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1. Foreword

1.1 Introduction

This document is an update to the previous guide to the MRCPsych Part 1 OSCE exam. The structure should be relatively self-explanatory and it is intended to provide advice and tips which will improve your performance in the CASC exam.

This paper does not address the written aspects of the MRCPsych exam. The curricula for each paper are detailed on the trickcyclists.co.uk website and the entire curriculum is available from the College.

1.2 Conventions and styles used in this document

Tip! This indicates a hint or tip regarding style or practice.

Conversational content is in a box, and is in a different typeface. These are the things that you might want to say.

1.3 Background to the use of OSCEs in the MRCPsych exam

1.3.1 The OSCE

The OSCE (Objective Structured Clinical Exam) was first developed at the University of Dundee in the late 1970s (Harden & Gleeson, 1979; Harden, Stevenson, Downie, et al, 1975). The advantages at the time were stated as being:

“The examination is more objective and a marking strategy can be decided in advance. The examination results in improved feedback to students and staff.”

(Harden, Stevenson, Downie, et al, 1975)

Even at this early stage, simulated patients were proposed as having advantages over real patients, particularly when it came to consistency.

The OSCE format has penetrated most medical exams in the western world and form a major part of the United States Medical Licensing Examination (USMLE) exam. They also feature in the PLAB. These days, it is highly unlikely that a UK medical student will graduate without undergoing a number of OSCE exams.
1.3.2 The OSCE in the MRCPsych Exam

In spring 2003, the Individual Patient Assessment (IPA; the ‘long case’) was replaced by an OSCE. Previously in the long case, the candidate interviewed a patient for one hour, and then presented the full history and mental state examination to two examiners in ten minutes. They then had to interview the patient in front of the examiners for ten minutes, demonstrating aspects of mental state. Finally, they were then questioned on various aspects of the history or mental state for a further ten minutes.

The patient was real, and this was one of the criticisms of the original exam. There was huge variation in the complexity of the case. Some candidates had to interview someone who was relatively well, and had had only one or two episodes of illness. Other candidates had to interview elderly forensic patients with decades of psychiatric illness, admissions, prison sentences, and multiple physical illnesses. The exam was never going to be seen as ‘fair’.

By replacing the old individual patient assessment, the college could have much more control over the content of the exam. They could also have more confidence in the consistency and equity of the exam content. The ‘patients’ were no longer real, and were replaced by actors who had been briefed and coached to simulate real cases. The script was therefore the same for every candidate and it became much easier to compare candidates across the board.

1.3.3 Normative versus Criterion-based Assessment

‘Normative-based’ assessment (NBA) dictates that a specific number of candidates will pass depending on the overall performance of the group. If applied to the MRCPsych clinical exam, this means that approximately 75% are destined to pass whatever the average score. You could score 95% on the exam under NBA and still fail if 80% of people get 98%. Cynics could argue that this allows the Royal College to maintain their revenue stream from the exams, as wells as having some control over overall pass rates.

The shift in assessment in many institutions in recent years has been towards ‘criterion-based’ assessment (CBA) where candidates are marked according to whether they meet specific criteria which have been agreed beforehand. Under CBA, every candidate can pass the exam as long as they perform well and meet all the criteria. This is arguably a much fairer way of determining the skills of the candidates.

The Royal College did not adopt a ‘pure’ OSCE method for marking the original OSCE. Instead they graded each candidate from A to E on a variety of areas. An example marking sheet was provided by the Royal College and is shown below (Figure 2). Despite supposedly being an objective exam, scoring was fairly subjective, and not criterion-based.
This has not been improved in the CASC, with all signs being that it will represent a further step away from any kind of criterion-based assessment. The Royal College appears to be indicating that candidates will be given one of four grades for each station (See Section 2.6.4 below).

1.3.4 Pass Rates

Generally your chances in the old OSCE exam were good and there is no reason to believe that things will change significantly with the CASC exam. There was approximately a 75% pass rate in the IPA and the OSCE exam and this hasn’t changed enormously over the last 8-10 years. Pass rates in the Part I exam from 2000 onwards are shown below in Figure 1.

![MRCPsych Part I Pass Rates 2000-2007](image)

**Figure 1. MRCPsych Part I Pass Rates 2000-2007. From data provided by Royal College of Psychiatrists**

The ‘new’ OSCE exam was introduced in Spring 2003 with little overall effect on pass rates. If you look at the pass rates before and after the introduction of a radically different mechanism of assessment (i.e. the OSCE), it is hard to perceive changes that might reflect a fundamental shift towards criterion-based assessment. One would predict that the CASC exam will not result in radically different pass rates in the clinical exam.
Further, there is a trend in recent years towards a decline in the overall pass rate, probably due to reductions in the pass rates in the clinical exam since the written exam pass rates are increasing.

Figure 2. Example RCPsych Marking Sheet for the old OSCE (Spring 2003 – Autumn 2007)
2. The ‘new’ MRCPsych Exam – 2008 onwards

2.1 Overview

From March 2008, the MRCPsych exam will change from a two-part exam to a four-part exam, primarily in response to changes in postgraduate medical education. Details of the individual exams are given below in Table 1.

Table 1. Format of the new MRCPsych exam

<table>
<thead>
<tr>
<th></th>
<th>Paper I</th>
<th>Paper II</th>
<th>Paper III</th>
<th>CASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>3 hours</td>
<td>3 hours</td>
<td>3 hours</td>
<td>80mins + 120mins Clinical Exam</td>
</tr>
<tr>
<td>No. of questions</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Type/ Style of Questions</td>
<td>MCQs and EMIs</td>
<td>MCQs and EMIs</td>
<td>MCQs and EMIs</td>
<td>Similar to OSCE</td>
</tr>
<tr>
<td>Requirements</td>
<td>12 months whole time equivalent in psychiatry.</td>
<td>At least 18 months whole time in psychiatry.</td>
<td>Between 24 and 36 months whole time equivalent in psychiatry.</td>
<td>Between 30 and 48 months.</td>
</tr>
<tr>
<td>Workplace-based assessments</td>
<td>4x Mini-ACE 2x CBDs</td>
<td>4x Mini-ACE 2x CBDs</td>
<td>4x Mini-ACE &amp; 2x CBDs (at ST1 level) AND 4x Mini-ACE &amp; 2x CBDs (at ST2/3 level)</td>
<td>8x ACE (2 in developmental psychiatry and 6 in other areas)</td>
</tr>
<tr>
<td>Cost</td>
<td>£195</td>
<td>£195</td>
<td>£195</td>
<td>£565</td>
</tr>
</tbody>
</table>

Essentially, there are now three written exams and a Clinical Assessment of Skills & Competencies (CASC). A simplistic view is that Papers I and II have replaced the old Part I written exam, and Paper III is similar to the Part II written. The most significant change is that there is no clinical exam until you have passed all of the written exams. The CASC is likely to be similar to the OSCE, but with the addition of linked stations consisting of two stations of 10 minutes duration each.

The College is planning to run three 'diets' over the course of the year, with all papers being held in Feb/ Mar & June; Jun/ Aug & November; and November.

Workplace-based assessments (WPBAs) will be completed throughout training and will be recorded in the trainee's portfolio. Interestingly, you can 'bank' a Paper III pass for 18 months allowing three tries at the CASC before having to resit Paper III.

2.2 Format of the Written Exam(s)

The format of each paper will be broadly the same and will consist of multiple choice questions (1-5 single best answer) and extended matching items (EMIs). Although the balance of the two types of questions will vary slightly, it will generally be around 75% MCQs and 25% EMIs.
MCQs take the form of ‘1-5, single best answers’. These consist of a stem of 1-2 sentences, followed by five options. The candidate is required to choose the single option which best fits the question stem. Extended Matching Items (EMIs) are slightly different. Each set of EMIs is given a theme, followed by a 'lead-in' statement explaining what the candidate is required to do. There is an option list. A series of vignettes are then given and the candidate is required to choose the best option from the option list.

2.3 Exam content

The college have suggested that Paper I will focus on "areas such as history taking, treatment explanation and record keeping". Paper II will concentrate on areas "such as psychotropic drugs, advanced psychology and neuropsychiatry". Finally, Paper III will test "a) clinical areas of psychiatry, mapping on to the specialty areas (including general adult as a specialty) of knowledge expected at this level of training, and b) critical appraisal of research relevant to clinical practice".¹

2.4 The new CASC exam

According to the College:

"The Clinical Assessment of Skills and Competencies (CASC) examination for June 2008 will be a 12 station examination testing candidates' competency in clinical skills appropriate to their stage of training. Stations will comprise linked pairs (i.e. 6 linked pairs) of stations with a clinical task in the first station linked to a second, related task in the second station. Candidate instructions in the first station of each pair will inform, in broad terms, the candidates as to what task they will carry out in the second of each pair. Each station will consist of 2 minutes preparation time followed by ten minutes attempting the defined task. A one minute warning will be given."²

It is important to note that the format will change subsequent to June 2008 to what is likely to be the final vision of the CASC exam:

“The Clinical Examination...will be an OSCE type examination of two parts, completed in one day. The first part will contain ten single, 'stand alone' stations each lasting 8 minutes (including reading time of 1 minute). The second part will

¹ http://www.rcpsych.ac.uk/exams/newassessmentprogramme2008/newstructure.aspx
² http://www.rcpsych.ac.uk/exams/about/mrcpsychcasc.aspx
consist of 5 pairs of 'linked' stations, which will allow for the assessment of more complex competences. Each station will last 12 minutes (to include 2 minutes reading and preparation time)."  

2.5 Blueprint for the CASC

A typical blueprint for the CASC (courtesy of the Royal College) is shown below in Table 2. This indicates which types of skill can be tested within each specialty, along with the general proportion of stations made up of this type of OSCE. It can be seen that history taking, mental state examination, and risk assessment make up approximately 75% of the exam.

Table 2. Blueprint for the CASC

<table>
<thead>
<tr>
<th></th>
<th>General Adult</th>
<th>Old Age</th>
<th>CAMHS</th>
<th>Learning Disability</th>
<th>Psychotherapy</th>
<th>Forensic</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>30-40</td>
</tr>
<tr>
<td>Mental State Examination</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>30-40</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>15-30</td>
</tr>
<tr>
<td>Cognitive Examination</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>10-20</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5-15</td>
</tr>
<tr>
<td>Case Discussion</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>15-30</td>
</tr>
<tr>
<td>Difficult Communication</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5-15</td>
</tr>
</tbody>
</table>

Additional notes include:
1) History may include obtaining collateral history as well as taking a history directly from the ‘patient’
2) Risk assessment may include assessment of capacity
3) Case discussion can be with medical and paramedical professionals as well as lay people including the patient, family, carers and other professionals. It also includes skills related to psychotherapy formulation (cognitive and dynamic) and discussion of treatment.
4) General Adult includes all subspecialties
5) There will be minor variation in the percentage of stations for each skill area according to how skills are represented in each station. This is due to some station constructs assessing more than one skill (e.g. risk assessment requiring a mental state examination or difficult communication occurring within the context of a case discussion)

http://www.rcpsych.ac.uk/exams/newassessmentprogramme2008/newstructure.aspx
2.6 OSCE Structure in the CASC

Each station is built from a number of elements:

1) A construct – this is used by the examiner to assess candidates’ performance
2) Instructions to candidates
3) Instructions to the role player
4) Marksheets

What follows is the information provided by the College in their CASC Candidate Guide.

2.6.1 Construct

The purpose of the construct is to define what the station is set out to assess in such a way that the examiner is clear as to what constitutes a competent performance. These have a standardised format with elements in common between stations of a similar type. For example a history taking station may include directions such as:

“The candidate can be expected to take a history and carry out an examination of mental state that is focused, fluent and demonstrates empathy with the patient’s experience. They should demonstrate an appropriate mix of open and closed questioning and display advanced listening skills. A ‘checklist’ approach to history taking should not be rewarded.”

There will then follow guidance about what particular areas of the history a competent candidate would cover followed by some general comments that differ little between stations e.g.:

“Candidates should stick to the tasks indicated in their instructions. They cannot obtain extra marks for straying outside the task identified. A very good candidate may not identify all the features present. As this is an assessment of skill they should be appropriately awarded. Conversely a poorer candidate may identify many symptoms but not explore them adequately; in particular they may not seek to understand the individual patient’s experience. The marks for such a candidate should reflect this poorer performance.”

In stations where the candidate is expected to communicate with a lay person the initial part of the construct may state something like the following (in this example the layman is a patient’s husband):

“The candidate can be expected to give information in a focused and fluent manner. They can be expected to demonstrate empathy with the husband’s concerns. They should display an appropriate mix of open and closed questioning and display advanced listening skills in addition to actually
imparting information. A didactic pseudo-academic lecture should not be rewarded. The candidate should avoid the use of jargon and overly technical language but should simultaneously not patronise the husband.”

2.6.2 Instructions to Candidates

Outside each booth the candidates will, in the ‘preparation’ time, be given access to a series of instructions that detail what is expected of them in the station. These will consist of some information required to set the scene followed by explicit instructions as to what they are expected to carry out. These specific instructions will be in bold and bullet point format to assist clarity. Sometimes negative instructions will be included e.g. “The candidate is not expected to obtain a risk history.” This is to assist the candidate in establishing the focus of the station.

2.6.3 Instructions to Role Players

The instructions for role players are designed to give them sufficient information to play the required role and also to deal with eventualities when candidates stray from the defined tasks. They are set up in such a way that the response to candidates will vary according to the degree of skill elicited by candidates. An example would be that a candidate who is rude or abrupt may be met by irritability and/or hostility just as would be the case in a real clinical setting.

2.6.4 Marking sheet

“On the basis of candidates’ performance as defined by the Construct examiners decide on a global Pass or Fail mark. They are asked to further differentiate candidates performance as described in the Grade Descriptors below but it is only the Pass (including ‘Pass’ and ‘Borderline Pass’) or Fail (including ‘Fail’ and ‘Borderline Fail’) decision that counts in deciding who passes and fails overall.

“Additionally examiners will mark against a number of ‘Areas of Concern’ to enable useful feedback to be given to candidates. These are not part of a marking checklist and are to be used for feedback only. If a single examiner identifies a candidate as having skills that are concerning, that will not be fed back. It will only be so when more than one examiner identifies the same ‘Area of Concern’.”
2.6.5  Grade Descriptors

The following grade descriptors are intended to give examiners a guide about what to look for in a candidate’s performance when selecting the appropriate grade. They should be used in conjunction with each station’s specific construct.

Should a significant element of the candidate’s performance fall into a ‘failing’ grade then that is the appropriate grade to award.

**Pass**
The candidate demonstrates a level of basic competence with a clinical approach that is justifiable, fluent, appropriately focused and technically proficient. The candidate shows a sensitivity of approach seeking not only to actively involve the patient in the clinical interaction but also to take their perspective, to motivate them and to instill a positive therapeutic alliance.

**Borderline Pass**
The candidate demonstrates an adequate level of competence displaying a clinical approach, which whilst it may not be fluent, is clinically justifiable and technically proficient. The candidate shows a sensitivity of approach and an awareness of the need to actively involve the patient, carer or other individual in the clinical interaction.

**Borderline Fail**
The candidate fails to demonstrate an adequate level of competence displaying a clinical approach that at times is unsystematic or inconsistent with accepted practice. Technical proficiency may be a concern. The candidate shows a sensitivity of approach but does not respond to or adequately acknowledge the patient’s, carer’s or other individual’s contribution to the clinical interaction.

**Fail**
The candidate fails to demonstrate competence, with a clinical approach that is incompatible with accepted practice. Their performance may show inadequate reasoning and/or technical incompetence. The candidate may show lack of respect, attention or empathy for the patient, carer or other individual involved in the clinical interaction.
2.7 Linked stations

2.7.1 Format

The exact format of the stations, including the content, is not yet clear at the time of writing. The College have only published one example linked station on the website. This is shown below. I have it on good authority that the reason for this is that the College have so few stations in their bank that they can’t afford to spare a couple on the website!

However, the principle of a clinical task followed by a PMP is probably a reasonable way to approach the exam. Make sure that you simply don’t learn a series of clinical tasks and PMPs, expecting them to be neatly linked. It is more helpful to think about the skills needed for a clinical OSCE and the skills and competencies needed for PMPs.

2.7.2 Example linked stations from the Royal College

Very few example linked stations have been published (see above for reasons why). The College has published one example in its CASC Candidate guide. This is below:

<table>
<thead>
<tr>
<th>Station A</th>
</tr>
</thead>
</table>
| You are about to see Sarah Green an eighteen year old student who has been brought to Accident and Emergency by her mother. It is suspected that she has ingested a recreational drug at a party just over 30 hours ago. Her mother describes her as being “Paranoid”.

- Examine the patient to establish what abnormal beliefs she holds
- Establish whether any other psychopathology is present
- You are not expected to take a drug and/or alcohol history

You may wish to take notes, as at the next station you will be required to explain to her mother what you have established her daughter is experiencing.

<table>
<thead>
<tr>
<th>Station B</th>
</tr>
</thead>
</table>
| You have just interviewed Sarah Green. You are now about to meet her mother, Amanda.

- Take a history to identify why Mrs. Green believes this to be drug related
- Explain the findings of your mental state examination of her daughter
- Ensure that you address her ideas, concerns and expectations

You can assume that Sarah Green has given her consent for you to disclose this information to her mother.

### 2.7.3 Additional examples

It is possible to imagine a few scenarios which would probably achieve the objectives of the examination in terms of testing skills or knowledge. Some additional example linked stations are shown below in Table 3.

These vary a little in style and some aspects (e.g. short-answer questions) have been borrowed from example exams and rumours about the final exam. Nothing should be considered set in stone.
Table 3. Examples of linked stations in the CASC.

Please note that these are not actual stations. Stations 11-14 have allegedly been used in CASC pilots.

<table>
<thead>
<tr>
<th>Station #1 (Clinical)</th>
<th>Station #2 ('PMP')</th>
<th>What is this station testing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessment of young woman with eating disorder (anorexia nervosa). Hypotensive and low BMI. Her mood is also low and she doesn’t want to come into hospital. Take a relevant clinical history. She also wants to become pregnant.</td>
<td>Discuss management of her eating disorder and her possible pregnancy with consultant colleague. Outline your management plan. OR Discuss with relatives the diagnosis and likely management, with an emphasis of family factors that may be relevant.</td>
<td>1) Establishment of diagnosis; assessment of comorbidity. May include consideration and criteria for inpatient admission. 2) Appropriate management plan. Ability to communicate with anxious relatives.</td>
</tr>
<tr>
<td>2. You are asked to conduct an assessment of a young man in police cells. He has a history of psychotic illness and aggressive behaviour.</td>
<td>Complete sections of a court report which are in a short-answer question style. For example: &quot;Is this man sane and fit to plead?&quot; &quot;Identify key triggers to his offending behaviour&quot; &quot;Would you recommend a mental health or criminal procedures disposal?&quot; &quot;What conditions might you place on a community sentence?&quot;</td>
<td>1) Your ability to take a focused, risk-based assessment of an individual with a forensic history. 2) Your ability to formulate an appropriate approach to risk, and your understanding of the legal frameworks.</td>
</tr>
<tr>
<td>3. You are asked to assess a man with a history of psychotic illness who has been non-adherent to his prescribed medication. He is rather agitated and irritable. During the interview he reports that the devil has been commanding him to abuse his nephew who is under the age of 16.</td>
<td>Discuss with consultant your history, mental state, and management of the case.</td>
<td>1) Risk assessment; mental state examination in a rather hostile individual. 2) Formulation of management plans and awareness of appropriate risk issues. Also, your ability to balance issues of child welfare.</td>
</tr>
<tr>
<td>Station #1 (Clinical)</td>
<td>Station #2 (‘PMP’)</td>
<td>What is this station testing?</td>
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<tr>
<td>4. You are reviewing a young woman with a history of rapid-cycling bipolar disorder which has been generally unresponsive to lithium and valproate/semisodium valproate. Her mood is starting to elevate and although not clearly manic, she is elated and pressured in her thinking. She wishes to come off her medication and start a family.</td>
<td>Discussion with consultant relates to the management of (rapid-cycling) bipolar disorder as well as perinatal issues related to the treatment of an unstable bipolar disorder.</td>
<td>1) Mental state examination of bipolar disorder; history taking in order to determine diagnostic issues. 2) Management of unstable bipolar disorder and understanding of perinatal psychiatry.</td>
</tr>
<tr>
<td>5. You are asked to see a man with newly-diagnosed bipolar disorder who works as a nurse in the hospital. He is elated, slightly grandiose, and his insight is deteriorating. He believes that he doesn't need supervised for potentially risky procedures and says he knows more than the doctors anyway.</td>
<td>Discuss your history and management plan with consultant.</td>
<td>1) Mental state examination; assessment of insight and risk. 2) Formulation of management plan and consideration of issues such as detention, management, and future employment.</td>
</tr>
<tr>
<td>6. You are asked to assess a man who is irritable, preoccupied and convinced that his wife is having an affair. It is probable that he has delusions of jealousy/Othello syndrome. He expresses anger towards his wife. He allows you to speak to her but does not want you to tell her he 'knows' she has been unfaithful.</td>
<td>You must obtain additional information from the man's wife and also discuss your likely diagnosis with her.</td>
<td>1) Mental state examination. 2) Communication skills and tact. Issues of confidentiality important, and you will be expected to address issues of risk with her.</td>
</tr>
<tr>
<td>7. You are asked to assess a 75-year-old man with a history of recurrent depression. On assessment, he has marked cognitive impairment which is not attributable to treatment. You are guided heavily towards a probable diagnosis of Alzheimer’s disease.</td>
<td>You have to explain your findings to the son (who is the main carer). He believes that his father's difficulties are simply a recurrence of depression and he has read about 'pseudodementia' on the internet.</td>
<td>1) Cognitive assessment and relevant personal history. 2) Communication skills and ability to get a corroborative history. Breaking of diagnosis.</td>
</tr>
<tr>
<td>Station #1 (Clinical)</td>
<td>Station #2 (‘PMP’)</td>
<td>What is this station testing?</td>
</tr>
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</tbody>
</table>
| 8. You are reviewing a CMHT patient who has been increasingly difficult to manage in the community over the last few weeks because of agitation, irritability, loss of insight, and impulsive behaviour. You don’t have his notes but his keyworker (a social worker) has brought him up for assessment. Some of his symptoms are consistent with hypomania/mania. | You have to discuss your findings with the social worker and consider admission (if indicated). The social worker is of the opinion that his presentation is due to personality disorder rather than mental illness. | 1) Mental state examination.  
2) Ability to communicate with a colleague but primarily your skills in resolving potential conflict. You will be expected to address issues of diagnosis and may be required to challenge the views of another professional, justifying your position. |
| 9. You have been asked to review a middle-aged man in a medical ward. He has recently experienced a heart attack but wants to discharge himself. The consultant physician feels that he shouldn’t go home and wants you to consider detaining him in order to prevent him from going home. | You must offer feedback on your assessment to the physician and explain your decision on grounds for detention. | 1) Assessment of capacity and previous psychiatric history. You will also need to demonstrate understanding of the legal basis of detention and treatment.  
2) Communication skills: You will be expected to deal with a consultant physician who may not share your views and so diplomacy is being assessed. |
| 10. You have been asked to interview a 63-year-old inpatient woman with chronic depression who is not eating or drinking, and has been losing weight. The staff are concerned that she is constantly saying that she is dead and has no brain. She is more forgetful than she has been. | You have to discuss your management plan with the consultant. | 1) Mental state examination. Diagnostic issues of psychotic illness versus affective disorder, including Cotard’s syndrome.  
2) Use of ECT; capacity to consent to treatment if you believe you have no brain; role of compulsory treatment in patient who is losing weight; other investigations needed (e.g. MRI). |
| 11. You have to take a history from a mother to assess whether her son has ADHD. She has brought in a letter from her GP (you have to read this in the station). | Once you have determined the diagnosis, you are asked to discuss the management plan with the boy’s father. | 1) Ability to take a history of ADHD, with appropriate questions about context and other factors  
2) Communication skills |
<table>
<thead>
<tr>
<th>Station #1 (Clinical)</th>
<th>Station #2 (‘PMP’)</th>
<th>What is this station testing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. You are asked to take a history from a 15-year-old girl with a history of depression. There are some trauma-related symptoms, related to bullying, which are unlikely to meet diagnostic criteria for PTSD.</td>
<td>Discuss your management plan with your consultant.</td>
<td></td>
</tr>
<tr>
<td>13. An old man has been brought into A&amp;E by his daughter. He has some paranoid ideas about his neighbours. You are asked to assess psychotic symptoms and “any other psychopathology”.</td>
<td>You have to discuss your findings with his daughter, who has apparently got some information from the Alzheimer's society. It would appear that the most likely diagnosis is dementia.</td>
<td></td>
</tr>
<tr>
<td>14. You have been asked to assess a young male patient who has recently been discharged from hospital. He is asking/demanding to see one of the nurses. He apparently has handcuffs and a knife in his bag.</td>
<td>You meet with the nurse in question. She asks you about her safety and wants to know what the patient said to you.</td>
<td></td>
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</tbody>
</table>
2.7.4 Specialty Stations

In contrast to the previous OSCE exam, which only examined ‘general adult’ clinical scenarios, the CASC will probably include at least one specialty station, which may be linked. Before becoming unduly anxious about the nature of these, it is probably worth considering a number of factors which will limit what you could realistically be examined on:

1. You are not going to have to examine a child. It would be unethical to have a youngster as a simulated patient. A younger adolescent is unlikely, but someone in their late teens is possible. However, they are practically an adult by this stage in terms of assessment, likely diagnosis, and management.

2. It is probable that the college will consider it politically incorrect to have someone ‘pretend’ to have learning disability for the exam. Daniel Day-Lewis got away with in ‘My Left Foot’ but the average simulated patient won’t be able to carry the role.

What this means is that if these specialties are going to be examined, you are in all probability going to have to take an informant history. Some possibilities are explored in Table 4 below which suggests some example specialty stations.

Table 4. Examples of specialty linked stations in the CASC

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Station #1 (Clinical)</th>
<th>Station #2 (‘PMP’)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disability</td>
<td>Take a history from a residential home worker about an individual with recent disturbed behaviour.</td>
<td>Discuss your differential diagnosis and management plan with your consultant.</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>Take a history of impulsive/challenging behaviour from the mother of a 10-year-old boy.</td>
<td>Discuss further investigations and management with the consultant.</td>
</tr>
<tr>
<td>Old Age Psychiatry</td>
<td>You have been asked to see a 75-year-old woman who has been displaying problems with memory in recent months. She’s not eating, is disinterested, and her mood is low.</td>
<td>Take a corroborative history from a relative which will help you clarify the diagnosis. Discuss your management with them. (Dementia versus pseudodementia)</td>
</tr>
</tbody>
</table>
3. Strategy and Tactics for the new exam

3.1 Adapting your approach to the CASC

Whilst the skills and techniques that you will be asked to demonstrate haven’t changed substantially, there are a few areas where the CASC will necessitate a change in strategy:

1. The overall skill level required will be higher – the exam is placed towards the end of basic specialist training and higher standards will be expected.
2. The introduction of linked stations will mean that you will essentially be performing PMPs immediately following a clinical station.
3. The linked stations are longer (11 minutes rather than 7 minutes) so you will need to be cognisant of what kind of OSCE you are doing (stand-alone or linked) and adapt your approach accordingly.

3.1.1 PMPs in the clinical exam

Most people’s conceptualisation of linked stations is that they will consist of a clinical task followed by something akin to a PMP. However, there is no reason why your clinical knowledge can’t be tested simultaneously with your ability to reason and argue. Once the first exam has occurred in June 2008, it will be a little clearer.

When you’re doing the first part of a linked station, try to be thinking about what they might ask you in the second part. In many cases it should be possible to make an educated guess. For example, if the station is about anorexic symptoms, you might be asked in the second station to: a) discuss management with anxious relatives; b) discuss your management plan with your consultant; c) make a case for detention under the Mental Health Act and forcible refeeding with a physician. Each of these will require different approaches, and potentially different information. It is still unclear whether the linked station will tell you what you have to do in the second station so in many cases you should aim to have the necessary information to be able to fulfil a variety of follow-on tasks.

Compared to PMPs in the previous exams, where you were in a position to learn fairly stock answers to a range of clinical problems, the ‘PMP’ in the CASC will require you to adapt your answer to the specific clinical situation. You will have to be able to think on your feet. That doesn’t mean that you can’t prepare for it, but your preparation should allow you to adapt your responses to a variety of scenarios. For example, in the case of the anorexic case above, you should be able to formulate a management plan that may or may not depend on her consent to voluntary admission/ involvement of the family/ psychological approaches/ etc.
3.1.2 Timing

As stated above, the linked stations are longer by 4 minutes. Therefore, performing a 7 minute OSCE in an 11 minute station is going to cause problems. ‘Rescue’ questions might help, but they are not going to solve the problem of having too much time. Each clinical task (e.g. routine review of patient with schizophrenia) should be prepared in two formats:

1. A seven-minute OSCE – focus on the most important things.
2. An eleven-minute OSCE – what else would you include? Should you use the extra time to get a bit of personal history, or get more detail on comorbid symptoms?

3.1.3 Taking Notes

In the previous version of this guide, I suggested that note-taking should be minimal and in many cases shouldn’t be required. However, in the linked stations you will be expected to carry information forward into the next station and you may be quizzed about it. Therefore, you will have to be prepared to take some notes for linked stations. These don’t have to be extensive – they are not going to form part of the patient’s clinical case notes – but if you are asking about depressive symptoms, for example, you might want to list the positive and negative findings as you go.

You will always be able to skirt around gaps in your history taking, but it is possible that the examiner will have a detailed description of the clinical presentation of the patient and making up symptoms that weren’t there, or missing important findings will contribute to your overall score.
3.2 Cultural Issues in the Exam

3.2.1 Differential pass rates

I suspect that a whole book could be written about this. There are clear differences in the pass rates between those who graduated in the UK and those who didn’t. The pass rates for different medical schools are shown below in Table 5. It is important to note that these results precede the OSCE, but the proportions are probably going to be fairly similar. Second, the differences in pass rates are most pronounced for the clinical exam, suggesting that it is not simply a knowledge issue.

Table 5. Pass rates in the MRCPsych Part I Exam 1997-2002 by Medical School (Oyebode & Furlong, 2007)

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Pass Rate (MCQ)</th>
<th>Pass Rate (Clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK (n=1506)</td>
<td>67.9</td>
<td>86.8</td>
</tr>
<tr>
<td>Republic of Ireland (n=246)</td>
<td>52.4</td>
<td>86.8</td>
</tr>
<tr>
<td>Indian Borders (n=344)</td>
<td>38.9</td>
<td>53.0</td>
</tr>
<tr>
<td>Indian Subcontinent (n=998)</td>
<td>56.9</td>
<td>65.1</td>
</tr>
<tr>
<td>Other (n=1428)</td>
<td>57.4</td>
<td>62.3</td>
</tr>
<tr>
<td>Total (n=4522)</td>
<td>59.0</td>
<td>73.0</td>
</tr>
</tbody>
</table>

Therefore, a consideration of cultural issues is very relevant to preparation for the MRCPsych exam. What follows is a brief précis of some of the most commonly-encountered issues.

3.2.2 Body language

Different cultures will interpret different aspects of body language in different ways. For example, in Nigeria, close physical proximity is seen as a sign of warmth, interest, and rapport. In the UK, sitting very close will be viewed with suspicion at best, and at worst, will make the patient very uncomfortable. You should therefore make efforts to understand important differences between UK cultural conventions and those of your native country and modify your behaviour accordingly.

Whatever your cultural background, the exam is highly likely to involve actors and examiners who are Western, most likely to be white, and the exam will be taking place in England. You will therefore need to have an understanding of body language in the UK. You may also need to practice ‘overriding’ your own natural tendencies to express body language that you have learnt growing up.

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4 If the actors are representative of the population ethnicity.
5 Although it will be taking place in Hong Kong later in 2008.
This can be a difficult task, and the best way of tackling this if you think that you have problems is to practise in front of colleagues and/ or in front of a video camera.

3.2.3 Spoken language

Those individuals for whom English is not their first language are undoubtedly disadvantaged (For example, see: Oyebode & Furlong, 2007). Not only does the exam require you to speak English, but it’s a psychiatric exam where understanding exactly what (and how) things are said is crucial. Subtleties of language can be very important. Most ‘foreign’ candidates therefore have to work twice as hard.

There’s not much you can do about this, unfortunately. Interviewing as many people who speak English is important, as is reading literature in English. Do whatever it takes to increase you exposure to accents, slang, and dialects. You might even want to consider watching soaps on TV. Ask your colleagues to watch you interviewing patients and comment on particular (stock) phrases that may be causing problems. Like most things, the more patients you see the better placed you will be to understand them.

Particular difficulties can arise when candidates use linguistic styles that reflect their own cultural expectations. For example, in some societies there is much reverence for the doctor and patients go to the doctor to have him tell you what is required. However, in the UK many patients expect to be given a choice of options and be allowed to choose themselves. This can cause problems when you have to discuss a possible treatment with a patient. Many candidates from overseas appear to struggle and become more patriarchal when giving information. Again, if this is an issue for you then you should practice in front of a video camera or colleagues.
4. Preparation: On the Day

4.1 Dress the part

You should ‘dress the part’ for a number of reasons:

1. If you look good, you will feel good. If you feel good, your performance will be better.
2. It makes the examiner view you as a professional. If he considers you a potential colleague, who is trustworthy and competent, your chances are improved.

Most examiners are male, white, middle class, and probably fairly conservative. Therefore, you should dress to match the expectations of this demographic. For men, this will mean a dark suit, shirt, and tie. For women, this will mean a smart dress/ skirt or a trouser suit. There will undoubtedly be some ethnic variation among this and this should generally be considered acceptable. Headscarves are generally appropriate but there is an increasing expectation that doctors will be prepared to make concessions to personal beliefs in order to achieve better relationships with their patients. Use your judgement. Whilst a kilt is undoubtedly smart, and worn by many people in Scotland, most psychiatric patients in England will not be expecting their doctor to wear a kilt, and will probably view it as being more than a little unusual.

You want to make sure that you are remembered on the day as “that candidate who did a really good interview”, not “that candidate who wore traditional highland dress”. Just because you can do something, doesn’t mean that you necessarily should. Exam day is not the day to assert your individuality or your national identity. Aim to conform to the expectations of your examiners.

4.2 Eating and drinking

You are likely to fall into one of two categories. Someone who cannot eat anything on the day of the exam, or someone whose appetite is unaffected. Whether you eat breakfast or lunch is probably going to have less of an effect on performance than the anxiety which is driving the reduced appetite!

However, try to make sure that you are adequately hydrated for the exam. Anxiety causes a dry mouth and you don’t want to be talking with your tongue stuck to the roof of your mouth. Stick to water and don’t drink so much that you need to go to the bathroom 10 minutes into the exam. Take a small bottle of water with you to the exam but dispose of it before the exam starts.
4.3 Other tips

Other things you should or shouldn’t do:

1. As a general rule, don’t chew gum. It doesn’t look good and if it drops out on the patient’s lap, you’ll probably fail that station.

2. Make sure that you have brushed your teeth. It may sound simple but you may be required to get close to the patient. Nice fresh breath can only help your relationship with the patient. Buy some of those minty, quickly-dissolvable films (sometimes called ‘fresh breath strips’ that you pop onto your tongue. You could take one every now and then, but make sure that you do it in the minute before the station.

3. Take at least two pens. You may want to be able to give the additional pen to the patient if you are performing a MMSE – this will allow you to continue scoring or prepare the next stage. Also, sod’s law\(^6\) says that your pen will leak or fail on the day. Carry a backup!

4. You might want to consider carrying a small LED pen torch on a key ring in your pocket. You will probably be looking in people’s eyes and mouths frequently enough to justify this, and at least you will know where the torch is (See Use your eyes below).

\(^6\) The same as Murphy’s Law: If anything can go wrong, it will.
5. The Exam Itself

5.1 Outside the station

You have to read the question. It sounds obvious, but frequently candidates do a good job of convincing the examiner that they have not read the question by asking completely the wrong things. It doesn’t look good when you are trying to demonstrate your polished psychiatric skills, if the examiner is questioning your ability to read and understand instructions. An example is if the OSCE asks a candidate to discuss pharmacological augmentation strategies for depression. You do not need to:

- Take a history of depressive symptoms (you can assume that the patient has depression)
- Discuss ECT (the question is about pharmacological augmentation strategies)

Also, it also looks bad if you have to keep referring to the copy of the question which will be stuck on the desk in front of you. Learn to commit the task to memory quickly. Do not think that you can ‘buy’ time by going back to the question. Use one of the techniques in Section 6.1 instead.

Tip! Read the last part of the question first. Be clear about what you are being asked to do before you read the case synopsis. If you do this, you will always know your task, even if your minute outside the station runs out. It will also help you to focus on aspects of the case most relevant to the task when you are reading through it.

You may want to use a small notebook to write down the most important information on the instruction sheet. The bare minimum to record would be something like:

Alice Smith: 30-year-old woman
Mother (Mary, 66yrs) has Alzheimer’s disease
Plan: Explain drug treatment for Alzheimer’s
She knows the diagnosis.

Use the time to make a list of important points you want to cover. For example, if you have to take a history of symptoms of hypothyroidism, list all the key questions. It’s perfectly acceptable to refer to
a notebook every now and then, especially if it indicates that you have a systematic approach to getting the information.

Since you will be completing linked stations in the CASC, there is likely to be a much greater acceptance of candidates carrying notepads to permit the transfer of information from one station to another. They might provide these to ensure that candidates don’t take information into the exam. If you do want to take your own, and the College don’t give clear information on what is available/ permitted, take one with no writing already in it. Consider getting a cheap one in case you decide to leave it somewhere/ ditch it/ forget it.

5.2 Entering the room – Give your candidate number

When you first enter the room/ cubicle, you will need to give the examiner your candidate number. If you forget to do this, you will find that they have to interrupt you in order to get it. This will break your train of thought and you could lose important seconds when you would otherwise be establishing rapport.

However, you shouldn’t do anything other than give them the essential information. Walk into the room, give them your number, and then forget about them and focus on the interview. You might want to give them a brief smile. You don’t want to make the examiner anxious because you’re so anxious. Look calm. Make them like you.

5.3 Use the Halo Effect

The halo effect suggests that attractive people are judged as having a more desirable personality than someone of average appearance. It does matter what you look like, how you dress, and how you behave. If you don’t believe me, then go to the exam in your underpants. Your clinical skills or charming personality won’t count for much! You have only seven to eleven minutes to convince the examiner that you should be allowed to pass, so ensure that the ‘halo’ effect is working for you, rather than against you.

The bottom line is that if the examiner likes you, and you appear to be a ‘good’, decent candidate, he will subconsciously mark you based on this assumption. You are more likely to score well if you look good from the outset, than if you start off badly. Make the first few minutes count:

1. Look the part. From the minute the examiner sees you, you should convince him that he can do nothing other than pass you. The patient and examiner is expecting a confident, well-dressed, professional so don’t disappoint them.

2. Put effort into your introduction. The first minute or two can make your break both your relationship with the patient and how the examiner will perceive you.
5.4 Understanding your ‘enemy’

In many ways, the actor is both your best friend and your worst enemy. If you can get them on your side, they will want to help you. If you annoy them, or they don’t like you, then they can make life more difficult for you. There are a few things to remember when you’re sitting down in front of them:

1. They are only actors. Even if they’re ranting and raving they are not going to hit you. Try not to be too scared by them. Remember this when you’re about to panic.
2. Don’t let them get bored. Try to keep them engaged, even if it’s simply talking about general stuff. A bored actor is prone to entertain themselves by being difficult. They’re not going to consciously refuse to give you information, but they may give you 5% less information spontaneously. That 5% may be the difference between passing and failing.
3. Don’t give them an opportunity to ad lib. Again, if it’s 4 p.m. on the last day, the actors are going to be tired. If there are awkward silences or you ask rude or stupid questions, you could provoke them into making your life more difficult.

5.4.1 Capitalising on basic human tendencies

Even though the actor will be in role, his/ her brain will continue to work (hopefully) and his attitude and behaviour towards you will be governed by a whole set of largely subconscious evaluations. If you look like his big brother who used to pick on him and make his life miserable, he may decide to make life hard for you, even if he’s not really aware of why he’s doing it. There’s nothing you can do about this other than hope that the actor is doing it for the money, not for some cathartic need to relive his difficult experiences.

You can stack the odds in your favour by being nice to them. Smile. Make eye contact. Do all the things that you would do if you wanted someone to like you. It’s harder to be angry at someone who is smiling at you than it is someone who is annoying you by asking the same question over and over again. Your key ally is the fact that you can make this person want to be on your side. Courtesy and respect (either for the person or their character) will help. Trying to be clever and catch them out won’t help.

Your primary goal is to get them to give you information that you might not have elicited by your own endeavours. The ‘method’ actor won’t come out of role all day and will only give you information that you bring out by questioning. However, we have all seen colleagues or candidates elicit information by doing very little. That is a real skill. If you can get another human being to tell you want to want to hear by doing very little, it probably has very little to do with specific consciously-applied techniques and relies much more on basic human psychology. This is where
“some people have it and some don’t”. However, the silver lining is that communication skills can be taught; they can be learnt; and they can be used to increase your chances of passing the clinical exam.

5.5 Introductions

5.5.1 Introducing yourself

As previously discussed (The Halo Effect; Section 5.3 above), your introduction is very important. Some important things to remember include:

1. Sit down before introducing yourself, unless the patient is already standing up. Nothing looks as bad as having a doctor addressing a patient whilst standing over them. This just emphasises the power differential and may make the patient feel uncomfortable. It only takes a few extra seconds to sit down and set the scene for a conversation based on relative parity.

2. Don’t sit too close to the patient in the first few minutes. It may be okay to reduce personal space a little if you have established a good rapport, but until this is obvious you should maintain an appropriate and professional distance between you. I’m not suggesting that you go and sit beside them, but gradually leaning forward can be a helpful tool.

3. Introduce yourself properly at every station without fail. Every station is a ‘new’ patient and you need to say hello to them. Try to develop a short introduction that you repeat with little variation (this will aid consistency). Waiting until exam day to try a new style is a recipe for disaster. Introduce yourself as a doctor, not as a candidate. Don’t pretend that you’re a registrar or anything you’re not – the College are not going to ask you to be anything other than the grade you are. The patient may not notice but the examiner will. You have to pretend they are a real patient. An example would be:

   **Good morning, I’m Dr Smith. I’m one of the doctors working with Dr Brown, your consultant. I’ve been asked to speak to you about the treatment that you’ve been having for depression. Dr Brown has suggested we try something different, and I’d like to tell you a bit about this.**

After making sure that you are happy with the room layout (Section 5.5.4 below), you would then ‘set the scene’ (see Section 5.6 below).
5.5.2 Getting the name right

What to call the patient seems to cause a lot of anxiety among many candidates. Do you address them by their first name or as Mr. or Mrs. Jones? In Ireland, it seems commonplace that patients are referred to by their first name (some doctors similarly). However, the exam will be taking place in England and the patients (i.e. actors) will probably be English. As a general rule, most British people expect, and like to be addressed by their surname – i.e. Mr. Jones. Not Jim.

A way of resolving issues that can arise is shown below:

1) If the instructions give you a name (e.g. Mary Jones), then refer to the patient as ‘Mrs Jones’. If they prefer to be called “Mary”, then they will tell you.
2) If you don’t have a name, then simply ask the patient’s name:
   a) If they say, “Mary Jones” then you should refer to them as “Mrs Jones”. They will always correct you if they prefer something else. It is often a reasonable question to ask if they prefer “Mrs” or “Ms”. Some people can be picky.
   b) If they say, “Mary”, then you should always ask if they mind being called by this name.
      Rumour has it that some examiners will fail candidates if they call the patient by their first name without asking their permission. It’s probably not entirely true but you don’t want to find out.

5.5.3 Shaking hands

Get into the habit of shaking hands with your patients for a number of reasons:

1) It generally looks good to examiners – it conveys confidence and professionalism.
2) Even though it’s the ‘casual’ 21st century, we should see ourselves as professionals who extend courtesy to people who come to see us. Very often, patients will still expect it from their doctor.
3) It tells you a little about the patient:
   a) Are their hands sweaty? Are they anxious?
   b) Are their fingers nicotine stained? Are their hands dry and cracked from excessive hand washing?
   c) Is their grip stiff – do they have EPSE?
   d) Do they refuse, suggesting that they may be paranoid or have contamination fears?

7 Although the actor will probably have none of these signs, you want to indicate to the examiner that you know about the usefulness of shaking hands.
When you do shake hands, it should be quick and firm. If you’re anxious, don’t hang onto the patient as it will alarm them. If you don’t normally shake hands, don’t wait until the exam until you start shaking hands. Do it at your clinics and on the ward long before the exam until it become second nature and looks comfortable. Try to do it as part of the introduction as you sit down – one natural movement. This will look slick and make you look (and feel) confident and controlled.

5.5.4 ‘Room’ Layout

Previous versions of this guide have discussed the importance of addressing the room layout. It is unlikely that the set-up is either wildly out of place, or requires much sorting. However, it is worth being aware of problems and how to rectify them in case issues do arise. If you can quickly sort out problems, then do it. You should be wary about completely changing the room layout, however, as this will waste time.

As you walk into the station, get into the habit of quickly assessing the room layout. You may find that the room setup isn’t how you like it – the previous candidate may have dragged their chair away at the end of the last interview, or the actor may have lost his temper and stormed about (unlikely). You should therefore aim to ensure the chairs are set up appropriately as part of your first few seconds. Ideally, it becomes ‘transparent’ and fluid. However, the examiner is likely to notice and credit you with your awareness of appropriate layout. Although you might not get points for reorganising the room, the ‘Halo effect’ (see Section 5.3 above) suggests that those candidates, who are viewed as being good, get better marks.

Remember to ignore the examiner and not make eye contact – you are not interviewing them, and you don’t want to make it obvious that you are trying to look good! Leaving an apple for the examiner won’t work.

Ideally, the chairs should be at 90 degrees to each other, and if at all possible (and especially if the patient is agitated or aggressive) you should aim to be between the patient and the door.

Tip! Experiment with distances between you and the ‘patient’ so that it becomes instinctive. Do this with colleagues rather than real patients as you might get into trouble otherwise. If your knees are touching, you are too close!

There are some great videos available online of chat-show hosts being unconsciously unable to let go of their guest’s hand. Boy does it look odd after the first few seconds.
Ideally, try to rearrange chairs just after you have introduced yourself, and practise this so that it becomes natural. It works best if you can integrate it with a bit of smalltalk so that you retain control of the interview. An example might be: “Hi, I’m Dr Smith. Is it okay if I sit here?”.

5.6 Setting the scene

The following looks bad; as I’m sure you’ll agree:

Hi, I’m Dr Green. I’m going to tell you about Lithium. Lithium is a metal salt, which is used to treat bipolar disorder. Did you know that it used to be used in swimming pool filters? It’s now used in batteries. Oh, it works well as long as people take it, but many people don’t. You will need your bloods checked quite regularly as it may damage your kidneys and thyroid gland...

It doesn’t look good; as I’m sure you’ll agree.

5.6.1 Techniques to orient the patient

You have to ‘set the scene’ – you should tell the patient what you are going to do, how long you have to do it, and some of the topics that you intend to cover. Compare the above with the following:

Good morning, I’m Dr Smith – I’m one of the doctors working with Dr Brown, your consultant. I’ve been asked to speak to you about the treatment that you’ve been having for depression. It sounds as though your current antidepressants haven’t been as effective as we’d hoped and Dr Brown has asked me to speak to you about another treatment that we can try.

I’d like to tell you a little bit about Lithium treatment. I’ll tell you a little bit about what Lithium is and why we use it to treat depression. I’ll explain what we can expect from treatment in terms of response, and I’ll explain a bit about side effects and blood testing as well. Is that okay?

I’m afraid that I only have six minutes and I have to cover quite a lot of information, so you’ll have to excuse me if I go quickly. I’ll leave time for you to ask questions at the end.
If you outline what you are going to cover, you will minimise that chance that the patient will interrupt with a question, since you might intend to answer their question in due course. It also has the advantage of giving the examiner an idea of what you would have done, if you run out of time. Consider it your verbal ‘essay plan’.

Don’t worry too much if you get to the end and haven’t been able to allow the patient to ask questions. Simply apologise for running out of time and say that you’ll come back again later that day to answer any questions they may have.

### 5.6.2 Patient–centred approaches

An alternative approach is to give the patient an opportunity to ask questions at the beginning. This technique works best when you are explaining a treatment to a relative who may have his or her own agenda (e.g. a concerned relative wishing information). You shouldn’t use it too much as the patient can take over the interview, taking you away from the dialogue that you are likely to score points on.

It works like this (you have been asked to explain Alzheimer’s dementia to a relative):

**Good morning Mrs Wilson. I’m Dr Smith. I work with Dr Brown, the consultant who has been looking after your father.**

Dr Brown has asked if I could speak to you and explain a little bit about what we think might explain some of the problems that your father’s been having recently. Before I do this, it might be helpful to find out what you know, and to see if there are any specific questions that you wanted answers to?

A variation would be (if you have been asked to explain the prognosis of dementia to a relative):

**Good morning Mrs Wilson. I’m Dr Smith. I work with Dr Brown, the consultant who has been looking after your father.**

As you know, your father has been recently diagnosed with Alzheimer’s dementia. Could you tell me about what you already know about Alzheimer’s dementia, so that I can make sure the information I give you is what you would like to know?
5.7 Building Rapport

There are numerous ways to build rapport quickly – you need a whole repertoire. What follows is a small selection of techniques.

5.7.1 Using body language

5.7.1.1 Personal space

The amount of personal space typically depends on how well you know the other person. Smaller distances are used in more intimate situations. Personal space is usually larger for individuals with a status difference, and the distance is set by the higher status person. Women are generally able to tolerate (and get away with) a smaller distance than men. Figure 3 below illustrates typical personal spaces for different situations. You will generally want to be in Zone 3, with approximately 3-4 feet between you and the patient.

A few general tips may help you to gauge the correct distance:

1. If the patient keeps ‘reversing’ away from you, then you’re too close.

2. If any part of your body crosses an imaginary line running vertically upwards from the patient’s knees, then you’re probably too close. There will be exceptions to this rule, such as a reassuring hand on a shoulder, or offering the patient a tissue, but in most stations you should try to respect it.

3. If your knees touch the patient’s, then you’re too close.
5.7.1.2 Mirroring

This involves the doctor intentionally mimicking the patient’s body language. The theory is that people have positive social feedback towards others who are expressing the same pattern. In effect, it subconsciously causes the interviewee to have rapport with the interviewer. It is shown below in Figure 4.

Figure 3. Typical distances for personal space in different situations.
Good interviewers will do this almost automatically, and it looks entirely natural. Bad interviewers do it poorly, do it too much, and end up annoying the patient. Done well, it can quickly build rapport but make it too obvious and the patient will spot it. You have to practise this, ideally in front of a video camera so that you know when you can do it, and when you shouldn’t do it.

Simple strategies include leaning forward when the patient does, or crossing one’s legs shortly after they do. This has the same effect as paraphrasing what they have just said: it conveys the message: “I have understood you... we are getting on...”

5.7.1.3 Negative body language

Whilst the actor may not respond to some of your cues, the examiner might be aware of them, and interpret that you are anxious/ uncertain/ not confident/ etc. You should therefore try to ensure your body language is both appropriate, and most importantly, under your control!

Body language that gives negative signals includes:

1) Arms folded across the chest
   a) This makes you look defensive, rather than appearing interested and confident
2) Head down
   a) A head held up signals a neutral attitude. A head to the side means that you are interested.
      A head down appears judgemental.
3) Hands hovering around the face. This commonly indicates that:
   a) You are not comfortable with the subject matter being discussed
b) You are not being honest

4) 

A hand to the back of your neck

a) This signals that you want to end the conversation

5) Sitting too far back in the chair

a) This generally indicates boredom and/or disinterest. Not a good message to be sending if you want to establish rapport.

Look out for all of these signals on the videos that you do, and try to be aware of them during your interviews. Ask colleagues to highlight them in your interviews, and then reflect on how it may have affected rapport. At various times, I have seen trainees and exam candidates do all of these things. It is rare for them to be aware of it – they are unconscious signals.

5.7.2 Other techniques utilising body language

5.7.2.1 Getting an agitated patient to sit down

This often happens: the patient is too agitated to sit down and is pacing about. If you remain standing, you can appear a little confrontational and challenging. It is far better if you are both sitting.

If the patient gets up, rise shortly after them. Offer some comforting words such as, “Let’s sit down and you can tell me what’s been going on” and then sit down. Frequently, the patient will follow your cue and sit down. If they don’t sit down immediately, remain sitting and maintain eye contact. By assuming a submissive posture, you appear to be much less threatening to them. Do not sit down if they are overtly aggressive or you fear for your safety. In this case, take the usual side on, hands relaxed by the side, ‘on-your-toes’ stance that you will have been taught as part of your breakaway training. However, don’t expect to be having to wrestle with patients in your exam!

If they keep getting up and down, simply repeat the above manoeuvre encouraging them to sit down. When they sit down, keep leaning forward with good eye contact. The patient will often get up again if you appear disinterested or break eye contact. This is not a situation for making lots of notes!

5.8 What not to do in the exam...

1. Do not walk into the room and not address the patient. This looks really bad, but I frequently see candidates doing this. They are clearly thinking about the task in hand, but there’s no point in doing it if the patient (and the examiner) already has you written off as
rude and dismissive. You have one minute before you enter the room in which to plan what you are going to do and write down any checklists you want to have. Think about the task then, not when you haven’t even said “hello” to the patient.

2. **Don’t forget to smile.** Be nice to the patient. Smile at them. If you smile at them they will like you. If they like you then they will want to help you.

3. **Don’t get too caught up with chaperones.** I see lots of candidates say that they will get a chaperone for everything, including looking in a patient’s mouth or checking their hands. You wouldn’t get a chaperone in your routine clinic before checking a patient’s reflexes or shining a light in their eyes, so why would you do it in the exam? It’s a waste of time and makes you look daft. You would be better explaining to the patient what you are going to do and then get their explicit permission to do it.

4. **Don’t use silly or idiosyncratic phrases.** I have seen candidates, while getting consent for a physical examination say things like, “I will touch some parts of your body”. It usually happens when the candidate is anxious and distracted by figuring out what they’re going to do next. Unfortunately, it’s guaranteed to alarm the patient. Be clear and explicit. Say, “I'd like to perform an examination of your thyroid gland, which will involve asking you to swallow some water and I will feel the front of your neck from behind”. Don’t say things like, “I’m going to examine you. I will touch you, but it won’t hurt.” The patient probably wouldn’t have thought that you might hurt them until you mentioned it...

### 5.9 Use your eyes

When you go into the room, especially in physical examination stations look around you for ‘clues’. I have seen candidates speak for 2-3 minutes to someone who had a Snellen Chart 6 inches above their head before saying to the examiner, “I don’t have a Snellen chart”. The examiner of course cannot say anything. This makes you look daft. Similarly, candidates will sit in silence not knowing what to do when they are 2 feet away from a tendon hammer. So, some rules:

1) If there’s a tendon hammer, then you might what to check some reflexes. The College didn’t just leave it there by accident. You’re not going to lose marks by checking reflexes if it seems appropriate. Stations that will require testing of reflexes include:
   
   a) Cranial nerves  
   b) Upper limb neurological examination  
   c) Lower limb neurological examination  
   d) Thyroid examination

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[9] If you’re lucky and they’re in a good mood, they might subtly draw your attention to it. Most probably won’t.
e) Suspected drug overdose (unlikely to be in the CASC)

f) Conversion disorders (e.g. paralysis)

2) Similarly, if there’s a stethoscope there then assume that you should be listening to something. There’s no excuse for examining a thyroid gland within arms’ reach of a stethoscope and then not listening for bruits. You might also want to listen for evidence of pleural effusions.

3) When examining cranial nerves, look on the wall for a Snellen Chart, and look on the floor for a distance marker. If there is one, then use it. If there isn’t then try to indicate that you are assessing distance in some way. You can download Snellen Charts which are designed to be printed out on a sheet of A4 paper.

4) If you think that you should look in the patient’s mouth (EPSEs, for example), then look for a pen torch on the table. There’s likely to be one. Use it.

5.10 Making the Interview Flow

5.10.1 Linking phrases

You need to be able to move the patient through the interview in a way that allows you to cover your agenda but not look like you’re too domineering. The best way to do this is a combination of reflection and topic–shift. If it’s done well, the patient (and the examiner) won’t notice: they’ll be impressed by your empathic reflection and allow you to move the proceedings along. Some examples are given below:

5.10.1.1 From assessing mood symptoms to suicidality

You have told me a bit about how you have been feeling down in your mood recently, and how pessimistic you feel about the future. Often, when people are depressed they feel that life isn’t worth living. Have you felt like this recently?

5.10.1.2 From mood to anxiety

It certainly sounds as though your mood has been low for some time. It’s quite common for people with depression to have anxiety as well, and I’d like to ask you some questions about anxiety symptoms if that’s okay?

5.10.1.3 From recent events (history of presenting problem) to other psychotic symptoms

I think that I understand a little bit about the things that have been worrying you recently. Usually, when people are having troubling experiences, we routinely ask about other symptoms, some of which you may also have experienced. Is it okay if I ask about some of these other things?
5.10.1.4 From depressive history to personal history

From what you’ve been telling me, your mood symptoms have been quite bad. Although there isn’t always a clear cause for depression, there are sometimes connections between someone’s life experiences and the development of depression when they are older. It might be helpful to know a bit about other aspects of your life – can I ask you some questions to explore this?

5.10.1.5 From current problems to a relationship history

Thank you for explaining how your relationship difficulties have been affecting you. I think I have a better understanding of this. Have you ever thought about previous relationships, since there can sometimes be patterns in the relationships that people have? Would it be okay if I asked you some questions about your personal relationships in the past?

5.11 Ending the interview

In an ideal world, you will have completed the task in 6 ½ minutes and can round up neatly. You should try to learn a few closing phrases, which reflect what you would do in the real world. Don’t forget to thank the patient for their time or help – this generally looks good. However, don’t overdo it or use it out of place.

As an example, the following doesn’t really impress:

Ooops, there goes the bell. Thanks very much for telling me about the death of your wife.

Much of the clinical exam is about acting. If the patient is acting, you are allowed a bit of artistic license as well. This doesn’t mean that you should start reciting Shakespearean soliloquies (leave your skull and reminiscences about Yoric at home), but you can pretend that you have all the facilities that your (made up) situation would ideally have. So you can make reference to other members of the team. You might want to add that you will ask one of the pharmacists/dieticians/etc. to see them. Don’t forget to say that you can meet again later to answer any other questions (this is important if you did run out of time). If you think that interpersonal therapy would be helpful, then pretend that you have a therapist in your team and that the patient could be seen next week. In ‘OSCE–world’, no-one has to wait more than a few days for CBT!

Better closing phrases include:
I realise that we haven’t had as much time as I’d have liked, but hopefully I’ve been able to address some of your concerns. If it’s okay with you, I’d like to meet with you again in the next couple of days and we can discuss this further. Thanks again for your time.

Thank you for your time. You will probably have some questions, and I do realise that I’ve given you a lot to take in. I’ll ask the nursing staff to give you some written information on what we’ve talked about, and I’d like it if you can write down any questions that you have. I can come back later and try to answer your questions.

I’m sorry that we didn’t have enough time to answer all of your questions. However, I’m back on the ward at the end of the week, and in the meantime I’ll ask the nursing staff to give you some information on Clozapine. We also have a video that you can watch. I’ll ask our pharmacist to see you in a couple of days to tell you more about the drug, and hopefully I can answer any questions that you have when we meet up in a few days.
5.12 Difficult Areas in History Taking

You may be asked to enquire about the following areas. You need to do this tactfully but efficiently. Below are some approaches that you might find helpful.

5.12.1 Suicidality

This needs to be done in stages – you can’t just ask if someone is planning on killing themselves, even if they volunteer some suicidal thoughts. It doesn’t look good. A good way to do it is like this:

```plaintext
I’d like to ask you a little bit more about how low you’ve been feeling recently.
In the last while, have you ever felt so low that you’ve felt that life wasn’t worth living?
Have you felt like you’d rather be dead?
Have you felt so bad that you’ve thought about ending your life?
Can you tell me more about that?
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You can then go on to ask more detailed questions about planning, preparation, last acts, etc.

How you ask the next question in sequence depends on the answer to the previous question. If the patient responds to open questions, you can ask the next question (or variations of it) after each positive acknowledgement by the patient. I would generally require clear negative answers to the first two questions before abandoning the rest of the questions, and only if nothing else in the history or their body language suggests recent suicidal thinking. Some people will ask all questions – use your judgement.

5.12.2 Questions about psychotic symptoms

You need to be able to ask good, direct, unambiguous questions regarding psychotic phenomena. If you get to the CASC without being able to ask about thought broadcasting or delusions of control, then perhaps you would be better doing another six months of training.

You should be reading a good psychopathology textbook from day one of your training, and you should be referring to this regularly. Make sure that you understand clearly what each symptom and sign represents before you think about applying for the exam.

If you uncertain how to ask about a particular phenomenon, read the Present State Examination (Wing, Cooper & Sartorius, 1974) and learn some of the questions. You’ll find that most good psychiatrists already have. Ask your colleagues how they ask about particular symptoms. Remember that you have to practice new ways of doing it long before the exam so that it becomes part of your
style, otherwise you will look like you have just read a book on the train to the exam centre and shouldn’t be in charge of real patients with mental health problems.

5.12.3 Risk to others

There will be many stations where you increase your chances of failing if you don’t ask about risk to others. A good example is in post-natal depression; you will be expected to both assess suicidality in the patient and also any risk to the child.

You need to have developed rapport early in the interview, and if you show empathy, understanding, and a non-judgemental approach you will probably find that the patient will open up. You will often have to do lots of work to establish this trust, and you have to tread carefully. Try something like this:

| It sounds as though you have really been struggling with how bad you have been feeling. It must be really difficult to cope with a baby on top of everything else? It’s not unusual for mothers with depression to have lots of thoughts that they find worrying. Most mothers think that these thoughts make them a bad mother, but it’s usually because they’re unwell that they think like this. |
| Have you had any thoughts like this recently? |
| It’s common for mothers who are depressed to think that they can’t cope, or can’t go on. Sometimes they feel that their children would be better off without them. Often, they feel very guilty, and have thoughts of wanting their baby to be in a better place. |
| Have you ever felt like this? |
| I’ve had lots of mothers tell me that when they’re really stressed, they wish their baby wasn’t there. They sometimes have thoughts of wanting to harm their baby, and this makes them feel very guilty. Usually, these feelings are very confusing and difficult to talk about. But a lot of people have them. Have you ever had thoughts or feelings like this? |

Another approach into the subject is to ask about the relationship with the baby:

| I can see how it must have been difficult with you feeling so down. Sometimes mothers think that their relationship with their child is affected, and this makes them feel guilty. How do you feel your relationship with your baby has been lately? |
This very open method of asking might help to highlight particular problems worth asking about in more detail later.

5.12.4 Personality

Assessment of personality hasn’t cropped up in the OSCE exam as commonly as it might have. However, it’s helpful to be able to do it. A good linked station would be to assess someone’s self-harm/ depression in station 1 and then take an informant history of personality disorder in station 2. You should therefore have a well-practised strategy.

A brief tool that might have some utility was published in the *British Journal of Psychiatry*. It’s called the Standardised Assessment of Personality - Abbreviated Scale (SAPAS) (Moran, Leese, Lee, *et al*, 2003). It allows you to predict the presence of DSM-IV personality disorder with a sensitivity of 94% if they have positive answers to 3 or more questions. The questions are:

1) In general, do you have difficulty making and keeping friends?
2) Would you normally describe yourself as a loner?
3) In general, do you trust other people?
4) Do you normally lose your temper easily?
5) Are you normally an impulsive sort of person?
6) Are you normally a worrier?
7) In general, do you depend on others a lot?
8) In general, are you a perfectionist?

The scale won’t fill seven minutes of time, but may be a place to start. It would be helpful to ask the screening questions from the Personality Assessment Schedule if you wanted to hone down on specific traits and their impact upon the individuals emotional, occupational, and social functioning.

5.12.5 Other sources of good questions

- For questions about obsessive–compulsive symptoms, have a look at the Yale–Brown Obsessive–Compulsive Scale (Y–BOCS) (Goodman, Price, Rasmussen, *et al*, 1989) which will also list lots of different areas of symptomatology that you can enquire about.
- For assessing personality, the Personality Assessment Schedule (PAS) (Tyrer, Alexander, Cicchetti, *et al*, 1979) is a structured interview which aims to deliver an ICD–10 diagnosis of personality disorder. Its main value is in learning which questions about personality traits are
important to ask, and how to ask them. There is an updated version and a ‘quick’ version as well.
6. Troubleshooting

6.1 ‘Emergency’ Questions

Everyone will suddenly find that they forget what they were going to ask next. Rather than panicking and looking flustered, learn a few questions that you can ask almost automatically in this situation.

The aim is to keep the patient talking until you can get back on track, and at the same time appearing relaxed and in control.

Can you tell me more about that?
So you’ve been feeling <insert most recent emotion> recently? Can you tell me more about this?
Is there anything else that’s been worrying you?
How has that affected you?

You will notice that these questions are very good questions anyway – they are open and encourage the patient to describe their symptoms with minimal intervention from you. In an OSCE though, you have limited time, and you wouldn’t want to conduct the whole interview like this. Such questions might appear a little odd if they come out of nowhere, in the context of questioning about specific symptoms, so use them sensibly.

6.2 Speaking too fast

I’ve seen candidates who are so keen to get through their list of questions that they don’t really listen to what the patient is saying. As a general rule, there should be no excuse for speaking at the same time as the patient. This looks very bad, and is clearly counterproductive in terms of building rapport. It commonly arises when people are anxious and trying too hard. You end up looking like you care more about scoring points than you do about the patient. The Royal College won’t be impressed.

Always ensure that you allow the patient to answer before you ask your next question.

Remember that some patients might answer slowly, if they’re depressed for example. If the patient is talking too much (for example, hypomania), then try something like this:

Can I interrupt you there? That’s obviously something that’s important to you, and I’d like to ask you more about that at the end. There are some other questions that I’d like to ask before that though and I’d like to ask you a little bit more about...
If the patient is talking too fast, you may not have time to ask for the patient’s permission to move on every time. You do have to say why you’re moving on, and it doesn’t always hurt to offer some kind of apology for it.

### 6.3 Not being heard

Most OSCEs have been conducted in big halls, with dividers between stations – they are essentially glorified cube–farms. There is no reason to believe that the CASC will be any different. Most people who have sat the OSCE will probably say that they can hear what people are saying next door. In such situations, try to remain focused and don’t get distracted by the conversation next door.

You need to be heard by both the patient and the examiner. This can be difficult if you are anxious, as people tend to speak faster when they’re stressed. If you normally have a quiet voice, anxiety can make you effectively inaudible.

**Tip!** Slow your voice. Not so slow that you sound sedated, but enough that the patient can hear you. It will also give you more thinking time which will make you feel less anxious. Practise this on video before taking it to the exam – you need to know how much to slow your voice.

### 6.4 Keeping track of time

If you can’t pace yourself, you’ll fail. You will miss important information or will spend 3 minutes sitting in silence at the end and looking stupid. You have to know what information you want to cover and how long it takes you to do this.

**Tip!** Buy a digital watch with a countdown timer and set it for 6 minutes. Start interviewing patients with your timer so that you get a sense of time over the course of an interview. Practise asking about mood symptoms in 6 minutes. If you don’t manage it, don’t forget to ensure that you have taken a proper history from the patient in front of you. Most patients won’t mind an occasional bleep that you don’t respond to, but don’t do it more than once with the same patient or they will get annoyed!

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10 An office filled with cubicles is called a cube farm.
Tip! Start wearing your watch in a position where you can see it more easily during the interview (e.g. wear the face on the inner aspect of your wrist). Develop the skill of stretching/scratching your arm so that your watch is exposed and then quickly look at your watch out of the corner of your eye. Practice this so that it appears totally natural and so that you don’t break eye contact for more than a moment.

Sometimes you can catch a glimpse of the patient’s watch as well. I wouldn’t rely on this technique if a woman has her arms crossed, however – you don’t want to look like you keep staring at her breasts!

6.5 Forgetting things during the interview

6.5.1.1 Forgetting the patient’s name

Tip! If you sit down and realise you have forgotten the patient’s name, this is a good time to remember that you should have written it down (see above). If you didn’t, why not? Don’t panic; here’s a tip: Introduce yourself like this:

Hi, I’m Doctor Smith – I work in the team looking after your son. How do you prefer to be called?

Bingo! – You have not only got their name, you’ve also demonstrated respect for the patient’s wishes. If you have forgotten their relative’s name, try to ask a question where they have to say the person’s name – i.e. make the other person the subject, e.g.:

How have you been getting on with them recently?
Where do they come in the family?

6.6 Finishing too soon

Whilst you may finish an ophthalmoscopy station in 2–3 minutes, you shouldn’t really be finishing a station with more than a few seconds to spare. If you do finish too early, the examiner will sit there saying nothing and the last few minutes will seem like hours!

One option is simply to speak to the actor whilst staying ‘in character’. You can thank them for their time, and chat about various things to fill the time.
If you finish early, don’t waste your time. Spend a little time reflecting back on what you have covered. For example:

So you’ve told me about how your mood has been low for some time, and how your sleep and appetite are affected. It sounds as though you have really been struggling with your work, and that you can’t be bothered with things. I think I’m correct in thinking that you haven’t enjoyed anything recently either. Is there anything that we haven’t talked about which you feel is important?

This approach does two things. Firstly, you get the opportunity to demonstrate reflective listening. Secondly, you give the patient an opportunity to give you information. Often, (if they like you) they will subconsciously give you some clues to areas which you haven’t covered. If you’re lucky, the conversation will go something like:

It sounds as though your mood has been causing some problems. Is there anything else that’s been worrying you recently?

Er…I have been drinking more recently.

Really? Can you tell me about that?

And now you have something to talk about for the last few minutes.

Try to capitalise on the fact that your ‘patient’ is simply an actor who subconsciously wants to help you. If you have made them like you (not pity you), they will often be unable to stop helping you, as in the above example.

6.7 Dealing with Difficult Questions

There are always going to be questions that throw you. You might think that things are going well, until the patient jumps in with a question that you find difficult to answer. If you answer “yes”, then this might be offensive, or result in a breakdown of rapport. If you say, “no”, then you could be lying. What follows is a series of questions, listed by heading that could cause problems and some suggested answers.
6.7.1 Psychosis

Are you saying that it’s all in my mind?

No. What I’m suggesting is that they way that people are feeling can affect how they view things which are going on around them. It’s common for people to misinterpret everyday events, and I’m wondering if this might explain some of the things that you have told me.

6.7.2 Body Dysmorphic Disorder

What do you think? Is my nose big?

It’s not really important what I think. To me, your nose looks fine, but what’s more important is how you view particular parts of your body, and how that concern affects your life. I’d like to ask you some more questions about that...

6.7.3 Genetic risk factors

Patients will typically ask something like:

So it’s genetic? Does that mean my kids might get it?

OR

What are the chances that my son will get bipolar disorder as well?

What often happens is that people quickly panic and reply with information that is not only blatantly wrong, but can be upsetting and potentially catastrophic to someone who is feeling guilty and has just had a difficult diagnosis. I have often heard a conversation akin to the following:

So what you’re saying doctor is that there is a chance my children could have schizophrenia as well?

Yes.

What are the chances?

Erm...well...it’s about 50%.

My God, that’s terrible.

Yes, it’s a very serious condition. You need to take your medication or you could end up in hospital.
Not exactly instilling hope, are you? The problem is that the candidate doesn’t actually know the true figure and in their eagerness to look like they know lots of stuff to the examiner, has made up something on the spot. This makes you look stupid in two respects: not only do you not know the actual figure, but you are also willing to give the patient wrong information to make yourself look good.

The actual figure is closer to 5–10%. A 1 in 20 chance is very different to a 50–50 chance in most people’s eyes.

To avoid these pitfalls, follow a few basic rules:

1. Don’t simply give a percentage or a figure, even if you know it.
2. Make sure you do know it before you tell someone.
3. When giving information like this, ensure that the person is ready to hear it, and explain how the number is understood.
4. If you really don’t know, don’t say that you do. Do what you would do in the real world – simply say that you don’t have that information but that you’ll go and look it up for them, and get back to them.
5. Never make up numbers on the spot. Only give numbers if you know for sure that they are correct AND that the patient has been prepared to hear them.

Have a look at the following two examples:

Hi, Mr Smith, I’m Dr Green. I work with Dr Brown, the consultant whose been looking after you. I understand that you wanted to know a little bit of information about bipolar disorder?

Yes, my wife and I have just had a son and we were worried that our child might develop bipolar disorder as well. What are the chances that he will develop it?

That’s not as simple a question as it might appear. Studies have been done looking at this, but I can’t remember the exact numbers that you might be after. I’d rather be sure that the information I give you is correct and up-to-date. Would it be okay if I went away and checked the figures and can I then come back and give you that information?

Hi, Mr Smith, I’m Dr Green. I work with Dr Brown, the consultant whose been looking after you. I understand that you wanted to know a little bit of information about schizophrenia?
Yes, my wife and I have just had a son and we were worried that our child might develop schizophrenia as well. What are the chances that he will develop it?

That’s really quite a difficult question. There are quite a few studies that have looked at the number of children of parents with schizophrenia who will develop the condition themselves. Before I tell you the results, would it be okay if I explained a little bit about how most psychiatric illnesses develop and what factors affect whether someone will actually develop the illness?

Sure.

Most psychiatric illnesses are not as simple as a single gene. For example, there is only a 40–50% chance that identical twins with a parent with schizophrenia will both develop the illness, so genes only make up part of the story: there are lots of other factors involved. The overall chances generally reduce the less–closely related a person is to the person with the condition.

We know that a variety of factors play a role in whether someone develops the condition. In fact, we prefer to think of someone inheriting a ‘predisposition’ to an illness, rather than inheriting the illness itself. Upbringing, possibly other illnesses, life experiences, drug use, stress, and things like this can all affect the chances of whether someone will develop the disorder.

In terms of actual numbers, we believe the chances of a child of someone with schizophrenia developing the condition themselves is around 5–10%, but we can’t be sure of the exact number. That’s about a 1 in 20 chance. We do know that lots can be done to reduce this risk and it would be helpful to discuss some of these things at a later date. Perhaps I should pause there – do you have any questions about anything that I’ve just told you?

You should aim to build up to the actual figure, and ‘set the scene’ by explaining that an increased genetic risk does not mean that they will develop the disorder.

### 6.7.4 Backtracking, apologising, and staying in control

There may be times when you start panicking, or run out of things to say, and you start clutching at straws. I have seen candidates in an OSCE interviewing someone with anorexia, and about halfway through they run out of questions. Out of the blue, they will start asking questions which are totally irrelevant and begin to annoy the patient. Typically, the questions will be about psychotic symptoms, and will be very blunt. For example:

_Do you ever hear voices?_
Do you feel that people are after you?
Do you feel suicidal?

Rather than have the rapport completely break down, it may be appropriate to simply apologise for asking the question and then attempt to get back on track. Try something like:

I’m sorry; I shouldn’t have asked that question – it’s not that relevant. Could I change the subject? What I’d like to ask you about is how you view your body.
6.7.5  Dealing with patients who won't talk to you

This one always causes problems. You go into the room, only to find someone pacing about, possibly responding to hallucinations, and refusing to sit down or talk to you. Worse, they think that you’re involved in the conspiracy.

Firstly, don’t panic. We have all been in situations like this in our usual practice. The Royal College are not trying to fail you (although it may feel like it!); they simply want to see how you deal with difficult situations, how adaptable you can be in your history taking, and whether you can establish rapport with different patients. I would say to not blame the Royal College if you get this in the CASC. This is the ‘bread–and–butter’ of psychiatry, and you have to have a variety of tactics up your sleeve to deal with it. Remember that if you have failed this station in the past, it is likely to be due to something you did – simulated patients are extensively briefed and are still human: they want to help you really, but you need to work with them to get the information. Other people will have passed this OSCE so it isn’t an impossible situation. Believing it is too difficult, and giving up early will increase your chances of failing.

What follows are a few different ways of engaging with such patients. As usual, adopt them to your own style and try them out in everyday practice.

6.7.5.1  Abandon a rigid approach to assessing psychotic symptoms

Don’t think that the only way to pass this station is to go through as many psychotic symptoms as possible. Use some of the techniques discussed below to elicit the symptoms you want to find about.

You have to be prepared to ‘go with the flow’ and adapt your style to get information as it comes. Even if you are used to asking a set of questions in a specific order, you will find the interview much more productive if you can react to what the patient is saying, rather than forcing them to answer questions in the order that you want.

6.7.5.2  Don’t panic!

It is easy to spot which candidates are very uncomfortable in such situations. They typically look rigid, unsettled, and clearly anxious. This is hardly likely to put a psychotic patient at ease and the anxiety will impair your chances of doing well. Remember that the Royal College is putting a lot of emphasis on communication. You can do well by demonstrating your ability to engage a psychotic patient.
If you have been in the station for 2–3 minutes and have got no information, and the patient still isn’t talking to you, you must change your approach – you are doing something wrong. Getting frustrated at the actor/examiner/Royal College won’t help your cause. The common problems are:

1. You are too aggressive/ assertive. Telling the patient to “sit down and talk to me” is rarely productive, even if you say “Please”. Similarly, appealing to the patient’s sense of pity because you are doing an exam will only alienate them more – if they are being pursued by armed terrorists, they aren’t going to care about your plight.

2. You are trying to get information without having established rapport. They won’t tell you anything if they don’t trust you. Try to develop a relationship with them first – it is worth spending a couple of minutes doing this, even if you don’t elicit symptoms.

6.7.5.3 Keep your questions open

If you can’t/haven’t engaged the patient and got their trust, battling on and asking them about hearing voices (even if they appear to be) will only make your situation worse. Don’t think that the only way to score points is to demonstrate that you have learnt the Present State Examination (PSE). If you can elicit the information in other ways, you can still pass.

I often tell people that these sorts of stations can easily be passed without asking any ‘psychiatric’ questions. These stations are about rapport, engaging patients, and demonstrating that you can establish trust. For example, look at the following two excerpts of an interview (the patient’s part is in black, yours is in blue):

You’re part of it...you know...you all do...Can’t you hear it?

Do you hear voices?

Shut up about voices. You know what’s going on, you’ve got it all written down.

Do you feel that others are controlling your thoughts?

Why are you asking all these questions? You psychiatrists always ask me these questions. I’m not telling you anything.

Are you getting messages from people?

I’ve had enough of this...
[The patient walks out]

You can see that the interview breaks down because you’re not listening to what the patient is trying to tell you. His agenda is to tell you what is troubling him, but your agenda is to try to ask as many questions about psychosis as you can in order to pass the OSCE station. Contrast the above dialogue with a more open approach below:

You’re part of it…you know…you all do…Can’t you hear it?

Hear what?

Them...

Them?

The police…they’re after me.

After you?

Yeah, and you’re in on it as well?

In on what?

You know…it’s because of what I did?

What you did?

Yeah, when I found out about the terrorists.

You can see that you get far more information because:

1. You are not being challenging – you become someone who appears interested and ‘on the patient’s side’. Whilst not colluding with any delusions, you are in effect appearing to be willing to enter into their world. By becoming someone who is non-judgemental, rapport is
established simply as a result a shared factor: that neither of you is exactly clear as to what
is going on.

2. You are not trying to dive in with questions that can be viewed as hostile. If the patient is
guarded, they’re not going to tell you their symptoms simply because you asked about
them.

6.7.5.4  A suggested approach

Have a look at the following dialogue which gives some suggestions on how to develop a rapport
with a psychotic patient:

Hi, I’m Dr Green. I’m one of the psychiatrists working at the hospital. I know that the police have
brought you into A&E and I guess that you’re pretty angry about that. What I don’t know much about
is why you’ve been brought here. Can you tell me what’s been happening?

Why do you want to know?

Because I might be able to help?

All you psychiatrists do is lock me up...

You’ve seen psychiatrists before?

Yeah, last year. They put me in hospital and sectioned me.

I’m here to try and find out what’s brought you into hospital tonight and to see if there’s anything we
can do to help. Can you tell me what’s been happening?

Don’t you know? All you bloody doctors seem to know. That’s why you put me in hospital. ‘Cos you’re
in on it.

In on what?

You know.

I don’t actually. The staff here didn’t tell me anything. Perhaps you could tell me where you were
when the police met you?
I was in the social work department.

**What made you go there?**

I was trying to sort out this mess that I’m involved in. *He becomes distracted and appears to be responding to auditory hallucinations. He becomes more agitated and hostile*. No, I’m not saying anything more.

**Okay, but I can see that something’s really troubling you.**

Can’t you hear them?

**Hear what?**

By being non-confrontational and willing to be ‘on-side’, rather than being seen as the enemy, you can maintain a (fragile) rapport which will enable you to get information. For example, in the above dialogue, you have established that he has a psychiatric history, has been in hospital, and probably detained. And you didn’t even have to ask him directly!

You are also using reflection to demonstrate an understanding. By saying something like:

"You seem very irritable to me. Something is clearly worrying you. Can you tell me what it is?"

...you are indicating that you are ‘in tune’ with the patient.

### 6.7.6 Dealing with angry relatives

One of the OSCEs in the autumn 2004 exam was dealing with a mother whose son had been diagnosed with schizophrenia. Accounts of this station suggest that the actor was extremely angry, refusing to sit down, and caused much consternation among those candidates who failed this station. Examiners have reported that candidates came out of this station looking pale and dazed. Online forums have referred to this station as the ‘Angry Mom’.

The importance of such a difficult experience is that if you don’t handle it well, it can affect your performance on subsequent stations. It’s important to remember that there is unlikely to be one solution/one way of handling it. The College simply want to know how you deal with it. They won’t
have a marking sheet that says, “Candidate says ‘That’s terrible – you must be really upset’”. The scores are likely to be general such as, “Candidate uses reflection to build rapport”.

As with some of the above scenarios, getting angry at the actor or the Royal College will not help your cause. Addressing the concerns of an upset relative is a situation which does occur in psychiatry and it is a valid skill to be assessed. Such anger, if it occurs during the station, is likely to contribute to failure for a number of reasons:

1. You lose focus on what you should be doing.
2. You own anger causes you to tense up, and this will be betrayed in your body language.
   Two angry people facing each other, with furrowed brows, sweaty palms, and rigid postures rarely has a successful outcome.
3. You run the risk of demonstrating to the examiner that you either do not feel comfortable in such situations, or you can’t control such situations.

Experiencing anger is normal, and it is often due to ‘projective identification’ – the anger is hers, but she is communicating it to you in a primitive way. Some of the people on the forums were still referring to the actor as “that bitch”, so this anger is not going away easily! Being so angry at an actress does suggest something about the counter-transference. You have to be able to ‘contain’ her anger.

To do well, you need to be able to recognise your own responses to these situations and have some strategies for dealing with angry people. Remember, attempting to impose your own agenda won’t work. Hopefully, the following tips might help:

1. It is important to remember that such OSCE stations are not about your knowledge of factors contributing to the development of psychiatry, they are about communication skills.
2. Accept that you won’t be in control at any point during the station. Reassure yourself that the examiner is not looking for your ability to ‘take control’. Be prepared to ‘roll with the punches’.
3. Body language is vital. Remain relaxed, supple, and ensure that you are aware of how you are presenting yourself to the actor. A common mistake is to reflect the hostile body language of the other person (See figure 3):
4. Use ‘simple’ techniques such as reflective listening\(^{11}\). Use nods, verbal acknowledgements (such as “okay...uh-huh...mmm...right”), and if you are comfortable doing it, mirror the person’s body language by folding arms when they do, or leaning forward as they do. And if you do get them to sit down, for heaven’s sake sit down too! Even if you can’t get across what you have to say, all of this will be communicating rapport with the other person and will help you open up a dialogue.

5. You may have to reflect back the other person’s apparent emotions to demonstrate that you recognise their concerns. For example, “I can see that you’re really angry”, “You’re obviously upset”. Follow this up with phrases that suggest a collaborative approach. E.g. “I can see that you’re really upset about what’s been happening and I can understand this. What I’d like to do is try to answer any questions that you have. Do you want to tell me what your main concern is?”

### 6.7.7 Apologising

Often people get anxious about whether they should apologise to the patient/relative. There’s often no right or wrong answer, but it can often smooth things along brilliantly. For example, in the following situations it would be appropriate to offer an apology:

1. You are late (unlikely in an exam).
2. You have got the patient’s name wrong, or have totally misunderstood what they were saying.

\(^{11}\) In reflective listening, the interviewer tries to clarify and restate what the other person is saying. This can: increase the listener’s understanding of the other person; help the other to clarify their thoughts; and it can reassure the other that someone is willing to attend to his or her point of view and wants to help.
3. You are in a situation where an obvious wrong has been done, such as giving someone the wrong information or the wrong treatment.

However, how you apologise can be important. Some people consider it to be ‘safest’ to apologise for their feelings rather than your acts – but you have to play this by ear, and see what seems most appropriate. For example,

"I’m sorry that you’ve been kept waiting. I hope that it hasn’t inconvenienced you too much"

"I’m sorry that I seem to have misunderstood you. Can I go back and double-check that I have got the information correct?"

"I can see that you’re very angry and I’m sorry that you’re so upset. Perhaps it would be helpful to go over what’s happened and I can try to answer any questions that you have?"

It is worth noting that in the wider context, under Section 2 of the Compensation Act 2006, “An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty.” (UK Government, 2006) This essentially means that you are not admitting guilt or culpability for any act simply by apologising. You should consider it reasonably safe to do so in almost all circumstances.

6.7.8 Reasons for failing the CASC

There are a number of reasons why you might fail a particular station. These may include:

1. You miss important clues or cues. If the patient alludes to suicidal ideation (“I can’t go on anymore”) and you continue to ask about other symptoms and don’t come back to it, then you might suggest that you’d miss it in real life. This causes anxiety in examiners and reduces your chances of passing.

2. Even though you can pre-prepare a lot of the information you might deliver to a patient, in the exam you should ensure that it is tailored to the patient in front of you. It should never sound like a generic lecture.

3. You look as though you are unable to integrate the information that you are given. You should be able to adapt your approach depending on what the patient is telling you. Many people simply hammer away with a list of questions regardless of what the patient is saying or asking. Make sure that you can modulate your interview style and content according to the patient. This
will hopefully be less of an issue in the CASC where the standard of communication skills expected will be higher.
7. Practice, Practice, Practice

7.1 Setting up OSCE groups

People who are good at a skill tend to have practised it *ad nauseum* – that’s how we learn a lot of our new skills. OSCEs are no different.

Groups of 3–4 candidates are probably best, and small groups can come together with other groups to review progress, discuss problems and solutions, and run through OSCE questions under exam conditions.

Before leaping into doing OSCEs, you should each discuss what you hope to achieve, what each of your strengths and weaknesses are, and any particular goals each candidate has. Agreeing on a timetable would be helpful, so that everyone has had the chance to work systematically through a wide variety of different OSCEs.

Each session should last about 90 minutes. If you have a group of three, each person should rotate through a number of roles in each session:

1. Psychiatrist
2. Patient
3. Examiner

A good goal would be to work through 2-3 OSCEs per session, giving every candidate the opportunity to do each of the roles.

The importance of everyone taking their turns to be a patient cannot be emphasised enough. An OSCE exam is very much a performance, and until you are comfortable ‘getting into a role’ you will not be able to perform to the best of your ability in the exam. Being the patient also encourages you to develop and reflect empathy. If you can ‘act’ depressed, it is very likely that you can display appropriate empathy with genuine depressed patients – empathy is simply a result of accessing our internal emotional repertoire. Secondly, you will also develop an appreciation of how an interviewer’s manner and style makes you, as the patient, feel. You can then use this to reflect upon your own style. And finally, it can be fun to be a difficult patient for your colleagues. They can then make life difficult for you, and you will gain important experience in dealing with difficult interviews.

Each person should write one of the case scenarios each week. That person might want to be that patient, since the case will be ‘theirs’. It is also an opportunity to develop a character, an essential contribution to empathic skills.
7.1.1 A suggested session plan

For a 90 minute session, a plan might be:

Table 6. An example session plan for OSCE revision.

<table>
<thead>
<tr>
<th>Time (minutes)</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–30</td>
<td>Reviewing the tapes from the previous week</td>
</tr>
<tr>
<td>30–45</td>
<td>OSCE 1</td>
</tr>
<tr>
<td>45–60</td>
<td>OSCE 2</td>
</tr>
<tr>
<td>60–75</td>
<td>OSCE 3</td>
</tr>
<tr>
<td>75–90</td>
<td>Review each person’s objectives for next week.</td>
</tr>
</tbody>
</table>

You should use about 5 minutes to ‘debrief’ after each OSCE, and a structured approach to criticism is useful. You should take turns to be the ‘chair’, and this person’s responsibility includes the deconstruction after each OSCE, and keeping everything running to time. When giving criticism, the following acronym is helpful:

7.1.2 ALOBA: Agenda-Led, Objective-Based Assessment

The important questions for the candidate when using ALOBA are as follows:

1. **What would be the particular issues or difficulties for you here that you would like to work on** (specifistics, not generalisations)
2. **What would you like to practice and refine and get feedback on?**
3. **What are your personal objectives for the interview?**
4. **How can the group help you best?**
5. **What would you like feedback on, anything in particular you want us to watch for?**

For an overview of this approach, including information on Pendleton’s rules, check out:

http://www.skillscascade.com/teaching/teachinghow.htm

7.1.3 Reviewing tapes

It is important when reviewing the previous week’s tapes that each person should give comments on their own tape first. Candidates should attempt to link new learning (e.g. from that week’s session)
with findings from the previous week’s recordings. In this way, there is constant linking of old and new learning.

7.1.4 Videotaping interviews

You should aim to video as many OSCEs as possible. The ideal situation would be to record all OSCEs, and then archive them all to DVD or hard-disk. This will give each candidate a record of progress and a resource to refer back to.

This does require a very obliging colleague with a reasonably fast PC/ Mac and a DVD-writer. You should all contribute to the cost of DVDs from the outset. A bottle of whiskey for your digital archivist might not go amiss!

7.1.5 Addressing particular problems

The groups are an ideal opportunity to address particular areas where improvement is needed. This agenda needs to be suggested by the members, and you may wish to put aside time in each session for ‘problem-solving’.

Solutions should be creative, and developed by the group.

Tip! If you have difficulties in remembering the patient’s name, or a relative’s relationship to the patient in question, get someone to interrupt briefly every 60 seconds or so during the interview and ask you. This will be a pain, but it will encourage you to lodge this information in working memory.

Tip! Take ‘Time-outs’. When starting out interviewing patients it is often helpful to break it down into much smaller chunks than to wait until the end to debrief. Set a timer for 60–90 seconds, and break the interview to discuss rapport, observations of technique, body language, etc.
## 8. Other important techniques for the CASC exam

### 8.1 Modular approaches to the interview

Many candidates make the mistake of sticking to a rigid structure to the interview. Whilst this is helpful in ensuring that you don’t miss anything, it has several disadvantages:

1. It rarely appears patient-centred.
2. You can end up asking lots of irrelevant questions.
3. It takes time—you only have 7-11 minutes and you need to be able to focus on ‘profitable’ questions from an early stage.

#### 8.1.1 Description

Rather than thinking about every station has as a complete list of questions (a common approach) you break down all aspects of the psychiatric history into a series of ‘modules’. Example modules might include:

1) Mental State Examination
   a) Mood symptoms:
      i) Elation (included mixed affective states)
      ii) Depression
   b) Anxiety symptoms:
      i) Agoraphobia
      ii) Social Phobia
      iii) Generalised anxiety disorder
      iv) PTSD symptoms
   c) OCD
   d) Risk (self and others)
   e) Dependence/ harmful use symptoms
   f) Psychotic symptoms:
      i) Delusions and hallucinations
2) Other parts of the history
   a) Premorbid personality
   b) Past psychiatric history
   c) Previous drug and psychological therapies

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12 Whilst these might not form the focus of a station, they are likely to be relevant to a variety of different scenarios.
d) Psychosocial supports, family history, etc.

Many modules might be used concurrently, for example anxiety symptoms. Learn how to link modules seamlessly. Anxiety symptoms often occur in the context of depressed states, for example.

### 8.1.2 Lists of questions

In preparation for the exam, you should prepare two lists of questions for each module. The questions are likely to be determined by the ICD-10 criteria for specific disorders. The first list is your full set of questions that you would ask if you are asked to see a depressed patient. The second list is a shorter set of ‘screening’ questions that enable you to rule out, or identify other symptoms.

When you have done this, as an example, the approach to the PTSD station would require you to pull together the following modules:

1. PTSD symptoms (full)
2. Anxiety symptoms (screening)
3. Depressive symptoms (screening)
4. Substance misuse (screening)

The biggest advantage of this technique is that it allows you to adapt your interviewing style to pretty much any OSCE station that could crop up. You will always know the questions to ask, and you can ‘bolt on’ additional modules to accommodate the scenario. Stations such as ‘wandering’ pose challenges for most candidates, primarily because they can’t learn every single question for every station. But by sensibly selecting modules they can put together a series of questions without inducing panic.

### 8.2 Making notes

THE FOLLOWING SECTION IS DEPRECATED, I.E. IT IS PROBABLY LESS RELEVANT TO THE CASC SINCE THE STATIONS WILL PROBABLY BE TESTING MORE ADVANCED SKILLS THAN SIMPLY EXPLAINING CLOZAPINE THERAPY. HOWEVER, SOME OF THE PRINCIPLES REMAIN RELEVANT TO THE CASC.

Most people will make copious notes in preparation for the multiple-choice papers, covering a wide range of psychiatric knowledge. However, many people seem reluctant to make notes for the OSCE exam. After all, isn’t it just a clinical exam and you can’t make notes for that?

Wrong! Actually, there is a lot that can be done before the OSCE exam. In fact, much of the preparation for the exam will be of benefit in everyday practice (and vice versa).
Much of what you do in the exam will be of a fairly ‘scripted’ format, e.g. explaining lithium therapy; discussing clozapine; explaining antidepressants. Can you see a pattern emerging? Develop a list of headings that you would want to cover for any kind of treatment (both pharmacological and psychological), and then create a ‘proforma’ of sorts. My proforma might look like this:

1. What is treatment X?
2. Why do we use it? What illnesses is it used for?
3. What do we know about the effectiveness?
4. What about side effects?
5. How is it taken?
6. What else does the patient need to know?

I would then start filling in information under these headings so that I can then deliver a seven minute introduction to treatment X (Lithium, for example) whenever needed:

1. What is Lithium?
I would like to talk to you about Lithium. Lithium is a metal salt which has been used to treat psychiatric illness for almost fifty years.

2. Why do we use it? What illnesses is it used in?
Lithium is most commonly used to treat bipolar disorder, but it can also be used to increase the effectiveness of antidepressants in patients who are depressed.

3. What do we know about the effectiveness?
Lithium is most effective in people who tend to have mainly manic episodes. Like most treatments, people do best when they take the medication regularly. You shouldn’t stop the medication unless you have discussed it with your doctor first.

4. What about side effects?
Most people tolerate lithium without too many problems, but common side effects include nausea, diarrhoea, and a metallic taste in the mouth. In the early stages of treatment, people get thirstier and go to the toilet more often. In a small number of patients, Lithium can affect how the kidneys work. In some people, Lithium can also affect the thyroid gland. This is more common in women.

5. How is it taken?
It’s usually taken once a day, at night.

6. What else does the patient need to know?
Before we start lithium, you will need a few routine tests to check your kidney and thyroid function. We usually also do an ECG – an electrical tracing of the heart. This takes 2–3 minutes and is completely painless. In the first few weeks of treatment, you will need regular blood tests, but after the levels in the blood have evened out, you will generally only need your blood tests every 1–3 months. Your GP will also be asked to check your thyroid function every six months or so.

You get the general idea. You should do something like this for all treatments that you may be asked to explain. So that even if you can’t remember the details, you still have a systematic approach to discussing it with the patient. A basic list should the interventions below, and you should use the same headings every time. That way, even if you can’t remember the details, you have a structure to guide you.

**Table 7. List of treatments you need to be able to explain.**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychological</th>
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You will often get clues as to the ‘performance’ you have to give from the question. For example, if the scenario talks about failure to respond to drugs for OCD, and you have to speak about behavioural treatment, you should not talk about graded exposure – that is not the preferred treatment for OCD. You are likely to be expected to speak about ERP.

### 8.3 Pattern recognition

It is crucial that when you read the instructions, you not only know what you have to do, but you also know the skills that each OSCE is testing. It’s no good displaying your communication skills if the examiner wanted you to take a history, however elegantly you do it.

There are only going to be around 5–6 main ‘types’ of OSCE. Every OSCE that you do can be categorised as one of the following:

1. History taking
2. Mental State Examination
3. Communication Skills
4. Examination Skills
5. Practical Skills
6. Interpretation skills (data, etc)

**Tip!** With colleagues, write very brief OSCE instructions (you don’t need anything more) so that you have a collection of 100 or so. Practice reading them quickly and then identify immediately the focus of the OSCE (see list above).

Discuss any disagreement with colleagues so that you are confident that you can judge what is required in almost every kind of OSCE that you might come across.

### 8.4 Thinking like an examiner

You will hopefully have had a chance to behave like an examiner in some of the OSCE practice above. Like most exams, if you can think like the person who set the question, you can deliver the answer that is required. As part of the sitting down and going over OSCE questions, as suggested above in order to prepare answers, I would also suggest defining how you would score each question. For example, if the question asks the candidate, “elicit manic and hypomanic symptoms”, what criteria would you set?

You can get a list of all the OSCEs that have arisen in the exam so far from:

http://www.trickcyclists.co.uk/osces_past.htm

This will help you to begin to think critically about the exam that you will be sitting. Even though you might like asking about a particular symptom, and you might do it very well, there’s little point if it’s going to take 60 seconds and won’t score you any points. Therefore, you have to know what the examiners are thinking when they set the question – what criteria would they have set?

If this is forcing you to make big stylistic changes, then try doing the same OSCE first with your own criteria, and then using the criteria that you and your colleagues have drawn up. Ask for feedback from colleagues and try to see how you can evolve your technique if necessary.
I cannot overestimate the importance of being able to ‘guess’ what the examiners are trying to test. For example, if you’ve just been asked to elicit depressive symptoms, and you then go to a station where you have to interview a young depressed mother with a two-month-old baby at home and no social support, it is unlikely that the Royal College wants you to talk about depression again. It is more likely that this OSCE is going to be about assessing risk. Remember that the Royal College is attempting to assess a number of different skills. If you are halfway through the exam and every station seems to be about mental state examination, the chances of yet another station on the MSE becomes less likely (although not impossible).

You might want to keep a mental or written tally of what kind of OSCE you have done as you go along. Don’t forget that depending on where you start the exam, the balance will shift.

8.5 Stations you should not allow yourself to fail

Some stations are either core skills that you absolutely have to be able to do at this stage, or have specific ‘lists’ that you can memorise beforehand. The following is a rough and ready list of stations that you should feel confident going into before the exam. Use the scales or familiarise yourself with the components of the skill under test:

1) Assessing suicide risk/ history taking post-overdose
   a) Use the Beck Suicidal Intent Scale

2) Assessing risk to others (e.g. post-natal depression/ Othello syndrome)

3) Assessing capacity
   a) Read the Adults with Incapacity (Scotland) Act 2000 to give a guide to key components of capacity. The relevant section is part 6 of Section 1. You can find it at:
      i) http://www.trickcyclists.co.uk/pocket_psych/AWI_2000/awi_a.htm#1

   b) You can then formulate questions specifically to deal with these aspects of capacity.

4) Cranial nerves/ neurological examination
   a) In the CASC, this is less likely to be the entire basis for a station. However, you need to practice these until you can do it when you’re asleep.

8.6 Final tips for the exam

Finally, in the last few minutes before you start, try to relax. People who are confident appear relaxed, as they have the experience to cope with the situation. You don’t have to be totally confident, but it will help to look it.
Similarly, if you have a bad station then put it out of your mind and commit totally to the station that you’re in. Chances are things didn’t go as badly as you might think, and you don’t want to fail future stations because you can’t forget the one that you thought you failed.

8.7 Recommended Reading


8.8 References


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