Royal College of Anaesthetists

Observation of RCS OSCE

RMS visited the MRCS part B (OSCE) exam on Tuesday 16 October 2018.

Summary of the Exam & General Observations

The part B exam aims to test the following 4 domains

- Anatomy and surgical pathology
- Applied surgical science and critical care
- Clinical and procedural skills
- Communication skills

It is testing broadly the same level as the primary FRCA, in that is required for passage from core into higher/specialist training.

The exam is open to anyone with a medical degree equivalent to allow provisional or full GMC registration. Therefore F1s and F2s can take the exam.

One OSCE circuit consists of 18 x 10 minute stations (1 minute for scenario information and 9 minutes with the examiner) plus two prep and two rest stations. Two rounds are run each day (am + pm).

The exam is an intercollegiate exam i.e. RCS England, RCS Glasgow, RCS Edinburgh, RCS Ireland. Each college runs the exam, there is a common blueprint. There is a best practice group, which has members from all four colleges. Independent assessors 2 per exam (not active examiners) carry out audit and QA to ensure consistency and reliability between test centres/different examiners.

The RCS has a large examiner pool and examiners seemed to work flexibly doing 2-3 days out of the week to fit in with clinical commitments.

Due to building works at the RCS they are using a purpose built exams suite at the RCGP - There was a lot of space! i.e. 22 physical stations to run 18. This allowed for preparation and rest stations. It was run in a purpose built exams centre (in the RCGP) and each station was in an individual room. There were two circuits of 11 stations with a short coffee break (candidates and examiners) in between the first 9 and second 9 questions.

The RCS use a checklist (20 marks) and a 3-point BLR global score (fail, borderline, pass). Marks are recorded manually on a mark sheet and the College staff transfer manually to collate overall results. Results are not released to the candidates until approx.. 2 weeks after the OSCE has run.

Lay examiners are used in the communication and history stations. They mark alongside a College examiner. Each examiner is marking different domains. The College examiner marks clinical skills in history taking and presentation of clinical findings and formulation of a diagnosis, further investigation and management and the lay examiner awards marks for communication and professionalism (checklist). They then agree the overall BLR global score. If they disagree the College examiners decision over-rides the lay examiner.

<u>Question/Domain based observations</u>

Knowledge based questions:

The anatomy questions were very knowledge based and similar to ours. Physiology, pathology knowledge was usually applied to a clinical context.

History based stations

Generally took the form of 6 minutes to take the history and then three minutes to present the case and talk about differential diagnosis and on going investigations and management

Communication:

Both these were preceded by a 10 minute 'preparation' station where a clinical scenario was given and then the candidate moved to the next station where they either had to have a discussion with a simulated patient (e.g. an endoscopy for an oesophageal narrowing) or a telephone conversation with the consultant to discuss a management plan.

Procedural based stations:

Two examiners were used for these – e.g. suturing skills using specific suturing simulation equipment. The examiner also used quite a lot of related clinical knowledge based questions throughout the station (e.g. differences between mono and poly filament sutures). There was also clinical reasoning/decision making – e.g. this is a bleeding artery in a deep cavity - candidate had to select a suture from a selection of different sutures and tie off the vessel.

There was also a station where a simulated abscess was attached to the leg of an actor/simulated patient. The candidates had to go through the whole procedure of incision and drainage – interacting with the patient and correctly performing the procedure on the plastic abscess + answering some questions from the examiner. This allowed testing of knowledge, technical skills, communication and professionalism in one station.

Physical examination stations:

There were four of these and they were mostly system based e.g. CVS, lower limb, abdomen. The candidates had 6 minutes with the simulated patient and then 3 minutes summarising findings and formulating diagnosis and management plans.

<u>Quality assurance</u>

The RCS blueprint is a very concise document – 2 sides of A4 for an OSCE round. It was linked to the curriculum but only broadly at blueprint level.

Individual questions were more closely linked to the curriculum but also coded according to which domains were being examined (knowledge, skills, communication, professionalism)

Post exam metrics – they use a combination of qualitative (feedback from examiners, candidates and exam staff – e.g. logistics) and quantitative (Cronbach alpha, coefficient of determination [R^2] and intergrade discrimination) metrics. They then RAG rated both the qualitative and quantitative. Questions only come up for review only if the are amber /red in both domains over the course of two/three runs.

Reflection/future discussion points

- 10-minute stations felt a little less rushed than our 5-minute ones.
- If we wanted to run with some 10-minute clinical questions it would be relatively easy to covert/extend some of our questions by adding in a second part e.g. presenting findings or discussing clinical management of areas related.
- An OSCE of effectively 22 (including preparatory and rest) x10 minute stations is very long and would restrict the number of candidates we could examine.
- We don't have to make our blueprint too complicated.
- In addition to curriculum mapping we could be more specific on GMC domains being examined and more than one domain can be tested in a single question.
- The use of lay examiners seems like a good way of ensuring validity and possibly reducing the burden on professional examiners.