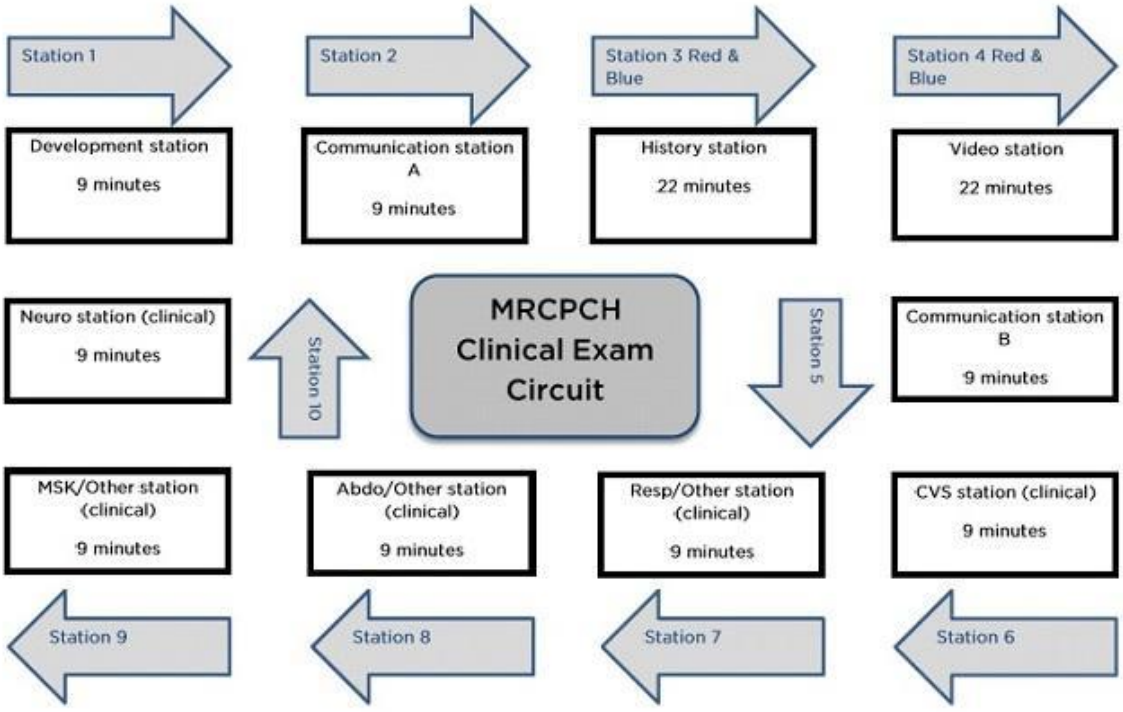
Report re visit to RCPCH OSCE Saturday 27th October
Visit made by D Doyle & D Rowand

Background
The MRCPCH Clinical OSCE is the final part of the MRCPCH exam (membership). The level of knowledge and skills expected are those of a newly appointed ST4

The format of the exam is centred on OSCE stations with interactions between candidates and real patients and their carers, using children with genuine signs and comorbidities. It is not practical to use the same patient in a single station for an entire circuit. Patients are used frequently swapped around, as they become tired, distracted or uncooperative

The exam is held 3 times per year. On this occasion, it was held at GOSH, who acted as "hosts". The hosts provide patients known to them as exam subjects. Typically, 12 candidates are examined in the morning round, another 12 in the afternoon

The exam is made up of a total of 10 stations, 9 of which are based on interactions with patients, the remaining station is a computer based station. The majority of the stations are 9 minutes in length, with a 4-minute gap between stations. Very little information is given to the candidates outside each station, other than knowing which station it is:



The clinical stations cover systems – CVS, Resp, Abdo, MSK, Neuro and Development. In these stations candidates are expected to spend 6 minutes performing a task (usually

an examination – general or focused, related to that system). During the final 3 minutes the clinical findings are presented and the candidates answer a variable number of questions from the examiner – what is your diagnosis? what tests would you consider? how would you manage the patient? etc.

The majority of the stations focus on examinations and diagnosis - based on a system basis or history. Acute management – resuscitation / use of SIM is not included

The remaining 2 short stations are based on communication – candidates may interact with an adolescent or more typically a carer / parent. Again, a brief summary by the candidate is made at the endo of the station

The history station is a total of 22 minutes in length – 13 minutes interaction with patient carer, 9 minutes presenting case and answering questions, discussing management options

The computer based station is again 22 minutes in length. Candidates view 10 short stand alone, unrelated patient videos with an accompanying question. The questions are a SBA format – what is the diagnosis? what is the post appropriate test? what is the treatment etc. and may include up to 8 options. The validity of this format is that it allows unusual clinical scenarios / pathologies to be asked which would not be available in the host's patient population group

Standard setting
The examiners do not have any advance knowledge of the individual patients and their diagnosis. There may be up to 4 or 5 patients for each station A proforma for each a patient is provided with a very brief Hx and details of relevant clinical findings. Examiners are paired and together examine / assess each child for their stations. A decision is made as to where to focus the candidate, what signs they are expected to elicit and what questions should be asked by the examiner. This process seemed to be very variable. The interaction between the pair of examiners was sometimes very brief. Each patient was very different – the neuro station included a 17 yr. old with a Hx of a SAH aged 10 with specific ocular palsy, but also a 2 year old child with marked cerebral palsy.

Anchor statements are available for each station which highlight expected standards across the various marked domains *(copy enclosed)*

Marking
(Copies of the marking sheets are enclosed)
Each station is marked in 3 domains specific to each station – graded Clear Pass to Unacceptable. These grades however do not form the basis of any check list marking. An overall mark is given by the examiner using the same ratings. There isn't a clear relationship or correlation between the domain scores and the overall rating score. The overall rating score caries a numerical value, 12 for clear pass down to 0 for unacceptable

Category	Mark	Comment
Clear pass	12	Demonstrates the competencies expected of a newly appointed ST4; this includes candidates who have satisfied the requirements and those who excel
Pass	10	Has achieved the standard despite some minor failings
Bare fail	8	Has made an unacceptable number of minor errors or performed in a way that is not satisfactory
Clear fail	4	Usually means a poor performance
Unacceptable	0	Uncommon; for unprofessional behaviour (rough handling of a child, rudeness, etc.) or for extremely poor performance

Examiners are encouraged to write notes / comment for candidates marked less than a Pass

The pass mark in the video station is calculated using EBEL

The maximum marks available is 120 for 10 stations. The pass mark is fixed at 100. – said "to reflect an average of a pass across 10 stations" Compensation is allowed across the 10 stations – clear pass compensation for a bare fail.

At the end of the morning / pm OSCE round there is a call over – marks are called out and recorded – mark sheets are later optically read. Call over is used to ensure that adequate feedback is detailed for those possibly failing candidates

Discussion with Exams Manager – Dan Crane
The exam set up was quite busy and frenetic. As a result, there was only a limited opportunity to speak with the exams manager. Topics we spoke about included:

- The pass rate is approx. 67% - despite what I feel is a high fixed pass mark
- Full OSCE mark sheets are returned to candidates when pass / fails details published. This highlights the need for the need for detailed feedback for those candidates scoring less than a "pass".
- The appeal process is becoming increasingly demanding. This highlights the problem caused by inconsistencies between domain marking on OSCE sheets and overall rating mark. As many as 70% candidates are successfully upgrading a clear fail to a pass
- GMC currently support the format of the exam – using a varied number of real patients. Balance of argument re issues re reliability and that the exam is a more realistic reflection of patient seen in clinical practice
- Future plans –
  The video station may be dropped
  Increase use of actors – particularly for History stations
  Increased structure of questions in OSCE – "Super structured OSCE"

Positive things that may be applicable to Primary FRCA

- Longer stations should allow more detailed assessment

- Dividing each station into an initial "doing / task part" and a later "question" part would allow an examiner to assess a candidate's performance and knowledge, using a varied level of domains
- BLR could be applied to this format – provided both parts of an OSCE station are standardised for all candidates. This is not done in the MRCPCH OSCE due to the very variable nature of the different patients
- The history stations do work well - I would envisage this format being successfully applied to the FRCA (using standardised actors). e.g. Taking a Hx form a high-risk patient with comorbidity for elective surgery followed an assessment of candidate re their knowledge of pre-op optimisation and risk etc.

Negative things

- Longer stations mean fewer stations and fewer candidates. The actual OSCE round at MRCPCH did not start until 10.00, with only 1 round in the morning, another in the afternoon. This format would not be compatible with the number of candidates in the Primary FRCA
- The problems of using real patients highlights the problems of non-standardised OSCE stations. This should be avoided in the Primary FRCA. We should continue to use actors with standardised Hx
- Parallel stations e.g. 2 longer simultaneous Hx stations using actors with the same Hx / story allows a mixture of short and long stations on the same circuit. However, these stations would require some sort of standard setting before the start of an OSCE circuit – This would have a logistical / time implication
- I would discourage routine full disclosure of the OSCE mark sheets to candidates. At present, we provide a summary of station marks, not copies of full mark sheets. My impression is that candidates are closely reviewing all aspects of the marking sheets and using them as a reason for instigating an appeal. This has become an increasing logistical burden for the MRCPCH exam management
- Individual rooms are used for each OSCE station – The OSCE is run in an OPD clinic, a long corridor with a series of rooms. Like Roger, I have visited the RCP facilities as per his report. This does highlight the limitations of the facilities which we have at RCoA. Using an open floor format with "dividers" causes significant concern re noise pollution, candidates listening to / observing other stations etc.