Tips on Passing the OCI

The OCI (or M-OCI) component of the exam is the long case component of the FRANZCP exam. It is the more difficult of the two components, the other one being the OSCE. Due to recent changes in the exam, a pass in the OSCE with a fail in the OCI leads to one sitting only the OCI. However; a fail in the OSCE, irrespective of the OCI result, leads to the candidate resitting the entire exam.

This particular information is put together to help you pass the OCI. For the purposes of this document 'OCI' is used to refer to both OCI and M-OCI.

Cruise Through the Fellowship

Structure of the OCI

The OCI consists of 5 domains

1. Data Gathering – Content
2. Data Gathering – Process
3. Mental State Examination
4. Data Synthesis
5. Action Plan

Approaching the OCI

The most important thing to remember here is the **setting**: You are an Advanced Trainee / Consultant Psychiatrist seeing the patient in your clinic and you have to manage the patient as you would in practice.

You have 50 minutes to interview a patient followed by 20 minutes of thinking time. In the first part of the viva you must 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, diagnosis and differential diagnosis (up to 7 minutes for Registrars and 10 minutes for Exemption Candidates). In the second part of the viva you must **present** and **justify** a detailed management plan.

How to make best use of the 50 minutes

In the OCI every question you ask the patient should be relevant to your data synthesis (Formulation) and management plan. For example, if you ask the patient how they support themselves financially, it is because it is useful for your psychosocial rehabilitation part of your management.

Continues on next page

How to make best use of the 50 minutes

During the exam, divide your 50 minutes as follows:

1. 20 minutes for Diagnostic Interviewing
2. 10-15 mins for asking the questions that will lead to a sophisticated Formulation
3. 5 mins for Mental State Examination to cover questions that have not been covered during the first 20 mins or for current mental state questions (not necessary if done in first 20 mins)
4. 5-7 mins for relevant physical and cognitive examination
5. Last 3-5 mins to focus on patient's short and long term needs

Diagnostic Interviewing

This is one of the most crucial parts of the Psychiatric interview. Without establishing a working diagnosis through competent psychiatric interviewing, it is impossible to ask the right questions that will lead to a good psychiatric formulation.

Examples from next page

Diagnostic Interviewing

Example 1

If during the interview (20 minutes) you have conclusively established the diagnosis of schizophrenia, then the next 10-15 minutes can be effectively spent on asking the relevant questions all of which will lead to a relevant formulation, i.e. presence or absence of the following: family history (biological familial predisposition), obstetric complications (neuro-developmental hypothesis, correlate of treatment resistance), academic difficulties and peer group dysfunction (neuro-developmental hypothesis), epilepsy (composite hypothesis, *Sachdev*), drug misuse (biological contributory factor, unmet dependencies model, social hypothesis, self-medication hypothesis), vocational functioning (maintaining factor) etc. As you can see, the above questions will lead to developing a sophisticated formulation combining biological and psychological elements along with maintaining factors. The aim here is to be able to link the formulation with your management plan. E.g. one may present a psychodynamic formulation but should be able to justify the use of that formulation in management. The key is relevance.

Diagnostic Interviewing

Example 2

You establish a diagnosis of eating disorder with no co-morbid mental illness. What questions must you ask in the next 10-15 minutes to come up with a relevant formulation? Family history (history of mental illness generally is relevant but not as relevant as asking about history of eating disorders, history of weight problems in the family), personal history (of relevance here is parental attitudes to eating, appearance or weight as opposed to general relationship difficulties, role models, eating habits around dinner table etc.). The point here is two people with early psychosocial maladjustments may go on to develop two completely different disorders; one depression, the other anorexia nervosa. This is because of the gene-environment interaction in most cases.

Diagnostic Interviewing

Example 3

In several people with mania, you will find perfectionistic traits or attitudes of striving for perfection. This leads to social and sleep rhythm disturbances, hence the evidence base for Interpersonal Social Rhythm Therapy (IPSRT) in management.

Every psychiatric disorder has a clear genesis, during the exam it is your task to make sense of why this individual developed **this** particular illness at **this** point (or at a point in time).

Your diagnostic interviewing, formulation and management plan have to link in with each other and be coherent.

Formulation

As mentioned, the only way to come up with a good formulation (data synthesis) is through relevant psychiatric interviewing once a working diagnosis is established through good psychiatric interviewing. Psychiatric interviewing skills are the key here.

For each psychiatric disorder there are certain predisposing factors, precipitating and perpetuating factors. The complex interplay between these has to be brought out during presentation so that you can manage them accordingly.

Examples from next page

Formulation

Example 1

Obstetric complications is known to be a correlate of treatment resistance (Nasrallah). This would then in management pose certain barriers to response it is more likely that the patient may not adequately respond to antipsychotics, necessitating the use of Clozapine in the future.

Formulation

Example 2

Depression: An individual with diabetes and hypertension has a different presentation of depression than one without. This is because vascular depression has a different presentation due to likely sub cortical deficits and presents with apathy, psychomotor retardation, anergia etc. (common in old age depression).

Thus in formulation, the mention of a vascular hypothesis of depression indicates its awareness and in management it presents as a barrier to response to antidepressants (may need ECT) and often can be associated with executive dysfunction (impacting on psychosocial rehabilitation).

Formulation

Example 3

Alcohol or drug use: Alcohol or drug use is present in a large proportion of our patients. The presentation, formulation, management and prognosis is significantly different from one without alcohol or drug use. Imagine two people with depression; one using alcohol, the other not. Why is this the case? As you will know, the following factors play a role: a familial diathesis, unmet dependencies during childhood, peer group facilitation through alcohol etc.

A very important factor that is often neglected is the self medication hypothesis; the possibility that the individual is using alcohol to treat the condition. It is only if this hypothesis is taken into account that one will look at reviewing the diagnosis, optimising psychiatric treatment in conjunction with alcohol dependence treatment (Dual Diagnosis Model). As you see, if the possibility of self medication is not considered, the management takes a different path of “Stop alcohol first, it causes your problems”.

Mental State Examination

Needless to say, most of your mental state examination would have been completed during your phase of diagnostic interviewing. If you have focussed on only previous admissions, then spend 5 minutes focussing on current mental state ruling out relevant co-morbid conditions.

E.g. If an individual has schizophrenia, rule out OCD and Anxiety as both may impact on psychosocial rehabilitation (not being able to travel on buses etc.). You must have a repertoire of questions (1 screening and 3-4 diagnostic) at your quick disposal. You must have a good knowledge of phenomenological terms.

Physical and Cognitive Examination

You need to perform a relevant examination, not a general MMSE. In an individual with schizophrenia, it is the frontal functioning that is most likely impaired and interferes with psychosocial functioning. Hence, a focus on frontal assessment is required. If at any point during your first 20 minutes you suspect cognitive difficulties, go straight to cognitive examination.

The same applies to physical examination; examine for what you expect to be important based on clinical relevance.

Patient Needs

This is one of the most important aspects of the interview that is often neglected and a reason for a lot of candidates failing. The interview is not just a case but a real person.

Show your curiosity in genuinely trying to find out what the patient needs (goals and needs). This can be done with combination of insight and judgement assessment through specific questions at the end.

Cruise Through the Fellowship

Now that you know how to use your 50 minutes effectively, the next step is effective use of your 20 minutes.

How to use your 20 minutes?

All of the earlier mentioned leads to you coming up with a number of buzzwords. E.g. The patients may have told you about their depression in detail. Your buzzword is **psychological and biological features of depression**.

Sexual and physical abuse described in some detail – **early childhood maladjustment** punctuated by...

Has worked in several jobs but the longest being 5 months due to difficulty coping – **vocational dysfunction**.

You can write an entire case down, formulation and management (see later) in 20 minutes by having a template and filling the blanks in with buzz words. The key here is to come up with lots of buzz words for all patient descriptions.

Management

Your management is easy if you have obtained the relevant information.

Divide your management into domains of Risk, Clarification of Diagnosis, Treatment of Symptoms and Long Term Treatment (relapse prevention, psychosocial rehabilitation and drug and alcohol relapse prevention).

Mention Barriers to implementation and prognosis.

This information goes a long way in helping you through the OCI. It will take a bit of work to address each of these sections. But once you master it all, not only will you pass the OCI, you will also excel in clinical practice. Remember; this presentation format is extremely useful in seeing patients effectively and writing competent letters to the GP. If you decide to go into private practice, these techniques will help you in seeing patients efficiently and dictating letters quickly saving you time.

If you feel you need further support, consider the **CTF Clinical Course and the Psych Interview Online Course**. Candidates who are giving the **OCI component** only can now attend the first day of the clinical course as a stand-alone program focusing on Observed Clinical Interview in specific.

For an early start and to master interviewing skills, subscribe to Psych Interview. Since the 5 components are intricately linked, one cannot pass the Formulation and Management section if you have not addressed the first three components. Psych Interview prepares you for the first three components thoroughly, enabling you to go on to develop a relevant formulation and management plan.

We hope you found the information useful. Good luck for the exams!