



OSCE 9

Candidate Instructions

This is a **7 minute** station.

You are the emergency consultant rostered for the morning ward round in the short stay unit/observation ward.

On the round you have seen a 26 year old woman, Jessica, who was admitted overnight with abdominal pain. The patient has had multiple presentations to both her GP and another emergency department over the past 3 months. Nursing staff report that the patient seemed settled overnight. However, on the nursing observation round the patient said her pain was not improved. She requested analgesia and asked to see the doctor.

You have taken a history, examined the patient and informed the patient that you will review the chart and her investigations and return to discuss the situation and your plan for management. Your examination revealed a soft abdomen with no 'surgical signs' or other concerning features.

The patient chart is available for review.

Your tasks are to:

- Discuss the situation with the patient and answer any questions
- Develop a further management plan and explain this to the patient

This OSCE will assess the following domains:

- Communication – 50%
- Prioritisation and Decision Making – 20%
- Health Advocacy – 30%



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Examiner Instructions

This is a **7 minute** station.

The candidate is the emergency consultant rostered for the morning ward round in the short stay unit/observation ward.

The candidate is about to review a patient on the ward round who was admitted overnight with abdominal pain. The candidate has already seen and examined the patient and is now about to review them after consulting the notes. The patient, Jessica, has had multiple presentations to both their GP and another emergency department over the past 3 months. The assessment as documented in the ED clinical note is attached. The clinical note and an observation chart are also available in the examination room.

The scenario is that the patient had extensive investigations previously, including blood tests, urine, STD swabs, abdo/pelvic US and CT abdo which were all normal. Prior surgical opinion identified 'no apparent surgical cause'. On this occasion, the patient was seen by a competent JMO and the case discussed with a senior registrar. Blood tests/urinalysis unremarkable, β -hCG negative. No imaging has been done on this occasion. The patient was reviewed by the general surgical team who did not feel the patient warranted admission or further investigation as a surgical inpatient. However, as the patient described ongoing symptoms, they were admitted to the short stay ward overnight for review in the morning by the consultant (candidate).

There are not supposed to be any outstanding questions regarding whether the patient has had appropriate care thus far, or any ambiguity regarding the outcome of the surgical assessment.

The candidate's tasks are to:

- Discuss the situation with the patient and answer any questions
- Develop a further management plan and explain this to the patient

This OSCE will assess the following domains:

- Communication – 50 %
- Prioritisation and decision making – 20%
- Health advocacy – 30 %



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Role-player Instructions

- **Gender:** Female
- **Age range:** 25-30
- **Role to be played by:** SP (actor)

You are a sensible, rational person who has been admitted to the emergency department (ED) short stay ward overnight for observation after presenting to hospital yesterday evening with abdominal pain. You presented with an exacerbation of pain while at work. There was no obvious precipitant, but you have had pain over the past few months. You just felt “unable to cope” and “at my wit’s end” so came to ED.

Although the pain is improved from last night, you are still in pain this morning and are frustrated that the cause has not been identified by the doctors. You have seen the nurses this morning and refused analgesia as you are waiting to see the doctor and want answers.

Past Medical History: Nil significant

Medications: Oral contraceptive pill

Drug Allergies: Nil

Social Hx: Non-smoker, social drinker (weekends if going out, not usually at home), live with flatmates, no previous sexually transmitted diseases, no current partner

Occupation: Accountant

Menstrual Cycle: Last menstrual period was normal 21 days ago (28 day cycle – on oral contraceptive pill)

Background

The background to this episode is that you have had similar pain off and on (mostly on) for the past 3 months and are at your wits end.

The following points summarise your symptoms – the candidate has been given most of this information in the notes:

- The pain is in the middle of your tummy, just above your belly button and does not move anywhere else
- You describe it as a *severe ache*, it is not really sharp or burning
- There is no relationship to food but lately you have felt that you can’t eat because of the pain, although you don’t feel nausea
- You have not had any vomiting, belching or reflux/waterbrash
- You have not had any fevers or other symptoms of infection like sweats or chills,
- You have not had any diarrhoea or constipation
- You are going to the toilet normally
- You have not had any weight loss or noticed any blood or mucus in your bowel motions



- All tests so far have been normal
- You are on the pill
- You had a negative pregnancy test

Initial visit to GP – about 2 months ago

You went to see your GP who was initially helpful and arranged some investigations which included blood tests and urine test which were normal. You had a negative pregnancy test. The GP had thought it might have to do with your ovaries or appendix, but when the tests were negative you were told that that wasn't likely. You went back to see your GP again about a week later because you were still having the pain. The GP then sent you for an ultrasound which you had, and again were told that everything was normal. Vaginal swabs were done and were negative for STDs. It was then after about a month that you started to feel like no one was listening and you became less confident in your GP.

First ED visit – 2 weeks ago

Because you had ongoing symptoms you visited a (different) hospital emergency department. You were admitted to the general surgery ward where they repeated blood tests and performed an ultrasound and a CT scan of your abdomen. You saw the surgeon once briefly before you had the scan and when you asked them what could be wrong to cause the pain the only reply you got was "we'll have to wait and see". After you had the CT scan when you were back on the ward you were told by a nurse that the doctors had looked at the scan and it was normal and you could go home. You were frustrated by this because no one gave you any explanation. They suggested you go back to your GP.

Back to the GP - about a week ago

The GP said that there wasn't anything else they could do for you which really upset and frustrated you. The GP suggested trying some over the counter medications and advised you to go back to the hospital emergency department if the pain became really bad. That was about a week ago and since then you have been trying to deal with it and get on with things but the pain has been ongoing. While you were at work yesterday you had an episode of increased pain that caused you to double over. A colleague called an ambulance which brought you to hospital.

This episode is similar to previous ones with severe pain in the center of the abdomen. There was no clear precipitant such as food and you have not had any associated symptoms other than not feeling like eating because of the pain.

Current ED visit

When you came to the emergency department last night you were triaged and taken into the department where the nurses undressed you and assessed you. They gave you paracetamol which you state did nothing, and you were then eventually seen by the doctor who was nice enough but asked you all the questions which you'd been through before and in the end couldn't tell you anything more than they wanted to do more blood tests. These were done and you gave a urine sample. Another older doctor came and introduced themselves as the "senior registrar". They examined you again and told you that they were reassured by your examination and blood tests results. You told them that this pain had been going on for months. You hadn't had anyone explain what was going on and you were getting frustrated and felt like no one was taking you seriously. The senior registrar said they'd ask the surgeons to see you but felt that they would probably not have much to offer.

You were given pain killers and fluids in a drip which did help with the pain and were then seen by another doctor who introduced herself as the surgical registrar. She examined you and advised you that all the bloods were normal. She told you she didn't think this pain was surgical and suggested you see your GP and a gastro specialist like you were told when you went to hospital last time.



The emergency doctor came and said you could go home and that they would give you a prescription for analgesia. You could not believe that they would send you home without giving you an explanation for the pain and wanted to send you home on pain killers without finding out the cause. You became adamant that you did not want to go home without further advice from someone who really knows what is going on.

The doctors then decided to keep you overnight in the short stay ward where you are now waiting for the ED consultant (the candidate) to review you.

Overnight you have still been in pain but it is much better now - only 2/10. You have been able to sleep despite the surroundings (in the short stay ward).

You really want to know a diagnosis, but failing that an explanation of what may be causing your pain would be adequate. It is highly likely that you will NOT be given an answer during this discussion. The main focus of this scenario is to see how a candidate handles a situation in which there is no clear diagnosis or treatment in a patient who wants answers.

The candidate should explain that the assessments (history, examination and investigations) do not identify a cause and therefore it is very unlikely to be a significant or life threatening cause. The fact it has been of 3 months in duration should also be reassuring to the candidate.

The candidate may also explain that sometimes significant causes can present in an unrelated or unusual way and so you should seek further review if you deteriorate or your symptoms worsen.

You are not complaining about the care that you have received, just frustrated that no one knows what is wrong with you.

You are quite clear about the following points:

- You are NOT a drug seeker:
 - You don't take illicit drugs, you never have. You don't smoke and only drink alcohol at events like parties or birthdays.
 - If it is suggested that you are seeking drugs you will be angry and offended and less interactive with the candidate.
- You are not stressed / anxious / depressed / mentally ill:
 - You do not feel like you are stressed or under undue pressure in your private life, work is going well, you have a supportive family, you are not currently in a relationship but are fine with that.
 - If the candidate suggests that you need to see a psychologist / psychiatrist / counsellor / social worker you will not outright refuse but you will wonder why and reply that you don't think that it is necessary.
 - If the candidate persists in wanting to refer you to these services you will reply that you don't think that is required and that you will instead take this up with your GP.

Ideally the scenario ends with the candidate acknowledging your pain and desire to identify a cause, reassuring you that it is unlikely serious/life threatening diagnosis given the normal assessment, and endeavouring to provide access to reasonable follow up plan, including when you should seek more urgent review.



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Role-player Script

Scenario Outline

You have the following three aims from the encounter with the emergency consultant (candidate) with suggested timings.

Part 1 (0 – 2 mins) You want to know what is causing your abdominal pain

The interaction should start after (re)introduction with you asking the following opening:

“So doctor, you’ve examined me and read my file. What do you think is going on?”

- The candidate may recap and explain the findings of their assessment, and then give their opinion on your abdominal pain.

“So what do you think the cause of the pain is?”

- It is highly likely that you will **NOT** be given an answer during this discussion
- The candidate should explain that the assessments (history, examination and investigations) do not identify a cause and therefore it is very unlikely to be a significant or life threatening cause. The fact it has been of 3 months in duration should also be reassuring to the candidate
- The candidate will likely explain how this does (or does not) fit with specific diagnoses
- They may also explain that sometimes significant causes can present in an unrelated or unusual way and so you should seek further review if you deteriorate or your symptoms worsen

Your response depends on the interaction and how clearly the candidate’s explanation is and may range from confrontational:

“What do you mean you don’t know what’s going on, you are a doctor aren’t you?”

To accepting:

“I’m just frustrated that I can’t be given an answer?”

- It is likely that the candidate will not give you a definitive response because there is no clear diagnosis and the history and findings are deliberately ambiguous
- If you don’t get provided with a diagnosis, you at least want the doctor to give you a clear plan about what you should do from here, see part 3
- It is important that the candidate addresses your concerns and acknowledges your symptoms without being dismissive or labelling you as drug seeking, or time wasting, or malingering because there is no evidence of this.

If the candidate starts asking you for more details of the history – you should redirect them:

“We’ve already been through all this – it’s all in the notes!”



Part 2 (2 – 5 mins) You want to know what you are supposed to do about the pain

You want to know what the doctor thinks you are supposed to do about your ongoing pain:

“Well what am I going to do about the pain, I can’t keep coming into hospital”

“Are there any stronger painkillers I can take?”

- Better candidates should address the issue of no clear reversible pathology, issues of being on ‘Narcotics’, importance of GP involvement, alternative strategies.
- You are not drug seeking but a friend has told you about a patch you can’t remember the name of that is very good for strong pain:

“My friend said you should prescribe me a strong patch for the pain, can you do that?”

- If the candidate is accusatory or suggests you are complaining of pain for secondary gain:

“Are you calling me a drug addict?”

- You will not be happy with the suggestion only to “go back and see your GP” or advice to “keep taking pain killers” however if the candidate provides you with a reasonable plan and strategies to deal with the pain you will accept this.

If the candidate suggests that you are making up your symptoms or over-exaggerating the severity of the pain, you should get offended and defensive:

“Are you saying this is all in my head?” “Do you think I’m crazy?”

- They should acknowledge and legitimise your pain/symptoms and provide a plan to address it.
- Better candidates will handle this situation by explaining that sometimes people feel pain and other symptoms due to outside influences such as stress or anxiety or psychosocial factors, rather than due to clear organ pathology.

If the candidate asks about stress:

“I’m not stressed. Work is fine – I have a great circle of friends and a supportive family. I’m happy being single.”

If the candidate suggests that you need to see a psychologist / psychiatrist / counsellor / social worker:

“How will that help? I don’t think I need to see someone like that.”

If the candidate persists in wanting to refer you to these services:

I really don’t think that is needed, I’ll follow up with my GP”.

Part 3 (5 – 7 mins) You want to know what the next steps are from here

The candidate should also provide a plan for ongoing management. If they do not spontaneously begin this discussion you should ask them:

“So what happens now?”

- The candidate is likely to suggest that you be discharged home with a further plan for investigation and follow up which is likely to be through your GP. You are happy with this as long as there is enough detail, including suggestions for your GP to follow up on with investigation and referral, what further symptoms you should be concerned about, and when you should return to the ED



If the candidate provides unclear or minimal detail, such as “you should see your GP for advice”, you should ask for more information e.g.

“What exactly would you like them to do?”

You will not be happy if the response is dismissive (there’s nothing we can do):

“How can you send me home without even having a diagnosis?”

If the candidate provides inadequate closure (back to your GP with no detail):

“Are you going to just send me home without doing anything, then?”

If the candidate wants to admit you to hospital under the surgical team (which would not be appropriate) you should resist this:

“That’s what they did last time and it didn’t get me anywhere”

You will accept a clear plan that involves further review by your GP (or a specialist) with a view to ongoing investigation or evaluation of your abdominal symptoms. This may be a gastroenterologist review, it may be something like keeping a food diary, it may be a suggestion for further tests like endoscopy or laparoscopy or having some gynaecological tests.

“Ok, I’ll look into that”

If referred to a specialist you may ask:

“What are they going to do?”

If they mention colonoscopy or any other tests as an outpatient – respond with:

“Can’t you do that while I’m here?”



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Props list

- Copy of ED clinical from this presentation (inside and outside room)
- Nursing observation chart (inside room only)
- Patient should be in a gown on a hospital bed covered in a sheet/blanket (has spent the night in the short stay unit, sitting in a chair dressed in clothes is not suitable for this scenario)



Emergency Department Medical Record

Patient
Identification
Sticker**ED Doctor:** **Dr Tan** **Resident Medical Officer 2200**

26 F brought in by ambulance with abdominal pain

History of Presenting Complaint

Abdominal pain while at work, suddenly today. Could not cope with the pain so decided to come to ED.

No precipitant, central, constant, no radiation, no nausea or vomiting, no fevers, no dysuria,

No change in bowel habit, no diarrhoea, no blood or mucous in stool, normal flatus.

On OCP at day 21 of normal cycle. No PV discharge, pelvic pain or dyspareunia

Background

3/12 history of similar pain.

GP seen and investigations done about 2/12 ago (results confirmed but copies not available)

Bloods and urine screen negative

Abdominal and pelvic ultrasound normal

STD screen negative

2/52 ago seen at other hospital admitted overnight under surgeons

Blood and urine again negative

US and CT Abdo/Pelvis normal

Discharged with a diagnosis of 'non-surgical' pain

Past Medical History Nil**Medications** OCP**Allergies** Nil Known Drug Allergies**Social History** Non-smoker, social drinker (weekends if going out, not at home)**Examination** Well appearing of stated ageVitals normal – HR 65, BP 115/65, RR 12, SaO₂ 98% (Room air), Temp 36.6 °C

CVS/RESP – exam unremarkable

Abdomen – No scars present, soft to palpation, no guarding

No percussion tenderness or rebound, normal bowel sounds

Tenderness on palpation perimbilically but also generally, pushes hand away

No other significant findings on examination

Impression Abdominal pain of unknown aetiology differential includes surgical and non-surgical causes.**Plan** Bloods/urine,

Analgesia, fluids

Surgical review due to recurrent presentations

U+E, FBC, LFT's, Lipase all normal, BhCG negative CRP negative, U/A NAD

ED Doctor: **Dr Smith 2330** **General Surgical Advanced Trainee**

Above noted 3/12 history, no associated symptoms.

Exam today mild central abdominal tenderness, distractible, no guarding, not peritonitic

Bloods today normal, previous investigations while surgical inpatient last month all normal (Reviewed today)

Assessment – non surgical cause for abdominal pain, not requiring surgical admission, suggest GP/medical outpatient review.

ED Doctor: **Dr Tan** **Resident Medical Officer 2345**

Surgical review noted – patient still describes 7/10 pain, refusing to go home as states 'still in pain and does not know what the cause of the pain is.

Plan As discussed with ED Senior Reg admit to Short Stay Unit for consultant review in am.**Surgical consultant ward Round 0700**

Agree with overnight assessment-no further surgical input needed.



Emergency Department Record

Patient Identification Sticker

Nursing Progress Notes: All entries to be dated, timed, signed, name printed and designation indicated.

1700 26 year old brought in by ambulance with abdominal pain. Observations attended within normal limits. Waiting for doctor review.

2200 Intravenous line inserted and bloods drawn. As per doctor

2330 Medical review. Observations attended within normal limits.

0400 Asleep

0600 Settled night, sleeping most of the shift. Observations attended and normal.

0800 Waiting for doctor review, pain not improved. Requesting analgesia.



CONFIDENTIAL Examiner Rating: OSCE 9

CANDIDATE
barcode

EXAMINER
barcode

Domain	Criteria	Marking rules to be 'at a minimum level of competence'/other comment	Criteria met / not met
Communication (50%)	• Introduces self and purpose to review patient on ward round and explain an ongoing plan • Attempts to establish rapport • Establishes (asks) the concerns of the patient early in the encounter • Demonstrates empathy and acknowledges patient's pain and frustration • Demonstrates a professional and respectful approach throughout encounter ○ Must not accuse patient of drug seeking or malingering • Uses appropriate non-verbal skills e.g. body language, space between doctor and patient, eye contact ○ Sits in chair at patient level to reduce power differential • Uses appropriate verbal skills for the situation e.g. clarity, tone, speed, pauses • Uses language appropriate to the patient's level of understanding / avoids jargon/ explains medical terms • Allows the patient to react emotionally to the situation and acknowledging patient's frustration at lack of a diagnosis • Uses de-escalation techniques when required ○ When patient asks "Are you saying this is all in my head" and/or "Do you think I'm crazy?" • Actively listens e.g. paraphrases and clarifies what has been said by patient • Responds appropriately to non-verbal cues (eg. patients anger and frustration at lack of diagnosis) • Emphasises important points – ○ Gives the patient a definitive plan for dealing with the pain ○ Is able to set limits in the consultation with explanation to patient (eg when asked to prescribe a "strong pain patch") ○ Develops a negotiated and agreed plan with patient for ongoing management (which is to discharge patient) • Encourages the patient to ask questions, provides opportunity for questions and answers appropriately • Summarises the encounter and confirms patient understanding of candidates intended management plan	• Demonstrates a professional and respectful approach throughout encounter ○ Must not accuse patient of drug seeking or malingering • Uses appropriate verbal skills for the situation e.g. clarity, tone, speed, pauses • Allows the patient to react emotionally to the situation and acknowledges patient's frustration at lack of a diagnosis • Is able to set limits in the consultation and justify these to patient (eg when asked to prescribe a strong patch) • Develops a negotiated/agreed, definitive plan with patient for ongoing management (which is to discharge patient and establish a safety net)	

Prioritisation & Decision Making (20%)	• Explains the rationale for making the assessment that the cause of the pain is unlikely to be serious ○ Able to justify to patient why candidate does not think there is a serious cause ○ Prioritise a list and justify which diagnoses are unlikely based on assessment findings ○ eg Appendicitis, cholecystitis, bowel obstruction, AAA, ectopic pregnancy, others • Summarises and prioritises the key issues that must be addressed during and following the emergency encounter ○ Managing the patient's pain ○ Establishing a diagnosis (or lack of) and explaining this to patient ○ Providing a plan for further review (GP, gastroenterologist) • Links clinical information – unremarkable assessment findings/normal investigations with evidence based practice to explain decisions made ○ Further investigation as an inpatient is unlikely to be helpful ○ Pain needs to be addressed using a variety of techniques which may include analgesia and non-pharmacological measures. • Provides a rationale to explain decisions about ongoing assessment (to explain the decision to limit further assessment of abdominal pain in the current emergency department visit when it will not alter management) • Acknowledges and appropriately addresses patients ongoing pain • Provides a rationale to explain and justify decisions about ongoing treatment (further investigation and management will be as an outpatient ○ eg, GP follow up to review progress and potentially refer to specialist such as gastroenterologist • Provides a rationale to explain disposition decisions (discharge patient home and is able to provide a rationale for this) ○ Explains with justification why further inpatient admission is inappropriate • Provide patient with discharge advice that prioritises when patient should seek further review ○ eg, if develops concerning symptoms such as fever, collapse, or any other significant change	• Explains the rationale for making the assessment that the cause of the pain is unlikely to be serious • Provides a rationale to explain the decision to limit further assessment of abdominal pain in the current emergency department when it will not alter management • Provides a rationale to explain and justify decisions about ongoing investigation and management as an outpatient and the decision to discharge patient home.	
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Health Advocacy (30%)	• Incorporates the patient's chronic clinical state and the patient's wishes when making decisions • Recognises the importance of addressing the patient's pain • Incorporates the patient's concerns when making decisions • Able to recognize that inadequate management of the pain may be a barrier to further care • Implements strategies to prevent a patient ceasing their emergency care prematurely eg, ensures adequate engagement in proposed management and disposition plan, offers social work support, offers other avenues of support, successful verbal de-escalation if required • Provides understandable instructions for the patient on discharge, including the likely progression of their clinical course, and reasons to return for review such as fever, persistent, vomiting, collapse, significant change to severity or nature of pain • Utilises common public health information when deciding on patient management (Deals appropriately with issue of request for narcotic analgesia) • Sets clear limits, inappropriate use for this indication, requires an authority to prescribe • Explains appropriate analgesic plan to avoid issues such as addition, dependence • Identifies (Seeks) findings on assessment that increase the likelihood of a patient being vulnerable eg, lack of social support, financial pressure, occupational, relationship issues, or drug and alcohol issues • Tailors treatment and disposition decisions for a patient to account for the presence of vulnerability factors (ensures plan for discharge will not leave patient without support) • Integrates extra services such as offering social work +/- counselling to increase the likelihood of successful outcome or to assist patient in seeking access to follow up with GP +/- specialist eg gastroenterologist	• Recognises the importance of addressing the patient's pain and incorporates the patient's concerns when making decisions • Deals appropriately with issue of request for narcotic analgesia, sets limits and recognises and manages the risk of dependence • Provides understandable instructions for the patient on discharge • Integrates extra services such as offering social work +/- counselling to increase the likelihood of successful outcome or to assist patient to seeking access to follow up	
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