MRCEM Part C: 125 OSCE Stations

SECOND EDITION

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Contents

Foreword to First Edition		v
Dedication		v
Acknowledgements		v
Preface to Second Edition		vii
How to use this book		x
Introduction to the MRCEM Part C: OSCE examination		xi
Chapter 1	History taking	1
Chapter 2	Communication skills	103
Chapter 3	Systems examination	145
Chapter 4	Joint examination	189
Chapter 5	Psychiatry	235
Chapter 6	Practical skills and teaching	259
Chapter 7	Acute adult presentations	393
Chapter 8	Paediatric acute presentations	433
Chapter 9	Trauma presentations	467

Chapter 2

Communication skills

2.1 Introduction
2.2 Speaking to an angry patient, parent or relative
2.3 Breaking bad news
2.4 Clinical decision unit handover
2.5 Needlestick injury
2.6 Obtaining consent for a procedure
2.7 Difficult referral
2.8 Driving after a seizure
2.9 Major incident
2.10 Conflict resolution – request for antibiotics
2.11 Conflict resolution – refusing tetanus immunisation
2.12 Febrile convulsion
2.13 Difficult conversation with a colleague
2.14 Explaining a new diagnosis - diabetes mellitus

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2.1 Introduction

Good interpersonal skills are fundamental for senior clinicians. These cannot be tested in other parts of the exam and subsequently form a significant part of any practical exam including the MCEM Part C. Tasks may include:

- Teaching or explaining a treatment or management plan
- Breaking bad news
- Managing an angry patient
- Managing a difficult colleague

Ultimately all of these scenarios require the candidate to be able to share information in an appropriate manner while demonstrating an awareness of what the other individual involved may be thinking or feeling. Effective communication will require a candidate to have considered what the task is asking them to achieve while showing a considered approach to the person they are interacting with.

Important elements to demonstrate include:

- Good use of body language, e.g. active listening or non-threatening posture
- Using terminology suited to the scenario – specifically avoiding unnecessary jargon
- Demonstrating understanding of the concerns of the other party involved
- An ability to remain calm
- An ability to build rapport with others
- An ability to use silence appropriately
- A reassuring and confident manner
- Behaving sensitively towards others

Inevitably some of these skills come more easily to some candidates than others. However with practice of different scenarios and reflection on how they should be tackled (assisted by the mark sheets provided); all candidates should be able to meet the criteria to pass these stations.

After practising some of these scenarios candidates should ideally be able to get into the role and avoid feeling awkward or inhibited. As in all stations it is best to behave as if the scenario is a real one during a normal day at work.

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2.2 Speaking to an angry patient, parent or relative

Curriculum code: CC7, CC12, CC14, PAP17

When dealing with someone who is angry one of the key skills is to prevent the situation from escalating. There are several things that can be done to reduce the tension during such a meeting. As with any meeting always start by introducing yourself and clarifying who it is you are speaking to. If you are in a public area it will be more appropriate to go somewhere private and possibly take another member of staff with you. Though the conversation may begin with you both standing, always suggest you continue talking while sitting down – offer the other person a seat.

It is very important that the person you are talking to feels you are taking their concerns seriously so you must show them that you are taking time to understand the problem. This is demonstrated by using appropriate body language and allowing them time to speak without interruption to show you are listening to them. With regard to the objective structured clinical examination (OSCE) station this will clearly be further reflected in the global marks received.

Once the angry party has explained their concerns it is important to clarify the facts as you understand them; it is appropriate to summarise events that have occurred and check any areas of misunderstanding. To do this you must have as many facts to hand as possible and it is always worth checking data in the exam, e.g. relevant notes may be available for you to read, or (more likely) X-rays may be available for you to show the complainant.

It is appropriate to apologise because someone is unhappy with the treatment they have received and this is often adequate to defuse a situation. An apology does not necessarily constitute accepting that you or your department are at fault. It simply acknowledges the other party's dissatisfaction. Having said this it is not necessary to tolerate derogatory or offensive comments about staff or the department. A balance must be reached on a case by case basis of being prepared to listen to someone who is angry and supporting your staff appropriately.

The discussion should then move onto how to deal with whatever has happened. The first priority is to ensure the individual involved is ok and that there is a safe and sensible management plan in place. This should be mutually agreed with all parties satisfied with the plan. The next priority is to explain that any concerns are taken very seriously and there are several methods that can be employed to prevent something happening again. This may involve speaking to a member of staff directly, educating staff at formal teaching sessions or discussion at departmental meetings. If someone feels their concerns are going to be dealt with to prevent similar errors occurring they will often feel reassured.

Finally if someone remains unhappy, it is important to provide them with information on how to make a formal complaint. Explain that they can receive advice and support to complain from the patient advice and liaison service (PALS). If a case is approached with a suitable amount of understanding, and is seen to be taken seriously, a formal complaint can often be avoided.

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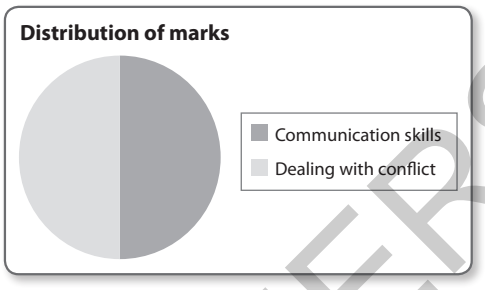
Scenario



One of the receptionists has informed you that Mrs Hill has arrived demanding to see 'whoever is in charge'. She has just received a letter stating that her daughter who was sent home from the department 5 days ago with a sprained wrist has a fracture of her radius and should attend the outpatient department next week.

She is upset and angry with the treatment her daughter has had and the way the new information was sent to her. She is annoyed that they were treated by an 'incompetent' doctor and that it has taken so long for anyone to notice a broken bone on an X-ray. She is also worried her daughter's arm will never heal properly.

Meet Mrs Hill and discuss the issues that arise.

MARK SHEET	Achieved	Not achieved
Reviews notes and X-ray before speaking to mother		
Introduces self to mother appropriately		
Confirms mother and patient's identity		
Offers mother a seat		
Uses a sympathetic tone throughout the consultation		
Asks mother to explain her concerns		
Allows the mother to speak without interruption		
Apologises to mother		
Asks how her daughter is now in terms of pain and function		
Explains the diagnosis		
Offers to show mother the X-ray		
Demonstrates X-ray to mother appropriately		
Explains the events during the initial assessment chronologically		
Addresses the mother's concerns one at a time		
Does not blame the doctor involved		
Is honest about the system and potential for missed fractures		
Explains X-ray reporting to identify and recall missed fractures		
Defends the junior doctor when mother questions their ability		
Explains a plan to prevent similar incidents in the future		
Explains an appropriate plan to manage the missed fracture		
Offers the mother opportunity and information to complain formally		
Global mark from mother		
Global mark from examiner		

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Instructions for actor

You are Mrs Hill, the mother of a 9-year-old girl Debbie. You have gone to your local ED to complain about the way Debbie has been treated by one of the junior doctors. You both attended the department 5 days ago because Debbie had pain in her right wrist after a fall in the playground at school. After an X-ray you were told she had only sprained her wrist and it would get better with some rest and simple pain killers like paracetamol. Debbie has not used her wrist very much since but is starting to use it more gradually. Today you received a letter from the department saying Debbie's X-ray had shown a fracture and you have been given an appointment in a week's time (**Figure 2.2.1**).

You are very angry that the junior doctor told you the injury was only a sprain. You think they were too young and shouldn't be making such important decisions. You are upset that for the past few days you have been telling Debbie to use her arm even though it was broken. Also you feel the news of the fracture was sent in a very uncaring way.

You would like to know what is going to happen to Debbie's arm and if it will ever heal. You also want to know if the junior doctor will be reprimanded and how the department will stop this ever happening again.

Though you are initially angry if the doctor answers your concerns well you slowly calm down. You also accept that the fracture was hard to see on the X-ray if it is demonstrated to you clearly.

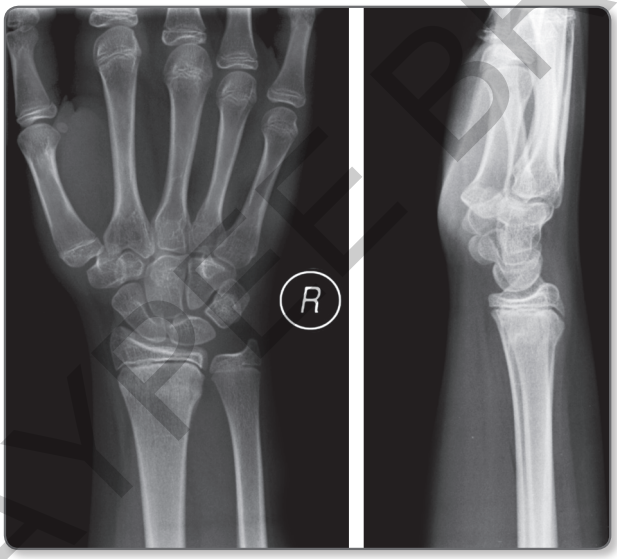

Figure 2.2.1 Debbie Hill's X-ray (with subtle distal radius buckle/torus fracture)

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2.3 Breaking bad news

Curriculum code: CC12, CC13, CMP6, HMP5

For exam purposes this specific station generally involves delivering a life-changing diagnosis or informing someone of the death of a loved one. The basic principles of this station require the ability to provide information in a sensitive and thoughtful way. Several elements can be applied to any station where the candidate is asked to provide information to an individual whether it is 'bad news', a diagnosis or a management plan.

Typical scenarios in the exam involve telling someone their loved one has died or has suffered a catastrophic event where it is not appropriate to give any interventional treatment, but simply to keep them comfortable until they die.

The setting

It is vital to ensure a quiet room where there will no interruptions. There should be comfortable seating and tissues available. In order to offer the individual ongoing support and a continuing link for communication while in the ED, another member of staff (normally an experienced nurse) should also be present.

Prior to beginning the meeting it is important to ensure familiarity with the patient's name and all events up until the present time.

Breaking the news

Before giving such life-changing news it is vital to make introductions and ensure you are speaking to the correct person. Following this, it is appropriate to offer sympathy and explain you are sorry the individual has had to come to the hospital under such difficult circumstances. Before discussing events it is always wise to discover how much the person knows about events so far. Whether they expect their loved one to be very well with minor injuries, or already expect they are likely to die, will significantly change the way the subject of bad news is introduced.

Depending on how much the individual is aware of it may be necessary to provide some brief background information as to what has happened. However there shouldn't be significant delay before stating that you are sorry but you have bad news. You can then explain that their loved one has died or is very ill and going to die. Though this may seem abrupt is it important that the message is clear and does not leave the person you are speaking to with any doubts or false hope. Sentences should be kept short with clear easy to understand information. We suggest one 'warning shot' (e.g. I'm sorry to say that I have some dreadful news for you), followed by the clearly-stated facts (e.g. 'Sadly Mrs Smith died shortly after arriving at the hospital'). Euphemisms (e.g. 'passed on'; 'gone to a better place') should be avoided as they can cause confusion.

Having explained this fact it is important to give the patient some time to absorb what has been said. Allowing silence is an important factor which will come more naturally to some than others. The next few moments will depend on how the individual responds to the bad news but it is important to remain sympathetic, patient and to restate the facts if necessary.

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Following this it may be necessary to explain certain events, treatments or test results. Be guided by how much it seems the person wants to know and can process as this may not be the time to go through unnecessary details.

Further support and actions

Once information has been provided and understood the task moves on to some more practical aspects. The loved one should be asked if they would like anyone else contacted. This may include family and friends, or asking a religious minister to attend the ED.

Prior to seeing the patient individuals should be warned about any disfiguring injuries and the presence of any medical equipment. Time should be taken to make the patient presentable and as soon as it is appropriate the individuals can be allowed to see and spend time with their loved one. It is common to be asked if the patient can be touched or spoken to and usually both can be encouraged.

Further practical aspects after death (paperwork, death certificate, funeral arrangements) are arranged through the hospitals bereavement office and there will normally be relevant information leaflets available which can be provided and explained.

Organ donation

In many cases, it is appropriate to enquire into the patient's wishes regarding organ donation. For example, you might ask if they carried an organ donor card.

Local guidelines vary but in general for the purpose of exams a detailed knowledge of policies and guidelines is not necessary. In general terms if a patient is a potential donor their case should be discussed with the local transplant coordinator. The organ donor register can be checked by them and relevant issues can be discussed with the next of kin and key family members. Sufficient time will be allowed for family to come to terms with events so far and understand death is going to occur.

Caution should be used in discussing the withdrawal of life-sustaining treatment at the same time as the possibility of organ donation. It should be clear that the primary concern is the care of the patient and not the need to facilitate donation.

Once there is acceptance that the patient is going to die, it is recommended that those close to the patient should be reassured that organ donation is a normal part of end of life care, that negative or apologetic language should be avoided and that organ donation should be described positively. It should also be made clear that the standard of care received will be the same whether they give consent for organ donation or not. The extent to which information is shared initially will depend of the response of the individuals present but it is likely that they will need some time to reflect on the situation before any decisions are made.

Scenario

You have been dealing with the case of Mr Downton who is a 66-year-old man. He was found collapsed on the pavement while walking to work and arrived in ED via ambulance with a

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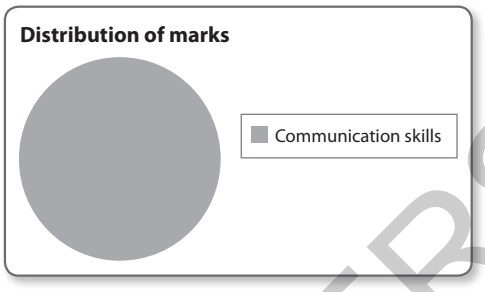
Glasgow coma score of 5/15 (eyes 1, verbal 1, motor 3). He is intubated and ventilated and has returned from the CT scanner. His brain CT has been reviewed by the neurosurgical consultant who has said he will not survive from his intracerebral bleed and he should be made comfortable **(Figure 2.3.1)**. His wife has just arrived alone. Explain the situation to Mrs Downton.



MARK SHEET	Achieved	Not achieved
Asks if nurse is available to support patient's wife		
Introduces self to patient's wife		
Confirms wife's identity		
Asks if wife wants anyone else present		
Offers sympathy that wife has attended under stressful circumstances		
Clarifies what wife knows so far		
Explains events, CT findings and neurosurgical opinion		
Explains in clear language that husband is going to die		
Offers to show wife CT scan		
Demonstrates CT findings clearly and appropriately		
Allows silence and time for wife to reflect		
Asks if wife would like anyone else telephoned – offers to do so		
Asks regarding religious beliefs/wishes		
Explains need to involve coroner		
Asks regarding organ donation		
Suggests discussing case with transplant coordinator		
Asks if wife has any questions		
Asks if she would like to see husband		
Demonstrates appropriate level of empathy with wife		
Global mark from wife		
Global mark from examiner		

Instructions for actor

Your name is Jean Downton. You have been telephoned by your husband's work colleagues telling you that your husband Mike collapsed just outside his work and was taken to hospital by ambulance. You do not know what has happened but have just arrived by taxi at the local ED and been asked to wait in another room.

Your husband is normally fit and very well with no medical problems or medications. He has recently been getting headaches but hadn't seen the general practitioner yet. Both your children live abroad and you have no family locally but some good friends are nearby.

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You are extremely upset and do not understand how this happened with no warning. Unless the doctor is very clear in explaining your husband is going to die you hold onto some hope he will get better and say you look forward to when he is better. If the doctor does not offer to show you the scan, you ask to see the results and have them explained to you.

Your husband was not religious. He was on the organ donor register but you forget this unless asked directly what his wishes were. Though this upsets you, you know it was important to him.

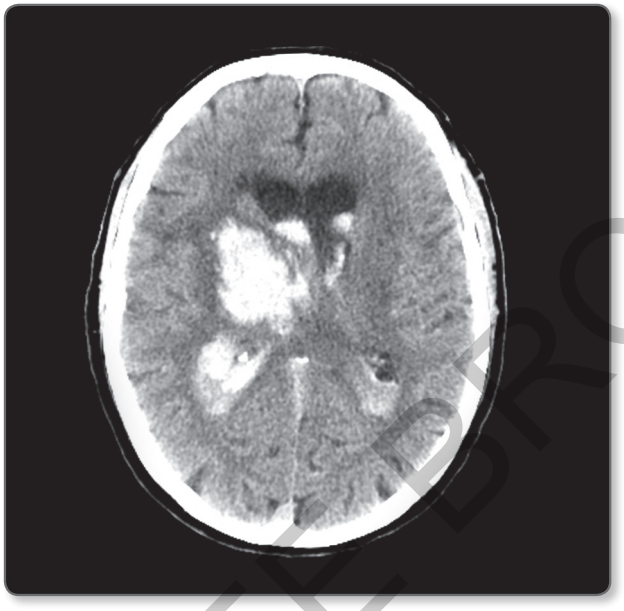

Figure 2.3.1 An image from Mike Downton's brain CT

Reference

Organ donation for transplantation. Clinical guideline 135. National Institute for Health and Care Excellence, London, 2011. www.nice.org.uk/CG135

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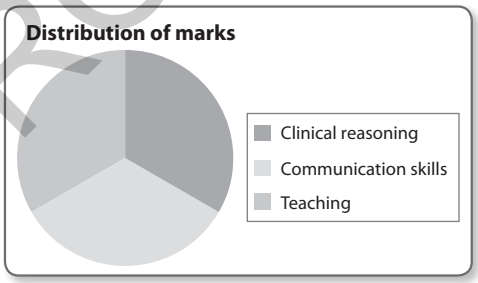
2.4 Clinical decision unit handover

Curriculum code: CC1, CC5, CC8, CC15, CC21, CC23, CAP18, CAP27, HAP25, CAP6

This is a regular task in most EDs where patients who have been placed in the clinical decision unit (CDU) must be handed over and reviewed. With any handover of patient care there is the possibility of information being missed and patients not receiving appropriate and timely treatment. Doctors performing this task must be vigilant to ensure management plans are reviewed and modified as necessary. Required tasks and management plans can then be implemented as necessary whether they involve further investigations, referrals to in-hospital specialties or discharge planning. As with any ward round it also provides a valuable teaching opportunity. Remember in the exam to look carefully at the pie chart to see how the marks are distributed. For example, is the examiner's emphasis on your knowledge or your teaching?

Scenario



You are reviewing the overnight patients on the clinical decision unit. They are being presented by a capable but inexperienced junior doctor. Go through the three cases with the junior doctor, ask any relevant questions and agree an appropriate management plan. Provide appropriate teaching on the cases.

The following information will be provided by the junior doctor with additional information available when asked for:

Case 1

This information will be presented by the junior doctor:

A 63-year-old man who was in the pub yesterday and was seen to trip over a wooden stool and hit his head on the stone floor. He was unconscious for <1 minute and walked to the ED. He has no other medical problems or medications and is normally independent. He has a normal examination except for a haematoma over his occipital area. The plan is for him to go home with head injury advice.

Additional information the junior doctor can provide if requested by the candidate:

- Full blood count, electrolytes and renal function, C-reactive protein and clotting studies are normal.
- ECG: normal sinus rhythm.
- Glasgow coma score (GCS) 15; neurological observations have been normal all night.
- Current condition: Persisting headache. Vomited overnight at 23:20, 02:15 and 06:50.
- No CT of the brain has been performed.

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Case 2

This information will be presented by the junior doctor:

An 18-year-old woman came to the ED after a paracetamol overdose 90 minutes ago. She has no other medical problems or medication. She has just arrived in the CDU to commence an infusion of acetylcysteine and then wait for her blood paracetamol levels to be checked 4 hours after the overdose.

Additional information the junior doctor can provide if asked by the candidate:

- Overdose: 10 × 500 mg paracetamol tablets simultaneously. No other substances
- The patient is clear and precise regarding timing
- GCS 15, heart rate 68 beats per minute, blood pressure 126/68 mmHg, respiratory rate 14 breaths per minute, oxygen saturation 100% on air, blood sugar 7.1 mmol/L
- Clinical examination is normal
- ECG: normal sinus rhythm

Case 3

This information will be presented by the junior doctor:

A 64-year-old woman presented with pleuritic chest pain and breathlessness. She had a pulmonary embolus 2 years ago and needed 3 months of warfarin. No specific reason was found. She has no other medical problems. She is on CDU waiting for a further blood sample to be taken for a D-dimer. If the D-dimer is normal she is due to go home.

Additional information the junior doctor can provide if asked by the candidate:

- GCS 15, heart rate 105 beats per minute, blood pressure 136/78 mmHg, respiratory rate 18 breaths per minute, oxygen saturation 96% on air
- Clinical examination is normal.
- Chest X-ray is clear
- ECG: sinus tachycardia

MARK SHEET	Achieved	Not achieved
Introduces self to junior doctor		
Confirms their level of experience		
Allows junior doctor to present first case		
Asks relevant questions to gain additional information		
Explains need for CT of the brain to be arranged		
Provides teaching regarding head injury guidelines		
Agrees plan for patient, answers any further questions		
Allows junior doctor to present second case		
Asks relevant questions to gain additional information		
Explains need to wait for 4-hour levels before treatment		
Provides teaching regarding paracetamol levels in overdose		
Agrees plan for patient, answers any further questions		
Allows junior doctor to present third case		

Cont'd...

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Cont'd...

MARK SHEET	Achieved	Not achieved
Asks relevant questions to gain additional information		
Advises low molecular weight heparin and admission for CT pulmonary angiogram		
Provides teaching regarding use of D-dimer test		
Agrees plan for patient, answers any further questions		
Provides advice regarding accessing further information		
Global mark from junior doctor		
Global mark from examiner		

Instructions for actor

You are a junior doctor who has recently started work in the ED. You are presenting three patients from the CDU to your senior doctor. You provide some basic information for each case and only provide the additional information to the doctor as and when they ask for it as you are not sure what details are important. Take their advice on management plans and ask them where you can look up guidelines or policies on how to manage each of these cases.

Discussion of cases

Case 1

The NICE guidelines state that following a head injury in an adult more than 1 episode of vomiting is an indication for a CT of the brain to be performed. A candidate should be able to ask relevant questions to identify any concerning features in the presentation and be able to discuss these with the junior doctor. The guidelines state an urgent CT of the brain should be performed in the presence of:

- GCS < 13 when initially assessed in the ED
- GCS < 15 when assessed in ED 2 hours after injury
- Possible open or depressed skull fracture
- Signs of base of skull fracture (haemotympanum, 'panda' or 'raccoon' eyes, cerebrospinal fluid leakage from ears or nose, Battle's sign)
- Post-traumatic seizure
- Any focal neurology
- More than one episode of vomiting
- Amnesia or loss of consciousness in those aged over 65 years, or with coagulopathy, in the case of a dangerous mechanism or if there is more than 30 minutes retrograde amnesia

Case 2

Acetylcysteine is effective if given within 8 hours of an overdose of paracetamol. However within this period of time there is no further benefit from receiving the drug any earlier.

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Within this time frame it is standard practice to wait for a 4-hour paracetamol level to confirm treatment is truly required. This prevents unnecessary treatment and minimises the frequency of hypersensitivity reactions to acetylcysteine which are relatively common.

This is however not the case in staggered overdoses or presentations 8 hours after an overdose.

Case 3

A candidate should be aware that in people at high risk for a pulmonary embolus, a D-dimer should not be used. The National Institute for Health and Care Excellence (NICE) offers clear guidance on the use of a D-dimer to investigate pulmonary embolism. Cases of suspected PE should be stratified as either 'PE likely' or 'PE unlikely'. This is based on the two-level PE Wells score. Those in whom a PE is likely should undergo a computed tomography pulmonary angiogram (CTPA) or receive anticoagulation until a CTPA. Those in the 'PE unlikely' group should have a D-dimer test.

Table 2.4.1 Two-level Wells score for pulmonary embolism

Clinical feature	Points
Clinical signs and symptoms of DVT (minimum of leg swelling and pain with palpation of the deep veins)	3
An alternative diagnosis is less likely than PE	3
Heart rate > 100 bpm	1.5
Immobilisation > 3 days, or surgery in previous 4 weeks	1.5
Previous DVT or PE	1.5
Haemoptysis	1
Malignancy (on treatment, treated in the last 6 months, or receiving palliative care)	1
Clinical probability simplified scores	
PE likely	> 4
PE unlikely	≤ 4

DVT, deep vein thrombosis; PE, pulmonary embolism.

References

Head injury. Clinical guideline 176. National Institute for Health and Care Excellence, London, 2014. www.nice.org.uk/cg176

Paracetamol overdose: new guidance on the use of intravenous acetylcysteine, 2012. www.rcem.ac.uk

Venous thromboembolic disease. Clinical guideline 144. National Institute for Health and Care Excellence, London, 2012. www.nice.org.uk/cg144

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MRCEM Part C: 125 OSCE Stations

SECOND EDITION

MRCEM Part C: 125 OSCE Stations, Second Edition is the ideal revision guide for candidates preparing for the MRCEM Part C exam. Each station opens with a summary of relevant clinical information, followed by a practice OSCE scenario. To facilitate structured revision, each station highlights which areas of the Royal College of Emergency Medicine's curriculum are being tested.

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- Curriculum codes listed in each station indicate the relevant areas under assessment
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