ECE: PRACTICE OCIs (an unofficial guide - by Felicity Plunkett) revised 2010

The observed clinical interview takes 50 minutes. Timed from when the patient *enters the room* (ideally the 'examiner'(s) and candidate should be in the room about 2-3 minutes beforehand.) The examiner should time the 50 minutes and make sure the interview ends then if the candidate has not already done so. Candidates can choose to end earlier if they want. The examiner then leaves the candidate in the room for their 20 min. "think time", before returning for the Viva. (If the patient leaves earlier than 50 min, the candidate has all the rest of the 50+20 min as "think time". Patients who leave within 20 min are replaced.) Obviously in practices all these aspects may not be quite doable, but try to make it as like the real thing as possible, including basic formalities with introductions and in how you address each other.

Timing and structure for the 40 minute Viva part:

Initial part takes max. **20 minutes** (including the candidate's presentation).

'1st examiner' starts the Viva with the following intro:
"Having considered the case, in ten minutes or less please summarize the salient features, including any important gaps in the history and mental state examination, and give your formulation, diagnosis and differential diagnosis. Your time starts now." (start the 10 min from now)

At the 10 minute mark during the presentation the examiner will state: **"You have had 10 minutes"** (but will not stop the candidate if they go on.) After this there is up to 10 min of clarification questions using the prompts. Focus on clarifying the history/gaps, phenomenology grasp, justification of their Dx and Diff Dx.

After 20 minutes, the '2nd *examiner'* begins the next part with the intro:
"Please present your action plan as if you were a consultant psychiatrist taking over the management of the patient at this time."

There are **20 min** for this part. If the candidate is still presenting management plan after ~18 minutes, the examiner should interrupt and tell them when **2 min** of Viva time remain (allows some clarifn questions).

The Viva is ended after **max. 40 minutes.** (NB: it can take less, i.e. between 30-40 min. If all has been covered fully and the grades are clear and not likely to alter, can end the viva pre 40 minutes.)

The "prompts" that examiners are allowed to use during the 30 minute viva are:

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

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

Brief Details re Grades: Surpasses, Achieves, Just below, and Does not achieve.

Data gathering process 20% (History-taking process – rapport, control, balance of open and closed questioning, summarising back appropriately to the patient, handling patient's reactions, etc.)	S A J D
Data gathering content 20% (History-taking content – fullness, crucial areas not missed, sensible prioritisation re which areas were covered, clarification of symptom and course details, etc.)(not MSE)	S A J D
Mental state 20% (Mental state conduct and presentation, including cognitive testing where appropriate – mark on appropriateness to patient, depth, comprehensiveness and significant omissions)	S A J D
Data synthesis 20% (summary, formulation, prioritisation, diff. diagnosis, integration and grasp of the case)(not MSE details)	S A J D
Action Plan 20% (Management Plan - organisation, targeting of key issues, breadth, evidence-base)	S A J D

Detailed Benchmarks for Marking:
(from the official version and from discussions with examiners)

Data gathering process
What does this cover?
- their interaction with the patient re empathy, good introduction and closing of interview
- their overall handling of the interview
- their technical competence in eliciting information

S	A	J	D

- **Surpasses the standard** - Clearly achieves the standard overall - a superior performance with prioritisation and sophistication
- **Achieves standard** - NB: the standard can still be achieved if there are minor deficiencies
    - manages the interview environment (where they and patient sit, manages situation if patient tries to interact with examiners or behaves oddly, etc.)
    - explains exam process and timing, orients the patient, appropriate introduction
    - engages the patient as well as can be expected
    - reasonable structure and organisation yet ability to follow important cues more flexibly and to focus on the important issues in the case, not just ask a rote list of 'history headings'
    - recognises emotional significance of the patient's story and responds empathically
    - can adapt interview style flexibly to patient and uses balance of open & closed questions
    - summarizes back to patient at times, appropriately
- **Just below** - as for achieves standard but there are deficiencies in a number of areas or poor prioritisation
- **Does not achieve standard** - Significant errors such as:
    - being insensitive
    - aggressive or interrogative or too-rigid approach
    - disorganized approach or inadequate control of the interview

Data gathering content
What does this cover?
- the quality, comprehensiveness *and relevance* of the information obtained

S	A	J	D

- **Surpasses the standard** -
    - Clearly achieves the standard overall - a superior performance with prioritisation and sophistication in history gathered with good depth and breadth.
    - Few if any omissions
- **Achieves standard** - NB: the standard can still be achieved if there are minor deficiencies
    - History and physical examn are relevant to the patient's problems
    - In 50 minutes *not* all history can be obtained of course, so the key issue is how they prioritise and whether they get enough detail about the key issues *for this patient*, and don't miss out any important aspects of history
    - There is appropriate depth and breadth
    - NB: MSE assessment details are not now assessed here
- **Just below** - as for achieves standard but there are deficiencies in a number of areas
- **Does not achieve standard** – significant deficiencies such as:
    - substantial omissions in history or other aspects of assessment (not MSE), no physical.

Mental State Examination

S	A	J	D

What does this cover?
- Conduct and accuracy of presentation of the MSE including cognitive assessment where appropriate (which should be meaningful & targeted). MSE is marked on appropriateness, depth (shld be appropriate to patient & time conctraints), comprehensiveness and significant omissions. Presentation should be succinct, with accurate phenomenological terms & appropriate positive & negative findings.
    - **Surpasses the standard** – MSE is relevant to the patient's problems/circumstances and is conducted and presented at a sophisticated level.
    - **Achieves the standard** – they conduct & present a thorough, organised MSE – assessing key aspects of appearance, behaviour, conversation and rapport, affect and mood, thought (stream, form, content, control), perception, insight and judgement.

- **Just below the standard** – minor deficiencies in technique, organization and/or presentation
- **Does not achieve standard** – significant deficiencies in technique, organization and/or presentation.

Data synthesis

What does this cover?

S	A	J	D

- how the candidate pulls all the information together
- whether they make sense of the patient's predicament
- whether they get to grips with the main issues for this patient
- **Surpasses the standard**
  - Clearly achieves the standard overall, with prioritisation and sophistication.
  - Clinical summary is accurate and succinct
  - Formulation is accurate and makes sense of the patient's issues and situation
  - Diagnostic differential and discussion of this are sophisticated
- **Achieves the standard**
  - Able to prioritise and synthesise the key issues
  - Missing or dubious or contradictory data are noted, as is the relevance of this
  - Formulation of the key elements of the case is reasonable
  - Diagnosis and differential diagnosis reasonably reflect the data gathered. Note that current advice is that if candidates use the DSM system they should cover all the axes. They should use a recognised system, not unusual or vague terms for the diagnosis
  - NB: synthesis of MSE findings is not assessed here in detail but it contributes to the whole
- **Just below -** there are deficiencies in some areas:
  - Summary of history may show inadequacies in their ability to evaluate
  - Diagnosis and differential are inadequate or not well justified
  - Formulation shows inadequacies and problems with prioritisation
  - Lack of synthesis with repetition of material, not succinct, may go significantly over 7 min.
- **Does not achieve the standard** – significant problems such as:
  - Errors in interpreting the significance of the history
  - Inability to support the diagnostic statement, or a significantly incorrect diagnosis
  - Inadequate formulation and lack of a grasp of the key issues for this patient - e.g. formulation is just another summary, poor prioritisation of the issues

Action plan

What does this cover?

S	A	J	D

- the candidate's proposed management of the case
  - **Surpasses the standard**
    - In addition to the criteria as below, management plan is prioritised and sophisticated
  - **Achieves standard**
    - Presentation of a prioritised, comprehensive and structured plan that emphasises the most important issues
    - Plan covers short and long term, is *relevant to the actual patient* and their socio-cultural context, and includes appropriate management of risk
    - Likely response to treatment and barriers to implementation of the plan are discussed
    - Evidence to support and justify planned treatment is mentioned
    - Candidate's own role in the patient's management is mentioned
    - The role of other professionals is also appropriately included
    - Prognosis is covered
    - Minor deficiencies are allowed
  - **Just below** - there are deficiencies in several areas as above
    - Plan is accurate but may not pay enough attention to the actual patient's specific circumstances
    - Plan is not very well-prioritised
  - **Does not achieve standard** - there are deficiencies in most areas as above
    - Management plan lacks structure
    - Management plan is not prioritised
    - Aspects of the plan are inaccurate or technically incorrect
    - Plan is too generic and not tailored to the patient's actual circumstances and issues