JAMES COOK UNIVERSITY
MEDICAL STUDENTS ASSOCIATION

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OSCE*Run* 23/09/2025

MBBS IV/V Stations

Credits and Disclaimers

JCUMSA OSCERun would like to thank Akruthi Balaji (MBBS6) for her contributions to writing questions for this event.

Stations are designed to simulate actual past JCU 4th and 5th year OSCEs, but JCUMSA does not have any actual insight into the marking process so all evaluation and feedback by volunteer assessors should be considered in this light. Where possible, stations and content delivered in the subsequent debrief presentation have been reviewed by a CMD clinician to add a level of quality control.

Stations will be shared with students following the OSCERun session. Each station will involve 2 minutes reading time followed by 8 minutes station time, and final 2 minutes for individual verbal feedback from the assessor. A buzzer will be heard at all three of these intervals. You must leave the room at the end of the feedback buzzer.

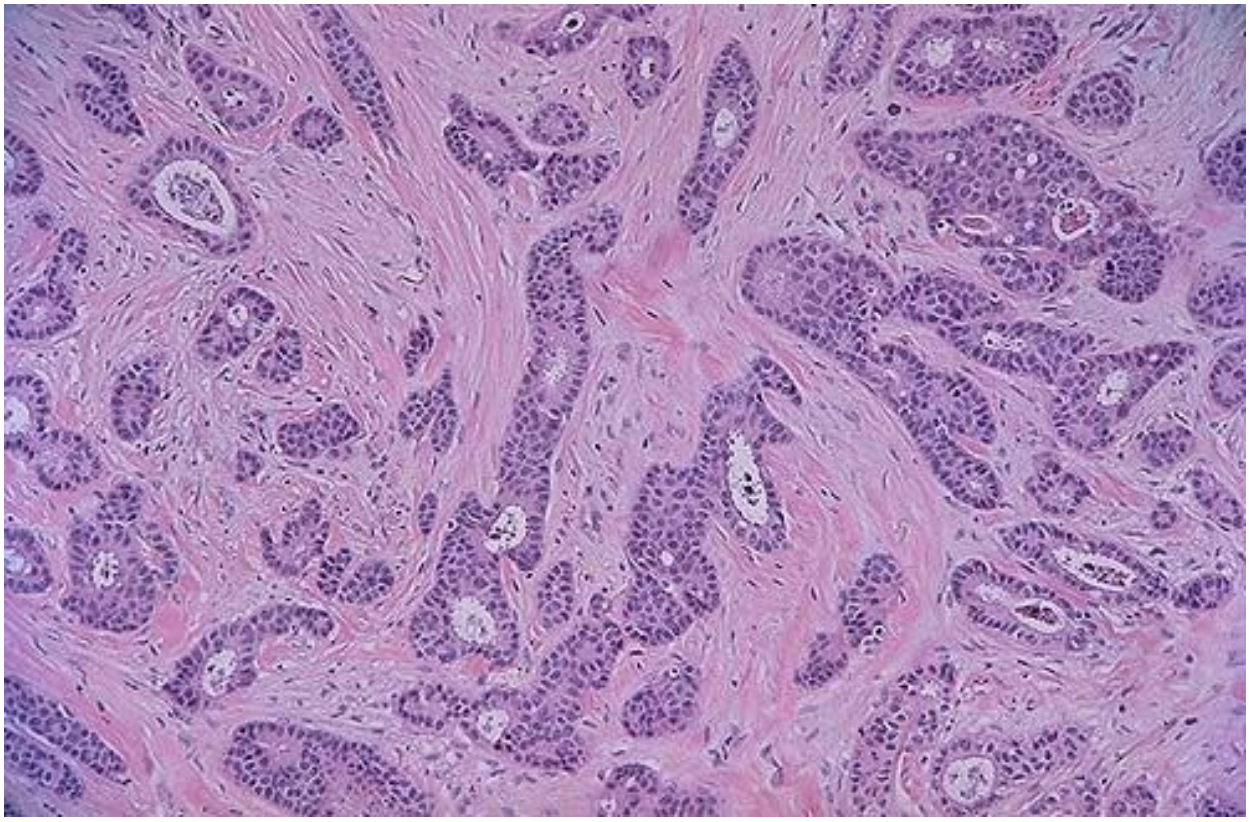
For any questions about OSCERun, please contact the OSCERun Convenor Srikaveri Sriram: oscerun@jcumsa.org.au who is leading the project.

OSCE*Run* 23/09/2025 Stations

1. Station 1: GP — Breaking Bad News + Counselling
2. Station 2: MSK/AH2 — Knee Exam + Ix/Rx
3. Station 3: ID/AH1 — Q Fever Hx + Ix/Rx
4. Station 4: RESP/CAH — Asthma Hx + Counselling

STATION 1 - CANDIDATE

You are the intern on your rural GP placement. You have been asked to see Brenda, a 57 year old female that initially presented to you 2 months ago with a lump in her left breast. Today, she has presented for review after a core needle biopsy of the lump 2 weeks ago. The results from the biopsy are as follows:



Histology report: invasive ductal carcinoma

Please complete the following activities. You will have 8 minutes.

1. Counsel Brenda on her results.
2. Answer any questions Brenda may have.
3. Answer the examiner's questions.

STATION 1 - VOLUNTEER PATIENT

PATIENT NAME: BRENDA FRANCIS | DOB: 05/08/1968 (57F)

Please do not provide additional information/hints to the candidates.

You are Brenda, a 57 year old woman who is just about to be diagnosed with breast cancer.

Opening statement: "I just wanted to follow up on the biopsy I had. I got a message saying that the results were back."

- You have been having breast cancer screening regularly since you were 50 years old and are shocked that this has been missed on your mammogram last year
- You felt the lump yourself in your left breast when you were doing your monthly self-checks 2 months ago, which is when you initially presented - this was your only symptom at that time
- The lump initially felt about a $1 coin in size, but now it feels more like a 50c coin in size - there have been no other changes to the lump
- The lump has always been painless
- You have no other symptoms currently: i.e. no weight loss, discharge from the nipple etc.

You don't want anyone else (e.g. family) in the room when you hear the news.
You want to hear the results today.

You think you've done all the right things: never smoked/drunk alcohol, good physical exercise, healthy diet choices, so you are wondering how this can possibly happen to you.
You are shocked that you have breast cancer and think that the test is incorrect, but slowly become more accepting of the news as the consultation progresses.

If the candidate asks whether you have any questions, ask the following:

1) **What happens now?**
2) **Will I be cured if I have treatment?**

STATION 1 - ASSESSOR

Candidate Name: _____ MBBS Year: _____

Please note that this is a mixed event - there is altered marking criteria for each year level, so please mark your candidate accordingly. Stop 4th year candidates at 6 minutes to ask the questions - but do not stop 5th year candidates.

INTRODUCTION/COMMUNICATION:

- ☐ Introduces self
- ☐ Gain consent from patient
- ☐ Explain what they are doing today and what it entails: having a discussion about recent investigations
- ☐ Completes hand hygiene
- ☐ Assures patient of confidentiality
- ☐ Actively listens to patient
- ☐ Establishes rapport with patient
- ☐ Straightforward, with non-medical terms used when talking to patient
- ☐ Respectful throughout interaction

BREAKING BAD NEWS:

- ☐ Uses SPIKES or other systematic approach
- ☐ Tailors approach to patient interaction
- ☐ Asks patient if they would like someone else to be present in the room with them
- ☐ Asks if the patient is happy to receive their results today
- ☐ Discusses the sequence of events leading up to this review:
    - Talks about initial presentation
    - Asks about possible symptoms: nipple discharge, change in breast shape/colour, other lumps, weight loss etc.
- ☐ Asks whether the patient was aware of what the biopsy might show
- ☐ Establishes the level of current knowledge the patient has
- ☐ Asks ICE
- ☐ Provides a warning shot (e.g. “as you know we took a biopsy, and unfortunately the results were not as we hoped”)
- ☐ Clear simple delivery of diagnosis: breast cancer

- ☐ Provides information in small chunks: slow, respectful, clear delivery
- ☐ Takes appropriate pauses as necessary: gives the patient time to process
- ☐ Demonstrates empathy
    - Recognizes and responds to patient emotions
- ☐ Summarizes information provided
- ☐ Checks for patient understanding
- ☐ Offers ongoing assistance to the patient
    - Includes providing pamphlets or other written information about diagnosis and future steps
- ☐ Asks if the patient has any questions

PATIENT'S QUESTIONS:

1) **What happens now?**
    - ☐ Refers patient to oncology
    - ☐ Demonstrates empathy that this may be in the city (away from home)
    - ☐ Recommends a PET scan
    - ☐ Outlines some treatment options: surgery, chemo, radiation, immunotherapy, hormonal therapy etc.
    - ☐ Reassures patient
    - ☐ Recommends support groups or places to gather further information: e.g. Breast Cancer Network Australia, Cancer Helpline etc.
    - ☐ Suggests follow up review in GP clinic to go over information again and develop a care plan
2) **Will I be cured if I have treatment?**
    - ☐ Demonstrates empathy for patient's situation
    - ☐ Does not lie about prognosis (e.g. "I'm so sorry, but at this stage I don't have enough information to answer that. Hopefully in the next few weeks once we've completed other tests I can answer you better.")
    - ☐ Explains that further scans (e.g. a PET) or biopsies (e.g. sentinel lymph node biopsy) may be needed to establish cancer staging/prognosis
    - ☐ Breast cancer generally has a good prognosis

QUESTIONS:

Stop 4th year candidates at 6 minutes to ask the questions - but do not stop 5th year candidates.

1) **What is the triple test for breast cancer?**

- ☐ Explains that this is the gold standard for diagnosing breast cancer
- ☐ Outlines the 3 components:
    - Clinical examination: medical history + physical exam
    - Diagnostic imaging: mammography, USS, MRI - depends on age and breast density
    - Biopsy: usually either FNA or core biopsy

2) **List 5 features on a breast exam that you may expect in a patient with breast cancer**
    - ☐ 5+ of any of the following:
        - Enlarged axillary lymph nodes
        - Obvious change in size/shape of breasts
        - Visible or palpable lumps
        - Traction on skin
        - Pulling/inversion of nipples
        - Peau d'orange appearance
        - Nipple discharge
        - Weight loss

OVERALL ASSESSMENT			
Professional Competency	**Level of performance**		**Criteria**
Communication skills Weighting: 4	**Fail**	⬜	● No rapport established ● Uses medical jargon
	Borderline fail	⬜	● Minimal empathy demonstrated ● Does not give patient time to process
	Borderline pass	⬜	● Some rapport + empathy developed ● Some areas of awkwardness
	At expected standard	⬜	For 4th years: ● Good rapport + empathy demonstrated ● Actively listens to patient For 5th years: ● Strong rapport established ● Good empathy + respect displayed ● Clear objective of consult outlined ● No medical jargon used throughout interaction
	Outstanding	⬜	For 4th years: as above PLUS ● Clear introduction into today's consult

			For 5th years: as above PLUS ● Efficient while maintaining patient respect and empathy
History skills Weighting: 4	**Fail**	⬜	● Blunt, rude or no explanation provided
	Borderline fail	⬜	● Some attempt at breaking bad news in an empathetic way ● Overloads patient with information
	Borderline pass	⬜	● Clear attempt at breaking bad news with empathy ● Some development of a structure to conversation
	At expected standard	⬜	For 4th years: ● Utilizes SPIKES or other similar structure ● Discusses sequence of events leading up to presentation ● Asks if patent has any questions For 5th years: ● Systematic approach to breaking bad news ● Establishes current patient knowledge ● Outlines sequence of events ● Clear simple delivery of diagnosis ● Asks if patient has any questions + checks understanding
	Outstanding	⬜	For 4th years: as above PLUS ● Checks patient understanding ● Checks for current patient knowledge For 5th years: as above PLUS ● Provides a warning shot ● Summarizes information provided
Management Weighting: 2	**Fail**	⬜	● No answers provided
	Borderline fail	⬜	● Gives vague answers ● Lies about prognosis
	Borderline pass	⬜	● Expresses that they need more information to answer patient questions ● Suggests that referrals may be needed ● 3 or less clinical features listed on exam
	At expected standard	⬜	For 4th years: ● Recommends further imaging and referrals ● Outlines basic cancer treatment options ● 2/3 triple test features listed ● Lists 4 clinical features on breast exam For 5th years: ● Refers to oncology + recommends PET scan ● Suggests follow up review

			● All triple test features listed ● Lists 5 clinical features on breast exam
	Outstanding	⬜	For 4th years: as above PLUS ● Specifically mentions oncology + PET ● All triple test features listed ● 5+ clinical breast exam features listed ● Demonstrates empathy for patient situation For 5th years: as above PLUS ● Expresses treatment may involve being away from home ● Recommends support groups/provides written information ● Explains that triple test is gold standard for breast cancer diagnosis ● 6+ clinical breast exam features listed

OVERALL COMPETENCY				
Fail	**Borderline fail**	**Borderline pass**	**At expected standard**	**Outstanding**
Competence not demonstrated in the skill being assessed. Major omissions with performance being disorganised or illogical. ⬜	Overall competent in the skill being assessed but omitted a few points. Some inaccuracies and may struggle to complete the task. ⬜	Competent performance of skill being assessed, with some minor omissions or technical errors. ⬜	Competent performance of skill being assessed was well done, with very few omissions or technical errors. ⬜	Excellent performance of skill being assessed. Fluid and competent performance. ⬜

STATION 2 - CANDIDATE

Charles is a 21 year old man who has been brought in by ambulance following a traumatic knee injury he faced while playing soccer 2 hours earlier. The history is vague, but you know it was a high impact force that struck the knee. The joint is red and swollen. You are the ED intern on the shift and have been asked by your supervisor to take a quick history and perform an exam on the patient.

The ED nurse took a brief history with the following details.

PMHx/Surg Hx: nil medical conditions

- Appendectomy 3yrs ago, nil complications

Nil medications. NKDA.

FMHx: nil known

SocHx:

- Non-smoker, occasional drinker, good diet, poor physical activity → has tried to improve this so plays soccer 2x a week (started 3/12 ago)
- Student at JCU

Please complete the following activities. You will have 8 minutes.

For 4th years:

1. Perform a focused knee exam on Charles.
2. Answer the examiner's questions.

For 5th years:

1. Take a focused history of presenting complaint, focusing on excluding red flags. You are NOT expected to take a full history.
2. Perform a focused knee exam on Charles.
3. Answer the examiner's questions.

STATION 2 - VOLUNTEER PATIENT

PATIENT NAME: CHARLES WASOWSKI | DOB: 15/05/2004 (21M)

We kindly request that you wear shorts/pants that can easily pull up, so that the candidate may examine your knees.

Please obey all commands from your candidate as if you are a real patient, and do not provide any hints to the candidate.

ONLY 5TH YEAR STUDENTS ARE EXPECTED TO TAKE A HISTORY, which is as follows:

Opening statement: "I've got some pain in my **right** knee since playing soccer today, but now it just feels really unstable"

You weren't able to mobilise right after the injury, but have been able to walk into the ED consult room, albeit with "extreme pain". Your BMI is **31.2**.

History of Presenting Complaint:

- You were out playing soccer and you turned your right knee sharply to the left and felt the pain instantly on the front and inside of your right knee
- Pain is only in the R. knee, no-where else
- The pain is sharp in nature and has now turned into an ache
- The pain does not radiate anywhere
- The pain was bad initially but you put ice on it straight away and it improved, however still "very painful"
- Weight bearing makes it worse, as does bending your knee
- Paracetamol and ibuprofen have improved the pain slightly.
- The pain was 8/10 initially, but now is 6/10.
- Noticed swelling has been "pretty bad" and came on almost immediately
- Have not noticed any locking or other noises when you bend your knee
- Knee does feel a bit unstable
- Difficult walking and weight bearing with "extreme pain"
- No tingling or numbness in your lower limbs
- Last had a meal 4 hours ago

- You are not immunosuppressed

Systems review

- Nil subjective fevers or feeling hot or cold
- No recent infections or sick contacts
- Nil urinary changes or rashes, mild nausea
- All other questions negative on systems review

You have a joint effusion, along with tenderness at the fibular head, and your Lachmann's and anterior draw tests are positive.

If the candidate asks anything outside of the information listed here, tell them "you don't know".

STATION 2 - ASSESSOR

Candidate Name: _____ MBBS Year: _____

<u>Please note that this is a mixed event - there is altered marking criteria for each year level, so please mark your candidate accordingly. Stop 4th year candidates at the 6 minute mark to ask questions but do NOT stop 5th year candidates at any time.</u>

INTRODUCTION:

- ☐ Introduces self
- ☐ Gain consent from patient
- ☐ Explain what they are doing today and what it entails: performing a knee examination etc.
- ☐ Completes hand hygiene
- ☐ Straightforward, with non-medical terms used when talking to patient
- ☐ Respectful throughout interaction

HISTORY TAKING: ***only for 5th years***

- ☐ Appropriate HxPC: asks SOCRATES
- ☐ Screens for red flags and broad differentials in systems review:
    - Ligamental tear → swelling onset, **sporting injury, young patients**
    - Fracture → ability to weight bear, **obesity**, excess alcohol intake, smoking
    - Septic arthritis → fever, history of trauma, immunosuppression
    - Systemic rheumatological disease → red eye, history RA/SLE/Crohn's Disease, morning stiffness, relieved with exercise
    - ARF → fever, migratory polyarthritis, previous episode, social situation, ethnicity
    - Gout → gender (male), dehydration, high alcohol intake/seafood intake, family history
    - Malignancy → B symptoms

EXAMINATION:

<u>INSPECTION</u>

- ☐ Inspects the anterior, medial, lateral and posterior knee; any 3+ of: valgus/varus deformities, wasting quadriceps, skin changes, surgical scars, erythema, bruising, swelling
- ☐ Observes gait → ***antalgic***
- ☐ Observes patella tracking during active flexion and extension
- ☐ Requests vital signs → ***normal except for mild tachycardia (HR 106) and BMI of 31.2***

PALPATION

- ☐ Palpates for wasting of quadriceps
- ☐ Feels temperature differences between knees
- ☐ Checks for crepitus
- ☐ Assesses for joint effusion using patellar tap → **POSITIVE** *(advise candidate if performed)*
- ☐ Palpates key structure of the knee joint BILATERALLY:
    - Anterior → quadriceps tendon, patella, patella tendon, tibial tuberosity
    - Lateral → lateral joint line, lateral collateral ligament, iliotibial band, **fibula head (TENDERNESS)**
    - Medial → medial joint line, medial collateral ligament, pes anserine bursa
    - Posterior → popliteal fossa and pulses

MOVE

- ☐ Assesses active flexion and extension → *nil restriction, albeit with pain*
- ☐ Assesses passive flexion and extension → *nil restriction, albeit with pain*

FUNCTION

- ☐ Half + full squat (usually performed with gait after general inspection)

SPECIAL TESTS

- ☐ Lachman test (?ACL tear) → **POSITIVE** *(advise candidate if performed)*
- ☐ Anterior draw test (?ACL tear) → **POSITIVE** *(advise candidate if performed)*
- ☐ Thessaly test (?Meniscal tear) → NEGATIVE
- ☐ Valgus/varus stress test (?MCL or LCL tear) → NEGATIVE

QUESTIONS:

Stop 4th year candidates at 6 minutes to ask the questions - but do not stop 5th year candidates.

1. **What is your provisional diagnosis for this patient, and two differential diagnoses?**
    - ☐ Provisional diagnosis of ACL rupture/tear
    - ☐ 2+ of: MCL tear, medial meniscus ligament tear, patella fracture
    - ☐ Justification provided for differentials

2. **What imaging would you order for this patient, if any?**
    - ☐ MRI knee → gold standard for soft injury/ligament injuries
    - ☐ X-ray knee* (meets Ottawa rules) → exclude fracture
    - ☐ USS Knee → soft tissue injury

3. **Assuming this is an ACL tear, what is your key management for this patient as the ED doctor**?
    - ☐ RICE → Rest, Ice, Compression, Elevation
    - ☐ Prescribe basic analgesia → paracetamol, NSAIDs (avoid opiates)
    - ☐ Referral to physiotherapy for rehabilitation
    - ☐ Referral to orthopaedics for potential surgical intervention (ie. ACL reconstruction)

*Note that an X-ray is indicated in this patient, as they meet the criteria for imaging as per the Ottawa knee rules (ANY of the following can be present):

- Age 55+
- Isolated patella tenderness
- **Tenderness at the head of fibula**
- Inability to flex knee 90 degrees
- Inability to bear weight (4 steps) both immediately after injury and in ED

OVERALL ASSESSMENT			
Professional Competency	**Level of performance**		**Criteria**
History taking Weighting: 2	**Fail**	⬜	• Poorly constructed history • Multiple errors • Nil relevant questions asked or history skipped altogether • Poor bedside manner or aggressive questioning
	Borderline fail	⬜	• History lacks focus, scatter gun approach • Does not screen for any red flags for knee pain

	Borderline pass	⬜	● HPC missing a few questions, but overall satisfactory ● Guesses “red flags” for knee pain
	At expected standard	⬜	For 5th years: ● Clear HxPC with all of SOCRATES covered ● Screens for at least 3+ red flags for knee pain
	Outstanding	⬜	For 5th years: ● As above + history is efficient ● Empathy demonstrated throughout interaction ● Clear clinical reasoning demonstrating differential diagnoses being excluded
Examination Weighting: 4	**Fail**	⬜	● Inappropriate or uncoordinated technique to examination
	Borderline fail	⬜	● Attempts to perform knee examination, however missing several key areas ● Exam lacks structure
	Borderline pass	⬜	● Performs adequate knee exam on single affected knee, following the general process of inspect, palpate, move and function, with few omissions
	At expected standard	⬜	For 4th years: ● Adequate and systematic approach to perform knee examination, including inspect, palpate, move and function, with minimal errors ● Performs knee exam on both knee for comparison ● Performs a special test For 5th years: ● Concise/focused and systematic bilateral knee examination, with minimal errors ● Performs the anterior draw and/or Lachman special test
	Outstanding	⬜	For 4th years: ● As above + outlines expected findings to the examiner, while identifying the “normal findings” seen ● Performs the anterior draw and/or Lachman special test For 5th years: ● As above + clear focus of examination with differentials in mind ● Ensures patient feels comfortable throughout ● Performs all relevant special tests in this case, including the anterior draw, Lachman and Thessaly
Diagnosis and synthesis of data Weighting: 2	**Fail**	⬜	● No differentials provided
	Borderline fail	⬜	● No relevant differentials provided

	Borderline pass	⬜	• Says 1+ relevant differential, but not ACL tear/injury
	At expected standard	⬜	For 4th years: • Mentions "ACL tear/injury" as provisional • At least 1+ relevant differentials provided For 5th years: • "ACL tear/injury" listed as provisional diagnosis • At least 2+ relevant differentials such as: meniscal injury, patella fracture, MCL tear • Justifies provisional diagnosis
	Outstanding	⬜	For 4th years: • As above + mentions 2+ relevant differentials • Justifies provisional diagnosis For 5th years: • As above + justifies all differentials provided
Management Weighting: 2	**Fail**	⬜	• No investigations or management provided
	Borderline fail	⬜	• Missing key investigations OR management incongruent or grossly inaccurate
	Borderline pass	⬜	• Mentions 1 or 2 relevant investigations • May mention RICE management however explanation incorrect or lacking sufficient detail
	At expected standard	⬜	For 4th years: • Mentions MRI and USS • Outlines RICE approach to management or similar For 5th years: • Mentions MRI, USS AND X-ray • Outlines RICE approach to management • Refers patient to physio or orthopaedics
	Outstanding	⬜	For 4th years: • As above + mentions X-ray • Rationalises investigations and management For 5th years: • As above + rationalises all investigations + management • Justifies X-ray based on the Ottawa score • Provides patient with simple analgesia

OVERALL COMPETENCY				
Fail	**Borderline**	**Borderline**	**At expected**	**Outstanding**

	fail	**pass**	**standard**	
Competence not demonstrated in the skill being assessed. Major omissions with performance being disorganised or illogical. ⬜	Overall competent in the skill being assessed but omitted a few points. Some inaccuracies and may struggle to complete the task. ⬜	Competent performance of skill being assessed, with some minor omissions or technical errors. ⬜	Competent performance of skill being assessed was well done, with very few omissions or technical errors. ⬜	Excellent performance of skill being assessed. Fluid and competent performance. ⬜

STATION 3 - CANDIDATE

You are a medical student on your rural placement. You have been asked to see George, a 64 year old man presenting with a fever for the past 3 days. You look through the notes and see that George last presented to the clinic 5 months ago, to receive his travel vaccines prior to visiting Indonesia.

Please complete the following activities. You will have 8 minutes.

1. Take a focused history from George.
2. Answer the examiner's questions.

STATION 3 - VOLUNTEER PATIENT

PATIENT NAME: GEORGE STANLEY | DOB: 14/09/1961 (64M)

Please do not provide additional information/hints to the candidates.

Opening statement: "I've been having a fever for the past 3 days and it's not going away. I'm normally quite well, so this is very unusual for me."

History of presenting complaint:

- You have been experiencing fevers + chills for the past 3 days, but haven't measured your own temperature.
- No one you know is sick.
- You have also been experiencing severe headaches, similar to a really bad migraine. You experience migraines from time to time but this feels different.
- You have also been experiencing some muscle aches and soreness everywhere
- You have been having some night sweats
- You have been very tired since the fevers started, and have barely been able to get out of bed, which is very atypical for you
- You have tried some paracetamol for the fever, but don't think that this is helping at all
- No cough, runny nose or sore throat
- No urinary or bowel symptoms
- No rash or other skin changes
- No confusion, no photophobia
- No chest pain

You have NOT had a Q fever vaccination before.

Travel history:

- You travelled to Indonesia for a month long holiday 4 months ago
- You took all the recommended travel vaccines (incl. Yellow fever, typhoid, japanese encephalitis etc.) 5 months ago (about 1 month prior to your departure to Indonesia)
- You adequately protected yourself against mosquitoes: slept with a mosquito net, regularly applied mosquito repellent, wore long-sleeved clothing
- You only drank bottled water, and did not eat any street food while you were there
- You went swimming in some freshwater 2 or 3 times as you thought the water looked lovely

- You mostly stayed in the city, only going for a few days to the countryside as you heard that the waterfalls were spectacular and that you had to visit
- No risky behaviours: no sexual activity, no tattoos, no IVDU etc.

PMHx: migraines

- Nil surgical hx
- Immunizations up to date (**except Q fever - but do not mention this to the candidate unless explicitly asked**)
- No allergies

Meds: nil

FMHx: nil

Social hx: non-smoker, no EtOH, good diet, stays physically active due to work

- Self-employed at a cattle farm

FMHx:

- Mother has rheumatoid arthritis
- Father passed away from lung cancer

If the candidate asks for any information that isn't listed, state "I don't know" or ask what they mean (i.e. to be more specific)

STATION 3 - ASSESSOR

Candidate Name: _____ MBBS Year: _____

Please note that this is a mixed event - there is altered marking criteria for each year level, so please mark your candidate accordingly. Stop 4th year candidates at 6 minutes to ask the questions - but do not stop 5th year candidates.

INTRODUCTION/COMMUNICATION:

- ☐ Introduces self
- ☐ Gain consent from patient
- ☐ Explain what they are doing today and what it entails: taking a history
- ☐ Completes hand hygiene
- ☐ Straightforward, with non-medical terms used when talking to patient
- ☐ Respectful and empathetic throughout interaction

HISTORY TAKING:

- ☐ Explores presenting complaint in depth: fever
    - Onset, duration, timing of febrile episodes
    - Subjective vs objective fevers, fever severity
    - Triggers and relieving factors
- ☐ At least 3 of the following associated symptoms asked: fatigue, night sweats, weight loss, rash, pain
- ☐ Asks about sick contacts
- ☐ Asks about infective symptoms, at least 2 from a minimum of 4 systems:
    - Respiratory: cough, sore throat, runny nose
    - Cardiovascular: chest pain, palpitations
    - Gastrointestinal: abdominal pain, nausea/vomiting, diarrhoea
    - Genitourinary: dysuria, change to frequency, haematuria, discharge
    - CNS: headache, photophobia, seizures, confusion
    - MSK: joint pain, swelling
    - Dermatological: rash, erythema, skin breaks
- ☐ Asks about potential exposures:
    - Contaminated food or water
    - Recent injuries

- Contact with animals
- Sexual activity
- Recreational drug use

☐ Takes a thorough travel history
- Location, travel dates, accomodation
- Recognizes that patient is up to date with their travel vaccines
- Insect bites
- Exposures: as listed above

☐ Asks about history of autoimmune disease: personal or family history

☐ Asks about history of malignancy: incl. Screening for B symptoms such as: weight loss, haemoptysis, haematuria, SOB, masses, bone pain, lymphadenopathy etc.

☐ Asks ICE

☐ Asks about immunizations

☐ Asks a general history:
- PMHx and surgical hx
- Medications and allergies
- FMHx
- Social hx

☐ Summarizes consult

QUESTIONS:

Stop 4th year candidates at 6 minutes to ask the questions - but do not stop 5th year candidates.

1) **What are your differentials for this patient?**

☐ Lists Q fever as provisional diagnosis

☐ Lists at least 3 other relevant differentials: dengue, EBV, CMV, Ross River virus, brucellosis, leptospirosis, Lyme disease, mycoplasma

☐ Justifies differentials provided

2) **What is Q fever and should this patient be vaccinated against it?**

☐ States that Q fever is caused by a bacteria
- Mentions *Coxiella burnetii*

☐ Mentions that Q fever is a zoonotic disease

☐ Recognizes that patient has occupational exposure to cattle
- Or mentions asking about exposure during justification

- ☐ Explains that they need to verify whether patient has already had a Q fever vaccination
    - Or justifies using this reasoning if already asked in history
    - Recommends using serology or skin test to confirm past exposure
- ☐ States that patient should be investigated for Q fever (i.e. serology) given symptoms and exposure
- ☐ Explains that vaccination should only be provided if no prior Q fever vaccination or infection
- ☐ Recommends patient be vaccinated if this is not an episode of Q fever AND that there has been no history of previous infection or vaccination

OVERALL ASSESSMENT			
Professional Competency	**Level of performance**		**Criteria**
Communication skills Weighting: 3	**Fail**	⬜	● No rapport established ● Does not wash hands
	Borderline fail	⬜	● Some rapport and engagement ● Uses medical jargon
	Borderline pass	⬜	● Non-medical jargon used, but unclear line of questioning
	At expected standard	⬜	● Good rapport established ● Straightforward questioning ● Clear stream of thought, patient able to follow well
	Outstanding	⬜	● Excellent rapport built ● Simple efficient questioning ● Empathy demonstrated
History-taking skills Weighting: 4	**Fail**	⬜	● No approach to questioning ● Does not explore presenting complaint
	Borderline fail	⬜	● No travel history asked ● Explores presenting complaint ● Questions are not structured or systematic
	Borderline pass	⬜	● Some clinical reasoning evident ● Semi-random approach to associated symptoms ● Some exploration into a travel history
	At expected standard	⬜	For 4th years: ● Clinical reasoning evident ● Reasonable approach to travel history, including

			exposures ● Asks a general history For 5th years: ● Clear clinical reasoning demonstrated ● Detailed travel history: incl. Exposures and preventative methods ● Screens for alternative causes of PUO other than infection ● Completes general history
	Outstanding	⬜	For 4th years: as above PLUS ● Asks about preventative methods while travelling ● Considers other causes of PUO than infection For 5th years: as above PLUS ● Summarizes consult ● Specifically asks about Q fever immunization
Diagnosis and synthesis of data Weighting: 3	**Fail**	⬜	● Irrelevant or no differentials provided ● No response to vaccination question
	Borderline fail	⬜	● Only lists 1 relevant differential ● Unclear response to vaccination question
	Borderline pass	⬜	● Lists 2+ relevant differentials, but does not mention Q fever ● Understands patient exposure/risk factors ● Some reasoning provided for vaccination question
	At expected standard	⬜	For 4th years: ● Lists at least 3 relevant differentials ● States Q fever is a bacteria ● Provides clear justification as to whether patient should be vaccinated or not For 5th years: ● Q fever listed as provisional diagnosis ● At least 2 other relevant differentials identified ● Justification provided for each diagnosis ● Recognizes that patient needs further testing prior to provision of vaccination
	Outstanding	⬜	For 4th years: as above PLUS ● Q fever listed as provisional diagnosis ● Justification provided for diagnoses ● States that vaccination should only be provided if no prior Q fever vaccination or infection For 5th years: as above PLUS ● 3+ relevant differentials listed ● Recommends serology and/or skin test to check for exposure to Q fever prior to vaccination ● Clear rationalization evident for response

OVERALL COMPETENCY				
Fail	**Borderline fail**	**Borderline pass**	**At expected standard**	**Outstanding**
Competence not demonstrated in the skill being assessed. Major omissions with performance being disorganised or illogical. ⬜	Overall competent in the skill being assessed but omitted a few points. Some inaccuracies and may struggle to complete the task. ⬜	Competent performance of skill being assessed, with some minor omissions or technical errors. ⬜	Competent performance of skill being assessed was well done, with very few omissions or technical errors. ⬜	Excellent performance of skill being assessed. Fluid and competent performance. ⬜

STATION 4 - CANDIDATE

You are a medical student working in the emergency department. A distressed parent brings their child, Brodie, an 8 year old male into hospital as he is making strange noises and is struggling to breathe. He is adequately stabilized by the medical team before being moved to the paediatric area, where you meet him.

Please complete the following activities. You will have 8 minutes.

1. Take a brief focused history from the family.
2. Answer the examiner's questions..

STATION 4 - VOLUNTEER PATIENT

PATIENT NAME: BRODIE SAMUELS | DOB: 23/04/2017 (8M)

YOU ARE THE PATIENT'S PARENT: either Chelsea/Charles (mum/dad)

Please do not provide additional information/hints to the candidates.

Opening statement: "My child has been having some trouble breathing and was making all these strange noises so I got really concerned and brought him in."

History of presenting complaint:

- Brodie has been feeling a bit breathless since yesterday, but you thought it was just because he had a bit of a viral infection
- This morning it got worse and he started making weird noises: this has never happened before and it made you very concerned. The noises only seemed to get better after he was treated by the paramedics and ED team.
    - ❖ If asked what the noises sounded like: they were squeaky and high pitched. The noises didn't occur with every breath.
    - ❖ If asked further: you mostly noticed the noises when Brodie was breathing out.
- Brodie had a temperature of 38 degrees last night, and you gave him some kiddies paracetamol and that seemed to help him
- A couple of Brodie's classmates have been sick: you're not sure what they have but your think it's just the flu
- You have heard about "sepsis" and how it's a terrible illness, and you are worried that this is what your child has
- They have had a decreased appetite since yesterday
- You have not noticed any changes in their bowel/urinary habits: they go to the bathroom by themselves (and no longer wet the bed), but you did not specifically ask Brodie
- Brodie is currently comfortable and asleep

Born at term, with a normal spontaneous vaginal birth and delivery, no NICU/SCU, no known medical conditions, no allergies

- No regular medications, had paracetamol last night for fever

Normal antenatal scans/tests - no concerns during pregnancy
Normal growth and development

Up to date with immunizations
No FMHx of any respiratory conditions

Social:

- Your partner smokes: but tries to do this outside away from Brodie
- You and your partner live together in a house that you own, along with Brodie and your pet labrador
- Brodie goes to primary school - he came home early yesterday as he was feeling unwell, and hasn't gone in today
- Neither you nor your partner have been sick

If the candidate asks for any information that isn't listed, state "I don't know" or ask what they mean (i.e. to be more specific)

STATION 4 - ASSESSOR

Candidate Name: _____ MBBS Year: _____

Please note that this is a mixed event - there is altered marking criteria for each year level, so please mark your candidate accordingly. Stop 4th year candidates at 5 minutes to ask the questions - but do not stop 5th year candidates.

INTRODUCTION/COMMUNICATION:

- ☐ Introduces self
- ☐ Gain consent from parent
- ☐ Explain what they are doing today and what it entails: taking a history
- ☐ Completes hand hygiene
- ☐ Assures patient confidentiality
- ☐ Straightforward, with non-medical terms used when talking to parent
- ☐ Respectful and empathetic throughout interaction

HISTORY TAKING:

- ☐ Explores history of presenting complaint in detail
    - Breathlessness: onset, timing, exacerbating/relieving factors
    - Noises: description, onset, timing, exacerbating/relieving factors
- ☐ Asks about at least 5 associated symptoms: fever, cough, runny nose, headache, nausea/vomiting, abdominal pain, rash, limp etc.
- ☐ Explores parent concerns:
    - Recognizes concern surrounding sepsis: provides reassurance and rationale
    - Recognizes concerns surrounding wheeze
- ☐ Asks about change to appetite/feeding
- ☐ Asks about toileting: change to urine/bowel habits
- ☐ Assesses whether something like this has happened previously
- ☐ Explores potential sick contacts
- ☐ Takes a social history:
    - Growth and development
    - Living condition + pets
    - Schooling
    - Smoking exposure

- ☐ Asks about past medical history
    - Antenatal and birth history
    - Medical conditions + surgical hx + medications
    - NICU/SCU
- ☐ Checks that immunizations are up to date
- ☐ Checks for history of atopy: hx of asthma, allergies, eczema etc.
- ☐ Asks about FMHx of atopy, respiratory conditions
- ☐ Summarizes consult

QUESTIONS:

Stop 4th year candidates at 5 minutes to ask the questions - but do not stop 5th year candidates.

1) **Brodie undergoes some investigations, including the following** (please give candidate Figure 1)**. Please interpret these results.**

- ☐ Mentions that this is a spirometry/PFT result
- ☐ Recognizes that there is a >12% increase in FEV1

PLUS

For 4th years:

- ☐ Makes a diagnosis of asthma
- ☐ Provides reasoning for diagnosis

For 5th years:

- ☐ Comments on age required to adequately perform spirometry
- ☐ Rationalizes that this is the first time symptoms have occurred, and likely in the context of illness, more likely to still be viral-induced wheeze
- ☐ Provides a differential of asthma, but states this requires further investigation when the child is well

2) **Brodie is provided with the following medications on discharge. Please counsel Brodie's parent on how to provide him with these medications.** (please give candidate Figure 2)

- ☐ Appropriately identifies preventer and reliever
    - Explains the role of each to the parent
- ☐ Recommends using a spacer
- ☐ Describes asthma inhaler technique
    - Talks about ensuring a firm seal

- Talks about spacer care: air drying spacer etc.

☐ States they would provide written information to help parents understand/remember
☐ Suggests follow up to review inhaler technique
☐ Uses layman terms
☐ Checks for understanding
☐ Expresses that they would like to go through this information with Brodie as well

OVERALL ASSESSMENT			
Professional Competency	**Level of performance**		**Criteria**
Communication skills Weighting: 3	**Fail**	⬜	● No rapport established ● Does not wash hands
	Borderline fail	⬜	● Some rapport and engagement ● Uses medical jargon
	Borderline pass	⬜	● Non-medical jargon used, but unclear line of questioning ● Assures confidentiality
	At expected standard	⬜	● Good rapport established ● Straightforward questioning ● Clear stream of thought, parent able to follow well
	Outstanding	⬜	● Excellent rapport built ● Simple efficient questioning ● Empathy demonstrated
History-taking skills Weighting: 3	**Fail**	⬜	● No approach to questioning ● Does not explore presenting complaint
	Borderline fail	⬜	● No PMHx asked ● Explores presenting complaint ● Questions are not structured or systematic
	Borderline pass	⬜	● Some clinical reasoning evident ● Semi-random exploration into associated symptoms
	At expected standard	⬜	For 4th years: ● Clinical reasoning evident ● Attempts paediatric history ● Asks a general history ● Explores parent concerns For 5th years:

			● Clear clinical reasoning demonstrated ● Detailed paediatric history: incl. Birth hx, growth, feeding, toileting etc. ● Explores a social history
	Outstanding	⬜	For 4th years: as above PLUS ● Asks about feeding and toileting ● Attempts a social history For 5th years: as above PLUS ● Summarizes consult ● Specifically asks about personal/FMHx of atopy
Diagnosis and synthesis of data Weighting: 4	**Fail**	⬜	● No attempt at interpretation ● No explanation provided to parent
	Borderline fail	⬜	● Recognizes investigation as PFT but no interpretation ● Uses medical jargon to explain medication
	Borderline pass	⬜	● Some attempt at PFT interpretation ● Explains medications in layman terms, but does not explain asthma inhaler technique
	At expected standard	⬜	For 4th years: ● Interprets >12% increase in FEV1 in PFT ● Diagnoses asthma ● Explains asthma inhaler technique For 5th years: ● Interprets >12% increase in FEV1 in PFT ● Justifies diagnosis of viral induced wheeze/asthma ● Clear explanation of asthma inhaler technique, checking for understanding ● Mentions spacer care
	Outstanding	⬜	For 4th years: as above PLUS ● Checks for understanding ● Mentions spacer care For 5th years: as above PLUS ● Comments on age required to adequately perform spirometry / reliability of PFT results ● Comments on reviewing technique with Brodie as well

OVERALL COMPETENCY				
Fail	**Borderline fail**	**Borderline pass**	**At expected standard**	**Outstanding**

Competence not demonstrated in the skill being assessed. Major omissions with performance being disorganised or illogical. ⬜	Overall competent in the skill being assessed but omitted a few points. Some inaccuracies and may struggle to complete the task. ⬜	Competent performance of skill being assessed, with some minor omissions or technical errors. ⬜	Competent performance of skill being assessed was well done, with very few omissions or technical errors. ⬜	Excellent performance of skill being assessed. Fluid and competent performance. ⬜

Figure 1:

	Pred	Pre	% Pred	Post	% Pred	% Change
FVC.....[l]	3.88	3.77	97	4.66	120	23.38
FEV 1.....[l]	3.34	1.77	53	3.11	93	75.23
FEV 1 % FVC.....[%]	85.27	46.97	55	66.70	78	42.03
PEF.....[l/s]	8.03	3.65	45	6.92	86	89.72
FEF 50.....[l/s]	4.81	0.84	17	2.22	46	163.93
FEF 75.....[l/s]	2.69	0.36	13	0.81	30	124.17
MMEF 25/75.....[l/s]	4.36	0.77	18	1.82	42	137.47
FET.....[s]		9.21		7.97		-13.42

Figure 2:

Brodie has been prescribed:

- Fluticasone 50 microg BD
- Salbutamol 4-6 puffs PRN