Westmead Psychiatry

The Westmead Guide to the RANZCP Clinical Examination

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Introduction

Every year I and the other consultants at Westmead, do tens of vivas with candidates from all over Sydney and beyond. Over the years it has become obvious that candidates tend to make the same mistakes or omissions when considering how to approach the exam. This document is based on our experience. It contains our suggestions on how to approach the exam to maximise your chance of passing first time.

This is the fourth version of this guide and since its inclusion on the APT website it has become very widely read. We have now had several iterations of the new exam and had feedback from College examiners in a number of forms. As a consequence we now have reasonable confidence about, if not the best way to approach the Clinical Exam, then certainly a way that is likely to yield success.

All that said, I have no doubt that this booklet will continue to evolve. I love feedback and suggestions for further improvement, so if you have some don't hesitate to email me at cryan@mail.usyd.edu.au.

Good luck with your exam.

Thinking about the vivas

Principles

You should develop a number of core principles to guide you through the clinical exam. These principles serve as things that you can return to whenever you're uncertain as to what to do. Some will apply only to the OCI, some to the OSCE, one applies to the whole shebang - The Prime Directive.

The Prime Directive

Basically, in this exam, the examiners want to know if you are one of them or at least, if you're the sort of person who's likely to become one of them with a couple more years experience. Your primary aim therefore, the aim that trumps every other consideration, is for you to, as much as possible, look like a proto-consultant, a very impressive Advanced Trainee.

The stated level of competence for this exam is that of someone who has completed their basic training and ready to move on to being an advanced trainee. Most of your examiners were never advanced trainees, as they qualified before that title existed. When they sat, the competence level required was that of a "newly qualified consultant", that is not the level required for this exam, but it is still quite a good level to strive for.

If you can manage to approach the level of newly qualified consultant, you will certainly have exceed the level of advanced trainee, and you will be rewarded with the correspondingly higher "surpasses standard" mark. It is a good idea to go for the higher mark, because if you can achieve it in some areas, it will act as some protection in other areas where despite your best efforts you fall short of the standard.

The way the exam is structured, it is possible to do so well in the OCI for example, that you need do little more in the OSCE than simply turn up and go around in order pass the whole thing. (I do not advise approaching the exam with this plan in mind, but it is possible).

Prior to the exam you should try to make yourself believe that you *are* of the standard of a newly qualified consultant, or at least pretty damn close to it. You are less knowledgeable and not as clinically wise as your examiners. You're prepared to bow to their greater experience, but you're a real live proto-consultant none the less.

Achieving this standard is harder to do than you might think, because up to now you have always been a plain old basic trainee. You might well have been a bloody good basic trainee, but there are things that basic trainees do that proto-consultants usually don't and vice versa.

The best way of emulating a consultant is to think of the consultant that you admire most - the one that you're already using as a role model. Every time you're wondering whether you should do something or not, ask your self this question, "Would Dr Hibbert do that?" If the answer is "no", then don't do it.

By the way, if you do not have a consultant role model, get one. If there are no suitable role models in the institution you're training in, change institutions now!

Bulldogging

If you get any chance, you must act as a bulldog for an exam, before you sit your own.

Bulldogging is an invaluable experience that lets you peer behind the veil of the exam and get a better understanding of it. It lets you see that the examiners are just humans. It lets you understand how easily things can wrong with the organisation. It lets you see how anxious a candidate can become and at least to a limited extent what mistakes candidates can make, so that hopefully you won't repeat them.

It will also let you see first hand the surprisingly complicated clockwork of the OSCE, which is not something you want to be trying to understand on the day.

What to wear

Putting on the Ritz

It should hardly be necessary to say this, but if you're going to play a part, you've got to look the part. Do not spare any expense with your outfit.

Men should wear a fashionable suit, impressive shirt and expensive tie. Do not settle on you're exam outfit without asking and considering the advice of others.

Women have a wider range of outfit choices but generally more aptitude in knowing what is right to wear. Remember that the majority of your examiners will still be male, so there is little to be lost by looking *very* subtly alluring. The aim here is for the allure to be so subtle that the examiners do not pick up on it consciously. People are much less likely to fail people that they like. Unfortunately while it will be relatively easy to play the allure card, without your male examiners noticing in most cases, you may get a female examiner (or two) and they will clock its use much more quickly. You should, therefore, be very cautious about playing the allure card. It is, for example, not usually wise to have on a skirt that is much shorter than that of your examiner.

When you've got your outfit sorted, make sure you wear it to several of your practice vivas. The real viva is not the time to find out that you can't undo your jacket buttons when you sit down, or that your new shoes give you blisters.

Where to stay

Staying in the Ritz

While we're on the topic of cash outlays, you should adopt the same hang-the-expense attitude to your exam period accommodation. There's no need to stay in the best hotel in the city that you're going to, but you should stay somewhere where you know you're going to be looked after.

Many hotels give corporate rates to people who identify themselves as coming from a particular hospital or as being connected to the College. Check this out on the phone before you go, and find out if you require a letter providing documentation of your "corporate status". If you do, a letter from your current consultant will usually suffice.

Forms

Signing up

While almost outside the scope of this little book, it is worth mentioning quickly that you won't get to sit the viva unless you can convince the College that you've satisfied all of their requirements. This is not easy to do. There are a myriad of forms that need to be signed and submitted all by certain dates and times. Too make things just that little more challenging, the exact nature of the forms and the dates by which they are to be submitted, have a habit of changing.

This means that you really have to regard the paperwork about the examination as a part of the exam itself, not merely a formality. Tedious as it may be, be sure to read all of the relevant documentation, and keep a watching brief on the College website. Pay attention to information put out by the ANZAPT and speak to your colleagues regularly to make sure that you have not missed out on some ill-publicised College missive.

ID photos

The College requires that you send a passport photo in with your documentation. Just like every other element of the exam, give this some thought and don't spare any expense.

For example, do not use a photo that you might actually have used for a previous passport. Passports require head shots that are square on, and demand that the subject wear a "neutral expression". You should tell the photographer (don't just use a booth) that these photos are not for a passport and that you must look your best. At the very least, you should be well groomed and you should smile. Do not sit exactly square onto the camera, but rather turn your shoulders slightly so that you look into the camera at a slight angle.

Why is this important? First impressions are everything. Your photo will be the first thing that your examiner will see of you. (The photographs are scanned and distributed to the examiners in an attempt to raise security). If your photo makes you look like an escaped convict or a political terrorist, then that will be your examiners first impression, and a first impression you'll need to dispel before you can start scoring points.

There is good study evidence that job applicants are likely to do better if their photographs are more appealing, even if everything else is held constant. (In the study some photos where digitally enhanced so that the subject's pupils were enlarged). Your photo should convey the impression that you are a young consultant that anyone would be keen to meet you. (I don't think you need to take belladonna for the shot, but do look your best).

But the whole thing is so stupid

Perhaps you disagree with some element of the exam. Perhaps you think that the OCI should be longer or that the OSCE should only four stations not six. Perhaps you think that the whole idea of using an OCI to assess performance is flawed and perhaps you even have excellent arguments to back-up what you say.

You know what? No one cares!

From now on forget about whether the exam is good, bad or indifferent. As far as you're concerned it doesn't matter. It is the only game in town and, apparently, you want to play. No one is going to be terribly interested in your opinion of the process as a trainee, and unless you can find a voice through the ANZAPT, you're not liking some aspect of the process is completely irrelevant.

If there really is something that is clearly and undeniably unfair about the exam process, then convince your colleagues of this and contact the College through ANZAPT or through the College registrar grouping. If you're not prepared to go through ANZAPT, then no matter how bad you think the thing is, forget about it. If you're still concerned by the same aspect after you pass, then join a College committee and try to change things from inside. My overwhelming experience is that people are far less concerned about these injustices once they are through, but if you remain concerned, that's good, because it is not like people are queuing up to donate hours of their time to these College committees.

In the meantime, remember these three things:

1. No exam process is perfect, so why would this one be?

2. The people who design and run the exam do the best they can. They invariably work as volunteers and do all they do in their own time. They are always genuinely committed to trying to make the process as good as they possibly can. Most of them are extraordinarily committed to the process, but all most all are amateurs with little or no training in adult education or exam design. They are going to stuff things up, get used to it.

3. You will tend to do better in the exam if you try to believe that it is a basically good process. So believe that, whether you believe it or not.

As it happens, although I have numerous concerns about the exam, and would change quite a few things if I ruled the world, I still think that the exam is "not too bad, not too bad at all".

The Observed Clinical Interview

The Observed Clinical Interview seems to be the major discriminator in the viva examination. It accounts for fifty per cent of the final viva mark. Technically you need not pass it, to pass the whole thing, but in actuality you've got Buckley's of passing the whole thing unless you do.

More principles

The OCI has its own set of overriding principles that apply in addition to the Prime Directive.

I'm not doing anything that I don't do everyday

This exam is simply about assessing a patient (a real patient) and making management decisions about him and presenting this to a colleague. You have done that everyday of your psychiatric career. You should by now be pretty good at it. If you're not good at it, you shouldn't be doing the exam. I'm going to assume from here on in that you are good at it. If you're not, really not (not just modest or anxious), then wait until you are good at it, before you sit the exam.

If you are good at it, you should feel basically confident about your ability to do what's asked of you. It also means that there are only relatively few extra things for you to learn prior to the exam; you know most of the stuff already.

If you're reading this booklet a long time before you sit, you should realise that this means that all the assessments that you do from now until the exam are actually practice for the exam. So, whenever you see a new patient, take the opportunity to do it properly. Improve your skills each time. Avoid taking short cuts or just relying on what others have said about the patient. Make your own assessment. This is not always possible; sometimes you need to take short cuts, but try to avoid them. You'll benefit and so, of course, will your patients.

Every patient is the perfect patient

Patients are chosen for the OCI on only two criteria. First, they must be a patient. Second, they must agree to participate. That's it! Well, they will be able to speak reasonable English, and they are supposed to be able to give a decent history, but these things things are secondary considerations. This arrangement is just fine for you, because you want to be a psychiatrist and a psychiatrist should be able to assess and manage psychiatric patients. All the patients are *psychiatric* patients, so whole thing fits together perfectly!

By the time you sit the exam there should be no such thing as the type of patient you don't want to see. Now, of course, you think that there are some patients you don't want. Perhaps you really don't want someone with anorexia. Perhaps it's anything but a old person. What ever it is, by the time of the exam, it cannot still be like that. To go into the

exam hoping that you don't get a particular type of patient is to go into the exam with an identifiable and rectifiable vulnerability. Work out now the types of patient you don't want to meet and then practice and read up about those patients so that, if you do get one, you'll be pleased.

"Every patient is the perfect patient".

I thought that might happen

There should be no time in the exam when something happens that you did not consider as a possibility. The exam is actually fairly predictable. Generally speaking it should go as advertised, but it won't always. At every stage, consider what else might happen and have a contingency plan for that. What if I know the patient that I'm introduced to? What if the patient is mute, blind, deaf? What if I'm only given fifteen minutes thinking time not twenty? What if I know the examiner? What if the patient is violent, or is overfamiliar, or is obviously physically unwell? What if the patient takes off his trousers mid-exam?

You will be quite anxious on the day, and are unlikely to be in the best frame of mind to think on your feet. If you've already considered any eventuality, even if only briefly, then you can fall back to your pre-prepared plan, with a reassuring "Oh yeah, I thought that might happen".

Preparing for the OCI

How many vivas exactly

The exams are steeped in mythology. Almost all of it is rubbish. No matter what anyone tells you, there is no quota system, the examiners are not instructed to fail X number of candidates, and the manufacturers of Andronicus Coffee have no influence over the College or its members.

One of the greatest myths is that you must do *N* number of practice vivas and failure to achieve *N* vivas will result in you failing on the day. This is simply dumb.

The mistake that most candidates make, is not to do an insufficient number of practive vivas, it's to think insufficiently hard about those vivas that they do do. There is no magic number of vivas, but after you do each viva, go away from the viva, sit down and think about what happened, think about the feedback you got and think about how you'll use this experience to make you're future vivas better.

There are only two reasons to do practice vivas. First you should do vivas to practice and try out techniques that you are going to use in the viva that you don't use in everyday interviews. You don't usually have strict time limits imposed on your interview and on the presentation. You don't usually see a patient with two other consultants in the room. You're not usually this anxious. You don't usually see patients in unfamiliar rooms in unfamiliar hospitals. All these things are worth experiencing and thinking about.

Second you should do a few vivas with patient types that you're unfamiliar with. If you've never worked with anorexics, do a viva with an anorexic, and make sure the person providing the feedback on the case knows a lot about anorexics so that they can give you

lots of pointers. Other patient types that are typically unfamiliar and feared are forensic patients, adolescent patients and rehabilitation patients.

Some people also find it useful to do a number of vivas because they find them incredibly anxiety provoking and find that repeated exposure helps this. If you're like that, then obviously a certain number of vivas will be helpful. However, don't just rely on exposure *in vivo*, remember that imaginational exposure works well too and you can do that much more efficiently.

What to study

One of the great things about the OCI, is that there ain't that much book learnin' to do before you go in. After all you're already pretty hot, having just finished the writtens. The main areas that are worth revisiting are phenomenology and management strategies for various disorders, including the evidence base for those strategies.

In fact, your main task in preparation for this exam is to think your way through the various possibilities that may arise on the day, and that doesn't require any reference to the texts.

What to find out

Unless you are sitting in your home state (or in the case of New Zealanders country), there will be some new terms that may be worth chasing up before you go. If your crossing the Tasman particularly, try to find out what they call their drugs over there. Not all drugs have the same trade names in both countries. This applies particularly for New Zealanders coming to Australia, as we have many drugs that are not available to you.

Legal terms and government departments don't translate well from place to place either. Generally speaking this won't matter too much but before you go, try to find out the local terms and acronyms for:

- Being detained involuntarily under the mental health act.
- Being obligated to undergo treatment in the community under the mental health act.
- An order preventing another person from approaching you under if that person has been violent or intimidating.
- The department responsible for public housing.
- The department responsible for the welfare of the intellectually impaired and/or children.

What to take in

The only things you may take into the exam room are some pens, blank paper or card, a timer, and a clipboard. Depending on how enthusiastically your bulldogs take on their role, you may be asked to surrender anything else you've brought with you, including bags and wallets. Expect this, and don't get fussed by it.

What to write on

You are probably used to writing assessments on plain hospital progress notes. Some of you may be unfortunate enough to be working in areas where assessments are routinely done on silly pro formas like the odious MH-OAT in New South Wales. Obviously you shan't be able to take either into the exams, so this will have to differ from your normal practice. (If you are using pro formas like MH-OAT, you should make every effort to stop using them now. They are only getting in the way of your training. At Westmead we have never used them).

Many candidates use a folded manila folder to take down and present their history. If this works for you that's OK, though I am not a big fan of the folded folder. I think it ends up looking a little scruffy, and tends to limit the amount of space you've got to write. Most importantly, since your role model consultant never uses a scrunched up manila folder, or anything similar, it appears to violate the Prime Directive.

I'd suggest using pieces of blank high quality very light cardboard. These can either be kept separate or they can be joined with sticky tape down the side to create little booklets. You may also quickly add little *aide memoirs* to various preset pages once you're in the room and while you and the examiners are waiting for the patient. (Though don't assume you'll have time to do that). Light cardboard has the advantage over paper that it doesn't rattle if you're holding it and you're tremulous.

Take in plenty of paper of course, and not just enough to write your history on, you're also likely to need some for the patient to use for their cognitive testing (see below).

Do not assume that you will have a table to write on. I'd suggest taking in an expensive professional looking clipboard that you'll be able to lean on and also clip your electronic timer to. The patient may also require something to lean on if you get him to do any paper and pencil tests. Generally, they should use your clipboard, and if you're using card (as opposed to paper) you should be able to get by without the clipboard for the short period that the patient has it.

What to write with

If you haven't got a nice pen that you're happy with, now is probably the time to buy. What ever you write with, make sure that it isn't going to leak all over your impressive shirt and that you have a spare ink cartridge.

Do not use a drug company pen. Some examiners really hate this.

You should probably take in some highlighters as well to help you prepare the salient features presentation. You may also want to take a cheap pen (not a drug company one) that the patient can use for your cognitive testing. A second pen means you can keep writing while the patient is completing his assigned tasks, which can be quite important if your patient is very slow. (Make it a cheap pen, because you might forget to ask for it back).

Timer

Timing is everything. You are going to need a secure way of keeping close track of the time throughout the exam. In the presentation section, you're going to need to know the time down to the second.

I'd recommend, a small electronic timer clipped to the top of a clipboard. This has several advantages over using your watch.

First you cannot afford the possibility of not noting the time at the start of your exam. This would be an easy thing to do, considering how nervous you'll be. With a timer attached to the top of your clipboard, it will be hard for you not to start the timer at least as soon as you sit down and look at your paper. Second, you can then start your time at zero – it won't be necessary to note down your start time and then keep doing maths to work out how much time you've left. Third it won't be necessary to look repeatedly at your watch through the interview; it will simply be on top of your notes.

The interview

One of the great things about this exam is that most of it is completely under your control. The examiners actually have very little opportunity to place their stamp upon the process, and they won't have any opportunity at all until the exam has been going a whopping 77 minutes.

The whole interview, the first fifty minutes, are entirely under your control. Use that opportunity.

Going in

You will be brought to the examination room and introduced to the examiners.

First impressions

The exam is just another human interaction and the examiners are just other humans. Humans tend to make up their minds about things quickly; *really* quickly. There is a reason that people say "first impressions are everything". Within 60 seconds of the interview, the examiners will have decided whether they like you or not and whether they think you should pass. Of course they won't have done that consciously and to the extent that they are conscious of it they will try to suppress it, but they are only human and that is the sort of thing we humans do.

It gets worse. Not only have they decided within the first 60 seconds whether you have passed or failed but, they will then set about trying to prove their first impression to themselves. Human beings are pervasively subject to a *confirmation bias*, a systematic tendency to search for evidence that supports a hypothesis we are entertaining, rather than evidence that refutes it, and to interpret ambiguous evidence so that it supports our hypothesis. This is just a fact about human beings, about you as much as about the examiners, so there is no point belly-aching about it, but you had better take it into account. If the examiners have decided early on that you should pass they will seek to try to confirm that view. If they have decided that you will fail, the reverse applies.

This means that you must pay extraordinary attention to this first 60 seconds and the opening minutes after that. The examiners must warm to you immediately and it must never cross their mind that you might not pass.

Examiners don't like to fail anyone. They especially don't like to fail people that they like. They also don't like to have to go back on their original impression. Having decided early on that they can relax because you look really good, they will be reluctant to take on evidence that goes contrary to that position. They will go back on it, of course, if you make 'em, but they'd rather not. Having decided you're likely to pass they may see some omission as a minor miss of no real consequence. If, however, they have formed the opinion you are likely to fail, then that same omission may be seen as yet another example of what they are concerned about. Watch yourself do this when you practice as a co-examiner.

You *must* look like someone who thinks that she deserves to pass. If you look like someone who thinks perhaps she should *not* pass, you will communicate that to the examiners, and they will, understandably, but unconsciously, ask themselves whether you might be right. You shouldn't look cocky of course, but that is quite an unusual problem among candidates. Most candidates are not sure themselves that they really deserve to pass; after all there is so much they don't know. It is fine to feel like that, I'm still not sure that I know enough to be a consultant psychiatrist and I've been one for over ten years, but you must not *look like* you feel like that. At the moment you enter the exam room you must feel like you deserve to pass whether you feel like you do or not.

And the winners are …

Before you go into the exam, ask your bulldog for the names of your examiners and write their names down - you'll need them later to introduce them to your patient. (It is likely that the bulldog will remove your mobile phone once he has told you your examiners names, so make any last minute "good-luck" calls before you ask).

Having discovered the names of your examiners, do not allow yourself to be put off by your draw. Prepare yourself now for the possibility that you discover that you will be examined by the psychiatrist known universally as *Smiling Death* or *The Executioner* or *Killer Mulgoon* or who ever it is that all registrars know *for a fact* has never passed a single candidate in his life. For a start it will be complete rubbish. Needless to say, no examiner has failed every candidate before him. It may be that some examiners set higher standards than others; it would be surprising if that is not the case, but it is unlikely that the registrar body has got hold of secret College papers that document that Dr Mulgoon is particularly picky. It will all be fantasy and you don't want to be put off by fantasy. Make sure you have prepared yourself to meet *The Killer* and make sure that you know you won't be the least bit phased to realise that he is your examiner.

In the same vein, prepare yourself for other eventualities that might follow the discovery of your examiner.

I know you

In the OCI (as opposed to the OSCE), the College goes to a great deal of trouble to ensure that examiners do not have a personal relationship with candidates. Before the OCI each examiner must fill in a "can't see list" in which they are supposed to notify the exam coordinators of any candidate that they might have ever run across in a corridor so that they will not be allocated as their examiner.

The system usually works, but doesn't always. Examiners are only human. They can forget your name, or not recognise you from your little photo. This is particularly the case for examiners that you may have done a trial OCI with or examiners that may have been your tutors at university.

If you walk in and you know the examiner, don't panic. So you know the examiner. So what, that's good. If the examiner is OK with it, you should be too. It will almost always be an advantage. If the examiner likes you it's an obvious advantage. If the examiner hates you (possible I guess), then she will feel she needs to over-compensate to give you a fair hearing. If the examiner realises at the last minute that they know you and wants to swap things around, that's OK too!

If you have failed before and are about to meet one of your prior examiners, that is also OK. It is extremely unlikely that the examiner will remember you. Failing a candidate is unpleasant for the examiner, but it is hardly burnt onto his brain. I hate failing people, but to be honest, I can't remember who I've passed or failed by the time I'm queuing for taxi at the end of the day. Even, in the extremely unlikely event that she did remember, it is vanishingly unlikely that the information would negatively prejudice her. If you get the same examiner, just think that "you thought that might happen" and get on with it.

Meet and greet

As daft as this is going to sound, make sure you practice walking through the exam room door. Hesitation at the verge is a non-verbal communication of uncertainty. You are not uncertain. You know you deserve to pass. So don't hesitate. Visualise this walk through and practice it over and over again. No hesitation. Look at the examiners in turn. Smile and shake their hands. Listen to their names, just make sure that they have not changed since you were told who they were going to be ten minutes previously (it is possible that you were told the wrong names). Find the chair. Sit down and collect yourself.

All of this should be completely predictable. It is really important. Get it completely right. Work out what you'll do if only one examiner is present, if both are running late, if there is an observer etc etc.

Read any good books lately

There is supposed to be a two minute gap between you being introduced to the examiners and the patient being brought in. There is the potential for that being an awkward little hiatus, but again it is completely predictable. The examiners are instructed not to engage you in conversation during this time and it is probably the perfect time for writing any *aide memoirs* you might wish to on the pieces of card that you've brought in.

Exactly how much interaction you have with the examiners depends on how good you are socially and how anxious you are. On the one hand completely ignoring the examiners is unlikely to further your rapport with them (though it won't count against you). On the other hand, I don't think this is the time for a quick gag.

If for some reason the arrangement of the furniture is not to your likely you may rearrange the furniture during this time. Do not do this unless you have a really good reason. Rearranging the furniture is not necessarily the best way to build rapport either, after all the examiners have probably arranged the furniture the way they like it already. However this is your chance if for some reason the décor lacks that certain *feng shui*.

Patients are slightly more difficult to control than examiners. Do not assume you'll get your two minutes (so do not be completely dependent on your *aide memoirs*) and do not be surprised if two minutes becomes five minutes. Work out what you'll do for a short and for a long hiatus.

Enter the patient

The patient will then be brought to the room by an invigilator (bulldog). You will be responsible for introducing yourself, explaining the role of the examiners, and orienting the patient to the task. You will be expected to take responsibility for the interview, including if necessary its premature termination.

Timing

Your time will start as the patient enters. You will be maximally anxious at this time. You cannot, however, afford to miss noting the start of your time. Whatever timing strategy you use make sure that you will be able to track your fifty minutes from now. It is very common for candidates to start their timer as they begin the interview, but after the introduction. If you do this, you may be 60-120 seconds out in your timing, and the exam will end before you thought it would. Do not allow this to happen. If you forget to start the timer at the beginning, start it late and guess how much time you have left looking to underestimate the time remaining. If you can't do that, ask the examiners for the time remaining and start your clock then.

Don't let the timer interfere with establishing that initial rapport with the patient. Practice turning the timer on without a significant break in eye contact as the patient walks into the room. If you're using a timer that goes beep, try to shut it up, either with its own options or by sticking something over the timer's speaker. (The ANZAPT website contains links to detailed instructions on how to cut the feed to a timer's speaker).

Introductions

All of this is also completely predictable. So think about it. Think about possible variations and get it right. The College CD-ROM includes a segment on beginning the interview. Watch that and emulate it. That is what the College want. Give it to them.

Data gathering process accounts for 10% of the marks. The guidelines on this focus on the introduction. They say this 10% is "marked on how well the candidate introduces the interview and attempts to establish rapport, the candidate's general approach to eliciting information, and closure of the interview." Again this puts a heavy weighting on the first (and last) few minutes.

If all has gone to plan so far, the examiners are already of the unconscious opinion that you'll pass. Your job now is to keep confirming that opinion. The longer they think it, the less likely they'll change their mind. If they are still thinking it by the last 13 minutes of the viva, you'll practically need to kill the patient with your management plan to have them fail you.

Introduce yourself to the patient. Introduce the examiners by name. Thank the patient for coming. (Remember that many patients have come in from their homes for no other purpose than the exam. Patients receive no recompense for this. It is pretty damn nice of them).

Make the patient like you too. Make him want to help you pass as much as he can. Now everyone in the room is rooting for you. You are a long way ahead.

Setting the scene.

Tell the patient what is going on. Explain that everyone will be taking notes like crazy, but they are not taking notes on him. (This is especially important if the patient turns out to have persecutory ideas). Warn him that time is limited and that you might need to interrupt. Tell him that it is all confidential and explain that the interview is not primarily for his benefit, but for your's; and consequently thank him again.

Be careful not to overdo the confidentiality thing. Remember that most people the patient sees do not give a little confidentiality rider at the top of the interview and too much emphasis on it now, can sound odd and almost as if you might well spread this abroad. This can really unsettle some patients, and you don't want to be unsettling the patient within thirty seconds of meeting him.

Watch out for patients who misunderstand the process and think that their job is to keep information from you, to test you. Normalise the interview. Say that, for him, it is just like it is when he sees any other doctor. He can tell you anything he wants to, anything he thinks will help. Let him know too that you have no access to his notes or anything else, so he may need to explain everything to you.

If you're visiting from overseas, you might want to tell the patient that too. Most Australians like New Zealanders on principle and (hopefully) this also applies in reverse.

I am not in favour of telling the patient explicitly that you'll be talking for *50 minutes*. It is quite possible that this will be the first time that the patient will have heard the actual duration of the interview and you don't really want him saying, "Fifty minutes, oh no that's too long, I can't manage that", and then you having to spend the first five minutes of the interview convincing him to stay. Just say you'll be chatting *for a while*. Once the patient has got to like you, he'll be happy to stay as long as you like.

Ask the patient what he prefers to be called, or alternatively call the patient only by his honorific and surname. Some examiners do not like the modern trend of referring to everyone by his or her first name.

Thank him one more time (if it's not over the top to do so) and get going.

The patient who wants to leave

In the event of a patient walkout prior to 20 minutes the examination will be invalidated and a new patient will be found. If a patient walkout occurs after 20 minutes you will be examined on that clinical interview. The examiners will only intervene in exceptional circumstances.

The college CD-ROM includes a segment where a patient wants to terminate early. In that scene the candidate goes to extraordinary lengths to salvage the interview. Again you should emulate that. If you can get the patient to stay for at least 20 minutes that will be better for everyone involved. Remember that since every patient is the perfect patient it would be a shame to let this perfect patient slip through your fingers.

Ultimately there is a judgement call here. But if you can demonstrate that you can handle this difficult situation well right at the top of the interview that must be a significant advantage for you. Do not lie to the patient to keep them there. Don't tell him this is for his benefit for example.

If the patient leaves, the patient leaves. Think about how you'll respond to this. If you are given any sort of opportunity to choose whether to go with the current patient or not, say for example, if the patient left right on 20 minutes, always go with the current patient. That is better for the examiners, they won't get put behind. And whatever is good for the examiners is good for you.

Avoid letting the interview get to a stage where the examiners feel they must intervene. Try to handle the whole incident without looking to the examiners for any input except perhaps a final OK if you decide on early termination.

Some patients will want to go to the toilet at some point in the interview. If this occurs, ask the patient if they could hold on, but if not, graciously allow it. There is an unofficial policy, that if a patient is out of the interview room for more than five minutes, the interview will be considered ended. As this is unofficial, do not expect it to be adhered to and just go with whatever happens.

Occasionally something else will get in the way of the interview. A couple of exams ago there was a bomb threat at Westmead, mid-exam and the exam rooms needed to be evacuated. If this happens you will likely be asked to take up the interview where you left off.

Remember that what ever happens … "you thought that might happen".

The patient you want to leave

Almost the same, as the patient who wants to leave, but slightly more difficult, is the patient who doesn't express any desire to leave, but is considerably threatening or overwhelmingly offensive. I should stress at the outset that this is an extremely unlikely scenario, but, be prepared.

Again it is a judgement call, but, I think it is fair to say that if you feel are at genuine risk, or feel one of the examiners is, you will not be penalised and will probably be rewarded for terminating the interview. You should probably do this with a look to the examiners to seek their endorsement.

Taking the history

You will be observed … during a 50-minute psychiatric interview with the patient. … You need only bring writing materials to the examination.

This is something that you do everyday. You should be really good at it already. There are though a few fairly common mistakes that I'll go through below and there are a few things about the interview that will differ from what you do everyday.

Getting to know you

Begin the interview with demographic data in the same way as you usually do.

A surprising number of people gather living status data with the question, "are you married or single". This question is likely to make a number of patients immediately uncomfortable. Some patients are gay and will now be forced to explain this to you immediately; with you having made an implicit assumption that heterosexual is the social norm. Others will have

just had their relationship break-up and that will have contributed to their being in a situation where you are interviewing them.

I usually ask the patient, where she lives and who is there with her. I then try to clarify her relationship with that person.

Some people suggest that you should ask the patient what diagnosis they have been given or what medications they are taking at the top of the history so that you can a sense of what their problem is. I would advise *against* this though for three reasons. First, in my experience it violates the prime directive. Second, I don't really trust the unknown registrar who put this patient with a borderline personality disorder on an antipsychotic. I figure that I'm probably a better diagnostician than he is, so I don't want him misleading me. Third those questions seem unnaturally placed to me and they tend to get in the way of rapport. This is especially so if, right at the top of the interview you are asking the patient to list of six to ten different medications that they happen to be taking and that they can't remember all of.

If the patient is on a Disability Support Pension (or the New Zealand equivalent), I do not think that it is unreasonable to ask him what disability it is that he receives the pension for. Just don't assume that this is an accurate rending of his diagnosis.

You should also ask, about now, whether the patient is currently an in- or outpatient. (Not a question you need to ask in any other circumstances, so one you need to consciously attend to).

Timing again

One big difference between this interview and your normal interview is that, in this interview you have 50 minutes and not a moment more. That is not a huge amount of time.

Many candidates, perhaps because they are being observed – another difference – seem extremely reluctant to hurry the patient along or to nail them on particular points.

As a general principle certainly you should allow the patient to tell her own story as much as possible. This is particularly important at the top of the interview, because to intervene too early in the direction of the interview, risks you missing some extremely important element that may not have otherwise come out. However by about 10 minutes into the interview you really should have a reasonable idea what you're dealing with. Certainly by 15 minutes you should be fairly clear. If you're not, you really do need now to start pinning the patient down on stuff. This may mean some fairly directive questioning.

While taking the HPI you should be estimating how many other areas you are likely to need to cover in this interview. If for example the patient will need a full substance dependence history or a full cognitive exam or a brief physical exam or all three then you will have proportionally less time remaining to get the rest of the history. Every patient is the perfect patient, but some are less perfect than others.

Required inquiries if patient has alcohol dependence

Intake and style
- amount (in grams)
- time of first drink of the day
- drinks alone
- salience of repertoire

Withdrawal and intoxication
- blackouts
- morning tremulousness
- "eye opener"
- fits
- delirium tremens (& hallucinations)

Medical sequalae
- head injury and other accidents
- pneumonia, ulcers and GI bleeds, liver, pancreas, neuropathy
- during pregnancy

Social sequalae
- arguments over stopping
- relationship break-ups
- work - lost a job or starved of promotion

Forensic sequelae
- DUI, other charges (or warnings)

Attempts at giving up
- seen as a problem?
- longest dry spell
- agencies used - counsellors, Alcoholics Anonymous (> 1 chapter)
- detoxification
- anticraving or other medications

Other substances or gambling

All this said; do not allow the examiners to think that you are interrogating the patient. Occasionally candidates give the impression that they have an agenda and that the role of the patient is simply to further that agenda. Ironically this situation describes the reality of the exam to a tea, however it is very difficult to watch that sort of interview, don't let yourself be seen like that.

Empathy

Because you're nervous, your empathy radar may not be as finally attuned as it usually is. Be aware of this and try to avoid having the examiners see you appear to miss or not care about something that clearly, though perhaps subtly, upsets the patient.

Time is short, but not so short that you should stomp over or bypass something that the patient holds as really important.

Active listening etc

It's a bit clunky, but when you think about it, it won't be enough for the examiner to justify her mark for your data gathering process, simply by saying "I like the way she interviewed". She will almost certainly make reference to your use of various interview techniques. Make sure you give the examiner plenty of examples to refer to. Have a good balance of open and closed ended questions. Summarise back to the patient intermittently. Make it clear to the patient that you know what they are talking about, or that you don't and ask for clarification.

It just turns out that these techniques are, generally speaking, good interview practices even without consideration of the exam, so be aware of incorporating them in your day to day work.

Getting the HPI and using jump-outs

By the end of the interview you must either, have a clear idea of the patient's history of the present illness or you must have clearly demonstrated to the examiners that no one in your position could have formed a clear idea of the patient's history of the present illness. One of those two things must have happened.

Not all patients are fabulous historians. It is very common to see a candidate that is clearly so conscious of his time slipping away that, even though he does not yet really know why the patient is in hospital or when all of this really started, he has made a decision to plow on, presumably because he feels that if he doesn't he won't get to ask the patient about her family history or schooling or something. The only excuse for not having a good idea of the patients HPI, is that it is clear that it was not going to be possible to get that idea in this interview; and when I say "clear" here, I mean that it must be clear *to the examiner*.

Remember that the examiner will be sitting there thinking that if she were you, she'd be asking question A. She'll also think that if you had asked question A then it is likely that the whole history would have fallen out easily. (See how easy it is to think like this when you are practicing being an examiner). Unfortunately it is not possible for you to read the examiner's mind and to discover the exact wording of the magical question A. It is possible though to signify to the examiner that you know that you have not got a crucial part of the HPI and you are doing all you can to get it. You can do this with a jump-out question.

A jump-out question is question that jumps out of the normal context of the interview. It explicitly informs the patient (and the examiner) of your difficulty and what you think needs to be addressed. It is easiest to explain what I mean with a couple of examples:

> Mrs Smith, can I just go back for a minute, because even though it's clear that there have been all sorts of problems, I'm still not sure exactly what it was that made you think you needed to come to hospital.
>
> Mr Brown, I got to tell you. I'm still a little confused. You see even though it's clear you've had all sorts of things happen to you, you said that you were on a psychiatry ward … and this is a psychiatry exam … but I haven't heard you complain of any psychiatry-type problems. Can you make sense of this for me?

If you still can't get a sensible recounting of the history when you've prodded the patient like this once or twice, I think you have demonstrated to the examiner that you really have done your best and that your best would have been (nearly) as good as her best.

Phenomenology

Examiners love phenomenology. On busy admission wards people tend to gloss over phenomenology a little. Try to avoid doing that in your day-to-day work, but certainly don't do it in the exam. Nut out all bits of phenomenology carefully, so that you are clear exactly what the patient is describing. If, for example, the patient says they have panic attacks, make sure that they really are panic attacks and not just periods of intense anxiety. If the patient describes auditory hallucinations, find out what they say, whether they must be obeyed, where they come from, how many there are and whether they are associated with delusional notions.

There is very little to study prior to the OCI, most pre-viva study should be directed to the OSCE's. Phenomenology is the exception to this rule. Spend quite a bit of time getting phenomenology really clear in your mind. Be well prepared to give very sophisticated answers to questions on things like what you meant by pseudohallucinations.

The diagnostic dilemma

At some point in some interviews with some patients it should become clear to you that you don't know what's going on and you're not going to know what's going on. Moreover you should back yourself in this situation and tell yourself that it's OK that you don't know what's going on, because in your situation no one would know. At this point, which might arise at about 20 minutes you make the decision that this patient has become *a diagnostic dilemma*.

Diagnostic dilemmas are not unusual in the exam. After all the exam is odd in that you don't have any corroborative history, and you've no past notes to go on. Because of these limitations, diagnostic dilemmas will be much more common in the exam than thay are in real life. You should not be afraid to play the diagnostic dilemma card, but once played you've got to run with it because it will change the way you run the rest of the viva.

You should also remember that the examiners know no more of the patient then you do. As long as the examiners can see you made the best attempt you could to discover the diagnosis, they'll be happy with the diagnostic dilemma call, because that is likely to be their call to. Note though they won't be do pleased if they feel you could have cleared it up with just a few more questions.

Personality

An extraordinary number of candidates do not ask patients anything about personality. All patients should be asked about personality. What sort of person would you say you are? How would others describe you? What do you do when you're angry? What do you do when you're sad?

By the time you get to ask about personality you should also have some hypotheses about the patient's personality type, so that you can ask specific questions to test these hypotheses. Are you the sort of person who has a place for everything and everything in its place? Do you feel that people don't really understand you? Some people have no friends because they don't really like or understand people and don't want to, others would like to have friends, but they always find that people let them down or that there are misunderstandings; which are you? It sounds like people are often out to get you, is that how you feel?

Personality is not an easy thing to gauge. The move to examine candidates earlier in their career has put extra strain on your ability to get this under your belt early. It is hard, but not impossible. You should be making personality enquiries and judgements on every patient that you see in your day to day work from at least your second year.

Danger

It almost goes without saying, but … don't let the examiner think that you would risk anyone's life by not inquiring into something. Suicidality is obvious, but don't forget to ask about the safety of children, say, or the persecuting neighbours, or where he keeps the gun that he likes to go shooting with, if any of these are relevant. (See unforgivable gaps below).

I am generally opposed to the ubiquitous grids that find there way into the candidate's armamentarium prior to the exams. To my way of thinking these grids often serve to restrict a candidate's thinking, making them sound formulaic and they are therefore against the Prime Directive. Grids are not all bad though, particularly if they are used to map a landscape rather than create one. The Kingdom of Risk needs careful mapping, and the grid below is our attempt to make sure that all of it is covered. If you use it, do so to double check you've gathered all the relevant data. Don't use it for more than it is good for.

Risk		Past	Present	Future
To & from self	Active			
	Passive			
	Treatment			
To & from family	Active			
	Passive			
	Dom.Viol			
To & from others				

For example a young mother with a major depression, presenting after a motor vehicle accident, who has previously attempted to hang herself and who is now on tricyclic antidepressants may result in a grid like this.

Risk		Past	Present	Future
To & from self	Active	Hanging	MVA	
	Passive			
	Treatment			OD of TCAs
To & from family	Active		No thoughts of harm to children	
	Passive	Some emotional neglect		Where are kids going to stay?
	Dom.Viol			
To & from others			MVA	

The disorganised history and the safety net

Generally speaking we all gather histories in exactly the same way in exactly the same order. The main reason we do this, is because history gathering, while not especially difficult does involve a large number of areas of enquiry, and by asking after each of these in a well practiced order, we are far less likely to forget something or other.

Unfortunately not all patients are open to the idea of you collecting your history by your established order and usually by dint of their own disorganisation, force you to collect the history in a disorganised manner. This deviation from your usual script is often unavoidable, but makes it far more likely that you'll forget something. In the real world, this doesn't matter too much. Typically you'll notice the omission as you as sit down to write up the case and need simply to return to the patient to discover the missing piece. Sadly the exam doesn't work like that. There is no returning for a second bite at the cherry.

As a consequence of this you should learn to recognise when an interview is unavoidably disorganised and then to utilise a deliberate cognitive safety net to ensure that nothing vital is missed. The nature of the safety net will depend on you and your experience with practice vivas, but it is likely that having noticed that the history is disorganised, you will need to ask yourself, at the very least, "Have I asked about suicide, drug and alcohol and psychotic phenomena (if appropriate)".

Is there anything else I should know?

This is always a good question and will occasionally elicit a response like, "Um, I haven't told you about the time I stabbed myself in the stomach, is that the sort of thing you mean?" Some candidates though ask this question right at the end of the interview. While this might be the most natural time to ask that question, you really don't want to discover some crucial piece of information with only seconds of the viva to go. In fact at that point it would have been better to have remained ignorant, especially when you consider that the examiners too would have been none the wiser. Look to ask this question at about 40 minutes, perhaps before the cognitive testing.

Mental state exam as you go

If at all possible try to write large sections of your mental state examination as you're taking the history. You should be able to make reasonable notes on appearance, behaviour, affect, speech, thought form and content, perceptual abnormalities and insight. Make sure you write down *verbatim* quotes to give as examples of formal thought disorder.

This will save you a considerable amount of time during your thinking time that you'll be able to invest in formulation and management.

It is actually quite easy to do in most interviews, but if you've not done it before, you should practice it now in all the interviews you do. Note too that to do this you'll need to have some ability to easily flick from the page you're taking your history on, to your mental state page.

The brilliant idea scratch pad

It is very common at the end of a practice OCI for me to ask a candidate about whether they had considered some more obscure aspect of the case, which they had not commented in the presentation, and then to hear from the candidate that they had momentarily thought about that aspect, but that they had simply forgotten about it as the interview went on.

The sorts of things I'm talking about here are those things that interesting about this patient but are a bit off the headline concerns. For example it might be that there is an interesting psychodynamic point to be made, or that the patient suffers from such and such an illness which might lead to some unusual complication, or that the patient is from some cultural group where aspect X of the history is extremely relevant. These off-the-main-road highlights are often what make a case really interesting, but they can hardly be seen as part of the main game so they are often forgotten in the heat of battle.

The "brilliant idea scratch pad" is a little section of your notes, perhaps on the same page that you use to scrawl down some mental state, that you can use to write a word or two that will lead you back to this off-road highlight later in the interview or during your twenty minutes thinking time.

Cognitive testing

There will be very few patients in the exam that should not get at least basic cognitive testing. The patient was brought to the room by a bulldog. There is really no way of you knowing, for example, that the patient is orientated to time and place without you explicitly asking those questions.

A surprising number of candidates use the Folstien MMSE as their stock way of testing cognition; this despite well-documented serious problems with the Folstien. The Folstein is great for interns and RMOs chiefly because it comes in sticker form so that at least they'll do some sort of cognitive exam. I do not think that it is adequate for a psychiatrist. Serial 7's is a bad test of concentration heavily dependent on educational level. Spell WORLD backwards, similarly depends on the patients cultural and linguist background and is impeded by certain specific learning difficulties. Before the exam devise your own simple cognitive battery and be proficient at delivering it.

A detailed look at cognitive testing is beyond the scope of this booklet, but I have reproduced my basic cognitive screen below. I would pretty much do this on everyone. You'll note that it is much faster than the Folstein, and many examiners get justifiably irritable watching a candidate religiously ask the patient what city and season they are in, when there is very little doubt that the patient will have no cognitive deficit.

Basic cognitive testing
Orientation
- Time: day/date/month/year
- Place: name of this place/type of place

Immediate recall: recall of 5 objects

Concentration: Digit span

Construction: Clock face

General knowledge: Prime minister

Current events

Short term memory: recall of 5 objects

Box 2 – Basic cognitive testing

I am not suggesting, by the way, that this is the best way to preform basic cognitive testing, but by the time of the exam you should have your own battery that you are familiar with and that you can justify the use of. You should also have a personalised *extended* cognitive battery that you'll use if there is any suggestion that the patient may have significant cognitive impairment. Again I've reproduced mine below.

Note that you should have brought a paragraph of written material into the exam, that you can ask the patient to read. Illiteracy is very common, is a very important finding and patients will not reveal that they are illiterate spontaneously.

Extended cognitive testing
Basic testing plus

Parietal
- Three stage command
- Written command eg 'Please close your eyes'
- Apraxia
- Confrontation naming

Complex parietal
- Intersecting pentagons
- Paper reconstruction
- Clock drawing test
- Bisect a line

Frontal
- Trail making B (lateral convex)
- Luria's fist-palm-side (lateral convex)
- Alternating sets (orbitobasal)
- verbal fluency (medial)
- palmomental, grasp, pout, snout

Write a sentence

Read

Box 3 – Advanced cognitive testing

Do not ask patients what they had for breakfast as a way of testing longer term memory, unless by some quirk you happen to know the answer. Do not think that knowing the dates of World War II somehow tests long term memory, at least any more than any other general knowledge question.

There is very little justification for asking about proverbs. Contrary to popular opinion, proverbs do not test a person's ability to abstract, but rather a person's knowledge and memory of the culture of the person who is asking about the meaning of the proverb. It is not possible to abstract out the meanings of most proverbs – people simply remember their meanings. If you doubt this, try this quick quiz.

What is the meaning of the following popular Hawaiian proverb?

> *A fisherman of the shallow sea uses only a short line; a fisherman of the deep sea has a long line.*
>
> *(He lawai`a no ke kai papa`u, he pôkole ke aho; he lawai`a no ke kai hohonu he loa ke aho).*

Go on, you've got functioning frontal lobes. What does that mean? The answer is over the page.

I am reliably informed that is means something like “a person who has little knowledge of an area has few resources, while a person who’s knowledge is great, is wealthy”.

I am similarly underwhelmed by questions purporting to test abstraction by inquiries about the similarities between ice and water and oranges and lemons, though I do think that a question asking what a poem and statue have in common is more likely to yield a useful result.

Physical examination

The only physical examination expected is that which can be done in a consulting room, with no equipment and no disrobing of the patient, to look for overt physical signs which may significantly influence management. Examples would include examining for evidence of tardive dyskinesia, extrapyramidal side effects, or primitive reflexes.

Don’t forget this. Pretty much anyone on antipsychotics should get at least a modified AIMS examination. So do that. Moreover make it look like you’ve done it a million times (which by the way you should have). You should also think about the other sorts of patients that you might meet that will require a physical examination. For example Parkinson’s, anorexia nervosa and even conversion disorder occur not infrequently in exams and each require their own special brief physical exams.

When you do conduct an exam, do it flawlessly, within the limits of no equipment and no disrobing. Leave yourself adequate time to do it well. Do not get into the position of being seen to chaotically flail the patient’s arms around as a substitute for an upper limb neuro exam or prissily caress the patients Adam’s apple in some bizarre parody of a thyroid exam.

Example areas to consider in the physical exam

General apppearance
- colour (anaemia; jaundice)
- hand examination (nicotine-stained; nail biting clubbing; tremor etc)

Cardiac
- pulse (palpitations; increased heart rate)
- oedema (indicating fluid overload / collection)
- JVP

Endocrine
- Thyroid size or thyroid scar

Neurological
- Tremor
- Gait
- Evaluation for extrapyramidal signs
- Primitive reflexes

Superficial physical exam in anorexia nervosa

Height and weight and calculated BMI
"I'd like to check for the patient's blood pressure and for a postural drop. I'd also like to check for hypothermia"
Cardiac
- acrocyanosis
- bradycardia

Gastrointestinal tract
- dental changes
- petechiae on soft palate

Haematological
- anaemia

Dermatological
- dry & scaly skin
- Russell's sign
- carotinaemia
- lanugo

Box 1 -

Colour and movement

It is quite easy in the exam to become so focused that your interview style looses its usual warmth and colour. This is particularly a risk with depressed patients where candidates appropriately mirror the patients restricted affect, but then fail to escape this empathy trap for the rest of the interview so that they also lose any prosody or spontaneous movement. Obviously a good interview should largely mirror the patient's emotional state, but not so much so that the interviewer is unable to lighten the tone to provide reassurance or to test reactivity.

Finishing up

You are expected to terminate the interview appropriately. At that time you will stay in the room and the examiners and patient will leave.

Much of what applies at the opening, applies at the closing too. Your termination will be the last thing the examiners will see before they adjourn and begin to think properly about how you've gone. It is also stressed in the marking guidelines for "data gathering – process".

Also, like the opening, it is usually completely predictable. Make sure you know exactly when you're about to run out time. Make sure the examiners know you know so they won't begin to get anxious for you. Somewhere toward the end warn the patient that there are only a few minutes to go.

Try not to squeeze the interview up against the knock at the door. Certainly do not get to the stage where the examiners are ending the interview for you. Amazingly most candidates seem to time their interview perfectly for a fifty-*one* minute slot. It is as if there is some hope of squeezing just one more minute out of the patient and it is this last minute that will make all the difference! Don't do this. Finish at 50! Going on will just upset the examiners (really upset some) and eat into your twenty minute thinking time.

In the final moments, ask the patient if there is anything they wish to add. (There shouldn't be, you've already asked this question 10 minutes before). Thank her again for her time, get up, extend your hand, open the door and thank the examiners (though do this only briefly). Practice all of this over and over again so you've got it right. You must be in control of getting the patient out of the room.

Thinking time

Following the interview (or after 50 minutes from the commencement of the interview if there has been premature termination) you will have 20 minutes thinking time.

You should have fairly good idea of how you're going to divide your time in the tasks of the thinking time. Most people spend too much time on getting the presentation of the history right and then have left insufficient time to think about management. Exactly how much time you allocate to each task depends on the way you work, but you should not scrimp on your preparation of the formulation. Make sure you leave at least 5 minutes for consideration of management, though I'd have thought it better to leave 7 or 8 minutes really. If you've written a mental state as you go, you'll need less time to write that up.

Do not assume that you'll get your full 20 minutes and have a plan for what you'll do if they interrupt you early. This plan will consist of you saying "No that's fine. I'm more or less ready. Perhaps though you could let the examiners know that I only had *10* minutes of my thinking time!" Chances are that if there is any variation to your thinking time, it'll be the other way and you'll get more than you bargained for.

While you're writing, think about what questions your presentation is likely to inspire. Think about the definitions of the mental state terms you use. Think how you'll justify these diagnoses. Think about the evidence base for the interventions you're recommending.

The presentation

The examiners will return to the room when your thinking time is up. You will then be invited to present a succinct summary of the salient features of the case, an assessment of gaps in the history and the need for other essential information, a formulation, your diagnosis and differential diagnosis. You should accomplish this summary in 7 minutes or less. The examiners will tell you when you reach the 7-minute mark, if you are still presenting. They should say *"You have had seven minutes". Should this occur it is recommended you attempt to complete your presentation within 30 seconds. Significant time overruns will be penalised.*

Overview

This is it. Any idiot can take a history, but presenting a patient takes skill. This is where you first show the examiners that you're better than the average candidate.

At the end of this seven minute period the examiners should pretty much (almost consciously) have decided you've passed. The remaining 23 minutes or so will only be a formality. Even leaving aside the reality of human interactions, the marking guidelines themselves heavily weight this section. Data gathering content makes up 20% of the mark and data synthesis 30%. Some of the content will have been contributed to by the history

but it will be consolidated here. All of the data synthesis is presented and if one adds in, say, half the 20% of global rating for the presentation, your looking at about 50% of your marks right here.

Once again you are in total control, which is just the way you like it.

Second first impressions

Just as the first 60 seconds of the history gathering component were important, so are they here. It is like the exam has now started again. (In fact it's a lot like that, since the exam has now started again!). You are not coming off a blank slate, by any means, but this is the first time you'll have a real interaction with the examiners, and that is quite powerful. Even if you looked very good in interviewing the patient, if you look hesitant and like a person who thinks they should not pass here, especially in the first few minutes, the examiners are liable to question their original assumption that you'd pass. Fortunately, if you just keep looking good, that will confirm their bias that you're going through, and after that by the time you're on to management you'll need to be suggesting unmodified ECT before they'll start questioning their passing assumption a second time.

Timing for a change

The message we are trying to get out there is this: 'exceed the seven minutes at your own peril'.

Quoted from the OCI Examiners Training Session

Your presentation must end at seven minutes, and not a moment longer. (Well you might have 20 seconds longer but that is literally all). If you are not finished (or are not only seconds from finishing) at seven minutes, your examiners will interrupt you with "You have had seven minutes". Examiners hate interrupting like that. It makes them uncomfortable. Don't make 'em do it.

If you do get the seven minute call, you *must* finish your presentation within 30 seconds, and that will probably put you off your stride. For every moment you go past 7 minutes 30, the more and more anxious the examiners will get. They will know that the viva is beginning to spin out of control. They hate that feeling. It will be very difficult for you to pass if your presentation runs significantly overtime. Do not allow this to happen. I cannot stress this enough.

Exactly how you divide your seven minutes will depend on the particular patient but a rough schema will look like this:

1. Summary of the salient features of the history – 90-120 seconds
2. Mental state examination – 120-150 seconds depending on whether the patient needed detailed cognitive testing.
3. Formulation – 60 seconds
4. Gaps in the history – 30 seconds
5. Diagnosis and differential diagnosis – 60 seconds

An interesting conversation

As much as possible, you should see this presentation and the rest of the viva from here, not so much as you presenting and then being questioned, as you having a conversation with colleagues. Sure, they are older and wiser colleagues and sure, it's a rather one-sided conversation, but that nonetheless is what it is.

As much as possible, try to adopt a conversational tone. Don't let this approach sound casual at all. In fact be careful to remain exacting and precise, but also try to make it sound like you're chatting to your examiners as if you were one of them, because that, after all, is what you are trying to convince them you are.

Also make some effort to bring out the interesting features of this patient. All patients are interesting, and your's will not be an exception. The examiners are tired. They may have seen four other candidates today and possibly four others yesterday. Nonetheless communicate to them how interesting your patient was and make them want to listen to you.

You do not make something sound interesting by telling your audience that "this is interesting" any more than you make a joke amusing by saying "this is funny". You hold people's interest not only by making the content interesting but also by maintaining good eye contact, and by modulating your voice to exaggerate your normal changes in prosody, tone and volume. (Watch television presenters to get an idea of how to do this).

This is quite hard to do, especially as it is likely that your examiners will be making copious notes as you talk, and will try to modulate their own expressions so that they remain fairly blank and examinerish. Ignore this, and make as much eye contact as you can, trying to share it between the examiners. If there is an observer in the room, ignore her.

Opening gambits

Many candidates begin their presentation with a statement like this, "This case exemplifies a fascinating example of the need to diagnose and manage a patient with a treatment resistant schizophrenia".

I do not like these rather tedious opening gambits for a number of reasons. First they are tedious. They are very common - for a while there almost every candidate would tell me about how fascinating their patient was – so they do nothing to separate you from the field. Second they seem to go contrary to the Prime Directive. Third they take up valuable seconds of your presentation time. Fourth, and easily most importantly, they have the potential to put you at odds with your examiners within seconds of you opening your presentation. After all, if the examiners had decided that this patient had a treatment resistant *psychotic depression*, then by saying that the patient has schizophrenia, the first thing you've said to them is effectively "I've got the diagnosis wrong". If the examiners and you are destined to disagree on the diagnosis, at least give yourself the chance to lay out your case for your diagnosis first.

Another, less common, opening gambit is, "My history was hampered by the fact that Mrs Flanders was an extremely difficult historian". Again I don't like this. First it sounds like you're opening with an excuse. Second, it is possible that the examiners don't agree, they may simply think that you are a bad history taker. If they do think that she was a poor historian, there is no need to remind them of this, they were feeling sorry for you before you began to present.

My feeling is that generally speaking it is best to avoid the opening gambit altogether and a simply get into the history. There are only two exceptions to this. The first is when you've been left with an ugly gap (see gaps below). The second is when there is a very strong reason to believe that the history that the patient provided you is going to be inaccurate.

A patient with, say, Korsakoff's or dementia or delirium, is not going to be able to provide you with an accurate history. It seems reasonable to say before you begin that you recognise this and that although you'll relate the history as revealed to you, it may not be accurate. You may even want to start with a brief recognition of the limitations of the exam process with this sort of patient. In clinical practice after all, you'd likely not have spoken to this patient at all until you'd got a corroborative history, and if you'd starting speaking to them, you'd likely have broken off the interview early to seek corroboration. Patients like this will always be of the diagnostic dilemma type, and this opening gambit will be part of a recurring theme reflecting this.

Patients with suspected factitious disorder may also warrant a similar opening gambit but for slightly different reasons.

A succinct summary of the salient features of the case

This is the section of the presentation that causes the most heartache and that most candidates spend too much time on. The examiners are *not* after a summary of all the information that you and they just heard delivered. They are not dementing (probably). They can remember what happened 20 minutes ago. They were there. They know what the patient said, and they don't need to hear it again. What they don't know, and what they do want to know is, what did you think were the *salient features* of the history. What was most important?

This is quite different from the old long case, where you were expected to summarise everything you'd heard. The examiners were interested in that then because they had not been there. Things are different now.

Like the formulation, which I'll discuss below, there is no foolproof formulaic way to do the salient features, but here are two different structures which you can build upon as a basis You could use either or possibly take the best bits from both. Both have been used successfully by different candidates.

Just the salient features ma'am …

This is my favourite of the two as it has the clear advantage of giving the examiners exactly what the College has asked for. It is also inevitably shorter than the approach below and that allows more time for the rest of the presentation. It does though require a fairly high degree of confidence on the part of the candidate that they have understood the patient. As should be clear by now, I feel that you should have that confidence by the time you're sitting this exam, but I can understand the feelings of a candidate with a fair degree of confidence who still feels that they might take the somewhat more pedestrian but safer route of the eleven sentence method below.

Under the salient features schema, all you do is present the examiners with a list of the most salient features of this case. You need to be confident in your understanding of the case, because it is almost impossible to say in advance what the most salient features of any case will be, you'll just have to make 'em up as you go.

Obviously, the fact that the patient damn near killed herself prior to admission is salient, especially if they remain suicidal. It is very likely that the patient's social situation will be salient, assuming it provides support, or perhaps affords no or little protection. Really striking relevant negatives will be salient, but most relevant negatives won't be. Some phenomenological or symptomological elements will be salient, but they may not deserve much of your precious time. It is unlikely that some aspect of the patient's personality won't be salient. Beyond these quick hints, the nature of this patient's salient features will only become apparent, upon seeing this patient.

Another advantage (but also disadvantage) of this schema is that it will set you apart from the crowd (or at least it will unless everybody reads this little booklet and takes it up). But because it is new and different (and noyce), I'd suggest you preface it a little by the following spiel just to let the examiner know where you are coming from. (If everybody begins to present this way, the spiel will no longer be necessary).

> Rather then summarise the history which we all just heard, I am simply going to present what I regard as the most salient features of Mr Smithers case.

After this orientating statement you may then go onto provide these salient features in a list in order of saliency, though I suspect it would be sensible to start with demographics, assuming they are salient.

Its hard to be much more specific about this, but by way of any help I can give, I've reproduced below an example salient features about a patient who presented with a post-ictal psychosis. It also includes a cognitive impairment opening gambit:

> Before I begin it is worth saying that I recognise that there are reasons to doubt the veracity of some of the aspects of Ms Watt's history, owing chiefly to her significant cognitive deficits. I'll detail those deficits when I present her mental state findings.
>
> I saw Ms Lisa Watt, a 26 year old single mother and TAFE student who lives with her parents and three year old son.
>
> Rather than summarise the history we have just heard, I will outline what I feel are the *most salient features* of her history.
>
> Firstly there are the persecutory delusions which seem to have been vague and seem also to have disappeared almost as quickly as they arose. Even now though some vague persecutory ideation seems to persist.
>
> Secondly, there is the fact that the delusions resulted in her attempting to strangle her tutor, an act that she seems to have little remorse about, at least at this interview.
>
> Thirdly there is the poorly controlled epilepsy and a run of seizures that seem temporally related to the onset of the psychosis.
>
> Her compliance with therapy is notably poor.
>
> She has a history of opioid dependence and current cannabis use.
>
> She is a lady who had a very difficult and tumultuous childhood and adolescence, at one stage living on the streets. Though she has recently

been succeeding at TAFE apparently, it seems that she has previously had difficulty maintaining relationships, has been impulsive, committed acts of self harm and been uncertain of her course in life.

Finally her three year old son is an obvious important factor that will need careful consideration in any management approach.

Yes, well I'm not pretending that it's brilliant, but it give you a feel of what I mean. Note too how quickly you can say that. I can do it in one minute thirty, including the opening gambit.

The eleven sentence road to success

This approach is I think quite a bit safer than the one above, though not nearly so interesting, nor separating from the crowd. It also has the potential to run long unless you really practice it.

It involves reducing the history to a series of *one* sentence statements each addressing the areas below:

1. **Demographics**
2. **The type and duration of symptoms that the patient presented with.**
3. **A succinct list of other symptoms.** One hint for this sentence, and the one above, that is sometimes useful, especially in more complicated cases is to present symptoms in "symptom clusters". "Ms Flanders presents with a number of depressive symptoms, pervasively low mood, many of the biological features of depression and suicidal ideation. She also presents a range of somatic features, including low back pain, facial pain and frequent diarrhoea and abdominal bloating".
4. **Relevant negatives.** Only include these if they are really important as well as relevant. For example in a patient with clear panic disorder, "interestingly there is not history suggestive of agoraphobia".
5. **Risk issues**
6. **Role functioning**
7. **Current treatment**
8. **Past psychiatric history.**
9. **Drug and alcohol history.** Only include if relevant to presentation, otherwise omit.
10. **Medical history.** Only include if relevant to presentation, otherwise omit.
11. **Personality.** This is (almost) always salient.

Using this you'll have a maximum of eleven sentences. Even if some of the sentences are longish, you'll be hard put to speak for more than a minute thirty.

Needless to say there is considerable overlap between the "just the salient features" and th the "eleven sentence" approach. You may want to be in the position, on the day of the exam, where you could use either, or a hybrid of both.

The salient features section of the exam is quite hard to do and is again not necessarily something you do everyday. Normally your consultant won't have sat in while you assessed a patient on the wards so you'll usually deliver a longer summary. As you approach the exam, ask your consultant to indulge you an extra 60 seconds each time you present a patient to allow you to do a salient features bit on each patient. Tape yourself in the practice vivas. Hear what you say. Hear how long it takes. After each practice go back and revise your salient features section and work out how it could have been better (and usually shorter).

Miscellany

Use generic names, not trade names, whenever you mention a drug.

Don't let the examiner think that you take everything the patient says as gospel. If there is reason to doubt the patient's account of some aspect of the history (for example that he was innocent of the crime for which he was convicted, but was framed by the police), then preface your relating of that aspect with something that clearly signifies that you have not necessarily bought this what's been said. For example, "Mr Snake *claimed* that …"

Mental state

As difficult as the salient features bit is to get right, it is hard to really shine in its presentation – particularly if go for the safer eleven sentences approach. Your revelation of the mental state is your first chance to guarantee separating yourself from the field, so don't make it ordinary.

Appearance and behaviour

Describe the patient's appearance in as much detail as possible, so as to create a picture of the patient for the examiners as if they had never seen her. It is quite difficult to overdo this section and most people will run out of things to say before the person listening gets bored.

Include things like:

- state of health
- general cleanliness
- hair colour and style
- cosmetics
- tattoos - describe one or two in detail
- dress
- intravenous lines, ECG monitors etc

Avoid using stock phrases like “man of stated age” and "appropriately dressed". What is the appropriate dress, when one is a psychiatric patient in a viva?

Similarly describe the patient’s behaviour in detail. All patients offer an opportunity to comment on at least:

- posture - sitting, standing, open, closed
- eye-contact
- gesticulation
- whether the patient got up during the interview and how they behaved then

Thought form and content

Whenever you mention an abnormality of a formal thought, give a verbatim example of what you mean.

Generally speaking you will have mentioned abnormalities of content in the salient features section. In that section you should simply describe what the patient said, here you may give them their proper name. “He described well formed complex persecutory delusions as I outlined a moment ago”. Avoid the word “paranoid”, unless you want to give a discourse during the question session on what you meant and has been meant historically by this particularly interesting but complicated term.

Cognitive testing

When describing the results of cognitive tests that required the patient to write something down on paper (eg a clock face or the trail making B), pass the patient’s efforts to examiners as you describe it to them.

> As you can see, *(leaning over to show the examiner the paper)* the patient began the task well, but soon demonstrated an inability to change set, tracing only from letter to letter. When I asked him how he thought he’d done, he was unable to register his error.

Use one piece of paper per test. Don’t squash all your tests into the corners of a single sheet.

If you use the Folstien, do not just give a score out of thirty, unless the score is 30 and therefore you have nothing to report.

Insight and judgement

Do not describe the patient’s insight as “good” or “poor” and leave it at that. Describe the patient’s insight with respect to their insight into their phenomenology, their understanding that they are unwell and what illness they have, and their understanding and acceptance of treatment. All of these three elements may be disrupted independently.

I always find comments about the patient’s “judgement” problematic. The comment that the patient’s judgement was good, seems to equate roughly to “the patient agreed with me”. Before you make a comment on judgement, if you make any comment at all, make sure you can justify what you’re going to say.

Formulation

This should be the highlight of the exam. After an impressive mental state, this is the moment that you show your examiner that you are definitively hot.

The formulation is not a summary, so do not begin its presentation with the phrase “In summary …”. Find some other phrase. “This then, …” is my favourite.

A standard formulation

The formulation is a concise statement of how this patient got to be in this predicament at this time. There are no real short cuts on how to write it, and one of the reasons you’ll be paid so much when you get through this exam is that you can do it while others can’t. Having said that though, the schema below is not a bad place to start.

> This then, is a [age] year old [occupation] who presents after a [value-added presenting complaint]. That “represented the culmination of”/”was brought about by” an illness manifest by [features of the HPI]. This occurs in the context of [recent aetiological factors] and on the background of [more distant aetiological factors].
>
> It occurs in a [sex] with [description of the salient features of the personality], related no doubt to [aetiological factors pertaining to the personality].
>
> Interestingly ... [This optional paragraph allows some opportunity to discuss relevant psychodynamic issues, or some other interesting feature that really can’t go without mention – perhaps something from the brilliant idea scratch pad].
>
> This illness has [impact of illness in terms of disability and handicap], but fortunately [patient's strengths].

A value-added presenting symptom is a condensed restatement of the presenting symptom that adds something in the re-stating. For example if the patient took a large but impulsive overdose of paracetamol, this could be described as "a suicide attempt of high lethality, but low intent".

"Recent aetiological factors" might include a recent stressor, or current medical illness. "More distant aetiological factors" might include a relevant past or family history.

Caveats

There are numerous cases where this little aide memoir will only ruin the formulation if you try to fit the patient procrusteanly into it. One example is the diagnostic dilemma, where you really don’t know what the illness is. Another is the incredibly complex patient where it is often better to fall back on a formulation that features a problem list.

Gaps in the history

There is a natural rhythm to your presentation that sees you warm up with the salient features, impress with a superior mental state and then knock ‘em dead with an exemplary formulation. By the time you get to the gaps and diagnoses it is all over bar the shouting. Some people put the gaps before the formulation but I think this breaks that rhythm., The gaps seem to me to come naturally after the formulation, and can be introduced with

something like, "There are number of things I still need to know…". After this you can on to delineate, probably no more than, three areas of history you'd like more information about.

The good, the bad and the ugly

There are three basic types of gap – good, bad and ugly.

Good gaps are those things that you don't know and no one could know in your circumstances. These are things that either could only come from sources outside the room (eg old notes or relatives) or things that the patient wasn't going to tell you despite your obvious best efforts. Ideally these are the only gaps that you'll need to mention. Slightly less good gaps are those things you could have discovered if you'd had more time. These won't be unusual, given that you've only got 50 minutes, but while examiners should see these as inevitable, they will tend to believe that if they had been doing the interview, they would have found the time.

Bad gaps are those things you don't know because you didn't ask. You can probably slip in one of these but it would better if you didn't.

An ugly gap is that that, not only did you not ask, but you can't believe you didn't ask it, you know for sure that the examiners will have seen it, and you think it quite likely they'll fail you for it. This is something like not asking the outpatient with homicidal ideation, who has told you that he likes recreational shooting, whether he still has access to his gun.

If you have scored yourself an ugly gap (and hopefully this will only ever happen in a practice viva), that gap doesn't belong here but as an opening gambit.

> "Before I begin, I just like to say that I realise I did not clarify with Mr Twiliger whether he had currently had access to his gun. Obviously this is an extremely serious oversight. I realised that I'd done that as soon as the patient left and under normal circumstances I would simply have followed the patient out to the waiting room and clarified that with them. Of course that is not possible in an exam.
>
> Anyway, now that I've got that off my chest …, Mr Twiliger is a 42 year old entertainer …"

Diagnosis and differential diagnoses

Diagnosis

All the crunchy goodness of your presentation is in the formulation. The diagnosis is really an after thought, the icing on the cake.

Do not begin by saying, "Using the DSM-IV-TR multiaxial diagnostic system …". As well as making you sound like a dork and definitely being contrary to the Prime Directive, you are practically inviting the examiner to ask you about the DSM-IV-TR criteria for whatever diagnosis you make. This then either looks bad, if you don't know them, or is really boring, and suggests you *are* a dork, if you do.

Generally speaking I'd use DSM-ish diagnoses, but don't give any guarantee that you've stuck with research criteria. Under no circumstances should you ever diagnosis anyone with some illness or other "not otherwise specified" This would make you the Dork King of Dork City.

Also you should not feel yourself locked into DSM. DSM doesn't cover everything and if you think that the patient would be best described as having a "simple schizophrenia", or a "cycloid psychosis" or a "paraphrenia" or even "old fashioned hysteria", then be prepared to make those diagnoses, but also be prepared to justify them and justify them hard.

Even though I'd not explicitly use the DSM axes, I would tend to talk of the patient's primary and comorbid diagnoses, her personality and then any relevant medical condition. Do not mention anything to do with axes IV or V. Even the original authors of DSM thought axes IV and V were stupid, they only put 'em in cause the people who were paying them made them. Both those axes should been covered in the formulation.

> "Diagnostically then, I feel Mr Harris has a major depression with melancholic features. I also think that he has long standing social phobia. With respect to his personality, obviously one should be cautious about drawing too much from one interview especially if the patient is depressed, but I think he has marked premorbid obsessional features, and medically there is his recently diagnosed prostatic cancer"

Do not forget to include additional substance diagnoses if they are there or a diagnosis of Pathological Gambling. Candidates often simply forget to mention these co-morbidities despite having carefully elucidated them.

Even in the diagnostic dilemma case you should plum for a provisional diagnosis, but you'll change your delivery a little …

> "Well, I've already said that I'm really not sure what the diagnosis is, but my provisional diagnosis, and it is very provisional, is a …".

In the diagnostic dilemma the differential diagnoses obviously take on more prominence.

Differential diagnoses

Only include those differentials that you really think have a chance of being right. In most cases there won't be more than about three, but in a diagnostic dilemma there may be more of course.

I don't think there is time in the new format to allow any real discussion of the differentials in the seven minutes, but if you're ahead of time you might consider doing that for the major differential.

Remember that sometimes a comorbid diagnosis is also a differential if it occurred on its own.

> "I've suggested that this lady has a major depression and borderline personality disorder, but of course it may be that her personality disorder could explain all her symptoms on its own".

Remember that delirium is a differential diagnosis of everything, so while you needn't always put it in, you should have a good reason for leaving it out.

A relevant organic disorder (eg Organic Mood Disorder) is also usually appropriate, but don't mention it without giving some mildly possible aetiological medical disorder. Avoid, for example saying in a depressed 17 year old, "An organic mood disorder due to say a brain tumour".

One examiner will then invite you to amplify on aspects of your presentation, and to justify any conclusions you may have made.

Questions from examiner 1

One examiner will then invite you to amplify on aspects of your presentation, and to justify any conclusions you may have made.

Well it had to happen. Having had total control of the viva for the first 77 minutes now it is their turn. Of course if all has gone to plan, it doesn't really matter, because you've all but passed, but even here most of what will happen is fairly predictable.

Look mum, I'm an examiner!

You must try your hand at being a co-examiner at least a couple of times prior to the exam. The exam is a human interaction and the better you can understand the other's point of view the more successful that interaction will be.

One thing you'll note straight away is that observing someone else who is a fairly competent interviewer is boring. Occasionally, even with a competent interviewer, its also a little frustrating, as the candidate doesn't ask the perfectly obvious question that you've got in your head.

Another thing to note is that it is extremely difficult to stay focused for the whole exam. You can imagine that this difficulty is considerably worse, when you're doing the fourth viva of the day. This is an important lesson, because having learnt it you'll be less likely to freak out if the examiner asks you a question that you reckon you answered just two minutes ago, or seeks to clarify something you feel you could not have made clearer. Chances are the examiner simply drifted off when you said that, so simply repeat it (more or less), and see if that helps.

Most importantly for this section though, you'll soon see that there are not a huge number of possible questions that you can generate, and most questions will be completely predictable. I have covered some of these below.

Unusual historical and mental state features

If your patient exhibited any mildly unusual historical or mental state feature you're bound to be asked about it, so if you can buy anymore time in your twenty minutes thinking time, rehearse a nice response to what is essentially a Dorothy Dixer.

You can make it even more likely they'll ask a question like this by placing particular emphasis on the feature when you present it in the first place.

You (while presenting your mental state): "In addition to these cognitive abnormalities the patient presented a clear *Ganser response* to my question about the date".

Examiner (in the first question session): "You said the patient exhibited a Ganser response, could you be more specific about what you meant by that."

You (Gee I didn't see that question coming. Not!): "Sure. I was referring to the patient's approximate answer … . These sort of responses have also been referred to as *vorbeigehen* (by Ganser himself) and *vorbeireden* by later authors such as Whitlock, but I tend to steer away from the German pronunciation *[tiniest hint of a smile]*. In Ganser's original series …"

Remember that it is well worth studying and getting really good at phenomenology prior to the exam, because an exchange like this is fairly predictable, and whether examiners like it or not, it really can't fail but impress.

Please justify your diagnosis

This question is almost mandatory, especially now that examiners have now been restricted to questions that relate directly to the material and have to begin with little stock phrases. You're likely to be asked for similar justifications of your thoughts on the patient's personality and differential diagnoses.

If anyone ever asks you to justify anything about a patient, the answer is always structured in the same way.

"Well, from the patient's history … . From the patient's mental state … ."

Using those two headings, simply list off the things that made you think what you did. Don't sound like you're simply ticking DSM boxes, and remember that a lot of things that might make you think a patient has a particular diagnosis will not be found in the allegedly "aetiologically neutral" DSM.

Management

[Y]ou will be invited to present and justify a detailed management plan for the patient, assuming you were take clinical responsibility for the patient at this time. They should say*, "Please present your action plan as if you were an advanced trainee taking over the management of the patient at this time". You will be graded on your ability to prioritise, the accuracy and appropriateness to the individual patient of your plan, your understanding of barriers to implementation, your understanding of the level of evidence to support treatments suggested, and the accuracy of your appraisal of likely response to treatment and of prognosis. Please consider the role of other professionals as well as your role as an advanced trainee. No time limit is specified as some candidates may present their plan with minimal prompting. The second examiner may then invite you to amplify or justify aspects of your plan. … To ensure there is time for some questions the examiners may give you a time signal if you are still presenting when there are two minutes left.*

Only 10-13 minutes to go, and you have control of eight of them. It is just too easy this exam.

Keep it rolling

There is quite a knack to getting the presentation of management right, and this is something well worth practicing and thinking about in your practice vivas. The trick really is getting the right level of depth. If you go too shallow as you put forward your management plan it will sound like you're simply reading from a memorised checklist, but if you go to deep, the examiners may think you're getting bogged down.

If they think you're getting bogged down, they'll try to help you by asking a question or two, but that is not good. Once the examiners start asking questions, you have lost control of the ball, and all the brilliant things you would have said if they had let you continue may be lost.

Basically you want skip lightly from management heading to management heading providing only enough information under each to show that

a) you have tailored this response to this patient, it is not simply a thoughtless checklist, that you're mouthing

b) you know an awful lot about this and would be happy to explore this or any other element of management in more detail, they only have to ask – *after you've finished*.

As is the case for the whole exam, make sure you keep modulating your voice, and engaging the examiners as you speak. Make it clear that you are excited to be managing this patient (without actually saying "I'm excited to be managing this patient").

A general management outline

It's a little embarrassing to have to admit it, but most patients will get roughly the same management, so in fact it is relatively easy to anticipate what your management strategy will be long before you see the patient.

The most common patient is an inpatient with a functional illness. The management plan for all such patients, looks something like the list below. As for most of the viva, this is all fairly predictable, so you should have given a great deal of thought to exactly how you are going to put all of this.

As was the case for the presentation of the history, I'm not big on beginning the management section with a little opening gambit, nor with an outline of your management goals. There really isn't enough time for this and it tends to lead to you repeating yourself. There are probably exceptions to this general rule, though and occasionally it might be worth beginning with something like, "Obviously in this man, who has made so many serious suicide attempts, the major management goal is to keep him alive til we can correct his depression".

The management of the standard patient will range over these topics.

- Establish the patient's safety
  - This will include questions re ongoing suicidality, continued management in hospital, voluntary versus involuntary status etc.
  - It may also include immediate medical management, but that is unlikely in a viva patient.
  - While this is extremely important, don't spend too long on it. A lot of people appear to get bogged down right here, spending two or three of their eight minutes on a section that may not be particularly important for this patient.

- Gain further information
  - This will include corroborative history, perusal of old notes, speaking with staff who know the patient etc, to attend to good gaps
  - It may include further history from the patient, to attend to bad gaps. (Don't bring up ugly gaps again, lets hope they are forgotten).
  - It will also include investigations. Remember that many of these have likely been done already and don't parrot off a list of things that you wouldn't really do in a patient who's had schizophrenia for 10 years.
  - When you do mention an investigation, mention a brief rationale, but again don't get bogged down.
  - In many patients you might want to focus on one investigation that you feel is key. "I would order a range of the usual investigations for schizophrenia, but in this man, with his obesity and cold intolerance, I'd be particularly interested in his thyroid function tests".
- Reassure, educate and support
  - Including building rapport
  - No doubt the most important things that we do with patients and many people forget to mention them.
  - Outline briefly what you're going to tell Mr Williams about what his depression is and how you're going to get it better. Don't get bogged down here either.
- Liaise with nursing staff
  - What will you ask the nursing staff to do? How will you ensure the patient's safety with their aid? How will you enlist their help and promote their advocacy.
- Non-pharmacological individual therapies
  - Make mention of things like CBT or supportive psychotherapy or psychoeducation etc here. It usually sounds better to mention such things before we get into drugs.
  - Again don't just say, for example "I do some CBT" and leave it at that. Briefly explain what you'll actually do.
  - You may want to invoke the support of a psychologist here. This is good but don't make it sound like you'd simply ask the psychologist to do the dirty work, because either you don't know how to or don't want to. Explain what you'd be wanting the psychologist to do in a way that makes it clear that you could do it, it's just that you feel that the psychologist might be able to do it better.
- Physical therapies

  - Outline where you're going to go with drugs (or say ECT).

  - As always provide sufficient detail so that the examiner knows you know what you're talking about and here that probably involves mention of specific dosages, and monitoring for specific side effects.

  - Mention too what your plan would be if this first therapeutic trail fails. "If I saw no clear response in three weeks, I'd reconsider the diagnosis, but if I were still convinced of a major depression, I'd change to another class of antidepressants; in this man probably venlafaxine". One back-up plan is enough to give spontaneously.

  - Only use generic drug names.

- Non-pharmacological other therapies

  - Is there a role for the occupational therapist or the social worker?

  - Here is the place for group or family work.

- Horizon's for discharge and forming bridge to the community

  - What will have to have occurred before you'd be happy for the patient to leave hospital?

  - What things will you put in place as an inpatient to smooth his transition to outpatient management?

- Pharmacological management in the community

- Non-pharmacological management in the community

  - Including things like assertive case management, rehabilitation, work promotion, ongoing family work etc.

- Anticipated problems

  - Give one or two things specific to this patient that you really anticipate problems with and then, outline briefly the way you plan to head these off.

  - "In this man, I suspect that medication adherence will remain a big problem. We know that most of his relapses have followed his decision to stop taking his drugs. Hopefully, I'll be able to get on top of that by rationalising his medications as I've mentioned and by better psychoeducation, but it may be that I'll need to consider moving to a depot preparation and I'd probably discuss that option with him quite early in the piece".

"Anticipated problems" seem to give your management outline a natural end-point. You want to aim to reach them and stop talking at eight minutes. That will give your examiners only about two (occasionally five) minutes to ask some questions, and hopefully you've anticipated what those are likely to be.

Too long a presentation leaves no time for questions and will see you interrupted. Too short a presentation will be too shallow; you'll need to be asked about details. Examiners will see this as prompting and mark you down accordingly. This means the whole management spiel should take between seven and eight minutes. Note you've actually got some flexibility over timing here, but don't go longer than will leave two minutes, thirty seconds left in the viva. Beyond that time, you'll likely be interrupted. If you are still presenting your action plan with two minutes of the viva to go you should receive a two minutes to go warning rather like the "you have had seven minutes warning" in the presentation. Again, try to avoid this happening.

Management points

Calling the shots

Basic trainees *consider* management initiatives; consultants put them in place. Make sure you're sounding more like a consultant and are *making* decisions. Don't say "I'd consider putting the patient under the Mental Health Act". Say, "I'm still very concerned about the patient's safety, so I'll manage him under the Mental Health Act". People hate consultants that vacillate, so without being courageous, make decisions. You are still only an advanced trainee however, so don't be afraid occasionally to refer to checking things with your consultant, just don't do it too often.

This is another thing that's likely to be different to what you do everyday. After all, when you're a basic trainee it should be the consultant who is making the final call on decisions. Since this is different, you'll have to practice it.

Getting others involved

You are required *to consider the role of other professionals in the management of the patient*. This means that you should make liberal mention of your implementing the skills of nurses, occupational therapists, social workers etc. You should also refer to your use of psychologists, but be wary of giving the impression that you're going to hand over the core business of psychiatry to our psychological brethren. Rather than saying, "I'd ask a psychologist to do CBT directed at Mr Frink's obsessional features", say "I'd be keen to involve Mr Frink in a CBT programme and would ask the ward psychologist to be involved. This would probably start with some basic psychoeducation and then I might establish a hierarchy of concerns with Mr Frink …"

One of the others to occasionally involve is your consultant.

Priorities

You are required to *prioritise, the accuracy and appropriateness to the individual patient of your plan.* Do that by emphasising certain elements of your plan with both the intonation of your voice and by saying things like "… and this is particularly important in this man".

Prognostic considerations

You are required to *provide an appraisal of likely response to treatment and of prognosis*. You can do this in a number of ways. You should mention it in that section of the

pharmacological interventions where you say what you'll do if you're first plan doesn't work. You should allude to it again in the final anticipated problems section.

Some patients, especially those that have been obviously treatment resistant, will see this aspect mentioned toward the top of the presentation, perhaps in the formulation.

You may also consider finishing off your management section with a nod to this. I find that that is hard to do without it sounding too practiced and contrived, but you might consider something like, "So far Mr Candide has made an excellent response to treatment and I'd be very optimistic that will continue to do well", or "With so many actual and potential barriers standing the way of Ms D'Urbaville's recovery, I'd have to say that her outlook is extremely guarded".

EBM

You are required to demonstrate *your understanding of the level of evidence to support treatments suggested.* Keep this in mind when presenting your specific therapeutic interventions. The levels of evidence for particular therapies are another thing you should revise prior to the OCI, and then slip this knowledge in to surround your individualised management.

"We know from a number of trials that family interventions aimed at reducing so called high EE will significantly reduce the rate of relapse in schizophrenia. I don't know, but I suspect that Mr Jeffery's family may well exhibit high EE. I'd like to confirm that, and then start family interventions aimed at modifying it."

Say that sort of thing and you've likely bought yourself a question like, "Please be more specific about what you'd do to reduce EE in Mr Jeffery's family".

Treat all the problems

It sounds bizarre, but it is quite common for candidates to mention two or three comorbid psychiatric diagnoses but then go onto to outline the management of only one of them. Substance disorders are particularly neglected.

Don't forget to care for the patient's physical health either.

Children are also frequently left entirely out of the loop.

Local oddities

At least one of your examiners will be from interstate, possibly both will be, so do not assume that they know the meaning of terms within your state's Mental Health Act. In some states one schedules a patient, in others a patient is sectioned, but wherever you are you are entitled to hold a patient involuntarily under the Mental Health Act.

Different patients

Not all patients will be so good as to be inpatients with a common functional illness. You'll need to consider how you're going to handle other eventualities that will force you to think about other management approaches.

The diagnostic dilemma

The management plan for the diagnostic dilemma obviously holds an inherent dilemma – how do you manage what's wrong, when you don't know what's wrong?

Well it's not as hard as all that. First of all the front half of the management plan will concentrate more than usual on clarification of the diagnosis. We're not talking rocket science here!

After that the management plan can proceed along a fairly generic course until after you've liaised with the nursing staff. About here you'll be forced either to manage one illness or attempt to outline the management of several. The later is impossible in the time provided, so tell the examiners that you are going to assume that the patient does indeed have your provisional diagnosis and you'll now outline her management with that assumption made.

Note that in most diagnostic dilemmas this gives you the opportunity to nominate which of several possible management pathways you'll outline. If you think that the patient might have a depression with psychotic features, but could just as easily have schizophrenia and be depressed, choose whichever you're most comfortable managing as your provisional diagnosis.

Occasionally in a presentation, you'll have made one provisional diagnosis, but with reflection, forced by questioning, you'll be forced to admit that perhaps another provisional might have been better. If that happens to you, then you really have to assume it's the new provisional you're dealing with, and this may involve some (but not a lot) of thinking on your feet. This said do not simply change your provisional diagnosis because you think that is what the examiners think the patient has. Only change it, if you now think that, on reflection, an alternative diagnosis is more likely.

Something organic

Some patients reveal themselves early in the interview to be the sort of patient that might have an organic illness of some sort. Perhaps they are dementing, or they could be delirious. In these patients it is usually wise to bring forward considerably your cognitive testing, so that you might start that at say 20 minutes. Depending on the results of the initial tests you might also decide to do on to do advanced cognitive testing. It is a good idea, if you are going to do this, to tell the patient (and therefore the examiner) that you intend to return to their history directly, otherwise the examiner may begin to think that you are going to completely neglect the patient's personal history or premorbid personality for example. Thinking this would make the examiner anxious, and you don't want to make the examiner anxious.

Patients with odd illnesses

Anorexia nervosa is quite a common occurrence in vivas and requires a rather specialised management approach. There are several other similar illnesses, but not so many as you

might think. Others include patients with only personality problems, patients with conversion or other somatisation disorders and patients with pure alcohol or drug problems.

Patients in odd situations

Some centres bring well outpatients in for exams. These are quite tricky because there is often no particular current focus of management as the patient is well. Obviously such patients won't need transition back into the community and may not need their medications altered. Instead you'll need to concentrate on maximising their function and upon rehabilitation.

Patients in long stay rehab centres are easy to get for exams and are common. Again they have their own issues and if you've not done a rehab term, consider getting specialist advice on how to approach patients like these.

Patients in forensic centres are different again. For starters you may not need to plan discharge, they may not be going home! Again consider some expert guidance for this possibility.

Adolescence is an odd situation, and adolescents are fair game. Think how you're standard management plan will alter if you get a young person.

Questions from examiner 2

To ensure there is time for some questions the examiners may give you a time signal if you are still presenting when there are two minutes left. The other examiner may ask one question towards the end of this section. If there is time remaining, the examiners will ask you if there is any additional information you would like to add, before terminating the viva examination.

The ball is back with the examiners, one last time, but with only two (or at most five) minutes to go, nothing can really go wrong from here.

That's a tough one

This is the time when most examiners will begin to throw deliberately curly questions to try to convince themselves that you have not only "achieved the standard", but surpassed it. It is worth surpassing it if you possibly can – it might just help if the OSCE goes bad, but it is not really necessary. The important thing about this is, that it is the last thing you'll remember and if the examiners do throw a few tricky questions, which you can't answer, you may think that you've done badly in the viva, when in fact you've done well.

Once again it is possible to direct the examiners a little here. That leading mention of family interventions for high EE, could for example precipitate a question like this one.

Examiner: "You mentioned earlier that there were a number of trials that had shown efficacy in reducing EE, can you be more specific about those?"

You: "Sure. Expressed emotion was a concept first put forward by Vaughn & Leff in 1976, though you could easily date it back further to Brown's life events work of the late sixities. EE was very much an artificial construct consisting of …"

If you think that that is going to sound impressive you're right. It is not at all necessary to mention authors' names in the viva, but examiners can't help themselves but to be impressed. It is not really quite as impressive as it sounds though. After all, you were extremely like to meet someone with schizophrenia in the viva, and were going to be asked about their management. Only a few things actually help schizophrenia, so it should have been patently clear that having a prepared statement on the background of EE was only sensible. Especially if you were going to try to coax the examiner to ask the question in the first place.

If you can finish the viva here, things have gone about as well as possible. Unfortunately though you won't be able to prepare wonderful answers for all the possible patients you'll see nor all the possible questions you could be asked, so it may be that in trying to stretch you the examiners will ask you something you think you don't know.

Note that in this strangest of exams, it is only now, two minutes from the end that you're likely to encounter a question that you think you might not know the answer to. Even here though there is much you can do.

Let's say that their curly question is not the one you had planted for them. Let's say they ask you the question below and that your first response would be, "I have no idea".

"You mentioned that you might use other strategies to augment the effectiveness of the antipsychotics in this patient. Could you elaborate on your understanding of the evidence base that underlies such strategies?"

First, do not simply fire back to the examiners that you don't know the answer. There is no rush to answer any question. Everybody in the room knows this is a tough question. Take a second to think about your answer and another second to remember that you almost certainly know something about this. Its worth remembering too that the examiner is not required to know the answer to any question he asks, so just because he asks it, doesn't mean he could answer it.

A little consideration like this will give you an opportunity to realise that you know at least this much about the evidence base of augmentation strategies in schizophrenia.

"Well numerous agents have been used to augment the effectiveness of antipsychotics in schizophrenia. These include, other antipsychotics used in combination, other agents like lithium, mood stabilisers or even things like propranolol, and also of course other treatments like CBT and ECT. It fair to say that there are no strong evidence bases for any of them. For a few there are a few randomised control trials, but these tend to be small and methodologically flawed, but for most the level of evidence is at the open trial or case report level. (By this time hopefully you'll have recalled at least one trial you read about somewhere or did in journal club or something and so you can continue …). For example, there have been a number of trials comparing amisulpride augmentation with augmentation with placebo …"

There you go, you just managed to surpass the standard by providing an answer to a question about which you knew (or at least thought you knew) exactly nothing.

What not to do

Melissa Corr, an examiner with no shortage of experience has suggested that there are five things that she feels routinely cause people to fail. Her list is worth more than a little serious consideration:

1. The candidate misses important clues or cues
2. The candidate lacks a basic skepticism.
3. The management plan is apparently generic and applicable to any patient.
4. The candidate appears unable to integrate information gained.
5. Relevant issues in the case are explored without precision (eg 'exclude organic causes').

When too much preparation is not enough

Two for one

The new exam format demands an enormous investment of time for each practice viva done. Not only your time, of course, but the time of the friendly consultant who's agreed to practice with you. This is particularly so for the consultant who's agreed to sit in for the whole interview as well as your presentation and then to give extensive feedback. There ain't much change from half a day, if you do this properly.

Having made this initial investment you really should get as much out of this experience as possible. Make sure you go away and think about the viva in detail. Think about every aspect, especially the timing, and work out in what ways it could have been better.

One great way of doing this is to arrange to present the viva again to someone else, another consultant or a fellow exam candidate from your study group. Present your new version in seven minutes exactly (there is no excuse for overruns here) and then have your friendly examiner ask you a new set of questions.

If your new examiner was not your original consultant, but another consultant with exam experience note how closely their questions resemble each other.

Book early

It is not really possible to wait til you see the results of your writtens to start preparing for your vivas. You really must assume that you're going to get a viva spot and start preparing after a brief post-written rest.

One of the reasons you can't wait, is that if you do, all the people you want to do vivas with will have been booked up. Even if you're not going to start doing actual practices early on, at least book them for later. Then if you discover you will not get a viva place simply ring the examiner and cancel. If you ring as soon as you know, few people will be disappointed to find themselves with an extra half day at their disposal.

Book who?

The first thing to say here is that you should book a viva with who ever is good enough to do one with you. I am constantly amazed, and extremely pleased, by the amount of time most of my colleagues are happy to invest in trying to help candidates.

If you have a choice, consider all of the following:

- Choose people who will go the whole nine yards. In my opinion, is not really possible to give proper feedback, if you did not sit in with the candidate on a patient that you as examiner are ignorant of. (That said, this is a big ask of your senior colleagues and I don't think you can afford to be too precious about it. Even I occasionally have to admit that I just have time to do the whole thing properly on some days, and have to take short cuts like using patients I already know, or missing the interview bit).

- Choose someone who has been an examiner with the College, or at least has spent the considerable time required to look through and understand the new exam format. If the person's not done that, then be wary of their opinion on non-clinical matters at least.

- Choose at least some examiners who will make you anxious. These need not be well known "smiling deaths", I at least was made most anxious by those consultants that already had a high opinion of me. I was anxious because I didn't want that high opinion shot to pieces by one hopeless viva.

- Choose at least one examiner from another hospital, to experience some unfamiliarity with the surrounds.

- Choose some examiners with expertise in the type of patients you really don't want to get in the exam because you don't know much about them. If for example you've not done a rehabilitation term, find a rehabilitation psychiatrist examiner.

Video

If you're technically minded and even if you're not, consider videoing yourself interviewing a patient.

This is quite a bit of hassle. You'll need to find a video camera and descent microphone for starters and you may need several attempts at it before the tape is of usable quality. You'll also need the patient's consent of course and this may not be easy to obtain and will require some paperwork and procedures that will differ from place to place.

It is definitely worth all the effort however, as it allows you to see yourself interview (as your examiners will) and allows you to go through the interview with a supervisor who can stop or start the interview to comment on your performance.

Actually you can do too much practice

I am fairly convinced there is an analogy to be drawn here with Olympic preparation. You should not do so many vivas that you are too tired to do the real one really well. I believe sprinters, do not do any sprinting in the week or so before the big race. Do not do so many

vivas that you're not at least a little anxious on the day. Remember the Yerks-Dodson curve suggests you'll do better with a little anxiety on board. Do not peak too early.

Field work

Which hospital

Some time before the day you'll be told where you'll be doing the OCI. Once you know which hospital you're going to, it is worth finding out a little more about the place. Don't get too excited about being a detective, but if the hospital you're going to has a forensic unit on site, for example, you should know about that.

Ring the hospital and ask to speak to either the co-ordinator of the exams (you should have been given her name) or one of the senior psychiatric registrars. Tell the registrar who you are, that you'll be there to sit the exam and that you'd like to know if there is anything that you should know about the place. Reassure the registrar that you're not trying to cheat and you certainly don't want to know anything about any patients that may have picked out, but you would like to know anything that is public knowledge. You'd like to know anything that a registrar working in that city might know. Ask about access by car. Ask about parking. Ask what the unit specialises in and if there are any other units there that might provide patients. If the unit has, say a Huntington's Unit attached, you'd be crazy not to bone up on Huntington's.

Don't hang too much on this phone call. Basically any unit can produce any patient with any diagnosis. Also beware of strong tips. Unless someone is actually working in a place, the chances are that they won't know that much about what goes on there. Everyone seems to know, for example, that Westmead specialises in people with borderline personality disorder, but in fact people with this diagnosis are very rarely on the ward. Similarly Westmead hosts the NSW Huntington's Disease Unit but the chances of getting a Huntington's patient at an exam hosted at Westmead would be very low indeed.

Casing the joint

If you're going to another city, make sure you arrive at least a couple of days before the OCI. A day or two before you sit make your way out to the hospital and have a look around. When you ring the hospital to find out more about it see if the organiser could meet you for this visit.

The trip will give you some idea how long it takes to get from your hotel to the exam site (though remember to correct for peak hour if you're viva is first thing in the morning). Once you get out there, try to find out exactly where you'll be waiting before you go into the exam room. That will mean that on the day you won't be hassled about getting there and you'll minimise the novelty of the experience. Going into new experiences makes people anxious. You'll be anxious enough that day, so you should try to do all you can to minimise what anxiety you can.

Ask too if you can see and even sit in the office where you'll be seeing the patient. (This may or may not be possible of course, as these offices are often in regular use). If you get into the room, or even if you can't, find out what furniture will be in the room that day. Not only will this further minimise novelty, but it will also allow you to better visualise those opening minutes of the viva.

On the day

Make sure you will get to the exam centre with about 45 minutes to spare. An extraordinary number of people find themselves rushing to their vivas. Do not be one of these people. Being late is out of the question of course, but even being nearly late is pretty bad. For starters, if you are nearly late the examiners will be told that you're not here yet and that will make them anxious, and you don't want anxious examiners. Worse than that, candidates that come in late look rushed and flushed, and this is not a good look.

Different people have different preferences on how to get to the examine site. Some like to drive themselves, some like to take a taxi. However you choose to get there make sure that you can't possibly be late.

You'll probably be provided with food and drink when you arrive, but don't count on this and consider bringing something to eat and drink with you.

Local knowledge

If you are going interstate or overseas, it is worth a spending a little time researching some of the local oddities

Abbrev.'s

Psychiatric patients often become extremely familiar with a variety of terms, institutions or pieces of legislation that may have had a significant impact on their lives that they will describe in the form of abbreviations.

If you are not from that state or country, that abbreviation may not be familiar to you and you may either misunderstand the patient or need to spend sometime trying to find out what a particular abbreviation means. Often times this quest won't be helped by the patient not knowing exactly what the letters stand for.

The table below contains a number of these terms along with the local titles and abbreviations at the time of writing. Unfortunately these terms often change fairly regularly and it is probably worth quickly checking that they are still correct before you go.

Term	NSW	Victoria	Queensland	South Aust	West Aust	NZ
Child protection agency	DOCS Dept of Community Services					
Public housing agency	Housing Commission					

An order prohibiting contact with another individual	AVO Apprehended Violence Order					
Being detained under the Mental Health Act	Scheduled					
Legislation allowing one to make decisions for an incompetent other	Guardianship legislation.					

The local MHA

It is quite likely that your patient will have been detained under the local Mental Health Act, if not now, than previously. Though not strictly necessary, it would seem wise to have at least a passing knowledge of the local Act.

These days this information is amazingly easy to obtain, as all States and New Zealand have their Mental Health Acts on the web for easy perusal. Googling "Mental Health Act" and the name of the State or "New Zealand" will take you to a number of pages offering either the Act itself or more usefully, an idiots guide to the Act.

You don't really want to get bogged down on this task, just a quick overview will do. Remember that at least one of your examiners is unlikely to be familiar with the Act either.

Local drugs

New Zealander's coming to Australia have quite a lot of work to do here, as Australia uses many more medications than New Zealand does. To make life more difficult the two countries occasionally use different trade names to describe the same drug.

New Zealander's are probably under some obligation to be at least somewhat familiar with drugs not yet available to them. You can't really expect the patient you're seeing to know the side effect profile of the latest antipsychotic, that he's just been placed on.

Local places

Again don't get bogged down in this, but if you can easily discover the names of the various psychiatric hospitals in the city you're off to that may save you some time and may avoid some confusion.

Unless you're a Sydney-sider you have no real way of knowing that "a short stay in Cumberland" refers to a psychiatric admission.

Few cities have more than three or four major psychiatric centres. It is not really much to remember, if you can gather the information quickly. The table below shows the major stand alone psychiatric hospitals in the Australian capitals, Auckland and Wellington.

Sydney	Melbourne	Brisbane	Adelaide	Perth	Auckland	Wellington
Rozelle (formerly Broughton Hall or Callan Park) Cumberland Macquarie						

Some final suggestions

"I'll just do it and see how I go"

Many registrars tell other people and may even tell themselves that they are not really trying to pass as such; rather they are just going to sit and hope for the best. It is as if this first attempt is just a dry run. Do not take this stance.

The exam is horrible and if you're going to maximise your chances of passing it is pretty much going wreck at least several months of your life. If you fail, it will not be pleasant and while you should try to keep things like having failed in perspective, you will feel pretty dreadful. Therefore, you should aim for nothing less than passing first go.

Back yourself

It is not uncommon for me to finish a viva, where the candidate has not gone too well, and then before I start to give feedback, to ask the candidate what they really thought was going on with the patient, only to find that now (outside viva mode) the candidate will give a very elegant description of the patient's predicament. When I then ask the candidate, why they didn't say that 10 minutes before they say, "Well that is what I really think is happening, but I'm not going to say that in a viva, am I?" Wrong!

The examiners are trying to find out what you think and to see if that matches with their conception of a young consultant/advanced trainee. If you are thinking like a young consultant, and you should be, then what you think, is what the examiners are looking for.

What you think and what the examiners want to hear are the same thing! If you think it, it is almost certainly the right thing to say, so … and this is not rocket science … say it.

If you're not good enough to think the things that a successful candidate should be thinking, you're not good enough to sit the exam. If you are good enough then back your judgement, not what you think the examiners think your judgement should be.

How am I going?

Candidates have no ability to judge during the viva, how well or badly they are going. For starters, the examiners are keen to conceal what they are thinking from you and even without this there is just too much going on for you to successfully guess what the examiners are thinking. This being the case, you should not try. If you try you'll probably be wrong, and even if you're right, it is hard to see how this will help you. You're not going to start trying harder only when you realise that things are not going so well.

Because you can't tell how you're going you must avoid the temptation to believe that you can. Instead you've go to assume for the whole viva you're doing great. Everything is going swimmingly and the examiners have no doubt that you're going to pass. You should maintain this belief no matter how badly you might be tempted to think that you're actually going. You can't really know how you're going, so assume you're doing really well.

If mid-viva you come to the belief that you are failing, you will one way or another convey that belief to the examiners. Even if they hadn't thought this before, they will certainly start thinking it now. Things will almost start to spiral out of control. How ever you're going, you're going great.

You need to maintain this assumption after the viva as well. This is even harder than it is during the viva. People never recall adequately the good things they did in the viva, they will only focus on the bad. This means that you will tend to think that you've done much worse than you have. You can't afford to do this because you'll be sitting the OSCE in a day or two and you're going to need to go into that thinking that you did well in the OCI. It was quite common in the old two viva format exam for people to come out of viva one thinking they had bombed it, and therefore find themselves unable to do viva two properly, only to find out later, when they failed, that actually they'd got an A or B in viva one, they failed because of a lack lustre viva two. I have already heard similar stories with the new format. People thinking they've bombed the OCI, and not able to get up the considerable energy required for the OSCE, only to find later that the OCI had been fine.

How am I going? How did I go? Great I blitzed it!

The Observed Structured Clinical Examination

The Observed Structured Clinical Examination accounts for the other fifty per cent of the final viva mark. OSCEs are now used widely in undergraduate curricula, but for many current psychiatry reg's, this is the first OSCE they'll do. Like the OCI, the OSCE requires a considerable amount of consideration of the process.

More principles

The OSCE has its own set of overriding principles that are in addition to the Prime Directive.

You are there

The biggest mistake that people make when they approach the OSCE is to fail to get into role. This is hardly surprising as it requires you to do something that neither you, nor anyone else, in fact, is accustomed to doing – seeing pseudopatients, pseudorelatives or pseudostaff. Regardless, it is something you must master to maximise your OSCE chances.

Basically you've got to imagine yourself into a new reality and you have to do it over and over again for three hours. Its like some marathon episode of *Thank God You're Here*, without the chuckles.

Note that you do not have to do any acting. In fact if you think that you are acting, you won't succeed. An actor imagines themselves as a new person in a new reality; you must be *yourself* in the new reality. Its weird, but it is required.

From the moment you enter the room you must be yourself *in role*. You must be *you* dealing with whatever task you've been set and you've got to stay in role until you leave the room.

You were there, but now you're here

If being in role wasn't hard enough, you've got to exit that role and enter another all in under three minutes. Once you're out the door of one station, that station is dead and must be forgotten. It doesn't matter how badly you think you might have done, the next station awaits and you can't afford to carry the feelings of disappointment from the last station into the next.

Such active forgetting at a time of high anxiety is not easy to do. It takes effort and it is one of the things you should practice whenever you get a chance to practice an OSCE. The need to practice this skill means that when you practice OSCEs with, for example, your study group, you should always mock up two or more stations at a time.

You're the one what does it...

The OSCE's will frequently put you in a situation where you'll need to refer to other health professionals to complete the task. This is right and proper, but you must avoid the appearance of having off-loaded any difficult tasks to someone else.

When citing the use of a social worker, for example, don't say, "I'd get the social worker to find a nursing home". Rather, let the examiner know that you'll be utilising the social worker as a member of the team in the patients overall management, so for example you'll say, "Grandpa Simpson won't be able to return home and will need nursing home accommodation. I'll ask the social worker to liaise with the family and local services to try to find something suitable".

If you're going to speak with your supervisor about something, and given that you'll usually be told that you're an advanced trainee and therefore will have a supervisor that you should be speaking to regularly, do not give the examiner the impression that you think that speaking with your supervisor will be the end of the matter as far as your concerned. For example, if you were concerned about the professionalism of nurse on the ward you're working on, you should speak with you're supervisor, before launching into solving the problem yourself, however, don't just say "I'll speak to my supervisor and I expect he'll then go and chat to the nursing unit manager". Say instead, "I better speak with my supervisor first, but assuming he's in agreement, I might approach the nursing unit manager with my concerns".

... so do it

Another trap surprisingly common among trainees, is to find themselves in a situation where they find themselves uncomfortable about proceeding along a path, and then stalling there. For example, one scenario asked the trainee to address an issue with a child's teacher, without previously having cleared this with the child's parents. Many trainees appropriately pointed out that this raised significant issues around confidentiality, but some trainees then went on to say that they therefore could not discuss the issue further with the teacher. Now the teacher was the only other character in the scenario, and trainees who used the confidentiality principle rigidly like this, then found themselves only ninety seconds into a seventeen minute station, with nowhere to go. (The way the scenario was structured, it really wasn't that bad to be speaking with the teacher). No one is going to write a station where maximum marks are attained by sitting mute for sixteen minutes.

In other scenarios you may be asked to say speak with the media on some subject or other. In this scenario, it would be quite appropriate to suggest that you are probably not the best person to undertake this task, all things considered. Perhaps, for example, it would be better if your supervisor took that role, or the official College spokesperson were to take it on. That is perfectly reasonable point (and all possibility you'd be marked down for not making it), but having made it, you must, fairly obviously, go on to convey how you'll approach the media engagement anyway (assuming say that these more appropriate people were not available). An obstinate refusal to talk to the media, come what may, will not tend to score very highly.

If something needs to be done and it is not ideally done for various reasons, highlight those reasons, but then, get on and do it.

How am I going?

One tip to help with your active forgetting, is this: you have no idea how well or badly you're doing in an OSCE. It is not possible to tell how well you're going in the OCI either of course, but the OSCE makes it look like the OCI examiners hold up cards with a mark out of ten.

You are only in the station for 17 minutes. You don't have time to read the minds of the examiners and even if you did you wouldn't be able to, because they'll be doing their best to look poker-faced. Anyway the idea here is to immerse yourself in the task you've been set; the examiners should largely become invisible to you.

All of this uncertainty applies to each station, so you can bet your life that by the time you've hit your third station, any faint possibility that you may have been accurately able to discern how you are going has completely disappeared.

Basically you're back to the philosophy of the OCI. Regardless of how well or otherwise you think you might be doing, you've got to assume, as the exam continues, that you're doing great.

Preparing for the OSCE

Past papers

In most exams, the most direct road to success is to review past papers. Guess what, same here?

The College kindly publishes each and every OSCE station on its website as soon as the marks of each exam are finalised. (At the time of writing these were at www.ranzcp.org/members/exams/oscepol.asp). Study these OSCEs with a fine tooth comb. Practice them certainly, but don't stop there. After you've practiced a few, read the one's you've practiced in detail and try to work out exactly what the station writers were hoping their candidates would do.

Pay particular attention to the marking criteria, as these are the words that the examiners will have been referring back to as the candidates of those exams plied their stuff.

Unfortunately the marking criteria cannot be interpreted exactly as written. The criteria often appear to say that if a candidate makes a certain mistake or omission they must be marked down. Sometimes this will be the case and sometimes it won't. The marking criteria are never mean't as anything more than a guide for the examiners that will find themselves assigned to that station. The degree to which the guidelines should be adhered to is not be decided until a "calibration meeting" of all that station's examiners held on the evening before the exam. This meeting is a rather free flowing affair, with the dozen or so psychiatrist examiners all using the written criteria as a guide and trying to reach some sort of consensus. The result will be that some criteria will be seen as essential (if they were written that way), but that others, even if they appear to written that way, can be ignored if other aspects of the candidate's performance warranted it. The overarching guide to this meeting is a consensus view on what it is reasonable to expect of a trainee who has complete his or her advanced training.

It is important to understand this process, because some trainees mistakenly read the marking criteria absolutely literally and feel that if they do not cover every area mentioned they will not pass. This is wrong.

Everything old is new again

Note, as you go through the various OSCEs that the same criteria (written in essentially the same language appear again and again). Chances are that these oft repeated criteria will be in your OSCE marking sheets too, so make sure that you're able to meet them.

As time passes it is almost certain that some OSCE stations will be essentially repeated, though undoubtedly minor aspects of the scenario will be tweaked or altered. This will happen for a variety of reasons:

1. OSCEs are incredibly time consuming to write, and even the apparently tireless examination committee is not without resource limits.

2. Eventually we must meet a natural limit to the number of scenarios that can be written to cover the various aspects of the curriculum.

3. The College is aware that, to at least an extent, the examination focuses the attention of the candidature on the various elements of the curriculum that questions have focused on. If the there are important aspects of the curriculum that past candidatures have not tackled well, you can bet your boots that they will reappear in exams to come, in the hope that trainees will get the message that the College thinks this stuff is important.

How many OSCEs can you do?

Unlikely practice OCIs, practice OSCEs with consultants are hard to organise, so the answer to this question is probably, "as many as you can", because that won't be that many. Even big training schemes are unlikely to organise more than one or two practice OSCEs sessions with their trainees, so most of you're OSCE practice will be done with the other members of your study group or registrar cohort.

In addition to the past OSCE's published by the College, the ANZAPT website now has numerous OSCE's pooled from around Australia and New Zealand.

The British College has been using OSCE's for a while and economies of scale mean that there are numerous resources on the web for practicing their OSCE's. Be aware though when using these resources that the Brit's much shorter OSCE's (they are only 7 minutes) mean that much of the advice and the example stations available will only be obliquely relevant to Australia and New Zealand.

Ideally when practicing with your study group, set up your mock OSCEs so that there are at least two stations per practice. Don't forget to occasionally practice a station with an active bye.

Ideally too your practice sessions should see different members of the group adopt different roles:

- one should be the candidate (of course)

- one or two should be examiners (because just like in the OCI you want to understand what this must feel like). Make sure that the examiners have criteria to mark to. Marking an OSCE is not a gut feel process.

- one will often be the pseudopatient or other acting role (because you want to know what that feels like too)

- and one should be a fly-on-the-wall so that she might tell the candidate what he or she could have done better. You can't really rely solely on the mock-examiners or pseudopatient to do this last bit, because, as you'll find as soon as you start this, being either of them is a fairly full on process.

Remember too when you're being the examiner or actor that the real examiners and actors will repeat this chore sometimes 18 times in the day, with nothing but a sad 40 minute lunch break for rest. Examiners don't even get the three minutes between candidates, because that is when they are filling in your marks.

Write an OSCE

Like all other aspects of the exam, it is worth knowing what it is like to be the examiner. Writing an OSCE is extremely difficult and extremely time consuming, but it is worth while doing, so that you can better get inside the examiner's head.

You and your study group should have spent some time looking over the OSCEs of previous exams. Try to work out an area that hasn't been covered previously or hasn't been covered for sometime. Note that the area you pick must be covered by the curriculum. Now try to write an OSCE around that area. Do it as a group – that is what the examiners do, and then offer it up to another study group or to your local training director to try out in a mock OSCE.

What to study

The OSCE just like the writtens, purports to examine one thing, but actually assesses something else. It purports to assess whether you're suitable to be an advanced trainee, but actually of course it only tests how good you are doing the OSCE. This is not a fault with the OSCE, all exams are the same. It is just that the designers of exams hope that the two will be sufficiently similar tasks to make the exam have some validity.

I suspect that the exams do have some validity, because by my reckoning the best way to prepare for either clinical exam is to gain as much as you can from the time you spend doing your everyday clinical work. It's for this reason that I do not recommend a quiet term prior to the clinicals. The best place to hone your clinical skills is in the exercise of your clinical skills.

All that is all very well, but very few people are going to come up to the clinicals without some study. The question then is, study what?

The bulk of your study for the OSCE should be focused directly on the sort of issues you are likely to face in the OSCE itself. The most efficient way of attacking that is to do lots of practice OSCEs or, at least, to review lots of possible scenarios and work out, and study areas around, how you would attack those. Don't just think, "Oh I had better study mood

stabilisers", think, "I reckon they could set up a scenario where you're asked to start a patient on a mood stabiliser. How would I go about that? What stuff do I need to study to do that better"?

It is also worth thinking about the likely content of each station. There are significant limits to what can be asked.

There *will be* a general medical station (station 1) – they've told you that – so you'll need to do some general medical stuff, especially concentrating on the physical exam and interpretation of common investigations.

Everyone who can sit the vivas will have done some child psychiatry, so it will be very surprising if there isn't a child psychiatry station, and because they won't be able to find a child pseudopatient you'll almost certainly be speaking to a parent or a teacher.

Everyone who can sit the vivas will have done some consultation-liaison psychiatry, so it will be very surprising if there isn't one or two stations relevant to that. (It also turns out that consultation-liaison psychiatrists are often disproportionately represented on the examinations committee. I've know idea why. People tend to write questions on the areas they are familiar with. Expect a CL question).

Very few people will have done a forensic term, so while there are no guarantees, I'd not be spending vast amounts of time learning the ins and outs of OSCE forensics.

Understanding the clockwork

The OSCE is a surprisingly complicated beast, and you really should spend a bit of time, with your study group working out exactly how it works. The "instructions to the candidate" information sheet on the College web site, spells things out nicely.

The things that really confuse people are the bye stations and the fact that some candidates will commence the exam early to start at active byes. (If you are going to start in an active bye, you'll be starting twenty minutes before everyone else).

The OSCE is run with military precision. The people charged with running it, know it back the front. On the day though, many of the people involved will not be so confident with the process. Many examiners and almost all bulldogs will not have experienced it before. They will have been trained, but this has limits. It is quite likely that some people will be confused by the complex workings of the thing. You do not want to be among the confused.

You should know exactly why you might be called to start the exam early and exactly where this must mean you are supposed to start. You should understand the clockwork so well that you can argue with and correct an errant bulldog who thinks they have worked it out when they actually haven't. Do not, under any circumstances, argue with the bulldog unless you are sure you're right. You'll only be sure you're right if you've gone over this carefully in your head before the big day. If you are sure you are right, ask the bulldog to check with his or her supervisor. If the supervisor agrees with the bulldog, accept it and move on. The supervisors are very well trained, you are anxious as all get out. You think you're right, but you're probably not.

What to take in

The only things you may take into the OSCE are some pens, a timer and a stethoscope.

You'll need to give some thought to how you'll carry your stethoscope, especially if you're a woman and have no pockets. You do not want to leave it in one or other of the stations.

Strongly consider taking in provisions. Three hours and is a long time and you're likely to get hungry and thirsty. If your exam outfit has any sort of pockets, take in some lollies. Jellies are ideal because they are easily accessed, don't require unwrapping, can be eaten silently and will not melt onto your fingers. They can also be consumed rapidly. You don't really want to walk into the station still trying to swallow the last of your mintie.

Even this is not straight-forward. Some lollies make you thirsty. If you get thirsty, you may want to drink. If you drink, you may need to pee. You want to avoid peeing.

There are water stations scattered around the OSCE. If you want to take your own water, don't take in a bottle that makes you look like your running a marathon rather than being a young consultant going about her rounds. Again if your outfit has pockets, buy yourself a neat little hip flask and take a swig every now and then. (Not, perhaps, mid-station).

If like me, your PDA has become an extension of your personhood, be aware that it will be incredibly easy to accidentally take the thing into the exam. The College will not like this if it happens, so set a foolproof way of ensuring that you leave your PDA with the bulldogs. If necessary, set an alarm on the PDA now to go off half an hour before the viva to remind you to give it in.

Getting into the zone(s)

The OSCE circuit consists of four different zones – the stations, the three minute wait outside each station, the active bye and the passive bye. The stations are the places where you score the marks, but your success in the stations will depend greatly upon how you approach the other three zones.

Timing

I'd suggest you leave your OCI timer at home for the OSCE and go instead with a watch. Unlike the OCI, the OSCE divides neatly into twenty minute aliquots and there is little point dividing these further unless the station instructions ask you to do so. Any analogue watch with a clear dial, twelve numbers and a second hand will enable you to quickly tell where you're up to in any twenty minute period. A timer offers no significant advantage here as you really don't want to restarting the timer every second time you hear a bell. With eight or nine stations (including byes) there is too much opportunity for mucking the whole timer thing up.

If you decide to use a watch, make sure it meets the requirements above. This is not the time to rely on your grandmother's miniature, mother-of-pearl heirloom. No matter what time the exam begins (and you may assume the exam will start a little after the advertised time), you should reset your watch, so that for you it starts at midday. That way the first station will end at 12.20, the second 12.40 and so on. If your watch is large enough, it will be easy to gauge the passage of time with a simple glance. Once the exam gets going it is

unlikely that it will run fast or slow, but just to be sure check that you and the exam remain synchronised as time passes.

Experiment with wearing your watch with its face on your wrist, as this may allow you to keep track of time during an interview less conspicuously. Patients, even pseudopatients won't much like you continually (obviously) checking your watch.

Using a watch has several advantages over using a timer. First it is a more normal sort of time piece and does not immediately remind everyone that you are a candidate doing an exam, in the same way that setting a timer on a desk does. Second, since you are not allowed to take in a clipboard, you'll not be able to place it on top of the clipboard the way you can in the OCI. Fourth, there is no guarantee that all stations will have a table that you'll be able to place a timer on, so it's not clear where you should be putting it. Lastly, if you do put in on a table, it pounds to peanuts you'll leave it a station along the way, and you'll have to sheepishly return to grab it. (Of course most of these disadvantages also applied in the OCI, but in that format, I think the disadvantages are outweighed by the advantages).

The three minute wait

Of all the zones in the OSCE, the three minute wait is the most important. You should spend a deal of time working out how you'll use these vital minutes. I'd suggest you do something like this.

Ideally you should be leaving the previous station just as the bell is *about* to ring (see below). You should wait outside the door of that just exited station until it rings. As soon as it rings make your way to the X on the ground where you're to wait for the next bell. If you did leave the last station just before the gong, you should have three full minutes. Use them wisely.

Minute 1 – Eat, drink and be merry … well be relaxed anyway.

If the OSCE has six stations, two active byes and one passive bye it will run three hours. That is a long time if you're not having a break. There is no way you'll be able to keep up a relentlessly best performance for that long. You need to find breaks wherever you can and this minute standing on the X is one of the places.

Assuming the next station is a station and not a bye, spend the first minute trying to relax. You should practice this, as I'm guessing that relaxing will not come easily during this period. Ideally you may have done some relaxation training specifically for this moment, and if so, this is the time to think of your peaceful scene.

If the X is outside an active bye, take two minutes and if it's outside a passive bye take all three. (Just make sure that it *is definitely* a passive bye before you soak up all three minutes. It is extremely easy to get disorientated between stations).

This micro-break is also your opportunity to dip into the food and drink you brought with you.

You will of course be looking at the sheet outlining the task during your microbreak. If it is a really long task, ditch your microbreak and go straight into reading. You won't be able to relax anyway, if you spend the first minute wondering if you've enough time to read the task.

Minute 2 – RTFQ

This is the minute where you read the question. It is the most important minute of the station, and the one where things are most likely to go wrong.

Read the task set out before you. Read it and then read it again. Make sure you know exactly what it is that you are supposed to do. Like all exams you won't get any marks for an outstanding response to a question that you weren't asked. It is amazing how many times people assume that the task they have been given is one thing and it's actually another. Read the task slowly one more time to be sure.

If the question is lengthy, you might consider reading the last paragraph first. This should give you an idea of what you're supposed to be doing before you read the synopsis and that might help you focus on the aspects of the synopsis most relevant to the task as you're reading through it.

Watch out for **bold type.** Important instructions are often written in bold type, so as to stand out. Unfortunately, people can become so anxious in an exam that they may become bold-type blind, particularly if the bold type is at the end of the instruction. Look for bold type and read that instruction, particularly carefully.

One of the rules of planet OSCE is that you can be asked not to do something that you normally would do. Read these omit instructions with extra care (they are often in bold type). If the instructions says, for example, "you are NOT required to examine the patient's neurological system", then, guess what, you are NOT required to examine the patient's neurological system, even if, in the real world in this situation you would. Not only are you not required to do it, but if you do do it, you'll burn up valuable time and not get any marks for it.

Omit rules are not always straight forward however. If the instructions say "you are not required to conduct a *detailed* examination the patient's neurological system" (note the word detailed, which will not be in helpful italics in the real thing) you should not assume that this is the same instruction as that in the paragraph above. In fact this instruction probably indicates that you *should* make some passing examination of some relevant aspect of the patient's neurological system, just not a *detailed* examination. If you are offered this instruction, it is quite likely that omitting any neurological examination will see you marked down. Tricky ain't it. Well no, it's not actually, not as long as you read the question!

Now before minute three, just read the question again. Are you sure that you understand the required task?

Minute 3 – Getting into the scenario

Use the remainder of your wait to get into the scenario. Really try to put yourself there. Imagine that is just another day at work, and that the instruction you've just read on the card has instead been delivered to you by your usual consultant or by a fellow registrar or by who ever the card implies gave you the task. Imagine now that you're on your way to the scenario and that are standing in an elevator, say, thinking about how you'll handle it.

In this imagined real world, you'd be more relaxed. For example, you wouldn't worry that you really didn't know *everything* about the illness that the patient you're about to see has, you'd just be confident that you'll do your best like you always do. Use this minute to think about the things that you feel you'll need to cover from a real world perspective, as

opposed to an exam perspective. You have just got to trust that most examiners will have made their exam world significantly overlap with the real one.

In the real world of course, you're not usually restricted to just seventeen minutes, but sometimes you do face pretty steep time restrictions, so imagine its just one of those times. You might usually want more than seventeen minutes to introduce yourself to a patient and then explain the management of chronic fatigue syndrome, but seventeen minutes is all you've got, so get on with it.

During this time, you may also want to briefly consider what criteria you feel the examiners may have set for this station, using your knowledge of previous stations and your experience of writing your own station. If you do this at all, and I'm not sure I'd advise it all, do not spend very long on it and do not focus on it. It will be much more important to use this time to get yourself into role and to think about the problem from your usual clinical point of view. It will be almost impossible for you to second guess the examiner on the hop. Remember that the station's writers have worked on this station for many hours and would have spent a good deal of time thinking of appropriate criteria. You, now, have less than minute. It is unlikely that your efforts at second guessing will be terribly successful, beyond guessing the bleeding obvious. Too much thinking about what the examiner wants will get in the way of you getting into role and that task is vital.

The active bye

In the active bye, you'll be given some material that will relate to the next station. In all likelihood this will include some reading material, that you are expected to at least peruse if not digest.

Take your time with this. Re-read the question (you've got oodles of time), so that you can't possibly answer a different question and then carefully peruse the material given. Be aware that sometimes you are deliberately given more material than you could possibly take in seventeen minutes. This may be a deliberate manoeuvre on the part of the examiner and is not an unreasonable tactic. In the real world, we rarely have time to review all the information at our disposal.

In an active bye, you might want to take a little time to think about the criteria you feel the examiner will think important, but again, do not allow this second guessing to interfere with your getting into role.

The passive bye

These are definitely a mixed blessing. Certainly they provide you with an opportunity to rest, but if that just turns into an opportunity to fret, then you've not achieved much. Before the exam, visualise how you'll use this time, and then use it in that way, resting and recuperating. You may need to visualise several different ways of using it depending on whether you get it early or late in the course of the exam.

Do not allow this time to become an opportunity to reflect on how you think you're going so far. Remember that you can't possible know how you're going, so that all the reflection in the world can't help. How are you going? You're going well!

The station

Different stations have different themes and these are reviewed individually below. However all stations have certain elements in common and these are looked at here. In this section I'll tend to assume that the station is a clinical one, with a patient to see, but the principles apply whether you're seeing a patient, relative, professional or colleague.

Going in

First impressions

Just as in the OCI, first impressions are everything, but here you've a lot less time to make them.

Just like the OCI you must pay extraordinary attention to this first 60 seconds of each OSCE. Again the examiners (and any actors) must warm to you immediately and it must never cross any of their minds that you might not pass.

In the OCI you were protected by the fact that the OCI examiners don't like to fail anyone. This is less of a problem for examiners of the OSCE. The whole thing goes so fast and is such a conveyor belt, examiners can fairly quickly become fairly nonchalant about failing any one candidate, because they know there'll be another one along in three minutes. In the OCI, examiners have to account for their actions to their fellow examiner and accounting for a failure is harder than explaining a pass. In the OSCE, the examiners do not confer on marks, so an examiner can fail every candidate he sees and never justify his actions to anyone.

Before you get too paranoid though, remember that, just as in the OCI, the examiners won't like to fail anyone that they like. Moreover being liked is probably more valuable in the OSCE as it affords less time than the OCI for the examiner to get clear in her mind, to what extent she is adhering to laid out criteria and to what extent she is simply responding to her feelings about you as a person.

Like the OCI too, the examiner won't like to have to go back on her original impression. If she decides early that you look really good, you'll be fairly likely to hold that mind state for the rest of the seventeen minutes. Just like the OCI though this works both ways. If she has decided early that you are likely to fail you'll spend the rest of that station battling up hill.

You *must* look like someone who thinks that they deserve to pass.

Meet and greet

Practice walking through the exam room door without hesitation at the verge. Unlike the OCI formalities in the OSCE are kept to a bare minimum. There is not enough time for lengthy hellos to the examiners. You'll likely be met by one examiner at the door. He almost certainly won't introduce himself, but may greet you by name (mainly to make sure you're not someone else). He may shake your hand. In all likelihood he will then gesture to the actor possibly introducing her in role. He may or may not gesture to the other examiner and will ask you to set about your task. (Be aware that often the actor is one of the examiners). Often as not there will be a scripted instruction, such as, "This is the gentleman you've arranged to see. Please proceed with your task."

The examiner who greets you is also likely to be clutching an envelope carrying the previous candidate's marks. As well as greeting and orientating you, he may have to pass this envelope to the bulldog. In a small room, this may mean that you and that examiner may have to squeeze past one another as well as do the greeting thing. This is not really a problem of course, but can put you off a bit, so be ready for it. It may also mean that the examiner has difficulty doing both tasks – the greet and the envelope pass - in a timely manner. This is also not a problem, just be ready for it, if it happens.

Look at the examiner who met you. Smile and shake his hand if it was offered. Try to take in the scripted instruction. If you miss it don't worry. It will have been short and will have been designed to orientate you. It should not contain any surprises. All the information you needed to this point, will have been contained in the written instructions.

Assuming that the other examiner is not an actor and is sitting at the back of the room, you might want to acknowledge them extremely briefly. Do not do this with any more than a smile and head nod, and if the examiner is not in your immediate line of sight, you should feel free to completely ignore him. Do not be concerned if there is a third examiner in the room - there will often be an observer present. Observers are there either for their own education or for calibration purposes, they are not your concern.

The preliminaries out of the way, go straight into your role. From this moment on, you are in the scenario and the examiners may as well be in Timbuktu. Unless they interact with you again (many stations script some interaction), they are now disappeared.

What you'll do next will depend on the nature of the scenario, but whatever you do, do it like you would, if you were actually doing it.

Many scenarios will involve a pseudopatient. If this is the first time you've met the patient (according to the scenario) then introduce yourself to him exactly as you would in real life. Exactly as you would in real life, focus upon the patient and use all your powers to build early rapport. Smile. Fix the patient with your eyes.

Explain who you are. Explain what you see as the purpose and limits of the interview. Use the information provided by the scenario and incorporate that into your greeting. For example, mention that you are following on from a previous registrar, or that you've been asked to see the patient by your consultant or that the police often ask you to assess people etc etc.

Apologise as you normally would for anything worthy of apology. Seventeen minutes is a pretty short consult, so you might often apologise for that.

For example you may start off like this.

> Hello, I'm Chris Ryan. I'm one of the psychiatry doctors and I'm following on from Dr Jones whom, I think, you saw last week. Dr Jones is ill this week, but she asked me to see you to discuss how we should try to get on top of your depression.
>
> Now I've had a chat to Dr Jones and I've read her notes, so although I know its difficult seeing someone new, and I apologise for that, don't feel you'll have to go over everything again, because I've got a fairly good idea what's been happening.
>
> Now unfortunately too, we've really only got about fifteen minutes today, so let me apologise for that too. I did think we could do this though, even in that time. Perhaps I could quickly catch up

on where you're up to, and then let you know about the sorts of options for treatment Dr Jones and I had been considering and see what you think about them.

Does that sound OK?

Great, well, let me start by asking, …?

Obviously if the scenario says that you know the patient well, you'll need a slightly different patter.

More Feng Shui

In his little booklet, *Succeeding in the MRCPsych OSCE* (available at www.trickcyclists.co.uk), David Christmas suggests that British candidates should "get into the habit of quickly assessing the room layout", because, among other reasons, it may have been deliberately set up with furniture in the wrong place. I have a feeling that this sort of deliberate trap-setting might be considered unsporting by Australian examiners, so I doubt that you need be concerned about that. However, I may be wrong about that, and it is certainly possible the previous candidate may have left the room in disarray. So it would seem wise to get into the habit of a cursory glance at the interior design and to develop an easy patter that you'll use if you find that things need adjusting.

"Heavens, this chair is along way away, I might just pull it a bit closer, if it's OK with you".

I know you!

Organising an OSCE involves organising literally hundreds of candidates and examiners. Unlike the OCI, it is just too difficult for the College to avoid you being seen by someone you know. They rely on weight of numbers to even up any possible biases. (The can't see list for the OSCE does ask examiners to name candidates that they have a "close personal relationship with", with the implication that they might be excluded, but even this "you-really-shouldn't-have-slept-with-the-candidate" standard seems to be extremely difficult to adhere to in practice).

The upshot of all this is, that, particularly if you are sitting the OSCE in your home state, you will in all likelihood come across an examiner or two whom you know or may have worked with. If your current supervisor, the guy the you see everyday, is examining, he may end up as one of your examiners.

Hopefully, and very likely, this examiner familiarity will work in your favour. If not, too bad, there is nothing you can do about it, though you should be aware that it might happen and be expecting it - you thought that might happen! - so you won't get thrown off. (Remember that sometimes examiners adopt acting roles, so you really would be wise to mentally prepare for the possibility of meeting your Unit's Professorial Head in the guise of a hopeless alcoholic – prepare especially hard if the said Professor *is* a hopeless alcoholic).

If you do meet a consultant that you really feel you've had a bad history with, you might be a little reassured to know that almost all consultants will try to be scrupulously fair even in this scenario (which might again work in your favour). Also, since examiners are not supposed to confer on their marks in the OSCE, there will be little chance of the examiner you know contaminating the examiner you don't.

Setting the ground

Exactly as you would in real life, spend a bit of time finding out about the patient, and even though diagnosis may not be the primary aim of the consultation, spend a bit of time reviewing the patient's complaints.

Nobody comes into to see a patient they have never met before and says, "Right Mr Flanders, let me tell you about CBT for OCD".

Aside from anything else, in this scenario, you'll have been instructed to tell Mr Flanders about CBT for *his* OCD, so you will need to find out a little bit about *his* OCD.

You'll also need to find out a little bit about Mr Flanders. Unless you know him (according to the scenario), ask him briefly about his age, occupation and living circumstances. If nothing else that will build rapport. It is likely to that you'll discover some piece of information that will be important in tailoring the way you deliver your spiel. Fortunately, pseudopatients are much more time sensitive than actual patients and they are unlikely to go off on lengthy irrelevant stories about their children's hobbies or their interest in left handed screwdrivers after this sort of polite introductory enquiry.

Seventeen minutes is a quite a bit longer than most people think. There is time to do a significant amount of work that is not directed solely at the directed task. Good candidates in this exam, seem to have all the time in world, and set about their task in an unhurried workmanlike fashion. Try to go for a look like that.

Another advantage of this unhurried naturalistic beginning is that it will give you more time to remember what the hell CBT for OCD actually involves. It is amazing how this can come back to people as they slip properly into role.

The cryptic task station

The bulk of the session should see you attacking the central task. This will require you knowing what the central task is.

Usually working out the central task will be easy. It'll be the task they gave you on the card, outside the door. Unfortunately it won't always be like that, some stations set up as cryptic task stations, with a task-to-be-revealed.

These stations set you up to assume you'll be doing one task with the information on the card outside the door, but then redirect you to another sometime after you enter the room. A recent exam asked candidates to see a young woman who had that morning taken a small overdose, and directed them to speak with her about her major concerns. About five minutes into the course of the interview the pseudopatient reveals that the precipitant for the overdose was an inappropriate physical encounter with her psychiatrist! Neat eh?

Though unlikely to ever be popular among the candidature, the cryptic task station is probably fair game, as real patients are often a little cryptic, and real psychiatrists often have to think on their feet.

What can be done to prepare for the cryptic task station?

First and foremost, don't be surprised if you get one, but don't be continually looking for the hidden task in your stations either. Most stations are not cryptic task stations. Most may

require you to do more than simply address the superficial issues, but the other issues to address are not usually to-be-revealed, they are available to anyone with a bit of reflection on the scenario.

It may be sensible to have a slightly higher index of suspicion that your station might be cryptic task station, if the instructions on the card seem a little vague and non-specific (eg please attend to her major concerns), but again don't go in desperate to find something that may not be there.

It is probably worth routinely fishing for any hidden task somewhere near the top of the interview. After you have established rapport and taken a brief background, you might want to ask the patient if, before you begin on the task proper, he has any particular questions for you, or other concerns they wish to raise, or something similar. This will give your pseudopatient, who has by now decided that he likes you, an opportunity to bring up a concern about something that you were supposed to have elicited.

> Card: Mr Flanders has OCD. Please address his major concerns as he presents them today.
>
> You (after introduction etc): Thanks for that Mr Flanders. I thought today, we'd just look further about your concerns about OCD. How does that sound to you? Is there anything else you were hoping to get out of the session?
>
> Mr Flanders: Well, actually doctor things have moved on a little since I last saw you. See, my wife – Maude - died last month, and now my biggest worry, is how my children are coping.

Okay!

Your first task now is to avoid running from the room, screaming, "I know nothing about childhood bereavement!"

When a cryptic task is revealed, the first thing to do is to collect your thoughts. Pause and collect your thoughts. You weren't expecting this but neither was any other candidate. Unlike most other candidates, you had thought that something like this might happen.

It is perfectly OK to say nothing while you collect your thoughts. A moment's silence is fine, and better that you're quiet for a moment, than you launch off into some half-cocked plan, that you'll wish you hadn't embarked upon in about a minute and half.

In this case of course, there is probably no need for silence initially, as there is a ready made gap filler for this sort of surprise.

> You: Oh dear! I'm so sorry to hear that. That's terrible.

You can be silent now and think.

Do not, by the way, think, "This is cryptic task station. My goal now is to formulate a new primary task and set of secondary tasks". Thinking like this, live in the exam is not playing to your (considerable) strengths.

Think this. "Poor Mr Flanders. What's the best way I can help in the rest of this session?".

You do not of course need to have an immediate answer to this question, because you'll have several more minutes thinking time, while he reveals a whole new tranch of history.

> You: And your main worry now is how the kids are coping. Of course. Tell me. What happened?

After he's given you the rest of the history, then re-orientate him, and yourself and the examiners to the new task.

> You: XXX

Proceeding with the task

., or what it is that they understand about CBT or what they were hoping to get out of coming.

Make sure, of course, that the bulk of the session sees you attack the central task.

Remember though that every OSCE is extremely interested in how you establish rapport and interact with the patient (funny that psychiatrists would want to assess that!), so it is not like you've been treading water while you've been doing all that setting the ground stuff.

Having said all of that, you need to keep the task in mind at all times. If the task is to explain CBT for OCD and you spend too much time getting details on the patient's history, including say co-morbid depression, previously tried treatments, drug and alcohol use, you'll eventually be asking questions and scoring no points. It's a balancing act, but most people, at least when they start their OSCE preparation err too much on the "just the task ma'am' side.

Try not to deliver the task as if you're reading it out of a text book. You're explaining CBT to *this* patient, not to medical students in a lecture format.

Remember too that it may not be unreasonable to acknowledge that you'll not be able to complete a lengthy task in the time allocated and that you'll need to schedule "another appointment or two" to finish off.

It's the empathy stupid

Oddly it also seems common for the OSCE format to rob normally excellent clinicians of almost all their natural empathy.

You should be able to get around this if you've imagined yourself properly into your role. However, if you're still finding this hard, you might do well to mechanically remind yourself that empathy is important, and that Mr Flanders may be quite apprehensive about getting his OCD treated, or that Mr Kompowsky might find his persecutory ideation frightening, or

that Mr Van Houten is really scared that he's now started thinking of taking his own life, and that perhaps you should reflect your understanding of these feelings back to the patient.

Timing for an extra special change

Use your watch to monitor your time as you go. Unlike the predictable OCI, it is not really possible with the various OSCEs to pre-determine where in your task you should be at various points (unless this is specifically scripted). I suspect though that in broad brush strokes, you should probably be into your task by four or five minutes, though there will be rarely be a rush to be in much before that, and you should be looking toward termination with two or three minutes to go.

Stations that ask for a brief chat with the examiners in the last few minutes will require you to adjust these estimations accordingly.

Finishing up

There are now two types of OSCEs that can be divided by how they finish. There are those that finish up the task at the end of the OSCE at 17 minutes, and those that demand you finish the task with a few minutes to go so that you can have a quick chat with the examiners.

The full 17 minute OSCE

No matter where you're up to, the scenario will end instantly at the ring of the bell at seventeen minutes. Your mission is to finish the task on your own terms at 16 minutes and 45 seconds, and be outside the door to hear the seventeen minute bell.

With a few minutes to go, look to exiting the scenario, in the way that you leave scenarios in the real world. In the real world, you don't leave patients by getting up abruptly and announcing "I guess that's it"; so don't do it here.

Let's assume you are on station one, and that you set your watch to twelve at the first bell.

As your watch inches toward 12:18 you should, for example, tell the patient you'll have to finish up in a moment and ask if he has any questions or concerns. This gives your pseudopatient an opportunity to bring up some scripted prompt that she has not had an opportunity to deliver before. If she does this, address her concern directly and concisely. Everything you say to this response will score points.

If your pseudopatient doesn't have any other concerns, summarise what you've been talking about and, at 12:19:30 say your goodbyes, thank him for talking to you, tell him you'll make another appointment to catch up next week and then get up to go. All, just like you would in the real world. Although in the real world you've usually got to get the patient out the door of your office, not vice versa.

As you leave, you might again look very briefly at the examiners and smile to reassure them that you know what you're doing. They may seem a little surprised; almost all candidates seem content to be gonged out of the OSCE scenarios, hardly any leave on their own terms. They may even ask you, as they are instructed to, if the candidate leaves "early", whether you have anything else you'd like to do. If they do, and they probably won't because they are as aware of the time as you are, you should simply, glance at your

watch (to check the time) and say, “No, thanks, I think I’ve covered most things, and I think my time’s about to end anyway”, smile again and take your leave.

Obviously it is crucial that, as with every other moment of the exam, your timing is impeccable. This leaving-on-time thing looks fabulous, it really does, but it will backfire rather badly if you think your leaving at 12:19, but your actually leaving at 12:09. Once you step out the door, they won’t let you back in.

Most candidates seem to have the view that they should, quite literally use every second of their seventeen minutes. If I leave early, they say, I may have missed an opportunity to cover the vital point that will have made the difference to my passing or failing the station. This attitude is muddleheaded.

First, I am not suggesting that you leave the station early at all. Ideally you should be just leaving the station as the bell rings. All I’m really suggesting is that you include terminating the interview in the time you’re allowed. No one argues that you should not include beginning the interview in the time you’re allowed, but almost all candidates seem to think it perfectly acceptable to end the interview by bolting out the door, shouting, “Sorry, times up!” over their shoulder, as if no one had told them that they’d only have seventeen minutes for this interview.

Second, even though the OSCE is criterion based, it will be a very rare examiner indeed that will fail an otherwise excellent candidate just because they did not mention something that the sheet in front of them tells them it is mandatory to mention. As mentioned above, the examiners are instructed that the marking criteria are only guidelines. They are admittedly pretty strong guidelines and should be, because reliability is crucial in this exam, but they are only guidelines nonetheless. Moreover, the examiners are narcissistic doctors and will feel (with some justification I would argue – being a narcissistic doctor myself) that it is they, not some piece of paper, that is able to best judge the worth of a candidate’s performance. The upshot of this will be that if you’ve done an extremely impressive job in a station in all respects except one. Even if that respect that is listed as mandatory, almost all examiners will simply mark you down on that criterion, not fail you.

Third, even for the rare examiner that will fail you for not saying the magic mandatory phrase, there seems little reason to think that you’ll say it in that last minute if you’ve not said in the first sixteen.

Fourth, beginning and ending the interview are big parts of the criterion based performance. Every station either makes direct mention of these in the criteria or contains fluffy interpersonal criteria which would be strongly biased to a good beginning *and end*.

Fifth, getting out of the station at time gives you your full three minutes in the wait station, and as I’ve argued above this time is every bit as crucial as the time spent with the examiners.

Last, the examiners will assign most of your marks after you have left the room. Your efforts at termination will be the last things they see. You want that last thing to look really good.

The lets-have-a-little-chat-at-the-end OSCE

These OSCEs usually promise that the last X minutes of the exam will see you conveying your impressions or other information directly to the examiners, one of whom may be magically transformed from the patient he was a minute before.

Basically the same principles apply to these vivas as apply to the first type, but they are a little more difficult to carry out. Start the viva with your standard introduction, but, if appropriate to the scenario, include a warning that after about fifteen minutes you'll just be having a brief word to the psychiatrists over there.

Terminate the interview exactly as you would above, adjusting for the lesser amount of time, but instead of exiting, turn instead to the examiners and make it clear you're ready to move on to this phase of the station. You'll need to practice this manoeuvre, its not especially easy. If you can't get the finishing up with the patient thing right for this sort of station, don't worry, suspect it is less important in these one's than in the full 17 minute jobs.

Finishing early

If you do finish early, a rare but definite possibility, spend the last few minutes, before your exit routine, doing two things in order. First ask the patient if there is anything else that has been bothering her, in case there is some other element to the whole station that you've not been able to elicit yet (almost certainly, if the actor likes you, she'll throw you a life line). Second reflect back with the patient on what you have covered.

Get the look

Just as in the OCI, the candidates that do well are those that are able to communicate to the examiners that they are not phased by having been set this task. Indeed not only are they not phased, they are pleased to have been set it. They find the task interesting and challenging but not in any way beyond them. They always look as if they're in control with out ever looking arrogant.

This look is hard to maintain at the best of times, but it is nigh on impossible toward the end of three hours of torture. Paradoxically though it is at the end of the OSCE that you need the look most of all. The examiners have also endured three hours of torture – not as traumatic as your's but more boring. At the end of the exam, the examiners need the look more than ever.

That is the look you're going for. Make sure you get it.

Stations specifically setting a clinical task

These very clinical stations make up the bulk of the stations. So far we have had:

- Develop a management plan for panic
- Discuss a suicidal patient with his case manager
- Counsel a patient about ECT
- Counsel the relatives of patient recently diagnosed with Huntington's
- Assess a patient with chronic renal failure who wishes to discharge himself against advice

- Explain the management of chronic fatigue to a patient
- Speak to a mother about her behaviourally disturbed child
- Speak to a teacher about school refusal in a twelve year old.
- Assess the competence of a patient with chronic schizophrenia to consent to surgery
- Develop an initial management plan for bulimia nervosa
- Advise about the use of lithium in pregnancy

These are obviously the back-bone of the exam, and your best hope in dealing with them is to place yourself in the situation you'd be in if you were asked to exactly this task during the course of you're normal work.

I cannot emphasise enough, that if you're already good at what you do, you will be able to complete this sort of task at least satisfactorily. It is not necessary that you have a working knowledge of all the latest studies on chronic fatigue to successfully "explain the management of chronic fatigue to a patient". If you had been asked to do this in the course of your normal work, you would not have responded that you couldn't possibly because you don't know anything about chronic fatigue. Instead, you would, even if you didn't know anything about chronic fatigue, get on and do it, because you do know a lot about speaking with patients and about management schemes in general and you'd adapt that knowledge to this patient, perhaps thinking you'd get her back to see you again after you'd read up on chronic fatigue. Well what applies in real life, applies in the OSCE too.

Knowing specifically how to manage a patient with chronic fatigue would certainly have been an advantage to the candidates that attempted this station. But I am willing to bet that the biggest part of that advantage would have been that those candidates would have felt more confident than their fellows as they entered the room. This station was as much about establishing rapport with a difficult patient as it was about chronic fatigue and only an extremely cursory acquaintance with chronic fatigue management was all that was necessary to pass.

I have no doubt that many candidates had never seen a patient with chronic fatigue in their lives, but I am not confident I would have been able to tell which those candidates were.

Remember in these and in all the stations you may utilise resources that you'd normally find in the pretend environment. Feel free to tell the patient you'll be giving her a pamphlet you have on Chronic Fatigue or that you'll be referring her to an occupational therapist within the hospital in specialises in setting up exercise regimes. Don't get carried away this strategy and try not to make it sound too pre-rehearsed. Also, as in the OCI, avoid giving the impression that you're going to hand over all management to others.

Note from the list above that there has been the predictable emphasis on Child Psychiatry and Consultation-Liaison. If you've not done either of these for some time, you'd be wise to brush up on things like school refusal, depression in childhood, delirium and depression due to general medical illnesses.

It also seems extremely likely that you will be asked to start or otherwise explain some form of management to a pseudopatient. This sort of task fits well into a seventeen minute format and we've had one such question in each exam so far. Fortunately, there are a

relatively limited number of management interventions in psychiatry, so it would seem wise to have something practised and practical to say on most of them. In fact you almost certainly have something like this for most therapies already, so its really just tidying that up.

I'd suggest that you have something to say on all potential interventions using headings like these:

1. What is the treatment or what does it involve?
2. What are its indications in your case?
3. How does it work? (Often answered essentially with "we don't know")
4. What do we know about its effectiveness?
5. What are its side-effects?
6. How is it taken or conducted?
7. How will we end it?

Try to have something you're comfortable with for all of the following: antidepressants, lithium, other mood stabilisers, antipsychotics (especially clozapine), anti-dementia agents, CBT for depression, CBT for OCD, graded exposure and systematic desensitisation and the psychotherapies (esp psychodynamic, IPT and DBT).

Remember too that, particularly for psychological therapies, the primary aim of session 1 is to make sure that there is a session 2, so, as I've emphasised endlessly above, make sure you give plenty of attention to establishing a rapport with the patient and demonstrating you understand how they feel. A bland encyclopaedic explanation of the whys and wherefores of IPT (however accurate) is not going to score many marks.

General medicine - station one

Station one is always the station that replaces the old General Medical Exam. So far we have had:

- Conduct an examination of cranial nerves II, III, IV & IV in a patient with functional blindness
- Conduct a cardiovascular exam in patient on clozapine, and interpret slightly elevated lipids.
- Conduct a thyroid exam in a patient going for ECT.

This should be the easiest station in the OSCE. It's easy, because it is predictable and provides a good return for study of a circumscribed area. The basic play of station one is to conduct a physical examination, and since the patient is a pseudopatient, you can be pretty much guaranteed there will be nothing to find!

Preparing for the physical exam is a snack. All you need to do, is to purchase a text book that the physician candidates use to prepare for their short cases (Talley and O'Conner is still the standard), then simply rote learn the various exams and practice them over and over on willing relatives or study group members. (Nothing bonds a study group more, then a few dozen GIT exams between friends). You should also spend a morning or two with a recently passed physician trainee, just to get the whole rhythm of the thing right.

The physical exam should be the whole vaudeville routine you learnt a hundred years ago for your medical finals. For example, unless instructed explicitly otherwise, begin the respiratory exam (counter intuitively) at the hands and make it abundantly clear (perhaps without mentioning it) that you're looking for clubbing and testing for weakness of the small muscles of the hand.

So far the medical questions have been very focused on areas where psychiatry clearly crosses medicine. This is different to the old general medical exam where questions could have a medical flavour that had little to do with psychiatry. For the old format it seemed wise to brush up on your medicine by re-reading a good introductory medical text, like Rubenstein and Wayne. Now though that may not be necessary. It is still a little to early to tell, but given that such a great percentage of the marks is based on the examination (45-60%) I'd be inclined to focus on this rather than spending time learning about the latest treatments for rheumatoid arthritis.

Remember the "you are there" principle. Do not just tear into the examination and history without taking the time to introduce yourself, establish rapport and ask permission to conduct the physical exam.

The three stations so far have also required at least a brief history – actually in two of these the history wouldn't have been that brief. You should know roughly how long your examination of each system takes (including your commentary as you go) so you'll have a rough idea of how long you've got to take a history before you begin. If you're really good, you can examine and take a history at the same time (giving the commentary at the end), but this is too much for most people and I'd not recommend it unless you feel really confident with your physical examination technique (really confident!).

You may be asked to interpret some investigation or other, so be prepared for that. Before the exam you should really re-read (probably for the fifth time if you're like me) a little booklet like *ECG Made Easy*. Your study group should also find a tame radiologist to spend a few hours showing you around the basics of chest x-rays, head CTs and MRIs. Actual films seem a little unlikely given the need to standardise, but it will be easy to provide poster size prints of films or films that can viewed on a notebook screen. If you've really got one of those ace study groups, you might also track down a neurologist to give you a tute on reading EEGs. With all these things, all you really need to know is how to look at the thing *as if* you know what you're doing – that is, the order of approach, the standard patter etc. Thankfully it is not really necessary to *actually* know what you're doing – though, of course, that will be good if you can pull it off.

If you have looked good as you've read the CXR, proceeding orderly through the task with a confident patter is almost certain that the examiner will largely overlook the fact that you completely missed the large cavitating lesion in the left upper lobe and will simply bring you back to it, by asking what you think of this area.

It is necessary to briefly mention the station 1 from the New Zealand exam, if for no other reason than it is likely to spawn unnecessary panic among trainees. This station asked candidates to exam a patient prior to ECT suggesting that the patient may have had a

thyroid disorder. Unfortunately it was also scripted to reveal a history of bowel symptoms for which bowel cancer was a possible cause. The station, with its hidden agenda, was an unmitigated disaster. It was poorly written and conceived, as clearly reflected in the mean mark of only 11 out of 50. If the format of the exam had allowed it, it would undoubtedly have been recognised as offering no possibility of fairly discriminating between candidates and would have been excluded from consideration in determining the final mark. Unfortunately the exam format doesn't allow this sort of maneuver, especially for station 1, where some candidates have been promised at least the pass mark on the basis of having previously sat the General Medical Exam. I am only mentioning it here because it has the potential to put the wind up future candidates. Its presence does not signify that now anything is possible or that you must always be on the look out for a hidden agenda. It was a badly written question and that is the end of it. It happens. These questions are hard to write and occasionally the process will throw up a flop. End of story. Ignore that question and get on with your preparation.

Doctors (and other health professionals) in trouble

Stations that might be loosely grouped under this heading raise some issues that may have previously been dealt with in the old consultancy viva. So far we have had:

- Discuss an impaired junior medical registrar with a senior medical registrar.

Other likely scenario's might involve:

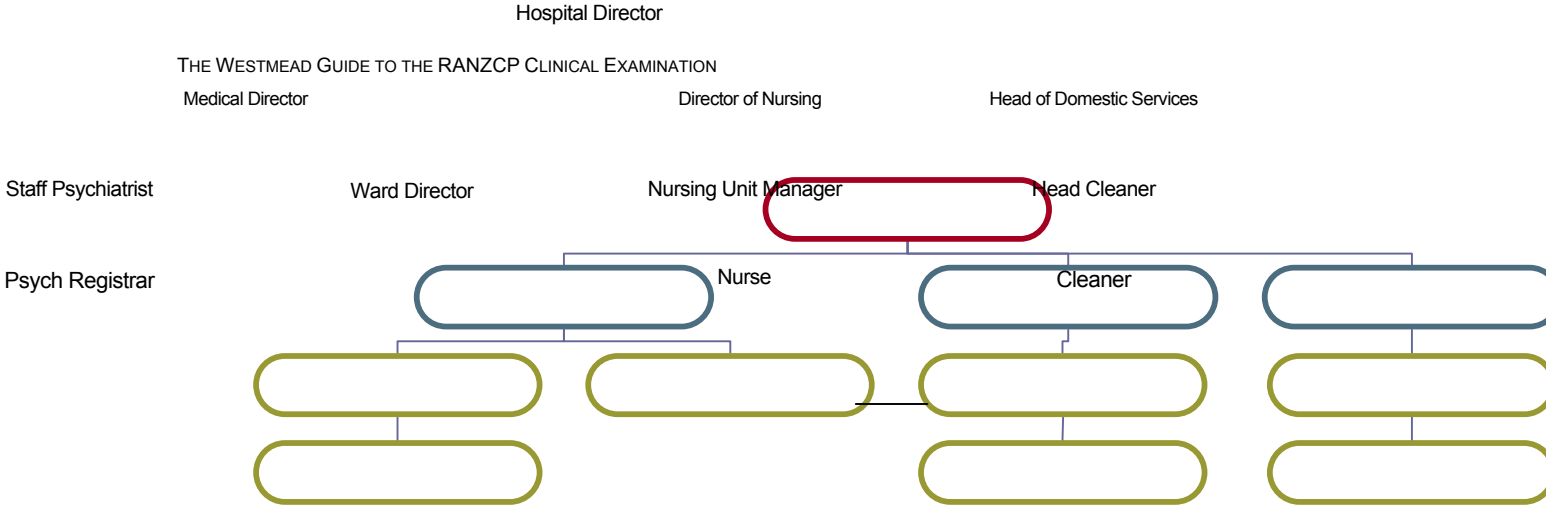
- A registrar or resident who is seeing a patient out of hours.
- A nurse who comes to work intoxicated.

The first thing to do in this sort of scenario is to ask yourself questions about exactly what your role is in this situation? What is the nature of your relationship to the person you are speaking to? Should you be responding as a friend, or as a professional colleague, or as supervisor? Are you acting as an independent clinician or as an agent of the hospital you work for or a responsible member of the College?

Try to figure this out, in your minute outside the door. Then once you're inside the room, clarify the nature of the role with the person you're speaking to and then let that person know what role you think you're taking. In the rare, and frankly best avoided, scenarios where you cannot but fill two roles, it is usually mandatory to state which hat you're wearing as you speak.

The second thing to bear in mind is the structure of the administrative hierarchy that all players (including you) are embedded in. This hierarchy should be utilised to solve the dilemma you're confronted with by adhering to a very simple rule. In hospitals and similar hieratical organisations everyone has a supervisor and it is the supervisor who is charged with the responsibility of … supervising. Never ignore a hierarchical structure (or at least never do it without a really fabulous reason).

To illustrate, imagine the hierarchies that might apply in a typical ward.



The simple rule for hierarchies goes like this: if you've got something important to address, only ever address it along the tracks that the hierarchy provides.

Imagine for example that you believe that a nurse on a ward is in someway impaired. The way to tackle this is not for you to speak with the nurse yourself. According to the hierarchy, the only way for you to track across to the nurse is via your supervising staff psychiatrist, through the ward director and then the NUM, and that is the way it should be done. This will mean that the nurse's supervisor, the NUM, will be able to fulfil his role of supervising the nurse. You can in fact speak to the NUM yourself about this matter, but only if you do so in the role of the staff psychiatrist's or Ward Director's agent. That is to say you told them about it and they told you to alert the NUM of your concerns.

Note too that in this particular hospital, the Ward Director has no clear responsibility for the person cleaning the ward, so that if you had had a concern about the cleaner, that concern would have had to have tracked up an additional step to the medical director, before whipping across to the Head of Domestic Services and down to the cleaner himself.

If you think that all of this seems like an enormous amount of bureaucracy for something that might be more easily dealt with by a simple quiet chat, like one friend to another, then remember step one – What is your role here? You may also think that this leads to a lot of people discovering something that might have been best dealt with quietly. Well some matters can be dealt with by a simple quiet word, but generally these are fairly trivial matters that you're unlikely to get thrown at you in the viva. If the concern is of sufficient magnitude that you think that the person's supervisor should perhaps know about it, then you should involve them, via the appropriate pathway, from the start.

Deal with a critical incident

XXX

Resolve a dispute

The OSCE's really lend themselves to testing a candidate's powers of dispute resolution. It is just too easy to set it up with actors either as the main game for a station or as a small part of a station focusing on something else. It is well worthwhile giving serious consideration as to how one resolves disputes before going in.

So far in this category we have seen:

- Manage a disagreement between ward and community staff about a patient with schizophrenia (pre-exam example questions).
- Assess a patient wishing to discharge against advice (June 2004).
- Explain the management of chronic fatigue to a patient interested primarily in natural treatments for candida (October 2004).

Disputes vary enormously of course, but there are some common elements. The suggestions below apply primarily to an occasion where you are called into a situation where an individual is in dispute with hospital staff, such as might occur with a discharge against advice, or when a relative is angry with his relative's care.

- Whenever there is a serious dispute everyone else involved or by-standing will anxious or annoyed, you must not be either, or at least it must not appear that you are. Try to adopt an air of quiet (but obvious) confidence that will (hopefully) radiate itself to those about you.
- When entering the scene, immediately identify yourself and establish via verbal and non-verbal communication that you are a friendly person, who seems to be in charge. Make it clear to the patient (or relative) that you are their advocate. I would say: "Hello. Mr Simpson. I'm Chris Ryan, one of the doctors. What can I do to help?" Smile broadly, and make open and slightly exaggerated hand gestures of supplication.
- In any sort of dispute never try to impose your point of view until you have let the other party (or parties) have their say. In fact, if it is at all possible, let them keep on telling you what the matter is, until they no longer wish to talk. (In the OSCE this will be easy because, unlike real patients, they are guaranteed to eventual stop talking). During the patient's monologue, do nothing but smile and nod and try to make it clear that you are considering all his points very seriously. Take care not to actually agree with any points that the patient may make against other staff, but do not dismiss them immediately either. Simply listen and nod in a vaguely sagely sort of fashion.
- When the patient has finished his side of the story, confirm that you have been listening and that you understand. Bear in mind that, delirious or psychotic patients will often be unable to take in more than a few key points, so in these cases, try to keep your responses simple. Even normal people, who are simply angry, won't be able to tolerate too much information. Agree with as much of the story as you can, taking care not to agree with psychotic phenomenology or direct criticism of staff.
- Demonstrate that you've picked up the emotion behind the patient's words. Try to identify yourself with the patient, just a little. For example:

  > "Obviously you're very keen to go home. That's understandable, you've been here a long time, and it is a frustrating place. If I were in your position, I'd want to go home too. But unfortunately…"

- When putting your side of the dispute convey the attitude of one reluctantly relating an unavoidable fact. Make it clear through the way you relate your side, that it is not your fault that Mr Simpson has to stay in hospital or that institutions often fall short of people's reasonable expectations, it is just a regrettable and unavoidable consequence of the situation. Depending on the circumstances you should appear almost as if, that were up to you, you'd let him have his way, but that unsurmountable forces were mounted against the two of you and that you both have no choice but to go along with them. Emphasise that the patient will get what he wants as soon as possible without making any actual promises that are not likely to come to pass.

- If the patient is extremely upset, delirious or psychotic there must be a risk of violence. In these cases you should be monitoring the distance between yourself and the patient, making sure you're far enough away to avoid being struck should he lash out. (Of course actual violence will be fairly unlikely in an OSCE).

Other likely stations

Time will tell what other types of stations our elders and betters may throw at us and for now it is mainly speculation. It is likely though they will draw on the sorts of areas previously covered by the Consultancy Viva. It would be worthwhile at least considering in general terms how you would approach a station that asked you to do any of the following:

- Devise a speech to a group about something (eg anorexia nervosa to private girls school)
- Speak to the media about something
- Set up a unit
- Devise a research project
- Deal with a critical incident.

Give a talk

Giving a talk, or speaking to the media follow essentially the same rules, so I'll deal with them together. It is unlikely you'll be asked to give a talk there and then, in the OSCE. More likely you'll be meeting with someone – a journalist, school principal or colleague – who wants to talk to you about giving a talk to someone else.

Do what?

What exactly was the person approaching you envisaging? What is the talk to be about? Who will it be to? What particular issues were they wanting addressed? What is the person hoping the talk will achieve?

At this point, or possibly a little later depending on the answer to the next two questions, you should ask yourself whether is right to go ahead and give the talk in the format requested. It is extremely unlikely that the scenario will be set up so that the best response is to walk away from the request entirely, but it is certainly possible that the best response may be to negotiate on the specifics of the request. For example it is almost certain that you should not talk about the specifics of a case like a person with schizophrenia killing someone – you're unlikely to know the specifics and even if you did they are likely to be the subject of pending court action. However it may be that this may be a genuine opportunity to talk in general terms about schizophrenia and dangerousness and to correct public perceptions about the dangerousness of people with mental illness.

Why now?

Requests to give talks or to speak to the media don't arise from thin air. Something has happened. Perhaps a patient with schizophrenia has killed someone. Perhaps a girl at the school has recently committed suicide. Perhaps there has been a wave of anorexia nervosa in the community and the local priest hopes that a talk from you will curtail it. Ask

the person asking you to talk what happened to trigger their request so you can put it all in context.

Why me?

Why is the person asking *you*? Given that you are an advanced trainee and not a fully fledged psychiatrist, this is a reasonable, indeed a crucial question. Ask whom ever you are speaking to why it is they have asked *you* to give the talk and suggest to them that there might be others who might be better suited (eg your consultant, another consultant with expertise in this area, or the College spokesperson on this issue). Do not spend too long on this aspect and certainly do not find yourself refusing to take part because you feel that you're not the best person. It is inconceivable that an examiner will write a seventeen minute scenario in which a best response is represented by a candidate refusing to engage the task. Also do not sound paranoid in your "why me" enquiry. Your aim really is to communicate to the examiner that you're not naïve and that you realise that there are a number of ways to skin a cat. Note that that since the scenario is asking you to skin a cat you'd better not wait too long before you start skinning.

What resources?

Having decided to go ahead and negotiated in broad terms the thrust of the talk, you now need to negotiate the setting. Much of this will have come out already but before you give a talk you need to be clear on all of the following because the details will greatly influence what it is that you say.

- When will you be talking? Have you sufficient notice to prepare properly?
- Who will you be talking to? How many people will be there? What type of people are they?
- How long will you be talking? What aids will be available to assist in getting your message(s) across?

If you are talking to the media you also need to know.

- What medium is it? (radio, television, newspaper)
- If it is a broadcast medium will the interview be live, and if not to what extent could it be edited without your consent. Again try not to appear paranoid, but rather well aware that a 25 minute interview can be reduced to a 10 second grab.
- If it is to be a newspaper article, ask if it will be possible to view a final draft before it goes to the editor.

The safest interviews are those that go out live or those where the journalist promises some review of the final draft. You should be aware though that with all media interviews there is a notion of paying your money and taking your chances, and that it is often a case of accepting little control or not doing the interview at all. (In the world of the OSCE you should always to the interview. In real life be extremely choosey).

Again though try not to sound paranoid while you're checking all this out. Indeed having decided you will give the talk, you should now aim to sound enthusiastic about the opportunity you've been presented with to further the publics understanding of our profession and the plight of our patients.

Occasionally it may be appropriate to enquire about payment, though in fact it will be rare for anyone (except a drug company) to want to pay you for your opinion. If the person does want to pay you, you should at least briefly consider any ethical implications that the payment entails.

Research

About now you should say that you intend to do a bit of research before you give the talk. This research should be encompass all of the following:

- A scholarly review of the relevant literature. (You may wish to spill out any facts you can actually remember about the topic).
- A discussion with some of the experts in the field. (Mention these experts by name, if you can think of them).
- A chat to some of the sort of people you might be speaking to, to get an idea from them what they'd like to hear.
- Lastly (remembering your role as an advanced trainee) you'll obviously be speaking about this issue with your supervisor.

Three points

Lastly, you should discuss with the person, what it is that you are actually going to say. This, of course, should marry clearly with what you've agreed to talk about in the initial negotiations and basically should be reduced to three messages that you're hopeful of communicating. Rank these in order of importance and be aware of the fact that you may not get across all three.

Finally thank the person for the opportunity to talk, clarify the next step in giving the talk (perhaps you'll call her later in the week) and then, as usual, leave at 16:45.

Set up a unit

This was an extremely popular question in the old consultancy viva and it is difficult to imagine that some examiner won't try to find a way to revisit it. Fortunately it is relatively easy to tackle if you've thought about it a bit and follows closely the schema you've already learnt for "Give a talk".

Neither of the two exams to date has included a set up a unit question though there was a very similar question in the sample questions released in 2004. In that case a local church minister has approached your clinic to discuss starting a support group for families bereaved by suicide. Several families in the area had suffered a suicide in the last year and the church wanted to do something to help these families – especially to help prevent further suicides.

I suspect that the most likely scenario will see a colleague, most likely a consultant psychiatrist or possibly a physician, approaching you to see if you would like to set up a unit of some sort or other with her, and wanting your thoughts and input into the project, which would, I expect, see you as a key player. In the consultancy viva this question only varied from exam to exam by the nature of the unit to be set up. Anything is possible, but I think the unit is likely to be drawn from general psychiatry, consultation-liaison or child, since these are the only terms that guarantee an even playing field. In my consultancy viva, a hundred years ago, I was to set up a specialist outpatient PTSD unit. Any disorder is a possibility, as is any specialist population (eg perinatal, non-English speaking background) or treatment intervention (eg patients needing ECT or DBT). What ever you're asked to do the answer is essentially the same, but it is vital that you keep referring back to the specifics of that disorder, population or intervention to avoid the answer sounding to checklisty.

Do what?

What exactly was the person approaching you envisaging? It is likely that a large part of this answer is included in information that you are supposed to provide, but get as clearly as you can what the person is envisaging and what role she expects you to play in it. (These are very reasonable questions, but make sure convey an enthusiasm for the project while you ask them).

It is extremely unlikely that the scenario will be set up so that the best response is to walk away from the request, and, as opposed to give a talk, it is also unlikely that there'll be too much room for debate about the specifics of the request, so only engage in that level of debate if your very confident you're on strong ground. Interestingly in the only sample we have, the clergyman asking for a suicide prevention group, a good candidate would likely have negotiated not to provide a suicide prevention group per se, because there is very little evidence that that would decrease the risk of suicide and some evidence that it may make things worse. Even in this case the candidate should go on to talk about what could be offered – perhaps a support group for the bereaved or strategies to improve knowledge of mental health issues or access to mental health services.

Why now?

Opportunities to start new services rarely come out of the blue. If money has become available; why? If the new unit is to come out of existing resources, why has it become a priority? Ask the person asking you to set up the unit, why they thought we should do this now so you can put it all in context.

Why me?

Again, you need to address the question "why me?" Here the question is less obvious than it is with a talk, so you should spend even less time on it and it is even more important not to sound reticent or paranoid. (This "paranoid position used to be a big problem with trainees sitting the consultancy viva, which is why I keep emphasising it).

What resources?

In the real world this is the most crucial question of all, but I suspect in the world of the OSCE, it should not be lingered upon to long, and is really only addressed to demonstrate that you are not so naïve as to believe that resources are endless and that you can have the best of everything you want.

Ask specifically what resources are available. I suspect it is likely you'll be told, something like that is yet to be clarified and that we should assume that (for the time being) that we can have what ever we ask for. If it is clear that resources will be limited, acknowledge this, but also acknowledge that units often (in fact usually) start small and that they can grow over time. No matter what the answer to this question, state that for the rest of this discussion we should consider the best possible set up, even if is something we are merely working towards.

If there are no new resources to commit to this project then it is worth stating the obvious fact that this means that something that we are already doing will need to be curtailed, but I'd do no more than mention this "downbeat" reality in the world of the OSCE.

Research

About now you should say that you intend to do a bit of research before you get into this thing fully. This research should be encompass all of the following:

- You should spend a bit of time to look at how others have gone about this task already. You'd like to look at the literature and you'd like to call up or visit a unit or two (I here there is one in Paris!). If you know any specific papers or specific units, don't forget to mention them by name. (It doesn't matter if you don't know any, but it is amazing how many candidates do know this information but for some reason don't mention it!).
- You like to try to determine the need for such a service. You can do this both by estimating the need from the literature available (this is you chance to deal the examiner you know the point prevalence of the disorder of concern) and by looking at existing figures in this area for this disorder.
- You'd like to find out how these people dealt with now. You should speak to local staff already experienced in treating this group, and get their ideas on how a new unit should run. (Aside from anything else your job will be a lot easier if these people are on-side.
- You will also get some input from patient and family representatives or groups.
- Lastly (remembering your role as an advanced trainee) you'll obviously be speaking about this issue with your supervisor.

Setting up a unit

Note that it is only now that you're getting to answer the actual question, which I guess serves to underline that all of the above needs to be addressed, but you've really only time to merely touch upon each point.

The specifics of this part of the answer will of course depend upon the exact nature of the unit envisaged and the nature of the illness or the special population. The easiest way to answer the question though is simply to describe in an organised fashion an existing unit you're already familiar with, and adopt this description to the unit you're being asked to set up. Before you go into the exam think about some of the specialist units you've worked in or that you know about and how they are structured.

In your discussion about the specifics of you're unit you'll need to touch on each of the following areas:

- Physical location: note that this could easily be within an existing unit, there is often no need to build a new building to start a new unit.
- Staffing: Unit head, medical staff (consultants, registrars, RMOs), nursing staff, allied health staff, administrative support, cleaners
- Administrative hierarchy
- Treatment approaches and programmes specific to this area.
- Referral network
- Teaching opportunities
- Research opportunities
- Opportunities for expansion and the spread of the excellence that the unit will engender.

Where to from here?

Spread of excellence is probably a good place to finish up this brief meeting. Let the person know again how enthusiastic you are about the project (try to do this non-verbally as much as possible, it sounds a little naff to keep telling someone how enthusiastic you are), and finally mention that you should now set up a second meeting with yourself, the other person and other key players to begin nutting out details. Thank them and as usual leave at 16:45.

Devise a research project

Again this type of question would have to be sitter for the OSCE, especially since you'll be expected to devise some research project during your advance training.

The general format will follow the set up a unit schema, but instead of describing matters such as staffing and treatment programmes, you'll be addressing matters such as appropriate study design, population and blinding. Unless you're a real whiz at this sort of stuff it will be well worthwhile briefly re-visiting your work for the writtens if it now seems a long way distant.

Field work

Recon

Just as with the OCI, you'll know before hand where the OSCE will be. The way that the exam is set up means that the venue has no more relevance to the way the exam proceeds than its physical layout, none the less I'd still recommend a quick reconnaissance trip a day or so before.

Again ring the hospital and ask to speak to one of the senior psychiatric registrars. See if you can arrange a very brief viewing of the proposed location. All you're likely to get out of this is a sense of familiarity on the day, but that will likely lessen your anxiety and that can't be a bad thing. You might also pick up hints on getting there and parking.

Unlike the OCI, the OSCE is often held in a place that is not strictly psychiatric property. Sydney OSCEs to date have been held in the paediatric outpatient department. This may mean that the registrar you speak to, literally can't let you in to see the environment. If that is the case, don't worry, its really not that vital.

On the day

As with the OCI, make sure you will get to the exam centre early. You're required to be there 60 minutes before the start and I suggest you get there at least 20 to 30 minutes before that.

The OSCE is a real circus. Seemingly hundreds of candidates descend onto this one venue with six to ten streams. In the OCI the candidates are usually mollycoddled. In the OSCE it's every man for himself. You're unlikely to be provided with any more than basic food and drink so bring your own if you need it.

Anticipate that the exam will start late. It is a logistical nightmare and it's amazing that it starts at all. Do not anticipate this so strongly that you yourself are late, or I guarantee the exam will start exactly on time.

Once it is up and rolling, there is no scheduled toilet break. There are the three minute wait zones, but a dash to the loo in one of these is not recommended. The venues are often outpatient departments not meant to cope with 200 people all wanting to take a leak at the same time. You should have a toilet plan for the OSCE, but I'll leave you to work out the details.

So long and thanks for all the fish

Good luck

In the end there is way no of guaranteeing that you'll pass the exam. All exams contain an element of luck and this one is no different. Some people claim that the exam is like a raffle, and that is true, but only to a limited extent.

It *is* like a raffle, but unlike most raffles you are in a position to buy nearly all of the tickets. You buy tickets by thinking about the exam and preparing as much as possible. You buy tickets by incorporating good practice into every patient that you see. You buy tickets by keeping an open mind and by challenging what you are told. You should start buying tickets on your first day as a registrar and buy them in bulk in the months leading up to the exam.

You can buy most of the tickets, but you can't buy them all. In the end you'll need just a little luck. So … good luck!!

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