INTRODUCTION
An ‘Objective Structured Clinical Examination’ (OSCE) is a short, simulated clinical scenario designed to assess the clinical skills of the examination candidate. This method of examination was first proposed in 1975 by R.M. Harden as one way of providing ‘a more objective approach to the assessment of clinical competence’.

In an OSCE examination candidates move through a number of short clinical scenarios which are designed to focus on a range of topics and specific clinical skills. This can be contrasted with the traditional clinical examination – the ‘long case’ – where the candidate would take a history and examine a patient in private, before presenting examiners with the findings, proposed diagnoses, required investigations and treatment. In his original article, Harden found that the OSCE results had a far better correlation with the written results of the students than the traditional approach as the patient (usually simulated) was the same for all students, while the examiners had a standard marking sheet, making their assessment both clear and reproducible.

Since its introduction the OSCE has become a widely used examination tool for both undergraduate medical student and postgraduate specialist examinations. It is currently a key component of the examination process in Obstetrics and Gynaecology at our institution. While it does not replace the need for written examinations to test purely factual knowledge, it does assess a different range of skills that are of a more practical nature.

Aspects of clinical practice that can be assessed in an OSCE range from taking a patient’s general history and asking questions appropriate to the presenting complaint to taking a focused history on a particular problem (such as a menstrual history or a sexual history), explaining investigation results in terms that a patient can understand (e.g. an abnormal fetal ultrasound result or an abnormal Pap smear), performing a specific clinical examination (e.g. a routine newborn examination) or acting out a clinical ‘action’ such as taking a Pap smear, performing neonatal resuscitation or dealing with a shoulder dystocia in labour.
**Medical students**

There is often a lot of concern surrounding the OSCEs by medical students as they are less familiar with the format than they are with written examinations, a familiar format first experienced at secondary school. The techniques of history-taking, examination, and counselling and talking to patients are relatively new to them. Nonetheless, these skills are just as important to their future success as doctors as the factual knowledge they gain from reading the textbooks.

**MRANZCOG candidates**

Candidates for the specialist entry MRANZCOG (Membership of the Royal Australian and New Zealand College of Obstetrics and Gynacology) exam may be more comfortable with history-taking, examining and counselling patients, but less familiar with the OSCE examination process. While the exams aim to mimic clinical practice, there is a certain ‘knack’ to passing them which requires an understanding of their format and how they are assessed.

**The importance of practice**

The old saying that ‘repetition is the mother of learning’ is no less true of OSCEs than it is of any other examination type. There is no doubt that the more practice cases and scenarios candidates experience, the more likely they are to pass the exam. This textbook has been written with the aim of providing a significant number of practice cases, together with a detailed marking scheme, so that exam candidates working in pairs will be able to assess each other objectively and improve their performance by reviewing ideal answers. Not all examination candidates manage to obtain enough practice before the OSCE exam, and the preparation of cases by ‘practice’ examiners is time-consuming, meaning that busy doctors are often unable to provide adequate time to go through practice cases. We hope that this book will allow candidates for an OSCE in Obstetrics and Gynaecology, either at undergraduate or postgraduate level, to gain sufficient practice before the exam to maximise their chances of a pass.

**BASIC OSCE STRUCTURE**

**Medical students**

The basic structure of OSCEs for medical students may vary from institution to institution, and you should check with your faculty to see what your institution expects. At our university OSCEs are usually made up of 1 minute reading time, followed by 6 minutes with the examiner, often with an actor playing the role of the patient. After the first 5 minutes (i.e. after 6 minutes of the 7-minute station), the examiner is required to give an indication to the candidate that only 1 minute remains before the end
of the OSCE station. At the end of the 7 minutes a bell is sounded and the examination candidate must move on to the next station.

**MRANZCOG candidates**
The MRANZCOG OSCEs have a uniform format for all candidates. At present the OSCEs are 20 minutes in total, with 5 minutes reading time at the start of the station, followed by 15 minutes with the examiner. Obviously these OSCEs are more complex than the cases for the medical students, and the candidates often have three to five scenarios to go through, which test a wide range of both obstetric and gynaecological knowledge before they can proceed to the next station. Generally at the first station the candidate takes a detailed history from the simulated patient (either an actor or the examiner playing the role of the patient and answering questions).

**Marking**
The OSCE examiner usually has a marking sheet with a set of marks assigned to key clinical points – either specific questions relating to history, examinations performed, differential diagnoses, or information on prognosis or implications for the patient’s health imparted to the patient. This rather rigid marking scheme means that marks can be gained only for the specific points indicated. However, it does ensure a uniform marking scheme for all examination candidates, allowing for the marks of two candidates to be directly compared.

One problem that arises with this marking scheme is that some candidates demonstrate more orderly and logical thought processes in the way that they direct history-taking, examination and investigation of the patient than others. Therefore, some OSCEs will have a proportion of marks assigned to ‘clinical competency’ (e.g. 5 out of 20 marks), so that well-organised candidates have the opportunity to distinguish themselves.

**Reading time**
Reading time is an integral part of the OSCE, and it is very important to use this time wisely. It is even more important in the MRANZCOG OSCE, as there are 5 minutes assigned, rather than the 1 minute allocated for the medical student OSCE. The amount to be ‘read’ may only amount to one or two sentences, but there is important information in those few short lines. The introductory information may be presented, for example, as a letter from a referring general practitioner, or as a short clinical description.

**Extracting maximum information from the introduction**
**EXAMPLE: Mrs Bloggs is a 41-year-old G3 P2 at 8/40 gestation presenting for her first antenatal visit.**

This introduction has already given us a number of pieces of important information. First, the patient’s age – she is 41 years old and of advanced maternal age. She will need to be counselled about the increased risk of
miscarriage (due to aneuploidy), gestational diabetes in pregnancy (she will need a glucose tolerance test rather than just a glucose challenge test at 28/40), pre-eclampsia and Down syndrome (one in 100 risk – need to discuss screening/amniocentesis/chorionic villous sampling).

Second, she has had two previous deliveries of greater than 20 weeks gestation. We will need to ask about the mode of delivery, the gestation at delivery and any previous pregnancy, delivery (e.g. shoulder dystocia), or post-delivery problems (e.g. post-partum haemorrhage, breastfeeding problems, Group-B streptococcal infections in the neonates). All of these pieces of information may impact on our management of the pregnancy.

Third, the patient is at 8 weeks gestation, so issues to be encountered are likely to occur, at least initially, in the first trimester. We will need to ask about early pregnancy problems (e.g. bleeding, pain, hyperemesis gravidarum, urinary problems). Finally, we are told that the patient is presenting for her first antenatal visit, so we will need to order and explain all of the routine antenatal screening (FBE, blood group and antibodies, rubella IgG levels, hepatitis B serology, RPR or other test for syphilis, offer HIV testing, midstream urine for culture, and possibly a first trimester ultrasound for dating the pregnancy).

Most of the introductory scenarios will similarly have information to be gleaned to a greater or lesser degree (see the boxed text below for common clinical points from the introductory statement). Use the reading time to jot down as much of the information or relevant history and examination details as you can, so that you remember it. It is easy to forget a seemingly minor detail that becomes very important to the scenario later on.

### Common points of information in the introductory statement

- **Age of patient:**
  - **Young patients (<21)**
    - Social/financial difficulties
    - Recreational drugs
    - Increased risk of STDs (esp chlamydia), consider screening if appropriate
    - Contraception, Pap smears
  - **Older women (>38)**
    - Increased risk of Down syndrome in pregnancies
    - Reduced fertility with increasing age, increased miscarriage risk
    - Increased risk of gestational diabetes and pre-eclampsia (in pregnancies)
  - **Post-menopausal**
    - Increased risk of osteoporosis, menopausal symptoms, cancers, prolapse, urinary incontinence and sexual problems (vaginal atrophy, reduced libido); ask regarding mammograms
**Be organised**

Adopting an organised approach to extracting clinical information from the ‘patient’, and addressing the clinical problems presented are crucial to your success in the OSCE. In the MRANZCOG (and in most medical student) exams, candidates are allowed to write notes on a blank sheet of paper, both during the reading time and during the examination time with the examiner. The candidates at our institution have an extremely high success rate, in part due to adopting a systematic approach to note-making. While there are any number of ways of organising your notes, below is one effective suggestion.

Divide the paper into three columns (see Figure 1.1). In the first column list in logical order aspects of the history you wish to ask the ‘patient’. In the second column list aspects of the examination you wish to perform. In the third column list investigations and management, which will usually

<table>
<thead>
<tr>
<th>BMI (&gt;30)</th>
<th>BMI (&lt;18)</th>
<th>Presenting clinical problem</th>
<th>Gestation</th>
<th>Parity</th>
<th>Aboriginal</th>
<th>Intravenous drug-user</th>
<th>Sex worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Counsel regarding diet/exercise</td>
<td>• Hypothalamic/pituitary anovulation if eating disorder</td>
<td>• Need to focus on this and address first in history</td>
<td>• Consider questions/conditions relevant to gestation</td>
<td>• Consider effects of parity on current gynae/obstetric problem</td>
<td>• Alcohol and drug-related issues</td>
<td>• HepB, HepC, HIV screen; liver function if HBV or HCV +ve</td>
<td>• Social/financial issues</td>
</tr>
<tr>
<td>• General health issues (heart disease, arthritis, sleep apnoea, blood cholesterol, etc)</td>
<td>• Ask regarding diet (adequate?) and exercise (excessive?)</td>
<td>• Gestation</td>
<td>• Consider effects of parity on current gynae/obstetric problem</td>
<td>• Cultural sensitivity/Aboriginal liaison officer to be involved</td>
<td>• Effects of drugs on pregnancies (e.g. IUGR, neonatal dependence, risk of abruption or FDIU)</td>
<td>• Recreational drugs</td>
<td>• Sexually transmitted diseases/PID</td>
</tr>
<tr>
<td>• Specific gynae and obstetric issues (increased risk of gestational diabetes, miscarriage, PCOS, operative risks, etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Social/financial issues</td>
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</tr>
</tbody>
</table>

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**BMI (>30)**
- Counsel regarding diet/exercise
- General health issues (heart disease, arthritis, sleep apnoea, blood cholesterol, etc)
- Specific gynae and obstetric issues (increased risk of gestational diabetes, miscarriage, PCOS, operative risks, etc)

**BMI (<18)**
- Hypothalamic/pituitary anovulation if eating disorder
- Ask regarding diet (adequate?) and exercise (excessive?)

**Presenting clinical problem**
- Need to focus on this and address first in history

**Gestation**
- Consider questions/conditions relevant to gestation

**Parity**
- Consider effects of parity on current gynae/obstetric problem

**Aboriginal**
- Social/financial difficulties; domestic violence?
- Alcohol and drug-related issues
- Cultural sensitivity/Aboriginal liaison officer to be involved

**Intravenous drug-user**
- HepB, HepC, HIV screen; liver function if HBV or HCV +ve
- Effects of drugs on pregnancies (e.g. IUGR, neonatal dependence, risk of abruption or FDIU)
- Social/financial issues

**Sex worker**
- Social/financial issues
- Recreational drugs
- Sexually transmitted diseases/PID
be dictated by information in the history or examination. For example, if the patient is a smoker you would list this in the history column and then draw a line across to management and ask for a CXR/lung function test (if working up for a gynaecological operation), counsel about the dangers of smoking to the woman’s health (including fertility), as well as that of her unborn baby (if pregnant or trying to get pregnant), or of her child (e.g. risk of SIDS if she has an infant at home).

At the bottom of the page an ‘Issues list’ can be drawn up, so that issues identified during the reading time or the history-taking are not forgotten later on when counselling the patient. Remember, the examiner has a tick list of clinical information to be gleaned from the patient when assigning your marks, and you want to get as many of these as possible. Good techniques at this stage will maximise your OSCE marks, helping you through the stage when you will probably be feeling at your most nervous and flustered.

### An ordered approach to history-taking and examination points

An organised candidate for the OSCE exam will use an ordered approach when taking a gynaecological and obstetric history, as well as when asking for points on examination. You will not usually be expected to actually perform an examination (it would be impossible for a simulated patient to endure 20 to 30 pelvic examinations), but you will be expected to know precisely what examinations you would like to perform.

The candidate then asks for the results of their examination. If you fail to ask for particular examinations to be performed the examiner will not reveal the examination findings, which may be crucial to the management of the patient. Thus, it is important to make sure that you approach the

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>EXAMINATION</th>
<th>Investigations / Management</th>
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</thead>
</table>

**Figure 1.1** An effective method for note-taking
history and examination in a thorough manner. Practice OSCEs help to get candidates into a routine where they are more likely to remember the key points of history and examination they should be asking for during the actual OSCE examination, when stress levels are at their highest.

Two important points to note about taking the initial history examination are: first, be thorough but efficient; and second, adjust the type and order of questions to address the particular presenting problem.

**Be thorough but efficient**

**Medical students**

In a medical student exam, time management is critical. There will often be several marks assigned to extra questions at the end of the OSCE case. Often candidates spend far too long on the initial history and examination phase. While they may get the majority of the marks for the first station of the OSCE, they will get an overall low mark because they have not been able to attempt the marks assigned to the later questions.

**MRANZCOG candidates**

There are likely to be up to five to six scenarios to pass through in a single MRANZCOG OSCE station. Therefore, it is important to leave enough time to actually get through all of the scenarios.

**Possible approaches – all candidates**

Split questions on history or examination into groups (no more than three at a time), and ask for two to three aspects of history or examination at once to save time. Be careful not to lump too many questions together, especially if they are potentially complex, to avoid confusing the examiner/simulated patient. Speak quickly, but not so fast as to render your questions unintelligible to the examiner. If they cannot understand what you have said they might miss it altogether and you will not get marks for the knowledge you have displayed. This last point is especially important for exam candidates from non-English-speaking backgrounds – speak clearly and practise with native English speakers if possible to ensure you can be understood on exam day. Don’t ask too many extraneous questions, such as aspects of history already given in the introduction, and keep questions designed to look for specific rare diagnoses to a minimum. While demonstrating your knowledge of relevant differential diagnoses, an exhaustive number of questions on rare conditions will eat into your examination time and are less likely to have marks assigned to them.

**Addressing the presenting problem**

It displays poor clinical acumen if the candidate blindly recites a long list of questions on history and examination without making any reference to the particular problem. The examiner is looking for a future clinician, not a robot. If the scenario is a gynaecological one, start with the gynae history first, and then ask for the past obstetric history, and vice versa. Take
a more detailed history regarding the presenting complaint, but less detail
with regard to aspects of gynae/obstetric history that is not relevant to the
particular scenario presented.

Think carefully when asking for aspects of examination. If the patient is
a 17-year-old girl who has not had sexual intercourse, do not blunder into
asking for a vaginal examination. If the patient is a 50-year-old woman
who has a past history of a hysterectomy, do not ask for a Pap smear! The
effective candidate not only has a rough outline or approach to their history
and examination, but can think on their feet so that the condition of the
actual patient represented in the scenario is considered at all times. After all,
this is exactly what happens in real-life clinical practice.

Suggested templates for gynae and obstetric initial encounters are
presented over the next three pages.

<table>
<thead>
<tr>
<th>History/examination of the gynae patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Questions that should be grouped together are listed on the same line.)</td>
</tr>
<tr>
<td><strong>History</strong></td>
</tr>
<tr>
<td>• Patient name and age</td>
</tr>
<tr>
<td>• Presenting complaint: what is the primary reason the patient presents today?</td>
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<tr>
<td>• Menstrual history:</td>
</tr>
<tr>
<td>- Age at menarche/menopause</td>
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<tr>
<td>- How many days since last menstrual period?</td>
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<tr>
<td>- Are cycles regular? How many days does she bleed? Average length of cycles</td>
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<tr>
<td>• Are periods heavy? (if so, how long has it been present? Clots/ flooding? How many pads used per day? Has she had any previous treatments? If so, how effective were they? Side effects?)</td>
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<tr>
<td>• Are periods painful? (if so, when during cycle? How does it affect daily functioning – e.g. number of days off work? Any treatments? Effective? Side effects?)</td>
</tr>
<tr>
<td>• Any intermenstrual bleeding? Post-coital bleeding? Post-menopausal bleeding?</td>
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<tr>
<td>• Sexually active at present? Any problems with intercourse? Dyspareunia? (If so, timecourse, and whether superficial or deep, or related to cycles)</td>
</tr>
<tr>
<td>• Contraception – types tried, failures/unwanted pregnancies, side effects</td>
</tr>
<tr>
<td>• Vaginal discharge (If present: colour, odour, itch, irritation?); past history; sexually transmitted diseases? (If so, treated? Contact tracing? Checked for other STDs?)</td>
</tr>
<tr>
<td>• Last Pap smear? Does she have regular Pap smears? (What frequency?) Normal? Ever abnormal? (If so, what treatment?)</td>
</tr>
<tr>
<td>• Last mammogram/breast ultrasound?</td>
</tr>
<tr>
<td>• Menopausal symptoms (if age-appropriate, or amenorrhoea)</td>
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</tbody>
</table>
• Urinary incontinence/symptoms; prolapse/lump in vagina; bowel symptoms
• Pelvic pain (not associated with menses or intercourse)
• Past gynaecological history: past diagnoses (and basis for diagnosis), past operations
• Past obstetric history (see obstetric history-taking for details)
• Past medical history; past psychiatric history
• Past surgical history
• Family history (of cancers, or medical and genetic conditions)
• Social history: home, relationships, work, financial/social stresses
• Smoking history; alcohol intake; other recreational drugs
• Medications; allergies

Examination
• General appearance (colour, secondary sexual characteristics)
• Vitals (temperature, blood pressure, pulse rate, respiratory rate); body mass index; full ward test (urine pregnancy test if appropriate)
  – (remember: inspection, palpation, percussion, auscultation)
• Thyroid, cardio-respiratory and breast examination
• Abdominal examination
• Inspection of external genitalia (lumps, skin conditions, ulcers, discolouration, atrophy), including urethral meatus
• Bimanual examination: Uterine size and shape; anteverted/retroverted; tenderness; mobility; adnexal masses
• Joint vaginal and rectal examination (if appropriate – for Pouch of Douglas nodules/tenderness)

Speculum examination
• Bi-valve to inspect vaginal walls and cervix (take Pap smears and high vaginal/cervical swabs if appropriate)
• Sims speculum to examine for prolapse (systematically examine anterior and posterior vaginal wall then vault) and urinary incontinence (loss of urine with cough).

History/examination of the obstetric patient: Antenatal history

• Patient name and age

Current pregnancy
• Spontaneous or assisted conception (IVF/ovulation induction; reason for infertility)
• Planned pregnancy? Wanted pregnancy?
• Gestation: last menstrual period (gestation by dates); if by ultrasound, when performed and findings (nuchal translucency, singleton/twins, placenta, other findings, e.g. fibroid, ovarian cyst)
• On folate or multivitamins prior to conception? Rubella/parvovirus/varicella checked prior to conception?
• Current pregnancy symptoms (ask appropriate to gestation: first trimester – hyperemesis, breast tenderness, urinary Sx; third trimester – backache, gastro-oesophageal reflux)
• Any screening Ix performed to date? What results?

Past obstetric history
• Pregnancies in order with their outcomes
• Early pregnancy losses: miscarriages (gestation, treatment, complications); terminations (gestation, mode of TOP, complications); ectopics (type, gestation, treatment)
• Pregnancies > 20/40 (gestation at delivery; medical complications of previous pregnancies; mode of delivery; delivery complications – post-partum haemorrhage, shoulder dystocia; puerperal complications – infections, breast-feeding issues, postnatal depression)
• Gynaecological and general history as above, but with less comprehensive questioning of gynaecological history

Examination
• General history is as above for gynaecological history, until the candidate reaches the abdominal examination
• N.B. Check urine for protein and glucose on dipstick
• Abdominal and vaginal examination depending on gestation

First trimester
• Abdominal/vaginal Ex: Is uterus palpable abdominally? If not, what size uterus on vaginal examination? Speculum for Pap smear if due

Second trimester/third trimester
• Abdominal Ex: symphyseal-fundal height (SFH); lie and presentation of fetus; single or multiple pregnancy; doppler of fetal heart (present? rate?); miscellaneous findings (fibroid, uterine tenderness)
• Vaginal Ex (only if appropriate)
  – Cervical length, dilatation, consistency, position, station of presenting part

History/examination of the obstetric patient: Intrapartum history

- Patient name and age
- Parity
- Single or multiple pregnancy
- Mode of previous deliveries; prior delivery complications
- Brief medical/surgical history
- Medications (including syntocinon), allergies
WrAppInG It up

After taking a detailed but appropriate history and examination, there will usually be a number of investigations and/or aspects of management or treatment to be initiated. The better candidates will end the first scenario with a list of problems or issues. Rather than just listing a lot of investigations and treatments, they will be linked to the issues identified. Never simply state that you wish an investigation to be performed, but state why the investigation is needed (i.e. what you are looking for). This lets the examiner know that you are thinking about the clinical case, and that you understand why you need to perform the investigations.

If you are recommending invasive investigations and/or treatments, you should be prepared to immediately mention possible risks of surgery or side effects of medications. There are significant time pressures in an OSCE, so you should interact with the examiner or simulated patient by asking them if they would like you to go into more detail. A statement such as: “There are potential complications of this surgery. Would you like me to discuss these in detail with you?”, is a good start. If it is not important to the particular scenario or there are no marks attached to it in the marking scheme the examiner may indicate that it is unnecessary to avoiding time-wasting.

Medical students

For medical student OSCEs there is generally only one scenario, unless your institution has longer OSCE times – 6 minutes is simply not long enough to allow for multiple complex encounters, but it is enough to allow for a series of further related questions.

Presenting complaint (often called by midwife/junior doctor)
Progress of labour (contractions, vaginal assessments)
Status of membranes, colour of liquor
Use of analgesia (pethidine? How long ago? epidural?)
Assessment of fetal wellbeing (fetal heart rate, CTG)

Examination
General: BP, full ward test of urine, pulse rate, temperature
Abdominal Ex: Lie, presentation, SFH, fetal heart, contractions
Vaginal Ex: Presentation, station, position, moulding, caput; cervix–dilatation, length, position; assessment of pelvis

N.B. This is likely to be a more fast-paced encounter focusing on management of emergencies and the history needs to be abbreviated to focus on the crucial issues that pose a risk to the mother and fetus(es). For example, make sure that this is not a trial of scar, a placenta praevia, multiple pregnancy or a breech presentation. Check for gestational diabetes, hypertension, anaemia or concerns regarding IUGR. Exclude significant maternal illnesses such as type 1 diabetes, asthma, epilepsy, stroke or cardiac disease.

WRAPPING IT UP

After taking a detailed but appropriate history and examination, there will usually be a number of investigations and/or aspects of management or treatment to be initiated. The better candidates will end the first scenario with a list of problems or issues. Rather than just listing a lot of investigations and treatments, they will be linked to the issues identified. Never simply state that you wish an investigation to be performed, but state why the investigation is needed (i.e. what you are looking for). This lets the examiner know that you are thinking about the clinical case, and that you understand why you need to perform the investigations.

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Medical students

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To wrap up the scenario for a medical student we would suggest aiming to spend 2 minutes on history-taking and 1 minute on the examination.

**MRANZCOG candidates**

As the first scenario is the first of several for a MRANZCOG OSCE, wrapping it up in a timely fashion is critical to having enough time to secure the marks assigned to the later scenarios. We would suggest trying to aim for 3 minutes for the history-taking, with a further 2 minutes for the examination in a MRANZCOG OSCE. Obviously there will be some stations where this will not be possible, so this is only a rough guide.

**MOVING ON: FURTHER ENCOUNTERS OF THE OSCE KIND**

**MRANZCOG candidates**

In the MRANZCOG OSCEs there will usually be further clinical encounters. For example, you may have further encounters with an obstetric patient at different stages of gestation. A gynae patient may become pregnant for a later encounter. You may encounter the patient before, during and after surgery, with a different set of clinical problems to be identified and managed at each scenario.

It is important not to assume that the clinical issues in the first encounter are to be the only ones for the entire OSCE. The issues can suddenly change from one encounter to the next. Always start each new encounter within a single OSCE station with an open mind and ask for a brief, fresh history and examination. If you forget to check on changes to history and examination in the same patient at different encounters you may miss important changes to the patient’s condition. Also be careful not to forget aspects of history or examination from the first encounter which may not become important until the third or fourth encounter. For example, there may have been a family history of breast cancer discovered in the first encounter which only becomes important when discussing the possible use of hormone therapy in the final encounter. Alternatively, a patient’s past history of a midline laparotomy from a burst appendix may only become important when considering performing a laparoscopy in the final encounter, necessitating a Hassan entry rather than a Veress needle, or a Palmers point entry rather than umbilical. Being able to refer to an issues list jotted down from the reading time and first encounter will minimise your chance of forgetting these key aspects of history and examination points in the later encounters.

Remember that it is not necessary to be brilliant in each encounter during an OSCE station in order to pass the station. It is possible that you may mess up one encounter. Try not to let that affect your subsequent encounters. Keep moving through the encounters trying to extract as many marks as possible from each. Almost all of the candidates for the OSCE
exam will do badly in some of their encounters – you will not be the only one. It is also possible that you may run out of time before completing all of the encounters or questions for the station. Again, this does not mean you have failed the station overall. Put it behind you and move on to the next station with a clear and calm head.

There are a number of particular types of questions in further encounters of the OSCEs that you can have prepared answers for. Many past MRANZCOG OSCEs have had questions asking candidates to describe how to perform a particular procedure (e.g. a forceps delivery, a gynaecological operation, and so on). Memorise a logical description of all common gynaecology and obstetric procedures, including positioning of the patient, prepping and draping, type of incision, short description of the surgical steps of the procedure, risks and steps to minimise the risks. Do not be exhaustive in your description, but emphasise key points. There are only likely to be a small number of marks assigned to the encounter. Examples of other questions you can have a prepared answer for include: describe types of electrosurgical injuries; describe how to locate and ligate the internal iliac arteries; describe how to perform an external cephalic version, or contraindications for vaginal birth after caesarean section.

It is important to practise discussing consent for medical treatments, procedures and/or surgery – particularly risks and possible complications. For example, if a candidate prescribes clomiphene citrate for anovulatory infertility but does not mention side effects or the risk of multiple pregnancy (and why multiple pregnancy is an undesirable outcome!), they have not fully informed the patient and may miss marks assigned to these points in the encounter.

**GENERAL PREPARATION TIPS FOR AN OSCE**

**All candidates**

This text aims to provide OSCE examination candidates with a number of practice scenarios. Practise as many as you can prior to the examination. Try to cover all aspects of the gynaecology/obstetrics syllabus. Also try to cover a large number of possible different formats, such as phone-call advice, emergency management, regular clinical encounters in outpatient settings, post-natal and post-operative complications, grief counselling, and dealing with angry or emotional patients. This will minimise your chance of being ‘thrown’ by an encounter format on the day of the examination. If there are published past examination questions for your OSCE, then practise those as well. Contact your mentors for face-to-face practice cases. It is a good idea to perform three or four practice OSCEs per week leading up to your examination. If you can form a study group with fellow candidates this will improve your practice as you will be able to observe other people practising OSCEs and thereby get tips of both what to do and what not to do.
Examiners are trained not to give any clues to the candidate as to how they are going in the exam. Do not expect encouragement from the examiner and do not feel you are doing badly if they do not show any sign that you are doing well. If the examiner signals that you should move on to other issues in your wrapping up of the first encounter, don’t keep reciting your knowledge. It is likely that they are trying to time-manage the OSCE to give you enough time for the further stations. Some candidates get frustrated that they have been unable to demonstrate all of their knowledge, but it is no use demonstrating knowledge for which there are no marks assigned in the station – better to move on to further encounters in the station with marks assigned to them.

In some OSCE stations you will finish with time to spare. This does not necessarily mean that you have missed information – some of the OSCEs may be shorter than others. It can be unnerving to have to sit there in silence for a minute in an OSCE. Try to think if there are any issues you have missed during the station, and discuss them. There may still be marks to be had. During a MRANZCOG OSCE, however, you may only gain marks by discussing matters relevant to the last encounter of the OSCE. The rules regarding medical student OSCEs will vary from institution to institution.

You must remember to list even the most simple or obvious things that may appear to be second nature to you; for example, stating the regular antenatal visits to an obstetric patient and the health checks performed at each antenatal visit. It is easy to forget to state the obvious (e.g. ‘monochorionic diamniotic twin pregnancy is a high-risk pregnancy’).

It is also easy to forget to state exactly what you want done for a patient admitted to the ward. Many candidates fall into the trap of assuming that management decisions will be made by others, as is common in a team approach to public patients. This is not the case in the OSCE. You cannot assume that the patient’s blood pressure and temperature will be checked or that the drain-tube output will be measured, unless you specifically ask for it. You should also set limits at which you wish to be contacted (such as an upper limit of blood pressure in a pre-eclamptic patient, an upper limit of blood sugar level in a diabetic patient or a lower limit of oxygen saturation in a patient with ovarian hyperstimulation syndrome, in case pleural effusions develop). You must treat your description of management for a patient as though you are instructing staff who have never seen the particular condition before. After all, in the examination it is important to demonstrate that you know how to instruct regarding regular observations for your patients.

When considering management approaches for a patient in a clinical scenario, always think in a conservative fashion. Choose the safest, most careful course of action. If in doubt, admit the patient for observation and investigation. It is better to be safe and cautious than take risks with the patient’s care.
Try to be engaging with the simulated patient, and appropriate (i.e. serious when discussing complications or grief-counselling, bright and cheerful when taking a history). Do not crack jokes with the patient or examiner – this will not make you look like a competent clinician and may offend the patient. Ask for permission before performing invasive examinations, such as vaginal or rectal examinations. You would not perform these without permission in real life, and should mimic this in your OSCE.

Finally, we wish you good luck, and hope that the practice exam questions contained in this text help you to successfully prepare for your OSCE examination.