

CANDIDATE INSTRUCTIONS AND GUIDANCE NOTES

MRCs PART B COMMUNICATION SKILLS

(Conducted under the Regulations for the
Intercollegiate Membership Examination of the
Surgical Royal Colleges of Great Britain and
Ireland held Overseas dated January 2011)

October 2010

MRCS PART B COMMUNICATION SKILLS EXAMINATION

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1. Introduction

The Communication Skills Section takes place at a hospital at the same time as the Clinical Section. There are two tests, Information Giving and Information Gathering.

The Section comprises an exercise with an actor playing the part of a patient or relative, based on information-giving and a second exercise with an actor based on information-gathering followed by presentation to a consultant. The tests are all based on a clinical situation, and you will be expected to give accurate clinical information as well as possess good communications skills.

The tests are separately marked, but a single overall pass or fail grade is awarded at the end. **There is no cross-compensation of marks between the Clinical and Communication Skills bays.** If you pass Communication Skills but not the Clinical Section, you will retain your pass, but you will have to re-sit and pass the Clinical component within the time limit in order to pass the IMRCS overall. If you pass the Clinical component but not Communication Skills, you will have to re-sit and pass Communication Skills within the given time limit before being awarded the IMRCS.

Mobile phones must be switched off at all times and if candidates are seen holding their phones it will be assumed that they are using them.

2. Proof of Identity

Candidates must bring proof of identity to the examination. Proof of identity must be an official document, such as a current passport or driver's license that includes the candidate's name, signature and photograph.

For the purposes of visual identification, any candidate sitting the examination will be required to remove any clothing and/or other item which covers all, or part of, the candidate's face. The Colleges will observe sensitivity and, in specific circumstances, privacy in the visual identification of candidates.

To facilitate the assessment of non-verbal communication skills and interaction with the examiner and patient (or actor in the role of the patient as the case may be), the Colleges will require candidates for the duration of the stations in question, to remove any clothing and/or other item which covers all, or part of, the candidate's face.

3. The Two Types of Scenario

The scenarios will vary in subject matter and inevitably you will find some more difficult than others, and some will take longer than others to complete. It will not be necessary to have completed any particular post to have sufficient professional experience for the scenario in question.

What is looked for is a competent performance within the time available rather than a fully comprehensive interview. You could finish early or run out of time yet still be competent, but you should always try to complete the interview if possible. Similarly, some situations or knowledge may be outside your level of personal experience but will be within the IMRCS syllabus, and the skill sought is the insight to recognise this and act appropriately, e.g. to say that you will ask their consultant to provide further details.

It is important to note that you are being assessed on communication skills **in a clinical situation**, so if you give seriously misleading or dangerous information or fail to elicit a critical fact by not asking a standard question, e.g. on medication taken in the Information Gathering bay, you may fail the task no matter how good your communication skills are.

4. General Skills

The general skills that will be looked for in both tests are as follows:

4.1 Introduction

- Gives name and explains role; checks patient's name
- Gives greeting appropriate to cultural environment (handshake not always appropriate)
- Non-verbal behaviour appropriate to culture (eye contact not always appropriate)
- Establishes purpose of interview
- Clarifies why interview is taking place:
 - from patient's perspective
 - from own perspective
- Checks that patient is happy to proceed
- Establishes desired outcome of interview
- Establishes baseline knowledge/understanding
- Uses open questions
- Listens
- Confirms what s/he has learned
- Signals move to information-giving at end

It is essential that the above points are performed well; it would be very difficult for a candidate to pass if this part was badly done.

4.2 General Manner

a) Picks up and responds to cues

Acknowledges and responds appropriately to verbal and non-verbal indications from the patient/relative about their thoughts/feelings/questions.

b) Listens actively

Makes it clear that s/he is listening through body language, encouragement to patient/relative to tell their 'story' and appropriate responses.

c) Uses empathy

Shows empathy for patient's/relative's feelings and/or situation both verbally and through body language.

d) Offers support

Makes supportive statements about the patient's/relative's feelings/situation and offers practical support such as details of counselling services, appropriate literature.

e) Presents information non-judgementally/does not impose personal beliefs

- Presents facts without influencing patient inappropriately; either takes a neutral position or makes it clear that the advice given reflects the surgeon's personal view based on experience and knowledge (as distinct from influencing the patient to make a decision that suits the surgeon).
- Does not express personal beliefs on controversial matters e.g. in treatment of patients from other cultures/religions.

f) Uses language patient/relative understands

Avoids medical jargon and uses language appropriate to the patient's/relative's level of understanding, perhaps adopting terms they have used themselves. Picks up on cues that patient/relative has not understood and offers further explanation. May use drawings as an aid where explaining.

g) Uses appropriate body language

Uses body language that conveys attention, empathy and respect but is not over-familiar, e.g. does not invade personal space. Respects cultural differences over use of eye contact and touching.

h) Questioning Style

Uses open and closed questions appropriately

Uses open questions to establish information non-directively and allows patient to take charge of interview, but uses closed questions when appropriate, e.g. when a yes/no answer is required, or to take back control of interview in order to cover essential points in limited time.

i) Information Giving

1. Conveys information and checks understanding

Conveys information in small, digestible pieces and checks that each has been understood before moving on.

2. Control of Interview

Allows control of interview to alternate between doctor and patient

Allows patient to take the lead where appropriate, e.g. surgeon pauses in mid-explanation to allow patient to seek clarification or offer further information, then regains control. The surgeon should remain in control overall but needs to allow the patient to take control at times to express their own needs and views.

3. Signposts change of direction

Helps patient to follow changes in subject matter/purpose of interview by clearly indicating new topic. e.g. "Now I need to ask you about"

4. Summarising

Summarises/indicates next steps

Gives a summary of main points at end of interview and lets patient/relative know what will happen next and/or where they can get further information.

5. Recognising and responding to patient's concerns, anxieties and doubts

Acknowledges patient's concerns, anxieties and doubts and makes appropriate responses.

j) Information Gathering only

Presentation Skills

1. Appropriate language

The candidate should switch to technical medical terminology.

2. Order (methodical approach)

The candidate's presentation should be logical, but no single method is preferable to another.

3. Comprehensive/succinct

The candidates should cover all the salient points but omit inconsequential ones, keeping to the 5 minute time limit.

4. Emphasis and significance

The history should be appropriate to a surgical context. The candidate should make reference to the patient's ideas, concerns and experience.

5. Interpretation of ideas and concerns

The candidate should be able to interpret the patient's ideas and concerns faithfully.

5. Examination Format - Information Giving Test

You will be given time to read a brief information sheet explaining the scenario for the exercise, i.e. who you are, the place and time, brief details of the patient or relative to be seen, and your particular task. For example, you might be asked to explain an operative procedure to a patient, give information about an operation that has taken place to a relative, or break bad news to a relative. An example of one such Candidate Information sheet is given in Appendix 1.

THE CANDIDATE INFORMATION SHEET MUST NOT BE COPIED, PHOTOGRAPHED OR REMOVED FROM THE READING ROOM

You will then be taken to the examination room or cubicle, where there will be two examiners and the actor who will play your patient or relative. One examiner will greet you, check your number and introduce him/herself and colleague, but will **NOT** introduce you to the actor – s/he will simply say 'You may start' so that the onus is on you to introduce yourself, check the patient's identity and explain your own role. You will then have 10 minutes to deal with the task you have been given.

You may re-arrange the chairs if necessary to reduce the 'barrier' between you and your patient.

There will always be two aspects to the task: a specific clinical task, e.g. explaining an appendicectomy, plus an element that is the particular communication skills focus of the scenario, e.g. a distressed or withdrawn patient.

You may well be able to accomplish the task quite satisfactorily within the 10 minutes available because some tasks will take longer to complete than others. If you finish before the bell, you should check that the patient/relative has no further questions and is clear on what happens next, then thank them and leave. Equally, you may require the full 10 minutes, but you should still aim to close the conversation effectively within that time by summarising, checking for further questions and explaining next steps.

The examiners will not intervene in any way during the conversation and will not ask you questions at the end. They will mark your performance on both your handling of the conversation and the accuracy of the information you give. (Don't forget, although the emphasis is on communication skills, if you give the patient/relative seriously misleading or dangerous information you will be failed on the task no matter how well you communicated with them.)

Some scenarios will deliberately go beyond the scope of a junior doctor's professional experience or authority. In such cases you will be expected to recognise that you should refer the matter upwards.

You should be aware that the actor playing the patient or relative will have been given a much more detailed briefing on the scenario than you have. You should therefore be prepared for aspects of the situation or the patient's condition to emerge in conversation and you should deal with this accordingly.

6. Examination Format - Information Gathering Test

You will be given time to read a brief information sheet explaining the scenario for the exercise, i.e. who you are, the place and time, brief details of the patient/relative to be seen, and your particular task. The exercise will normally consist of taking a history from an actor playing a patient or relative, then presenting the history to an examiner playing your consultant. An example of one such candidate information sheet is given in Appendix 2.

THE CANDIDATE INFORMATION SHEET MUST NOT BE COPIED, PHOTOGRAPHED OR REMOVED FROM THE READING ROOM.

You will then be taken to the examination room or cubicle, where there will be two examiners and the actor who will play your patient. Again, one examiner will greet you, check your number and introduce him/herself and colleague, but will **NOT** introduce you to the actor. The examiner will then explain the task and invite you to start. You will then have up to 10 minutes to take the patient's history. You may make notes if you wish using the materials provided. You may finish within the 10 minutes, in which case you will be able to use the time that remains to prepare to present the history to your consultant or you may start your presentation before the ten minute bell if you wish to do so. You should let the examiners know when you are ready to do this. If you start your presentation early, you should be aware the bell will still ring after the initial 10 minutes. You may ignore this bell.

(As with the Information Giving test, you should first of all close the conversation in a satisfactory manner, checking that the patient has no further questions and knows what will happen next. You should say that you will now speak to your consultant. The actor will then leave.)

After 10 minutes a bell will ring, at which point the actor (if still present) will leave and the examiner playing your consultant will ask you to present the patient's history. You will have up to five minutes in which to do this and to answer three standard questions.

When you have finished your presentation, one examiner will ask you three standard questions:

- What differential diagnosis would you suggest at this stage based on the history you have taken?
- What signs would you specifically look for when you are examining this patient?
- What investigations would you request for this patient?

As with the Information Giving test, this scenario will present a challenge in communications terms as well as setting you the task of communicating well in a specific clinical situation. For example, the patient/relative might be anxious or aggressive or very timid, and require drawing out, or be so talkative that it is hard to question them.

The examiners will mark your performance on both your handling of the conversation and the accuracy of the information you give. The emphasis is on communication skills, but if you give the patient/relative seriously misleading or dangerous information you will be failed on the task no matter how well you communicated with them. You will also be marked down or failed if you do not ask key questions that would materially affect the treatment of the patient, e.g. on other medication taken. You should be careful to use terminology appropriate to the patient's understanding, and then switch to appropriate language in presenting to the consultant.

In addition to the general skills mentioned earlier, there are some skills that are particular to the Information Gathering test:

6.1 Information-gathering points

- The **systemic review** is a **focused** one concentrating on **relevant** points. You will be expected to go through the features appropriate to a **surgical outpatients' clerking**, NOT the full history as taught at medical school. You should ask about other significant medical problems and carry out a brief systemic overview including medication and allergies.
- You will be judged on what you covered in the time – you may not have covered every aspect within the actor's detailed brief. It is not necessary to follow a set order of topics, but changes of topic should be clearly signposted to the patient, e.g. 'Thank you. Now I'm going to ask you about...'

6.2 Presentation

- The **presentation** to the consultant should follow a logical structure, be couched in appropriate clinical language (the patient is no longer present), should pick out the key points and should cover the information obtained thoroughly but succinctly.

6.3 Questions

You will be asked:

- What differential diagnosis would you suggest at this stage based on the history you have taken?
- What signs would you specifically look for when you are examining this patient?
- What investigations would you request for this patient?

7. Marking the Scenarios

There will be a separate mark sheet for each test, which will enable the examiners to indicate whether you performed satisfactorily on various points, some of which are general communication issues and some of which are points specific to each scenario. The scale does not translate into a mark, but acts as an aide-memoire to build up an overview of the quality of the candidate's performance.

The examiners will record an independent mark on a 1-4 scale. The final mark for each test is arrived at by adding the marks of both examiners for each component together. In Information Gathering bay there will be a separate mark for the interview and the presentation.

In summary:

- There are 24 marks available in total.
- The pass mark is 15.
- Candidates must pass at least two of the three components. The lowest mark required to pass each component is 5.

8. Communication Skills Syllabus

Communication skills will be assessed using observed behaviour during role-play in a variety of simulated clinical situations. The standard of performance will be that expected of a basic surgical trainee exiting the grade. Clinical scenarios will be based on the syllabus, but candidates may need to indicate the limits of their professional experience, competence and authority.

DURING THE ASSESSMENT TESTS THE CANDIDATE WILL BE EXPECTED TO:

Exhibit sensitivity to the needs of the individual patient/relative* during any consultation by:

- Treating each patient with respect and courtesy.
- Establishing a suitable rapport by demonstrating clear, honest and empathetic communication.
- Taking into account ethnicity, cultural, age and disability factors.
- Responding appropriately to verbal and non-verbal cues given by the patient.

- Taking a holistic approach to the patient and/or relatives.
- Listening to the patient's account.

Exhibit a professional approach to a situation. Professional in this context can be taken to mean an approach that is calm, measured and is not judgemental, paternalistic or patronising; does not seek to impose the doctor's own beliefs and values and encourages shared decision making.**

Typical challenges could include:

- Dealing with a variety of emotional responses by the patient and/or relatives.
- Dealing with a variety of pre-existing emotional states on the part of the patient and/or relatives.
- Dealing with patients/relatives from a wide variety of cultural/religious and ethnic backgrounds.
- Dealing appropriately with questions and situations that are beyond the level of competence of the candidate.
- Dealing with time constraints.
- Dealing with complaints appropriately

SPECIFIC TESTS MAY REQUIRE THE CANDIDATE TO:

Demonstrate an ability to communicate accurate information in an appropriate manner to patients and/or relatives in typical clinical situations such as:

- Obtaining informed consent.
- Conveying bad news such as an unfavourable outcome, unsatisfactory care or poor prognosis.
- Explaining the relevance, process, risk/benefits and possible impact of investigations in the context of a clinical situation.
- Explaining a diagnosis or differential diagnosis.
- Explaining options available including the process, risks and benefits of each and the option not to treat.
- Explaining uncertainties of diagnosis, outcome or prognosis.
- Explaining the opportunities available for further information including a second opinion.
- Involving the patient in decision making to the level that they wish.
- Checking for understanding and summarising at appropriate intervals.
- Using this feedback to regulate the pace and content of the consultation.

Demonstrate an ability to obtain a focussed medical history with relevant key points, in a variety of clinical situations, appropriate to the clinical case i.e. fit for purpose. During such a test, an ability to elicit the patient's concerns, ideas and expectations would be required.

Situations might include:

- Taking a brief history from a patient in the outpatient department or ward.
- A consultation with the relative of the patient.

Demonstrate an ability to convey appropriate information to colleagues and other healthcare professionals in an appropriate manner, to a satisfactory standard and using a variety of methods.

These could include:

- Verbal communications such as case presentations, to colleagues.
- Written communications such as medical records.
- Investigation request forms.
- Clinical letters to medical colleagues.
- Telephone communication.

Demonstrate the ability to use background information and that gathered during a consultation to formulate an appropriate response.

This could include:

- Discussing a management plan with a patient, relative or colleague
- The ability to summarise information appropriately

* Relative is understood to include partners, carers and “significant others”

** Professional Values are defined in the curriculum and *Good Medical Practice*

9. Results

Results will appear on the College website on the date specified on the admittance letter and written confirmation will follow at a later date.

10. Feedback to Candidates

With effect from the June 2009 diet, feedback to all candidates for Part 3 (Communication Skills) of the MRCS examination will comprise the mark awarded in each part of the Part 3 (Communication Skills) examination, together with the overall mark, the marking scheme and the grade descriptor. No further feedback will be available.

The mark descriptors are as follows:

MRCS COMMUNICATION SKILLS MARK DESCRIPTORS

Examiners award marks based on their professional judgement using the following generic mark descriptors as guidance:

Mark of 1 (Fail)

The candidate was not able to gather (or give) sufficiently detailed information in the clinical scenario. The information that was gained (or given) was not prioritised in a logical manner and may not have been conveyed clearly to the patient/relative/health care professional. There will have been an inability to adapt language or non-verbal communication as appropriate and little empathy demonstrated. Where requested, verbal and written responses will have been ambiguous or confusing.

Mark of 2 (Borderline fail)

The candidate may have gathered (or given) an acceptable level of detailed information in some areas of the clinical scenario, but not in others. Equally, this

information may not have been satisfactorily prioritised or presented. Language and non-verbal communication will have been appropriate to some, but not the majority of the sections of the bay. Verbal and written responses will have been partially satisfactory but still insufficient to demonstrate competence in skilled communication.

Mark of 3 (Borderline Pass)

The candidate was able to gather (or give) a satisfactory level of information in the clinical scenario. Some areas may have been deficient but these will not have been essential to the task. The presentation of information to the patient/relative/health care professional will have been clear and adequately prioritised. Language and non-verbal communication will have been predominantly appropriate and adapted as required. Competence in verbal and written responses will have been demonstrated.

Mark of 4 (Pass)

In essence, this grade represents any level of competence in skilled communication that is deemed to be above the borderline pass. Information has been gathered (or given) by the candidate satisfactorily throughout the majority of the scenario. This will have been prioritised and presented more than adequately to the patient/relative/health care professional, with no significant errors. Language and non-verbal communication were consistently appropriate and mutual understanding observed. Verbal and written responses will have demonstrated clarity and focus.

The foundation of skilled communication is accurate surgical knowledge and understanding. If candidates were to provide seriously misleading clinical information during their assessment this will be penalised, even if their communication skills are satisfactory.

Appendices:

- Appendix 1 Sample Information Giving candidate information
- Appendix 2 Sample Information Gathering candidate information

Appendix 1 Sample Information Giving candidate information

INFORMATION GIVEN TO THE CANDIDATE

Who the candidate is	A junior doctor in a general surgical firm
Where the candidate is	Day Surgery unit
When the scenario takes place	Weekday 11.00

Introduce yourself to the actor as a junior doctor in the general surgical firm

Instructions for the candidate

This patient, Joseph Green, has been shown on a barium swallow, organised by the GP, to have a stricture of the oesophagus that is causing dysphagia. The stricture looks benign on the barium swallow.

Your consultant will be with you for this list, but he has been called away unexpectedly for about 20 minutes.

You have been asked to talk to the patient in the meantime.

The patient has not been seen by a doctor since the barium swallow.

The patient is to have an oesophago-gastroscopy and biopsy. He wants to ask you some specific questions.

You have 10 minutes for this test. If you finish the task you have been set before then, end the interview as you would normally and leave. It is perfectly acceptable to finish early as some tasks will take less time than others.

A bell will sound after 10 minutes. You must stop then and leave the room.

A further copy of this paper will be in the examination room.

DO NOT REMOVE THIS PAPER FROM THE ROOM

Appendix 2.1 Sample Information Gathering candidate information

INFORMATION GIVEN TO THE CANDIDATE

Who the candidate is	A junior doctor in urological surgical firm
Where the candidate is	Outpatient clinic
When the scenario takes place	10 AM

Introduce yourself to the actor and explain your role.

Instructions for the candidate

You are a junior doctor on Mr. Stone's urology team.

Mr Stone has asked you to clerk a new patient in the outpatient clinic.

The GP referral letter is attached.

N.B. You have only 10 minutes to take the history, but you will not be penalised for not completing the task.

After you have taken the history, you will be required to present it to one of the examiners, as though s/he were the consultant. S/he will then ask you for your differential diagnosis, what signs you would look for on examination and what investigations you would request.

The patient will leave the room during your presentation.

A bell will sound after 10 minutes. You may then take a few moments to gather your thoughts before you start the presentation and questions, for which you have up to 5 minutes. If you complete your history taking before the 10 minute bell you may use the remaining time to plan your presentation, or, if you wish, you may start the presentation immediately.

You may look at your watch from time to time during the history taking so as to pace yourself appropriately. You may make notes and refer to them during the presentation.

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Appendix 2.2

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The GP referral letter:

The GP Practice

Drs G Jones and S Williams
17 High Street
Pintown

The Consultant Surgeon
St Vincent's Hospital
Pintown

Re: Harry Green, 69 Elm Lane, Anytown

Dear Doctor

This 60 yr old patient rarely comes to the surgery, but he came today complaining of passing pink urine.

Best wishes

Yours sincerely

Simon Williams