

Cambridge University Press
978-1-904-75225-7 - Pocket Guide to OSCE for the MRCOG
Khaled M Khaled, Roopa Nair and Barry Whitlow
Excerpt
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Difficult OSCE stations

Complaint/confrontation stations

Possible scenarios:

- Angry patient
- Angry partner or relative

What sort of questions/threats to expect:

- How many have you done?
- Why was a more senior person not doing it?
- I was not told that this could happen.
- I am going to sue you.
- I am going to the media/TV.
- I will get you struck off/report you to the General Medical Council.
- I will threaten you with violence.
- I will shout/raise my voice to you.
- So you are not to blame but your colleague was negligent, wasn't he?
- I want compensation – how much is it worth?
- Why was I not given an information leaflet on this before the procedure?
- What are you going to do about it now?
- I am not satisfied with your explanation.
- You don't know what you're talking about!

How to answer

- Be firm but non-aggressive.
- Keep an open posture but do not allow yourself to be bullied.
- Explain without using medical jargon what happened and why (if possible).
- It is the patient's right if they want to take things further and you advise them that their next step would be to contact the chief executive of the trust or the complaints officer.
- If they wish to seek legal advice, that is also their right.

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- They can go to the media or television if they wish, although you should not talk to such people unless directed by your defence organisation, trust press office or trust solicitor.
- They can lodge a complaint with the GMC/affiliated body if they wish – they can obtain your number from the trust if they so desire.
- If they shout, try to stay calm, with an open posture. Do not argue. Say that you can empathise with their predicament and offer the correct lines of contact if they are not satisfied with your explanation (patient advice and liaison service or chief executive).
- Do not implicate colleagues, even if you think they are to blame – that is for an independent review panel to decide.
- Do not give any cash figures as to what compensation they are entitled to, if any – again that is for the courts to decide, if indeed liability is proven.
- If no leaflet given, it is not necessarily department protocol to provide one and the individual doctor concerned with consenting the patient should decide whether you require additional information.
- Suggest patient advice and liaison service.

Briefly explain the complaints procedure:

1. Letter to chief executive.
2. Meeting with consultant concerned and/or department managers with or without the chief executive.
3. Independent review panel.
4. Settle out of court.
5. Settle in court.
6. GMC hearing/action.

Breaking bad news stations

These may involve diagnosis of cancer, intrauterine death or miscarriage.

- Speak clearly.
- Maintain good eye contact.
- Break the news in a stepwise fashion.

Domestic violence station

Domestic violence is an important issue in current practice. You must be aware of this. Make sure that you are aware of the essential aspects of this issue before the examination by asking a senior colleague.

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How to use the DVD

All candidates sitting the OSCE examination should be prepared to deal with certain difficult scenarios.

You will often encounter a role player in the OSCE examination, who plays the part of a patient in distress or in a confrontational situation. The OSCE is no different from the clinic, where registrars see their patients in the hospital atmosphere. If the candidate confines him or herself to that atmosphere they will have the best chance of passing.

The DVD enclosed with this book covers life scenarios that are all of paramount importance in clinical practice. The cases were selected from the most difficult scenarios possible, where experience cannot be gained except by watching these stations.

We appreciate that this is a very small part of the examination but such stations are designed to test the ability of the candidate to deal with difficult situations – and practice makes perfect.

We suggest that before you play the DVD you seek the advice of a senior colleague in your department who could help you or alternatively, ask a colleague and try to role play the scenario in the station before you watch it.

It may be useful if you make notes. This could help to improve your performance and identify your weaknesses.

The DVD cannot cover all the cases we would like to include but we hope that it gives you just an idea of the kinds of situations that you might encounter. We hope that you will be able to build on this to develop your own style.

Station 1

You are the registrar in clinic and are seeing Mrs B, who is 35 years of age. She complains of worsening periods over the past 2 years. You are required to take an appropriate history and discuss management options with her.

Examination findings will be provided.

Marks will be awarded for:

- introduction and appropriate eye contact
- listening to the patient and answering her questions
- taking a history – symptoms – onset and duration:
 - ◆ intermenstrual and postcoital bleeding
 - ◆ dysmenorrhoea/dyspareunia
 - ◆ previous menstrual patterns
 - ◆ obstetric history
 - ◆ contraception/smear
 - ◆ medical history
 - ◆ surgical history
 - ◆ drugs and allergies – including treatment for periods
 - ◆ smoking.

Examination reveals a 24-week sized mass with irregular contour, suggestive of fibroids.

Investigations:

- Full blood count
- Ultrasound scan
- Hormonal investigations not indicated
- Appropriate explanation of tests to patient.

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Treatment options explained to patient:

- Conservative
- Surgical:
 - ◆ myomectomy
 - ◆ uterine artery embolisation
 - ◆ hysterectomy
- Medical:
 - ◆ gonadotrophin-releasing hormone analogues
 - ◆ danazols
 - ◆ tranexamic/mefenamic acid: may not be fully effective
 - ◆ hormonal: may not be fully effective

} short term

Station 2

This is a structured viva. The examiner will ask you some questions.

A 38-year-old woman attends your gynaecology clinic requesting reversal of sterilisation.

Q. How will you approach this patient?

Answer:

- Sympathetic and understanding approach
- Reason for reversal explored
- Type of sterilisation if known
- Interval since sterilisation
- Obstetric history
- Counsel re:
 - ◆ lack of availability on NHS
 - ◆ success rate
 - ◆ need for investigations prior to decision.

Q. What factors related to the sterilisation could affect success rate?

Answer:

- Type of sterilisation – success rate best with clips, least with diathermy or excision.
- Interval since sterilisation – longer interval associated with lower success.
- Length of fallopian tube left – success rate lower if less than 4 cm.
- Area of tube to be reanastomosed – isthmo-isthmic has best prognosis.

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Q. What investigations would be performed before reversal?

Answer:

- Semen analysis.
- Assessment of ovulation.
- Laparoscopy:
 - ◆ to judge length of tube
 - ◆ co-morbidities such as pelvic adhesions or endometriosis, which reduce success.

Q. What are the success rates for the procedure?

Answer:

Success rates vary with type of procedure and operator experience. In good hands and with microsurgical techniques, rates of 75–80% may be achieved.

Station 3

Mrs Elder, a 38-year-old primigravida who is 16 weeks pregnant, is scheduled for amniocentesis. Down syndrome screening revealed a high risk of 1:8. Obtain her consent for the procedure.

Marks will be awarded for:

- appropriate introduction and eye contact
- avoiding medical jargon
- explaining the high-risk result and reason for amniocentesis
- exploring the patient's wishes if amniocentesis reveals Down syndrome
- checking whether patient understands
- explaining details of procedure
- complications, including risk of miscarriage
- results – fluorescence in situ hybridisation available in 48 hours, detailed around 2–3 weeks
- inviting questions and responding appropriately
- obtaining signature on consent form.

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Station 4

This is a structured viva. The examiner will ask you some questions.

You are called to the accident and emergency department to see 28-year-old Mary Bloom, who is complaining of severe abdominal pain. She has been receiving fertility treatment and has had two embryos transferred 23 days ago.

Q. What is the most likely diagnosis?

Answer:

- Ectopic pregnancy.
- Ovarian hyperstimulation syndrome (OHSS).

Q. What are the risk factors for OHSS?

Answer:

- Young age.
- Low body mass index.
- Polycystic ovaries.
- Use of gonadotrophins.
- Previous OHSS.
- Large number of follicles.
- Pregnancy.

Q. What investigations would you perform?

Answer:

- Blood investigations:
 - ◆ full blood count – white blood cells and packed cell volume (haemoconcentration)
 - ◆ clotting screen
 - ◆ creatinine
 - ◆ urea and electrolytes – for hyponatraemia and hyperkalaemia
 - ◆ liver function tests

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- ◆ albumin levels.
- Chest X-ray
- Ultrasound scan – ovarian size.

Q. What would be your management?

Answer:

Conservative management:

- admission – high-dependency or intensive care unit if severe
- intravenous rehydration
- analgesics
- thromboprophylaxis – thromboembolic stockings, heparin
- symptomatic relief of vomiting
- monitoring of parameters including vital signs, central venous pressure, abdominal girth, daily weight, urine output, blood chemistry
- paracentesis/pleural tap/dialysis
- albumin infusion.

Diuretics should not be used.

In severe cases, termination of pregnancy.

Q. How would OHSS be prevented?

Answer:

- Identification of risk factors
- Use of alternative methods of ovulation induction (ovarian drilling, clomifene)
- Avoiding downregulation
- Use of pure follicle-stimulating hormone
- Cycle cancellation/oocyte aspiration and cryopreservation of embryos
- Progesterone rather than human chorionic gonadotrophin for luteal phase support.