities and styles in asking questions and presenting information. Students should address each patient's concern as they would in a normal clinical setting.*
- The ability to communicate effectively with patients, demonstrating appropriate interpersonal skills, is essential to safe and effective patient care.*
- The standardized patients assess communication and interpersonal skills, for which SPs have participated in training.*
- Students' ability to document in the patient note the findings from the patient encounter, diagnostic impression, and initial diagnostic studies will be rated by physician graders. Students will be rated based upon the quality of documentation of important positive and negative findings from the history and physical examination, as well as their listed differential diagnoses, justification of those diagnoses, and diagnostic assessment plans.*
- We strongly encourage courses to arrange a single physician grader for each patient note who grades the notes from all campuses. In most cases, these notes can be accessed electronically via the internet.
- SP's should not be asked to evaluate technical or physical exam skills. Faculty physicians should evaluate technical skills.

INTEGRATED CLINICAL ENCOUNTER (ICE) AND COMMUNICATION & INTERPERSONAL SKILLS (CIS)*

- **The ICE subcomponent** includes assessments of both data gathering and data interpretation skills. Scoring for this subcomponent consists of checklists completed by the standardized

patients for the physical examination portion of the encounter, and scoring of the patient note by trained physician raters. The patient note raters provide global ratings on the documented summary of the findings of the patient encounter (history and physical examination), diagnostic impressions, justification of the potential diagnoses, and initial patient diagnostic studies.*

- **The CIS subcomponent** includes assessment of the important communication skills of fostering the relationship, gathering information, providing information, helping the patient make decisions, and supporting emotions. CIS performance is assessed by the standardized patients, who record these skills using a checklist based on observable behaviors.*
 - Examinees demonstrate the ability to foster the relationship by listening attentively and showing interest, care, concern, and respect.*
 - Helping the patient make decisions is demonstrated by outlining what should happen next, linked to a rationale, and by assessing a patient's level of agreement, willingness, and ability to carry out next steps.*
 - Examinees demonstrate ability to support emotions when a clinical situation warrants by seeking clarification or elaboration of the patient's feelings and by using statements of understanding and support.*

TESTING REGULATIONS AND RULES OF CONDUCT

Confidentiality statement: Students must understand that some of material used on this OSCE will be used on subsequent clerkships. Students must complete their own work and also not share any subject matter, test material or concepts with subsequent groups. It is known that breach in confidentiality is a breach in professionalism, which is outlined in the student handbook.

- **The student cannot discuss the cases with their fellow examinees, during breaks or at any time.**
- Students may not possess cellular telephones, watches of any type, pagers, personal digital assistants (PDAs), two-way communication devices, or notes or study materials of any kind at any time during the examination, including during breaks. These items must be stored during the examination.*
- Students should wear comfortable, professional clothing and a white laboratory or clinic coat.*
- The only piece of medical equipment students may bring is an unenhanced standard stethoscope*
- Students who arrive late may not be allowed to take the exam

Appendices

Appendix A& B: Patient Note & Examples*

Appendix C: SP Checklist Template

Appendix D: Terms used in the OSCE Examination*

Appendix E: Common Abbreviations for the Patient Note*

Appendix F: OSCE Warning and Station-Change Announcements

Appendix : A & B

Appendix : C

CLERKSHIP – Case Name:

Student # (or Name):

STANDARDIZED PATIENT CHECKLIST

N = no Y = yes E = excellent

Comments:

1		N	Y		
2		N	Y		
3		N	Y		
4		N	Y		
5		N	Y		
6	Student established rapport with me by listening attentively	N	Y	E	
7	Student showed genuine interest in me by being concerned and respectful	N	Y	E	
8	Student asked me to explain how this health issue today has affected my life	N	Y	E	
9	Student explained clearly (without medical jargon) what is happening with me medically	N	Y	E	
10	Student explained clearly (without medical jargon) what the next steps would be	N	Y	E	
11	Student provided information and content that was appropriate for me	N	Y	E	
12	Student asked specific questions to confirm my understanding of the findings	N	Y	E	
13	Student assessed my ability and/or willingness to carry out the next steps	N	Y	E	
14	Student demonstrated an understanding of the reason for my visit and any concerns I had	N	Y	E	
15	Student used statements of understanding and support to acknowledge my emotions	N	Y	E	

Appendix : D

TERMS USED IN THE OSCE EXAMINATION*

Lists similar to the one below will be available on-site for reference during OSCE administrations.

UNITS OF MEASURE

kg kilogram
g gram
mcg microgram
mg milligram
lbs pounds
oz ounces
m meter
cm centimeter
min minute
hr hour
C Celsius
F Fahrenheit

VITAL SIGNS

BP blood pressure
HR heart rate
R respirations
T temperatur

Appendix : E

COMMON ABBREVIATIONS FOR THE PATIENT NOTE

Note: This is not intended to be a complete list of acceptable abbreviations, but rather represents the types of common abbreviations that may be used on the patient note. There is no need to use abbreviations on the patient note; if you are in doubt about the correct abbreviation, write it out.

yo year-old	FH family history
m male	GI gastrointestinal
f female	GU genitourinary
b black	HEENT head, eyes, ears, nose, and throat
w white	HIV human immunodeficiency virus
L left	HTN hypertension
R right	IM intramuscularly
hx history	IV intravenously
h/o history of	JVD jugular venous distention
c/o complaining of	KUB kidney, ureter, and bladder
without or no	LMP last menstrual period
+ positive	LP lumbar puncture
- negative	MI myocardial infarction
Abd abdomen	MRI magnetic resonance imaging
AIDS acquired immune deficiency syndrome	MVA motor vehicle accident
AP anteroposterior	Neuro neurologic
BUN blood urea nitrogen	NIDDM non-insulin-dependent diabetes mellitus
CABG coronary artery bypass grafting	NKA no known allergies
CBC complete blood count	NKDA no known drug allergy
CCU cardiac care unit	NL normal/normal limits
CHF congestive heart failure	NSR normal sinus rhythm
cig cigarettes	P pulse/heart rate
COPD chronic obstructive pulmonary disease	PA posteroanterior
CPR cardiopulmonary resuscitation	PERLA pupils equal, react to light and accommodation
CT computed tomography	po orally
CVA cerebrovascular accident	PT prothrombin time
CVP central venous pressure	PTT partial thromboplastin time
CXR chest x-ray	RBC red blood cells
DM diabetes mellitus	SH social history
DTR deep tendon reflexes	SOB shortness of breath
ECG electrocardiogram	TIA transient ischemic attack
ED emergency department	U/A urinalysis
EMT emergency medical technician	URI upper respiratory tract infection
ENT ears, nose, and throat	WBC white blood cells
EOM extraocular muscles	WNL within normal limits
ETOH alcohol	
Ext extremities	

Appendix : F

OSCE Warning and Station Change Announcements(*except Psych)

Enter:

“OSCE participants, you now have 15 minutes for this encounter. You may view the door sign and enter the station when you are ready.”

SP Encounter 5 min. Warning:

“Participants, there are five minutes remaining; five minutes.”

Exit from SP Room:

“OSCE participants, time is up. Please exit your station and proceed to the post-encounter activity at the computer. You will have 10 minutes.”

(Note: Pediatrics has one student per rotation who will proceed directly to a 10 minute SP encounter. Students should be aware of this before OSCE begins).

Documentation Encounter 2 min. Warning:

“Participants, there are two minutes remaining; two minutes.”

End of Encounter:

“OSCE participants, time is up. Please stop typing and remove your hands from the keyboard. Now, you may put an “x” in any empty text box you did not have time to fill in, or an N/A if you left it blank intentionally. Click “Save” to submit your patient note, then proceed to the next station and wait for the announcement to view the doorsign.”