**SA/NT Trial OSCE 2017.2**

**OSCE STATION G**

**INSTRUCTIONS FOR EXAMINATION CANDIDATE**

Ashely is an intern who is new to Emergency Medicine. They are about to start their assessment of a 45yr old Aboriginal man who has presented to the Emergency Department with acute lower back pain. Ashley has asked to speak to you as the supervising consultant to obtain some advice on how best to approach the consultation.

Your tasks are to:

* Advise the intern on taking a focused history and examination for lower back pain.
* Outline Signs or Symptoms that indicate the possibility of serious illness (Red Flags)
* Discuss investigation options
* Explain to the intern how they can deliver culturally appropriate emergency care to this patient.

This OSCE will assess the following domains:

* Medical expertise (50%)
* Scholarship and Teaching (30%)
* Health Advocacy – cultural competence (20%)

**This scenario will run for a maximum of 7 minutes after you enter the room.**

**INSTRUCTIONS FOR INTERN ROLE PLAYER**

The scenario commences as soon as the candidate enters the room when the buzzer sounds.

This is a teaching station. The candidates have 7 minutes to teach you about assessing a patient with lower back pain.

You are an enthusiastic but inexperienced intern. This is your first day working in the Emergency Department and you are not confident in assessing a patient with back pain. In your clinical experience, the back pain patients you’ve seen have had musculoskeletal back pain or mild sciatica. You have not seen a patient who has had serious illness related to lower back pain. In your mind, although you haven’t seen the patient, you presume that the patient probably has musculoskeletal back pain and you have not considered more serious causes.

You do have competence in taking a basic history (HPC/PMH/Meds/Allergies/SH) and can do a basic clinical examination.

But you DO NOT know or would forget to ask about:

* Recent fever or recent systemic symptoms
* PMH: malignancy
* Steroid use causing osteoporosis
* IV drug use
* Red Flags for Back Pain
* Requiring Vital signs
* Straight Leg Raise Test
* Doing reflexes during a neurological exam
* MRI
* Cultural safety

If the topics are not already covered you should ask:

* What other questions should I ask?
* Is there anything else on clinical examination I should check for?
* I’ve heard that there are “red flags” for back pain. What are they?
* When should I get an X-ray? Or CT scan?
* Should I do bloods? What are the indications?
* What can I do to provide this man with culturally appropriate care? How should I approach him?

Your general approach to all candidates should be as similar as possible. The examiners for the station will give you a briefing and further guidance on the day.

**INSTRUCTIONS FOR THE PRINCIPLE EXAMINER**

You are a **passive observer** in this scenario. Do not involve yourself, unless there is a critical issue that the role-player cannot address. On entering the room candidates will hand you a sheet of labels one of which should be attached to their individual marking sheet. You should monitor the time during the scenario. One minute before the end a warning buzzer will sound. The candidate may finish the station early, if **all** tasks are completed and the role-player has no further questions. The candidate may then leave the room.

During the 3 minutes between candidates, please enter your final marks and comments on the individual marking sheets provided. These will be given to the candidates during the feedback rotation. There is also a summary sheet on which to record the overall mark for each candidate. Information from these sheets will be passed on to appropriate DEMTs at the end of the examination.

Each domain should be marked out of 7. The non-standard set pass mark for the station is 14/21.

**Detailed Assessment Criteria**

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| **Domain** | **Criteria are in Bold** *Criteria for a higher score are in italics* |
| **Medical Expertise**  **(50%)** | Describe an appropriate focused medical history on back pain included:   * **Pain Questions: Site/Onset/Character/Radiation/Associations/Time Course/Exacerbating/relieving factors/Severity** * **Symptoms of infection: fever/sweats/systemic malaise** * **Neurological: weakness/numbness/bladder or bowel dysfunction** * Past history   Describe Lower Back Examination including:   * Straight Leg Raise * **Neurological Exam: Motor (inc. reflexes)/Sensation** * **Signs of Cauda Equina: anal tone on PR/Saddle Anaesthesia over S2-5/bilateral leg weakness/**high urinary residuals   Red Flags: **(mention of at least 4 is mandatory)** *(>4 scores higher)*   * Recent Significant trauma * History of prolonged steroid use * History of osteoporosis * Prior history of cancer * History of a recent infection / Fever * IV drug Use * Low back pain worse at rest * Unexplained weight loss   Investigations:   * Plain X-ray (trauma) * CT (acute on chronic symptoms with no previous CT) – mostly of use in suspected infection/tumours/trauma rather than in degenerative disease * MRI: for patients with signs and symptoms consistent with cauda equine or other neurological deficits * Infective Screen: ESR/CRP/WCC/blood cultures – if suitable index of suspicion   Differential Diagnosis: **(at least 4 are mandatory)** *(>4 scores higher)*   * Musculoskeletal/sciatica/traumatic or osteoporotic #/osteomyelitis or epidural abscess or discitis/pancreatitis/vascular/renal/drug seeker/depression.   Dunn 5th edition p1252-1254 |
| **Scholarship and Teaching**  **(30%)** | **At least 3 of the following**   * Identify level of experience and/or understanding of intern * Information provided in a structured format * Provide opportunity for questions and clarification * Checks and responds to learning needs * Emphasises important points * Clear communication of appropriate depth and pace * Encourages participation * Active listening * Checks understanding * Summarises * Suggests follow up activities |
| **Health Advocacy (20%)** | **Provides examples of culturally appropriate actions (at least 3)**   * *Recognising that English may not be the patients first language* * *Avoidance of hand shaking* * *Taking time to establish trust at the start of the interview* * *Speaking softly* * *Asking about their background/country to determine if they live a more traditional lifestyle* * *Addressing the patient formally* * *Sitting next to the patient* * *Trying not to repeat questions about information already collected* * *Avoiding direct eye contact* * *Being aware that there may be gender issues that affect assessment* * *Avoiding touching the patients head without consent* * *Seeking advice about any potentially culturally relevant aspects of care* * *Involving the Aboriginal liaison officer* * *Understanding that family names and structures may differ* * *Differences in time orientation may exist* * *Cultural obligations may have higher priority than the patient’s own health care*   ACEM Statement on Culturally-Competent Care and Cultural Safety in Emergency Medicine (Mar-2010 S63) |

**ACEM Statement on Culturally-Competent Care and Cultural Safety in Emergency Medicine (Mar-2010 S63)**

<https://acem.org.au/getattachment/8a5b5a53-95f5-41db-8a60-0e2dcab578d1/S63.aspx>

**Cultural Safety:**

The fundamental premise that cultural safety actively addresses power imbalances and non-Indigenous privilege remains a cornerstone of the concept. However, cultural safety is now seen as being applicable for all health staff and for all patients, not just Māori, and as such aims to enhance the delivery of health services by identifying the power relationship between the medical practitioner and any patient, and empowering any patient to take full advantage of the health care service offered.

Cultural safety can be defined as patient care in an environment *“that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.”* It is primarily about the patient experience. Health care can only be perceived as culturally safe or otherwise by the patient who is participating in the service delivery.

**Cultural competency**

Cultural competency is a set of attitudes, skills and knowledge that allow an individual to interact effectively in cross-cultural situations. It requires a medical practitioner to continue to undertake a process of reflection on their own cultural identity and recognise the impact their culture has on their own medical practice. Cultural competence focuses on the capacity of doctors and other health staff to integrate culture into the clinical context and tailor care to meet patients’ social, cultural and linguistic needs.

**5.2 Statement of cultural competency in relation to emergency medicine**

The purpose of cultural competency and cultural safety in emergency departments is to improve the quality of health care services and outcomes for all patients.

The ACEM acknowledges that culturally competent practice, by aligning care to the patient’s socio-cultural and linguistic context, can: improve communication between doctors and patients; increase patient understanding; decrease patient fear and anxiety; improve patient satisfaction; and enhance the ease and relevance of clinical assessment.

Subsequently culturally competent care can: reduce unnecessary investigation; increase accurate and timely diagnoses; and increase adherence to treatment and attendance rates at follow up appointments. It can also reduce: reluctance to seek medical care; and discharge against medical advice and take own leave rates. Overall, it leads to better clinical outcomes and improved patient wellbeing.

**5.3 Non-discrimination and right to culturally safe health care**

Access to culturally safe care in emergency departments that is free of racism and other forms of discrimination is a right for all patients, regardless of ethnicity, gender, sexual orientation or other cultural identification.

The Australian Charter of Health Care Rights, endorsed by Australian Health Ministers in 2008 for use across the country, ensures patients have the *“right to be shown respect, dignity and consideration”,* and that *“the care provided shows respect to [the patient’s] culture, beliefs, values and personal characteristics.”*

**6.2 Cultural safety**

The ACEM will advocate for all emergency departments in Australia and New Zealand to continue to develop culturally safe environments for all patients. Systemic change within emergency departments will be promoted so that:

* Service provision is adapted so that it reflects an understanding of the diversity between and within cultures, including addressing institutional discrimination
* All staff in the ED provide patient-centred care that includes:
  + Taking a cultural history with all patients and their families/carers
  + Incorporating diverse health beliefs and health priorities into ED care and management plans
  + All patients, their family and/or carer have access to support people according to their cultural needs
  + All patients are given the opportunity to speak to a cultural and/or religious representative of their choosing
  + All patients who do not speak English as a first language are provided access to a professional interpreter service and information in their primary language, including for Indigenous language speakers
* Effective relationships are established and fostered with local primary health care providers that care for Aboriginal, Torres Strait Islander, Māori and other culturally and linguistically diverse peoples
* Feedback mechanisms are in place for consumer engagement that represents the cultural diversity of the department’s patient population (including being available in appropriate languages)
* The department fosters a work ethic of reflection regarding cultural safety and cultural competency and non-judgemental review of both individual clinician practice and the department’s care systems