LAY EXAMINER GUIDANCE NOTES

MRCS
PART B (OSCE)
EXAMINATION

February 2013

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1. Introduction

The revised MRCS (2008) was developed to meet the requirements of assessing trainee surgeons in MMC (Modernising Medical Careers) training programmes. Obtaining the MRCS Diploma is one of a number of mandatory requirements for trainees to progress from their second year of core/specialty training. These notes refer to the Part B OSCE (Objective Structured Clinical Examination) as modified in 2012 for introduction in February 2013.

The Part B (OSCE) examination has been produced by a sub-group of the ICBSE (Intercollegiate Committee for Basic Surgical Examinations) and this group is also responsible for the operation of the examination and its ongoing development. The revised examination was designed to incorporate some of the best features of the traditional College examinations with oral/clinical and communication skills elements that will be familiar from those examinations. However, it also allows the assessment of other areas such as surgical skills and patient safety. The Part B OSCE examination was introduced in October 2008 and was comprehensively reviewed after three diets in 2009. As a result of this review the 2010 version incorporated a number of significant changes from 2008. A further comprehensive review was undertaken in 2011 resulting in GMC approval for the changes which have been incorporated into the examination for 2013. The flexibility of the format means that all areas of the syllabus can be assessed.

The Part B (OSCE) examination is designed to be taken during the second year of specialty/core training and is set at that level. However candidates are free to enter when they wish and experience suggests that many will enter the examination at an earlier stage. Taking the Part B examination is permitted only after successful completion of both (MCQ) written papers that comprise Part A of the MRCS. Only four attempts to pass the Part B examination are allowed.

2. The purpose of the MRCS examination

The purpose of the MRCS examination is to determine that trainees have acquired the knowledge, skills and attributes required for the completion of core training in surgery and, for trainees following the Intercollegiate Surgical Curriculum Programme (see http://www.iscp.ac.uk), to determine their ability to progress to higher specialist training in surgery.

3. The structure of the MRCS examination

The MRCS examination has two parts: Part A (MCQ) and Part B (OSCE).

4. Overview of the OSCE examination

The Part B examination consists of a circuit of 18 examined stations presenting different scenarios and tasks. Each station is designed to test different skills or combinations of skills. A schematic of the structure is shown at Appendix 1. Additionally there are also preparation and rest stations within the circuit. Each

station will be of nine minutes' duration with one minute for reading instructions. The total duration of the Part B examination will be approximately 3 hours 30 minutes; this will usually be split into two halves to allow a mid-session break.

These stations will be divided into broad content areas (BCAs) as follows:

- Anatomy and surgical pathology (5 stations)
- Applied surgical science and critical care (3 stations)

These two BCAs will be grouped together for the purposes of passing the examination and will be known collectively as "Applied Knowledge" (8 stations = 160 marks)

- Clinical and Procedural Skills (6 stations)
- Communication skills (4 stations)
  - Giving and receiving information
  - History taking

These two BCAs will be grouped together for the purposes of passing the examination and will be known collectively as "Applied Skills" (10 stations = 200 marks)

All 18 stations are manned. Some of the manned stations will have two examiners, some one. In most stations with two examiners each will be marking different aspects of a candidate's performance. An outline of the format of the OSCE is provided as Appendix 1.

5. Domains

In addition to the four broad content areas examined, four domains have been identified which encompass the knowledge, skills, competencies and professional characteristics of the competent surgeon. These domains map to GMC's Good Medical Practice (GMP) and are assessed in the Part B examination as follows:

- *Clinical knowledge and its application:* the clinical knowledge specified in the syllabus; the ability to understand, synthesise and apply knowledge in a clinical context.

- *Clinical and Technical skill:* the capacity to apply sound clinical knowledge, skill and awareness to a full investigation of problems to reach a provisional diagnosis, the ability to perform manual tasks related to surgery which demand manual dexterity, hand/eye coordination and visual-spatial awareness.

- *Communication:* the ability to assimilate information, identify what is important and convey it to others clearly using a variety of methods; the capacity to adjust behaviour and language (written/spoken) as appropriate to the needs of differing situations; the ability actively and clearly to engage the patient/ carer/ colleague(s) in open dialogue.

- *Professionalism*: the demonstration of effective judgement and decision making skills ; the consideration of all appropriate facts before reaching a decision; the capacity to think beyond the obvious and to maximise

information efficiently; being alert to symptoms and signs suggesting conditions which might progress or de-stabilise; being aware of own strengths/limitations and knowing when to ask for help; the ability to accommodate new or changing information and use it to manage a clinical problem; to anticipate and plan in advance; to prioritise conflicting demands and build contingencies; demonstrate effective time management; demonstrate awareness and understanding of the importance of patient safety.

The four domains are assessed via the 18 stations. Each individual station has been designed to assess up to four different domains. The mark sheet for each station will clearly describe which domains are being assessed and how and what marks can be awarded for each domain.

6. Marking

In addition to the 20 marks available for each station for the domain assessments, each candidate will be given a separate, overall global rating for the station based on the assessment of his/ her overall performance. In stations with two examiners there will be a single agreed rating.
The ratings are:
Fail
Borderline
Pass

Marks out of a possible 20 and the global examiner judgements for each of the 18 stations are collected from all the examination centres. These are carefully checked and the performance of individual stations/examiners analysed for any inconsistencies. A regression analysis of the marks awarded against the examiner judgements is used for standard setting. Candidates must achieve a pass mark in both of the two grouped content areas "Knowledge" combining broad content areas Anatomy and Surgical Pathology and Surgical Science and Critical Care and "Skills" combining Clinical and Procedural Skills and Communication. Each of the two grouped areas must be passed at the same sitting.

The standard setting process takes up to two weeks so no results will be issued on the days of examination.

7. Exam organisation and timing

A training session for the 2013 version of the examination is provided for all examiners. This will normally be given at the start of each diet of the examination. The previous examiner mix will **change** to:

- Surgeon examiners may be selected to examine in any clinical, technical or communication skills station and in stations involving their declared basic science. In clinical stations surgeon examiners will also be expected to examine in any of the bays regardless of their own specialty;

- Basic science examiners will examine in their specialty areas.

- **Lay examiners will continue to examine with a medically qualified examiner in communication skills stations, but will now also examine in history taking.**

Examiners will be organised by the designated Supervising Examiner. For each block of examiners the block will start with a full formal briefing and allocation of examiners to stations. It is mandatory that all examiners attend this briefing. On intermediate days there will still be a briefing but it may be limited to changes or announcements since the previous day. Any new examiners during the block will be given the full briefing.

After allocation of stations, examiners must familiarise themselves with the station they are examining and adequate time will be allocated for this. Each station will contain a folder that will cover all aspects of that station and how it is to be examined and marked. **Please note that the mark of zero can be awarded if appropriate rather than the minimum domain mark of 1 in the 2010 version.** The folder will include candidate/patient/actor instructions and the detailed mark sheet. If the allocated station includes patients (real/ simulated/ actors) the examiner should make sure that they fully understand and are familiar with their brief. The examiner should also check physical signs and liaise with co-examiners (if applicable) about the station. It is very important that examiners are absolutely clear before the examination starts about what and how they are marking and that they are happy with the practical arrangements for running the station. If examiners think there are mistakes/inconsistencies or are concerned about any aspect of the station they must speak to the Supervising Examiner before the circuit commences.

Usually with stations involving real patients there will be a number of patients available with the same condition so they can be substituted during the day as necessary. Examination administrators will be in attendance throughout to ensure the smooth running of all aspects of the examination.

Each station lasts nine minutes plus one minute for the candidate to read the scenario before beginning the task. In stations requiring an observed task (physical examination or history taking) six minutes will be allocated for this with three minutes for discussion. There will also be preparation bays required for two of the communication skills stations. Rest periods/timing arrangements and circuit organisation will be locally decided at the respective College centres and will be notified at the briefing. Exam circuits will be identical morning and afternoon as morning candidates will be held back until the afternoon session starts.

If there are any untoward incidents during the examination in any particular station, for example failure of a prop or other equipment or difficulties with patients (real or simulated) the examiner should log this on the incident forms provided with details of the nature of the incident and the candidate number(s) affected. Examiners may be allocated to a specific station for the whole day as limited time during the lunch interval can make changing over difficult. If feasible the Supervising examiner, at their discretion, can rotate examiners at lunchtime. This rotation will normally be within stations of the same broad content area. If examiner numbers permit additional examiners may be allocated to take over in the afternoon circuit. These examiners should sit in as observers with the last few candidates from the morning circuit to familiarise themselves with the station. Usually examiners will be allocated to a different station on subsequent days.

8. General points for lay, nurse and technician examiners

In line with current infection control guidelines it has been necessary to introduce a dress code both for candidates and examiners. For candidates the following dress code applies throughout; for examiners the dress code only applies to those stations involving the candidates' contact with patients/simulated patients

and cadaveric material. Examiners may wear jacket and tie (or equivalent) at other stations. Examiners may also wear bow-ties or tuck ties in instead of having a shirt open-neck.

The dress requirements are as follows:

- No jackets
- Arms to be bare below the elbow
- No jewellery on the hands or wrists with the exception of wedding rings/bands

An acceptable form of dress would be a conventional short-sleeved shirt/ blouse, open at the neck or, for a long-sleeved shirt/ blouse, to have the sleeves rolled up throughout the examination.

- Lay, nurse and technician examiners must follow and not deviate from the instructions provided for each station. Opportunity for examiner feedback will be provided and encouraged daily together with suggestions for modification/improvement. Examiners must not attempt to modify the station while the circuit is in progress!

- Detailed marking instructions will be provided in stations.

- Timing is very important and candidates must be moved on at the end of the station. If candidates complete the station early they should remain just inside the entrance of the station until requested to move on. The examiner, or the lay, nurse and technician examiners should not engage the candidate in conversation during this time.

- Clinical stations examination or history taking will normally allow up to six minutes for the observed activity and three minutes for discussion. Examiners and the lay, nurse and technician examiners should simply watch and mark the examination and not interrupt or expect a running commentary. Candidates who give a running commentary should not be penalised for so doing. The candidate will then be asked to present their findings. If the candidate completes the task within the six minutes allowed they can indicate that they are ready to move on to the discussion section.

- Examiners should encourage candidates to use the hand gel provided before patient contacts and after contact with cadaveric material. The candidate's use of the hand gel should not, however, be considered when marking the station unless the marking instructions explicitly state it as a requirement.

- It is imperative that marks are entered for all the sections on the mark sheet and that marks are allocated for the specific domains indicated. Mark descriptors are provided on the mark sheets and in the station packs and these should be followed.

- It is also imperative that, in addition to the above marks, a single, separate, overall global rating is given for the station as a whole. For stations with two examiners, the single overall rating should be agreed by discussion. In the case of the Communication Skills station the overall global rating of the clinician has precedence over the lay examiner's rating.

- Full completion of the mark sheets will be monitored regularly and any gaps must be filled in as soon as possible.

- When reviewing a candidate's performance, examiners and lay, nurse and technician examiners should be mindful that the physical environment of the OSCE circuit may not provide high levels of sound-proofing for the next candidate waiting outside the station.

- All examiners and lay, nurse and technician examiners will need to remain at the examination centre until all marks have been collated and verified and the examiner meeting at the end of the day has been completed.

- Examiners and lay, nurse and technician examiners must not leave the station until the circuit is complete. In an emergency, contact a member of the support staff who will arrange a substitute with the Supervising Examiner.

- Mobile phones must be switched off for the duration of the circuit.

- If an emergency evacuation of the building is required the examiners and lay, nurse and technician examiners should remain with the candidate being examined in the designated evacuation area. If it is safe for the examination to continue it will re-start at the beginning of the station that the candidate was in at the time of the alarm.

- Current ICBSE regulations governing examiner behaviour will apply.

- There may be observers present during the examination**.**

9. Feedback

Examiners, lay, nurse and technician examiners will have regular appraisals by experienced assessors and will receive written feedback on their performance.

Specific feedback forms on the performance of the individual stations, with provision for suggestions to be made for modification or improvement will be provided in each station.

No written feedback is required for individual candidates. They will receive a breakdown of their marks in the various components of the examination.

Appendix 1 - Structure for the MRCS Part B OSCE from February 2013

MRCS OSCE assessment grid and matrix from February 2013	KNOWLEDGE BROAD CONTENT AREA								SKILLS BROAD CONTENT AREA												PILOT
	Anatomy and surgical pathology					Applied surgical science and critical care			Communication skills						Clinical and procedural skills						
									Giving and receiving information				History taking		Physical examination				Procedural skills		
	Anatomy 1	Anatomy 2	Anatomy 3	Surgical pathology 1	Surgical pathology and/or microbiology 2	Interpretation of data – visual and lab	Interpretation of clinical data	Critical care management	PREPARATION STATION	Talking with relatives and carers	PREPARATION STATION	Communicating with colleagues	History taking 1	History taking 2	Physical examination 1	Physical examination 2	Physical examination 3	Physical examination 4	Procedural skills – patient	Procedural skils - technical	Optional – any station as required
Examiners required →	one	one	one	one	one	one	one	one	–	surgeon + lay	–	one	surgeon + lay	surgeon + lay	one	one	one	one	one + assistant	one + assistant	
Domains tested ↓																					
Clinical knowledge and its application	20	20	20	20	20	12	12	12		4		4	4	4	4	4	4	4	4	8	
Clinical and technical skill						4	4	4					8	8	8	8	8	8	8	12	
Communication										12		8	4	4	4	4	4	4	4		
Professionalism including:- Decision making Problem solving Situational awareness and judgement Organisation and planning Patient safety						4	4	4		4		8	4	4	4	4	4	4	4		
Total mark	20	20	20	20	20	20	20	20		20		20	20	20	20	20	20	20	20	20	