# Using OCAs in ST3 to Hone Skills and for Exam Preparation

*This is a guide to doing practice OCAs in much the same way that trainees used to do the old mock OCIs, when preparing for that exam. The point of doing them in this way is to force you as a trainee to lift your game regarding core clinical skills, and to practice synthesis and integration and managing this succinctly in a timeframe. Synthesis skills are essential for both the MEQs and OSCE, and to better prepare you to be a consultant. I recommend doing at least three OCAs like this per run in 4th and 5th year, with your own supervisor and other local experienced supervisors.* *- revised 2019, by Felicity Plunkett*

*Set the practice up with a patient you don't know. Get a fellow registrar (or the examining supervisor) to organise a patient and get the patient's verbal consent to do this to help with your training.*
*The assessing supervisor is referred to as 'the examiner'.*

The **observed interview takes 50 minutes**. Timed from when the patient enters the room (ideally the examiner and trainee should be in the room about 2-3 minutes beforehand.) The examiner should time the 50 minutes and make sure the interview ends then if the trainee has not already done so. Trainees can choose to end earlier if they want.
The examiner leaves the trainee in the room for their **20 minutes "think time"** before returning for the Viva part. If the patient leaves earlier than 50 min, the trainee has all the rest of the 50+20 min as "think time". Patients who leave before 20 min are replaced, ideally, or the OCA cancelled and rescheduled. Obviously in practices all this may not be quite doable, but try to keep to the timing as best you can.

**Timing and structure for the 30 minute Viva part:**

Initial part takes max. **17 minutes** (including the trainee's presentation).
The examiner starts the Viva with the following intro:
***"Having considered the case, in seven minutes or less please summarize the salient features including any important gaps in the history and mental state examination, and give your formulation, diagnosis and differential diagnosis. Your time starts now."*** (start timing 7 min from now)

At the 7 minute mark during the presentation the examiner should say: **"You've had 7 minutes"** (but will not stop the trainee if they go on.) Trainees should aim for a presentation between 7-10 minutes max. as this forces you to be succinct and to prioritise. After this there's up to 10 min of clarification questions using the prompts as below. Focus on clarifying the history/gaps, phenomenology, justification of the Diagnosis and Differential Diagnosis.

After 17 minutes, the examiner begins the next part with the intro:
***"Please present your management plan as if you were a junior consultant taking over management of the patient at this time."***

There are **13 min** for this part. If the trainee is still presenting their management plan after 10 minutes, the examiner should interrupt and say that only **3 minutes** of time remain (allows for a few clarification questions). Ideally the management plan presentation should not run longer than 10 minutes. The Viva and the practice is ended after **30 minutes**. Then there's a feedback discussion, for another 20-30 min.
*NB: I recommend that the trainee starts the presentation with a brief demographic intro, then by saying what the key issues of the case are.*

**Prompt questions that examiners are encouraged to use during the 30 minute Viva are:**

- Please **Elaborate** ……… (discuss material in more depth)
- Please **be more Specific** about ..............................(more specific about information, treatment etc.)
- What are the most **Important or relevant** ....................................? (makes them prioritise)
- What **Alternatives** might you consider .................................?
  - (e.g. alternative explanations, alternative differential diagnosis, other treatments, etc. )
- What **Additional** ……….. (history, investigations etc.) .......................................?
- Please **Justify** ……(seeking evidence from patient or from literature, e.g. re diagnosis, Rx)
- What is the **Significance** of …? (something mentioned, e.g. re meaning, risks, prognosis)
- What are the **Limitations** of….? (encourages realism - re pitfalls, barriers to plan, etc.)

The examiner should try not to interrupt the trainee - it's the trainee's 'show' overall. They should not re-ask a question on the same issue more than twice. Move on to explore another area after that.

**Use a paper OCA form for feedback on the usual domains http://www.psychtraining.org/WBA-draft-OCA.pdf**

## Additional guide about the OCA domains for feedback:

**History taking process**

What does this cover? Interaction with the patient re empathy, good introduction and closing of interview, overall handling of the interview and technical competence in eliciting information. (and a guide from the old OCI exam):

- **Surpasses the standard** - Clearly achieves the standard overall - a superior performance
- **Achieves standard** - NB: the standard can still be achieved if there are minor deficiencies
  - manages the interview environment (where they and patient sit, manages situation if patient tries to interact with examiners or behaves oddly, etc.)
  - explains exam process and timing, introduces self and role and the examiners roles (their names aren't essential), reassures re confidentiality and that notes not retained, but that if any risk concerns they would need to talk to the usual doctor/team
  - ideally they should close interview and thank patient, not have examiners cut them off
  - engages the patient as well as can be expected
  - reasonable structure and organisation yet ability to follow important cues more flexibly and to focus on the important issues in the case, not just ask a rote list of 'history headings'
  - recognises emotional significance of the patient's story and responds empathically
  - can adapt interview style flexibly to patient and uses balance of open & closed questions
  - summarizes back to patient at times, appropriately
- **Just below** - as for achieves standard but there are deficiencies in a number of areas
- **Does not achieve standard** - Significant errors such as being insensitive, aggressive or interrogative or too-rigid approach, disorganized approach or inadequate control of the interview

**History taking content**

What does this cover? The quality, comprehensiveness *and relevance* of the information obtained (and a guide from the old OCI exam):

- **Surpasses the standard** -
  - the history gathered is relevant to the patient's problems and circumstances
  - sufficient depth and breadth of history and few if any omissions
- **Achieves standard**
  - history and physical examination are relevant to the patient's problems
  - in 50 minutes *not* all history can be obtained of course, so the key issue is how they prioritise and whether they get enough detail about the key issues *for this patient*, and don't miss out any important aspects of history
  - there is appropriate depth and breadth
- **Just below** - as for achieves standard but there are deficiencies in a number of areas
- **Does not achieve standard** – significant deficiencies such as substantial omissions in history or other aspects of assessment (not MSE)

**Mental State Examination Skills**

What does this cover? Conduct and accuracy of presentation of the MSE including cognitive assessment where appropriate (which should be meaningful & targeted). MSE is marked on appropriateness, depth (should be appropriate to patient & time constraints), comprehensiveness and significant omissions. Presentation should be succinct, with accurate phenomenological terms & appropriate positive & negative findings. (and a guide from the old OCI exam):

- **Surpasses the standard** – MSE is relevant to the patient's problems/circumstances and is conducted and presented at a sophisticated level.
- **Achieves the standard** – they conduct & present a thorough, organised MSE – assessing key aspects of appearance, behaviour, conversation and rapport, affect and mood, thought (stream, form, content, control), perception, insight and judgement.
- **Just below the standard** – minor deficiencies in technique, organization and/or presentation
- **Does not achieve standard** – significant deficiencies in technique, organization and/or presentation.

**Physical examination Skills** (not in the old OCI marking domains, but here's some general advice)

The physical exam is limited to what can be done in a consulting room without equipment or disrobing the patient. The aim of the physical exam is to observe or examine for overt clinical signs which may significantly influence management.

*What can trainees do? What's relevant to the case?*

- Evaluate extrapyramidal signs (e.g. do a quick AIMS)
- Hand examination (nicotine-stained; nail biting clubbing; tremor, sweating, hot or cold)
- Take pulse (palpitations; tachyarrthymias)
- 'foot of the bed observation' – sweating, pallor, jaundice, facial asymmetry (?CVA), stigmata of bulimia or anorexia (parotid swelling, knuckles, lanugo, weight)

- Periphery - pedal oedema, tone, track marks, moving all limbs?
- Enlarged thyroid if patient gives permission for you to touch their neck
- Inspection of gait and balance as patient arrives and leaves, or ask them to walk a few steps and turn.

*Some examples when the physical exam is especially important:*

- Patients with eating disorders
- Patients with organic brain disorders, esp. if elderly (e.g. primitive reflexes)
- Alcohol and drug abusers – peripheral stigmata
- Patients on meds that cause side-effects - neuroleptics re TD EPSE and akathisia, TCAs (tachycardia, postural dizziness)
- Pain patients (stiffness, gait, mobility etc.)
- Patients who've given you a Hx of a significant medical disorder of some sort (e.g. CVS disease)

**Data synthesis**

What does this cover? How the trainee pulls all the information together, whether they make sense of the patient's predicament, and whether they get to grips with the main issues for this patient. (and a guide from the old OCI exam):

- **Surpasses the standard**
  - the clinical summary is accurate and succinct
  - the formulation is accurate and makes sense of the patient's issues and situation
  - the diagnostic differential and discussion of this are sophisticated
- **Achieves the standard**
  - Able to prioritise and synthesise the key issues
  - missing or dubious or contradictory data are noted, as is the relevance of this
  - formulation of the key elements of the case is reasonable
  - diagnosis and differential diagnosis reasonably reflect the data gathered. Note that current advice is that if trainees use the DSM system they should cover all the axes. They should use a recognised system, not unusual or vague terms for the diagnosis
- **Just below -** there are deficiencies in some areas:
  - summary of history may show inadequacies in their ability to evaluate
  - diagnosis and differential are inadequate or not well justified
  - formulation shows inadequacies and problems with prioritisation
  - lack of synthesis with repetition of material, not succinct, may go significantly over 7 min.
- **Does not achieve the standard** – significant problems such as:
  - errors in interpreting the significance of the history
  - inability to support the diagnostic statement, or a significantly incorrect diagnosis
  - inadequate formulation and lack of a grasp of the key issues for this patient
    - e.g. formulation is just another summary, poor prioritisation of the issues

**Management plan**

What does this cover? The trainee's proposed management of the case. (and a guide from the old OCI exam):

- **Surpasses the standard**
  - in addition to the criteria as below, management plan is comprehensive and sophisticated
- **Achieves standard**
  - presentation of a prioritised and structured plan that emphasises the most important issues
  - plan covers short and long term, is *relevant to the actual patient* and their socio-cultural context, and includes appropriate management of risk
  - likely response to treatment and barriers to implementation of the plan are discussed
  - evidence to support and justify planned treatment is mentioned
  - trainee's own role in the patient's management is mentioned
  - the role of other professionals is also appropriately included
  - prognosis is covered
- **Just below** - there are deficiencies in some areas as above
  - plan is accurate but may not pay enough attention to the actual patient's specific circumstances
  - plan is not very well-prioritised
- **Does not achieve standard** - there are deficiencies in most areas as above
  - the management plan lacks structure
  - the management plan is not prioritised
  - aspects of the plan are inaccurate or technically incorrect
  - plan is too generic and not tailored to the patient's actual circumstances and issues