Clinical skills assessment for GP registrars

Objective structured clinical examinations are particularly useful in assessing interpersonal, practical and clinical skills

THE MICGP IS THE QUALIFYING EXAM for vocationally trained GPs in Ireland, and along with the Criteria for Satisfactory Completion of Training (CSCT), is a core element of assessment of specialist trainees. The exam includes four modules – single best answer MCQ, applied knowledge test, modified essay question, and the oral. Previously, there was a fifth module, the objective structured clinical examination (OSCE). This was discontinued as it was felt to be poorly discriminatory, and too expensive to run, requiring hired actors to play the part of patients. It is planned to introduce a clinical skills assessment (CSA) to the MICGP, but as things currently stand, GP registrars have no formal assessment of clinical skills as part of the MICGP exam.

The TCD/HSE GP Training Scheme decided to run an OSCE for third year registrars, as a formative assessment process, to allow observation of registrars consulting (albeit in an artificial environment), and provide feedback on performance. It was a learning exercise for all involved. This article describes the process, the benefits, and makes recommendations for the future. We believe that this is a model of clinical skills assessment adaptable to other GP training schemes, either on an ongoing basis, or until the CSA becomes part of the MICGP.

What is an OSCE?

OSCEs are an exam format where candidates rotate sequentially around a series of timed ‘stations’, designed to test clinical skills. All candidates complete the same tasks, in the same amount of time, and are evaluated on the same marking schedule. OSCEs are widely used in undergraduate and postgraduate assessment internationally, and are particularly useful for assessing interpersonal and practical skills, and the application of clinical knowledge in consultation.1

OSCEs were developed to address the shortcomings of the traditional ‘long case’ exam. It is a more reliable assessment in three main ways:

• Structured marking schedules increase examiners’ consistency and reliability
• Candidates perform a wider range of tasks and skills. This wider sampling gives a more reliable picture of overall competence. The more stations completed, the more generalisable and reliable the test
• Each station has a different examiner, providing multiple independent observations of each candidate, reducing individual examiner bias.1

The increased reliability and perceived fairness make OSCEs an acceptable test for candidates, and virtually all GP trainees have had experience of them for summative assessment (ie. ‘judgement’ tests, such as final medical exams), in their medical careers.

TCD-HSE experience

It is known that assessment drives learning – students
focus on how to pass the test, rather than on course learning objectives. A well-constructed OSCE can be a powerful driver for a candidate to learn desired clinical skills. This educational impact of the OSCE is what we were trying to achieve. We planned a formative assessment, ie, with teaching, feedback, and learning for the registrars as the main goals. As this was not a high-stakes examination, we did not set a pass mark; instead we used a four-point global rating scale – clear pass, pass, borderline, clear fail – that the examiner applied to grade each candidate on their performance.

It was decided that 12 clinical stations would give sufficient validity/reliability for formative assessment, and was also the limit to what we could achieve logistically. We felt that third-year registrars would most benefit from the process as it would provide some indirect preparation for the oral exam component of the MICGP, and they had sufficient time (in fourth year) to address any deficits identified.

Planning

OSCEs are logistically challenging and resource intensive, requiring appropriate infrastructure (one room per station); planning to ensure candidates can move through the circuit; medical equipment appropriate to each station (eg, examination couches, desks and chairs); and recruitment of actors.

Our training scheme is located in The Trinity Teaching Centre at Tallaght Hospital, where the infrastructure required was readily available, including equipment for the stations and general support. This left the task of deciding topics for cases and writing the stations. Stations are ‘active’ stations (ie. those involving a ‘patient’), or ‘theory’ stations (written stations). We contacted the Irish University Departments of General Practice, and colleagues in EURACT for OSCE stations we could use. Not only did this mean that we didn’t have to write all the stations ourselves, but the seven stations they provided had previously been tried and tested in an exam situation. Station topics are outlined in Table 1.

As there was no budget available to recruit actors, we used first and second year trainees as ‘patients’. We excluded fourth year registrars as we felt it might intimidate third years sitting the exam, given fourth years’ seniority in practice. This approach worked well. Trainees volunteering received specific training on their role, emphasising the need for confidentiality (and a reminder they would be in the candidates’ shoes in the coming years!). They were given detailed clinical vignettes, and advice on how to handle unanticipated questions from the candidates. Trainees were universally excellent at role play. Exam candidates felt that as they were familiar in dealing with patients, their answers were more authentic than those of actors they had encountered in other OSCEs. We believe their involvement extended the learning experience of the exercise to other trainees, and separately stimulated modelling for peer-reviewed practice.

The 12 stations required nine examiners (one for each active station). Examiners received training on the purpose of the OSCE (ie. formative assessment), the need to record feedback for candidates, key tasks for their station, and responses that would cause a trainee to fail that station.

Feedback

Feedback was sought from everyone involved (examiners, ‘patients’, and candidates), on the process of the exam, the value of participating, what could be improved next time, etc.

Trainee ‘actors’ were debriefed. They were reminded regarding confidentiality, asked how they found the process, problems with their station, and any feedback they had. We debriefed the candidates. They had found it intense, engaging, and rewarding. They felt the stations were very germane to general practice. They strongly felt it had been a valuable learning experience and should be repeated annually for third years. They felt a rest station would have been helpful. There was no strongly negative feedback.

Examiners reviewed each station. Broad feedback on process and candidate performance was recorded, any difficulties with stations were discussed, and advice for the future was considered. The main recommendation was to use a six-point global rating scale for assessment in the future, allowing greater discrimination for examiners.

Table 1

<table>
<thead>
<tr>
<th>Station No.</th>
<th>Outline of topic</th>
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<tbody>
<tr>
<td>1</td>
<td>Theory station: Dermatology photos and questions (psoriasis, hand foot and mouth disease, rosacea, pityriasis rosea and pigmented lesions)</td>
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<tr>
<td>2</td>
<td>Theory station: ECG showing atrial fibrillation (questions on CHA2DS2-VASc, management)</td>
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<td>3</td>
<td>History/exam/management: 45-year-old man with low back pain, wants an x-ray</td>
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<td>4</td>
<td>Mum with concerns about MMR vaccination, wishes to discuss with GP whether to vaccinate</td>
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<tr>
<td>5</td>
<td>Crisis pregnancy: breaking bad news and counselling re options</td>
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<tr>
<td>6</td>
<td>History/exam/management: Elderly female with a change in bowel habit</td>
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<tr>
<td>7</td>
<td>Professionalism: Private patient requesting to have his statin prescription put on his partner’s GMS prescription</td>
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<tr>
<td>8</td>
<td>Contraception: Young woman with a history of migraine with aura, requesting COCP</td>
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<td>9</td>
<td>Palliative care: Home visit to an elderly man with metastatic cancer and new onset rib pain</td>
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<tr>
<td>10</td>
<td>Depression: Nine months post-natal female complaining of feeling tired all the time; bloods normal</td>
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<tr>
<td>11</td>
<td>PSA test counselling: 53-year-old man presents for a PSA test (candidate had to discuss DRE too)</td>
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<tr>
<td>12</td>
<td>Theory station: Therapeutics (medication r/v, polypharmacy in an elderly nursing home patient)</td>
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Marking sheets for each station were analysed. The theory stations were graded and results collated for each individual candidate. The organiser met with the candidate group, reviewing each station, and giving general feedback from the examiners. She then met with each candidate individually, reviewing performance on each station, guided by marking/feedback sheets.

**What we learned**

Running the OSCE was an extremely worthwhile exercise. We have decided to make it an annual event for third-year registrars. Though time-consuming to prepare, much groundwork has now been done. Preparation and planning were key to ensuring a smooth process. Using our networks to locate OSCEs saved time, and in a couple of years we will have a bank of tried and tested exam stations.

Feedback was extremely positive. Candidates felt it was challenging but reassuring to have their clinical skills observed. As programme directors, it was fascinating to watch the registrars consult, as it is not an aspect of their day release activities.

Nevertheless, several stations highlighted weaknesses in their knowledge base, which have been subsequently addressed at day release activities.

**Could other schemes do this?**

Our scheme had the infrastructure and personnel required to run OSCEs. However, the beauty of running the OSCE as a formative assessment means there isn’t the same need to run OSCEs. However, the beauty of running the OSCE as a formative assessment means there isn’t the same need to run OSCEs. This would create a critical mass of examiners and reduce workload. Collaboration through the National Association of Programme Directors would create a shared bank of OSCE stations.

**Conclusion**

The ‘hidden curriculum’ is that part of any educational process not stated in the learning outcomes, but learned by students from the cultural environment of the course, or the attitudes of teachers. Clinical skills are the cornerstone of general practice, yet are not formally assessed as part of GP training – what message does that send to GP trainees? In unpublished data from an ongoing survey of 192 current trainees, 74% indicated they feel there is a role for a clinical component to the MICGP exam. It has been possible to run an OSCE efficiently within our scheme, providing good learning for registrars, and reinforcing the importance of clinical skills in general practice. We encourage GP training schemes to consider how best to assess the clinical skills of trainees, and this scheme is happy to assist at a local or national level.

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**References**

1. Bouriscot KAM, Roberts TE, Burdick WP. Structured assessments of clinical competence. Understanding Medical Education, ed. ASME. 2007, Edinburgh: Association for the Study of Medical Education. 7