The objective structured clinical examination (OSCE) is designed to assess the clinical aptitude of the examinee. Each case is represents a clinical scenario that a emergency physician could encounter in a normal working day.
Currently, there are twenty stations. Two of the stations are 'double stations' they are twice the length of the normal station and worth twice the marks. They are two rest stations and sixteen normal stations.
The instructions will state clearly which task is to be performed. The candidate is given one minute to read the instructions sheet and five minutes to perform the task.

There are five general tasks:

- History taking
- Examination
- Communication skills
- Procedure
- Teaching

Often the task is a combination of the above five areas and a pie chart is provided to illustrate how each area is weighted.

Below are examples OSCE score sheets. The recommended way to use these is to have one person perform to task while a second person marks the sheet. This should be done in a timed manner to simulate an actual exam environment.

Matrix for awarding the Global score

This matrix sets out indicative behaviour in generic domains of professional behaviour. It should be
used by the examiners and the role player where appropriate to determine the global score. Not every
domain will be applicable to every skill station. Please use the matrix to identify the

global score.
As a rough rule:
5 = mostly exemplary
4 = mix of exemplary and acceptable
3 = mostly acceptable
2 = mix of acceptable and unacceptable
1 = mostly unacceptable

Domain	**Examples of unacceptable behaviour**	**Examples of acceptable behaviour**	**Examples of exemplary behaviour**
Communication	No introduction, and no information about what the station is about Closed questions Not listening to the answer Gives the answer themselves Doesn't' warn patient of actions Uses jargon without explanation	Attempts to introduce themselves and to inform what about to do Some open questions Invites questions Occasionally interrupts inappropriately Attempts to explain what is doing Uses jargon but then explains	Introduces and informs what the task is about Open and closed questions used appropriately Good use of silence Invites questions from patient and answers well in plain English Keeps patient involved and informed constantly
Rapport and empathy	No attempt to establish rapport No response to body language or patient distress Hurts or embarrasses patient	Adequate rapport – Responds to distress but obviously uncomfortable, no eye contact Didn't offend but not always mindful of patient privacy or comfort	Excellent rapport Empathic, good eye contact, Appropriate body language Ensures patient comfort
Professional competence	Appears novice No structure to task Steps in wrong order Appears over/under confident Becomes uncomfortable or irritated	Logical structure but halting and stilted Has to pause to think Appears under confident Clearly anxious but able to control	Logical sequence Looks polished Confident Appears calm and professional
Pacing	Does not complete task	Appears hurried but completes task	Completes task within time and looks comfortable
Equal opportunities/ discrimination	Appears biased – exhibits racism, sexism or ageism Stereotypes patients	No apparent prejudice	Open non judgemental, actively accepting of patients cultural or

	in questions and answers Rude or patronising		behavioural differences
Team skills	No involvement of helper Doesn't listen to examiners or team	Some involvement with team/helper but works autonomously No interaction with examiner	Involves team/helper, maintains cohesive working environment Interacts well with examiner, accepting given cues

History taking OSCEs

History Taking - Endocrine - Thyrotoxicosis

Marking Criteria

Checks name of patient
Asks about presenting complaint (tired/jittery)
Asks about duration of symptoms
Asks about weakness
Asks about swelling in the throat/difficulty in swallowing
Asks about heat intolerance
Asks about sweating
Asks about tremor/shaking
Asks about palpatations
Asks about weight loss
Asks about dyspnoea
Asks about diarrhea and bowel habit
Asks about menstral cycle/abnormalities
Asks about visual disturbances/pain
Asks about past medical history
Asks about family history
Asks about social history
Asks about stress levels
Explain importance of investigation (blood test)
Explains need for further outpatient appointment (clinic/GP)
Explains potential for complications if untreated
Deals with questions appropriately

Global score examiner (out of 5)

Global score Role player (out of 5)

History taking – Suicidal patient

History: A 58 year old male is brought to the emergency department after having tried to commit suicide by hanging himself. During this attempt the rope broke. The patient has not suffered any physical trauma.
Task: take a history and suggest further management

Marking criteria

Brief introduction
Establishes rapport
Asks about events leading up to the suicide attempt
Asks about PMH
Asks about medications and allergies
Asks about previous attempts
Asks about details surrounding event (left note, carried out alone)
Asks about social support
Asks about future intent
Uses SAD PERSON score
Sex, Age, Depression or hopelessness, Excessive alcohol or drug use
Rational thinking loss, Separated or divorced, Organized or serious attempt
No social support, Stated future intent

Shows compassion
Uses open ended questions were appropriate
Shows open body posture
Indicates that patient is not safe for discharge and requires psychiatric review

History taking – STD

History: A 58 year old made presents with pain and discharge from his penis.
Task: take a history

Marking Criteria

Establishes time of onset of dysuria
Establishes exact site of pain – penis or abdomen
Establishes lack of radiating pain
Asks about exacerbating factors – ejaculation, sexual activity
Asks about associated urinary symptoms – frequency, haematuria, colour, smell, quantity, previous episode (3 = minimum)
Asks about other associated symptoms – discharge, ulcers, rash, blisters, fever, testicular pain, eye symptoms, joint pains (4 = minimum)
Asks about sexual partners over last year – when, who
Establishes that the patient has had unprotected sex with his wife and has had one casual encounter in the last year
Establishes that the casual encounter involved another man who performed oral sex on him (the patient)
Establishes that no condom was used
Asked if contacts HIV and Hep B status is known
Establishes that patient has not had sexual contact with wife since encounter
Establishes that the wife has no symptoms
Confirms that the wife does not need to know exact circumstances
Patient advised to abstain from or use protection during sex
Indicates to the patient that he may have contracted a STD
Indicates need for referral to GUM clinic for investigations and treatment
Explains importance of contact tracing
Remains non-judgemental
Encourages questions from patient

Global score

History taking – Needlestick injury

History: A nurse from the ward has been sent to the ED with a needle stick injury
Task: Take a history and give advise.

Marking Criteria

Confirm identity of patient
Asks about presenting complaint
Asks about type of needle (hollow)
Asks about injury site
Asks about depth of injury
Inspects site of injury (superficial scratch)
Asks if wound bled
Asks if washed wound
Asks if it is likely that inoculation of donor blood has occurred
Asks about known infection status of donor (HIV, Hep B, Hep C) with consent to read notes (2 points)
Confirms the donor is low risk
Asks about patient's own infection status (HIV, Hep B, Hep C)
Asks about patient's own tetanus status
Assess wound, determines low risk
Reassure patient unlikely to require PEP drugs
Discuss need to refer to infectious disease or occupational health
Confirms will take blood for storage as per OH policy
Confirms will approach ward team for donor blood tests
Answers any questions patient may have
Asks if any concerns
Deals with concerns

Global scores

History taking - Haematuria

History: A 67 year old man presents with a 3 day history of red urine.
Task: take a history, provide differential diagnosis and management plan

Marking Criteria

Clarifies presenting complaint
Establishes onset
Asks about trauma or urethral instrumentation
Asks about factitious causes (beetroot, berries, rhubarb, rifampicin)
Establishes time during micturation (beginning, end, throughout)
Asks about associated features (vomiting, fever, rigors)
Asks about abdominal pain
Asks about frequency and dysuria
Asks about discharge from meatus
Enquires about recent travel (schistosomiasis)
Asks about respiratory or other infection (post strep GN)
Asks about strenuous exercise (running)
Asks about previous nephrolithiasis
Asks about previous UTI
Asks about diabetes
Asks about HTN
Asks about Sickle cell disease
Asks about medication (anticoagulates/nephrotoxins)
Able to summerise and reach differential diagnosis (infection likely)
Discusses need for urine and blood tests
Discusses possible need for renal imaging (IVU/US/CT)
Discusses need for follow up tests with GP / urologist

Global score

History taking – PID

History: A young female presents to the ED with lower abdominal pain.
Task: take a history and suggest management

Marking Criteria

Confirms identity of patient
Asks for the age of the patient
Asks about chief complaint
Asks about the lower abdominal pain – exact location
Asks about onset
Asks about severity
Asks about nature of pain – colicky or constant
Asks about aggravating and relieving factors
Asks about previous episodes
Asks about associated symptoms – nausea, vomiting, diarrhea, constipation
Asks about urinary symptoms – dysuria, frequency, urgency
Asks about systemic symptoms – fever, chills
Takes gynaecologic history – vaginal discharge
Takes gynaecologic history – last menses, pregnancies
Takes gynaecologic history – sexual activity currently and uses of protection
Asks about history of STDs in the past – if yes – treatment and protection
Informs patient of differential diagnosis – need to rule out pregnancy
Explains need for pelvic exam and swabs
Explains what findings on examination would require admission
Explains need for antibiotics – IV or oral
Offers analgesia
Explains need to contact partner(s) for treatment
Explains need to abstain from sex or use condom until clear of infection
Explains possible complications including infertility
Explains need to follow up with GUM clinic or GP

Global scores

History taking - Endocrine - Diabetes

Marking criteria

Checks name of patient
Asks about presenting complaint-weight loss, urinary frequency and tiredness
Asks about duration of symptoms
Asks about polyuria
Asks about polydipsia
Asks about vision
Asks about abdominal pain
Asks about nausea and vomiting
Asks about past medical history
Asks about drug history
Asks about family history
Asks about social history
Asks about infection related symptoms urinary tract
Asks about infection related symptoms skin and feet
Explains symptoms and urinalysis likely to be new onset diabetes
Explain importance of confirming diagnosis with blood test
Explains need to commence treatment
Explains potential for complications if left untreated
Clarifies if patient does not understand
Deals with questions appropriately

Global score examiner (out of 5)
Global score role player (out of 5)

History taking – sexual history
History: Forty-year-old international businessman presents with concerns about sores in his mouth and around his genitalia.
Task: take a history and offer further management

Marking criteria

Checks name of patient/introduction
Establishes rapport
Uses open ended questions
Elicits presenting complaint and explores underlying problem
Takes PMH
Takes a sexual history
Asks about extramarital relationships
Asks about nature of relationships (multiple homosexual partners)
Asks about condom use
Explores patients concerns, shows respect and non-judgmental attitude
Indicates need for further examination
Indicates need for investigations (mouth swab, urethral swab, blood tests)
Indicates need for partner (wife) to be assessed and investigated
Discusses implication of patient's problem
Indicate need to inform GP
Agrees a clear course of action, referral to GUM
Offers counseling

History taking - Alcohol

<u>Instruction:</u> A 45 year old man presents to the ED with a minor head injury sustained at work. He smells of alcohol. Take an alcohol history…

	Adequate	Inadequate/ Not Observed
Establishes that alcohol may be important		
Asks about recent alcohol consumption		
Ask patient if he thinks alcohol may be a problem		
Asks CAGE questions		
Asks about job		
Asks about home stressors		
Asks about work stressors		
Asks about health concerns		
Asks about social history- children, wife		
Circumstances of drinking- social, alone		
PMH & Past Psychiatric History		
Summarises Findings		
Makes an appropriate risk estimate- behaviour risk plus work and home risks		
Indicates need for specific medical therapy- thiamine, withdrawal therapy if admitted		
Identifies need for patient counselling regarding alcohol intake- ?referral for detox or community alcohol health worker support		
Global Score		
Global Score for Role Player		

History Taking - Psychiatric Examination

Instruction: Young male presents feeling depressed and wishing to commit suicide. Only came because mother made him. Mother concerned because patient keeps hearing voices.

	Adequate	Inadequate/ Not Observed
Initial approach, introduces themselves and explains what he/she will be doing.		
Establish key aspects of the history. (Should not use too much time up).		
Requests the presence of a chaperone		
Take history from patient: A: Appearance B: Behaviour C: Cognition (see MMSE) S: Speech M: Mood I: Insight T: Thought abnormalities H: Hallucinations		
Examine Cognition: MMSE 1. Orientation of time: day, date, month, season, year (5) 2. Orientation of place: department, hospital, town, county, country (5) 3. Registration: 42 West Street, Long Town, Leeds (3) 4. Attention & Concentration: spell WORLD backwards (5) 5. Short term memory: recalls address (3) 6. Language: Name 2 objects: pen & watch (2) Repeat phrase: no ifs or buts (1) 3 part command: take piece of paper and fold it into 2 and place it on the floor (3) Read & obey: Close your eyes (1) Write sentence (subject, verb &		

make sense) (1) Copy diagram (1) Total = 30 normal = ≥23		
Provides summation of findings		
Management plan including investigation and treatment		
Global Score		
Global Score from Role Player		

History taking – headache

Task: Take history from this patient who is having severe headache since morning and tell the patient what it could be. And line of management.

History taking – palpitation

Task: take a history and discuss differential diagnosis

History taking – painful knee – Reiters disease
History: This 21 year man has had swelling of his right knee for three days
Task: take history and discuss differential diagnosis

History taking- sexual history

A 17 year old male attends with his Mother. He has a 3 day history of dysuria. Take a sexual history.

- Wash hands / alcohol gel
  - Ensure privacy / confidentiality
  - Introduce yourself
  - Confirm identity of patient and relative
  - Suggest may be appropriate for Mother to leave room

- Dysuria – 3 days
  - Discharge
  - Frequency
  - Sores/ itching
  - Testicular/groin pain/swelling
  - Previous episodes

- Sexual partner(s)
  - Recent casual or unprotected sex
  - Male or female?
  - Vaginal / oral / anal (giver or receiver?)
  - Foreign travel / sex?

- PMH, DH, allergies

- Explain you would like to proceed to examine the patient, discuss the diagnosis with the patient, arrange appropriate investigations, advice re. barrier contraception, contact tracing, GUM F/U

- Thank patient

History taking – HIV risk
One of your SHOs has just received a needlestick injury.

She is being seen by your consultant, who requests that you see the patient (donor) and assess their HIV risk.

- Wash hands / alcohol gel
  - Privacy / confidentiality
  - Introduce yourself
  - Confirm identity of patient
  - Consent (and explain situation)
  - Sensitive, tactful and empathic

- **Sex**
  - Hetero / bi / homosexual
  - Unprotected sex?
  - Multiple partners?
  - Recent STIs?
  - HIV status of partner?

- **IVDU**
  - ? IVDU
  - ? shares needles
  - ? partners IVDU

- **Blood products and transfusions**
  - Haemophilia?
  - Blood products prior to 1985?
  - Partners haemophilia or blood products prior to 1985?

- Tattoos

- Any Qs
  - Address anxieties
  - Thank patient

History taking – suicide risk

You are asked to review a patient on CDU. He presented following an OD of paracetamol. His levels are below the treatment line, and he would now like to go home. He does not want to stay overnight to see the self harm team. Assess his suicide risk.

- Read notes and confirm blood results
  - Wash hands / alcohol gel
  - Introduce yourself
  - Confirm identity of patient
  - Consent

- Review history
  - Explain that ideally should stay and see self harm team

- **Assess suicide risk (SAD PERSONS)**
  - **S**ex – male (1)
  - **A**ge - <19 or >45 yrs (1)
  - **D**epression (2)
  - **P**revious suicide attempts or psychiatric care (1)
  - **E**thanol / drugs (1)
  - **R**ational thinking loss (2)
  - **S**eparated, widowed or divorced (1)
  - **O**rganised or serious attempt (2)
  - **N**o social support (1)
  - **S**tated future intent (2)

- **Calculates and explains significance of score**
  - Score <6 – *may* be safe to discharge
  - 6-8 *probably* requires psychiatric consultation
  - >8 *probably* requires hospital admission

- Enquires re. home circumstances and supervision
  - Arrange community psychiatric follow up
  - Liaise with GP

- Checks patient understanding
  - Thank patient

History taking - Abuse

Your next patient is a 43 year old woman who has been assaulted. Take a relevant history.

- Wash hands / alcohol gel
  - Suitable environment
  - Female chaperone
  - Introduce yourself
  - Confirm identity of patient
  - Consent
  - Ensure comfortable – offer analgesia

- Identifies that this is domestic violence
  - Identifies extent of injuries
  - ? sexual abuse / rape
  - ? previous domestic violence
  - ? co-habiting
  - ? children involved
  - ? police involved - partner arrested

- Ensures safe environment for discharge
  - Offers appropriate support

- Thank patient

History taking – psychiatric
This 28 year old woman believes she is having the Devil's baby. She has some superficial self-inflicted wounds to her abdomen that have been treated adequately.

Assess her mental state.

	Not done	Partially done	Completed
Washed hands & alcohol gel			
Introduced self			
Check patient identity			
Obtains verbal consent for interview			
Comments on appearance			
Asks about thought disorders			
Asks about hallucinations			
Asks about insight			
Comments on speech pattern			
Asks about mood			
Attempts to check cognition - stopped			
Asks about psychiatric history			
Asks about psychiatric follow up			
Asks about medical history			
Asks about medications & compliance			
Asks about illicit drugs			
Has management plan			

History taking – DVT risk

This man has a painful left leg take a relevant history and perform the necessary examination to stratify her risk.

	Not done	Partially done	Completed
Washed hands & alcohol gel			
Introduced self			
Check patient identity			
Obtains verbal consent			
Lower limb surgery			
Bed Ridden or plaster cast			
Past history/family history of VTE			
History of active malignancy			
IVDU			
Tender along femoral or popliteal veins			
3cm difference 10cm below tibial tuberosity			
Dilated collateral veins (not varicose)			
Pitting oedema			
Alternative diagnosis			
Stratifies risk appropriately			
Arranges appropriate investigation			
Asks if any questions			
Thanks patient			

History taking – capacity

This 14 year old has been seen earlier by your SHO and has taken an overdose of 25 paracetamol. She is refusing treatment. Assess her capacity to refuse treatment.

	Not done	Partially done	Completed
Washed hands & alcohol gel			
Introduced self			
Checked identity of patient			
Verbal consent			
Checked details of overdose			
Check understanding of what will happen if no Rx			
Check understands what Rx involves			
Checks belief of facts			
Checks retention			
Able to process information and come to conclusion			
Tries to involve parents			
Identifies problem with dad			
Identifies that she is worried about being pregnant			
Gently persuades her to have treatment			
Happy for her to contact mum only			

History taking – PV bleeding

A 62 year old lady presents to your Emergency Department with PV bleeding. Take a relevant history from her.

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	Not done	Partially done	Completed
Washed hands & alcohol gel			
Introduced self			
Check Identity of patient			
Explain Procedure & obtain verbal consent			
Gynae	x	x	x
Age of menarche			
Age of menopause			
Vaginal discharge			
Last smear			
Significant PMH			
Lumps in breast?			
Sexual	x	x	x
Are you sexually active?			
How many partners have you had in your last 3/12?			
Dyspareunia?			
Sexual Instruments?			
Any questions			
Thanked patient			

History taking – thrombolysis
This gentleman has had an hour of chest pain and his ECG shows a myocardial infarction. Counsel him with regards to thrombolysis.

	Not done	Partially done	Completed
Washed hands & alcohol gel			
Introduced self			
Confirms identity of patient			
Obtains verbal consent			
Establishes patients knowledge			
Warfarin			
Haemophilia			
Severe liver disease			
Thrombocytopenia			
Stroke			
Recent surgery			
Trauma +/- Resuscitation			
Proliferative eye bleeding or vitreous haemorrhage			
Upper & lower GI bleeding			
Serious vaginal bleeding			
Pregnancy			
Hypertension Sys BP >200mmHG			
Hypertension Dia BP >120 mmHg			
History suggestive of Dissesection			
Aortic aneurysm			
Previous streptokinase			
Previous allergies			
1-2% Bleed rate			
Any questions			
Asks patient her decision?			
Organises treatment			

Thanks patient			

History – taking diarrhoea

A 27 year old student returns from holiday with diarrhoea. Take a relevant history.

	Not done	Partially done	Completed
Washed hands & alcohol gel			
Introduced self			
Checks identity of patient			
Obtains verbal consent			
Establishes where patient has been			
Establishes when went & returned.			
Establishes what is meant by diarrhoea			
How long has had diarrhoea?			
How soon after arriving did symptoms start?			
How many times a day opening bowels?			
Anyone else affected?			
Any blood?			
Any pain?			
Any vomiting?			
Any jaundice?			
Alteration in colour of urine			
Any fevers?			
Any rashes?			
Enquires about oral intake of fluids.			
Thanks patient.			
Summarises accurately			
Suggests Examination, blood tests, stool culture & possible referral to infectious diseases			

History taking – Mania
History taking - Cardiac
History taking - Jaundice
History taking - Limping Child
History taking - Pleuritic Chest Pain