OSCE Workshop
Sarah Mitchell

Facilitator Deck | 60 minutes

Workshop Format – Facilitator Instructions

- Rolling consultation: each trainee performs one segment, then hands to the next
- Actor remains in the room throughout – stays in character unless facilitator calls 'pause'
- **Critical rule – DO NOT announce the topic to the trainee:**
  - Ask: 'What would you cover next?' – the trainee must name it and then proceed
  - If they hesitate, wait 10 seconds before prompting. Naming the domain is part of the skill.
- After a segment, if wanting to note for good or bad, facilitator can pause to ask the group : 'What did they do well? What was missing?'
- Final 10 min: structured debrief (strengths → gaps → clinical pearls)

Session Timing (60 min)

- 0–3 min: Facilitator explains structure and reads referral letter aloud
- 3–33 min: Section 1 – Rolling history: Trainees 1–10 (~3 min each)
- 33–45 min: Section 2 – Examiner questions: Trainees 11–13 (~4 min each)
- 45–50 min: Section 3 – Conflict scenario: Sarah's response
- 50–60 min: Group debrief

⚠ **Adjust pace to your group – it's fine to skip a segment and go straight to debrief if energy dips**

REFERRAL LETTER – Read aloud before the session begins

To: Occupational Medicine Physician
Re: Ms Sarah Mitchell, 36 years old, Senior Theatre Nurse

Sarah has been on sick leave for six weeks following a health episode at work. She is employed at a large metropolitan public hospital in Melbourne and has been with the theatre unit for ten years. Her line manager has requested an occupational health clearance assessment before a return-to-work plan can be finalised.

Please assess and advise regarding fitness for work and any recommended workplace modifications.

No clinical details – candidates must elicit the story from the patient.

SECTION 1

History Taking

Trainees 1–10 | ~28 min | Facilitator asks: 'What would you cover next?'

TRAINEE 1 – Introduction & Consent

Reminder – ask trainee: *"Please go ahead and start the consultation."*

Facilitator checklist – what to listen for:

- Introduces self by name and role
- Explains purpose (occupational health clearance – NOT treating physician)
- Clarifies dual-role: report goes to employer AND to patient
- Obtains explicit verbal consent
- Invites patient to begin without interrupting opening statement

Phase: Pre-clinical – consent & setup

TRAINEE 2a – Investigation of Symptoms – Phase 1 – Nasal Symptoms

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Opens with open question: 'Can you tell me what's been happening?' – lets patient lead
- Identifies nasal symptoms as the first complaint: sneezing, runny nose, congestion
- Asks about eye symptoms (itching, watering)
- Characterises onset: when did nasal symptoms begin? (~18 months ago)
- Establishes work-relatedness: do symptoms occur at work? Improve on days off and weekends?
- Asks about timing within the shift: when do symptoms start after arriving in theatre?
- Key negative: no chest symptoms at this stage – asks and confirms absence

Phase: Phase 1 – rhinitis only, work-related (18 months ago)

TRAINEE 2b – Phase 2 & 3 – Progression to Chest Symptoms

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Asks when chest symptoms began (~10 months ago) – distinct from nasal onset
- Characterises chest symptoms: wheeze, chest tightness, breathlessness – not just 'breathing problems'
- Establishes work-relatedness for chest: onset during shift, resolves within hours of leaving
- Asks about the acute episode 6 weeks ago: what happened, how severe, how treated
- Asks about current status: symptoms now vs 6 weeks ago
- Explores what was different on the day of the acute episode (glove tray handling)
- Notes the progression: rhinitis first → chest later – asks patient if she noticed this sequence

Phase: Phase 2 & 3 – rhinitis + asthma progression, acute episode (10 months → 6 weeks ago)

TRAINEE 4 – Work-Relatedness of Symptoms

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Establishes work vs rest symptom pattern – the key discriminating question
- Asks about timing: how soon after starting shift do symptoms begin? How long to clear after leaving?
- Asks about variation between shift types, days, procedures
- Asks about colleagues with similar symptoms
- Asks about differences between glove types (powdered vs powder-free)

Phase: Work-relatedness – core of occupational history

TRAINEE 5 – Workplace Environment & Exposures

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Asks about actual job tasks – scrub vs scout nurse, duration of glove use
- Explores glove type and volume (powdered vs powder-free, hours/day)
- Asks about theatre ventilation and air quality
- Asks about shift pattern and length of theatre lists
- Asks about PPE – any respiratory protection used?

TRAINEE 6 – Past Occupational History

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Takes chronological occupational history from first job
- Asks whether symptoms were present in prior roles – community nursing (no theatre, no symptoms)
- Establishes how long in current theatre role (10 years)
- Asks about any other jobs with similar exposures
- Key negative: no symptoms before theatre work

Phase: Past occupational history

TRAINEE 7 – Past Medical History & Medications

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Past medical history: childhood eczema, hay fever, prior asthma diagnosis?
- Family history: mother hay fever, father eczema – atopic background
- Prior allergy testing? Skin prick tests? Results?
- Medications: cetirizine (when started?), salbutamol (when started?), any inhaled corticosteroid?
- Hospitalisations: the acute episode – treatment received, spirometry results

TRAINEE 8 – Non-Occupational Exposures

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Home latex exposure: gloves, balloons, elastic, condoms
- Pets, hobbies, gardening, home renovations
- Smoking history
- Exercise – any exercise-induced symptoms (she runs – no symptoms at all)
- Foods: banana, kiwi, avocado, chestnut (latex-fruit syndrome)

TRAINEE 9 – Functional Impact & Psychosocial

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Impact on daily life: sleep, function, exercise
- Mood and anxiety – normalise and explore
- Family situation and financial dependence on income
- Patient's own goals: return to theatre? Open to redeployment?
- Relationship with employer – any pressure or conflict?
- Illness beliefs: what does she think is causing this?

Phase: Psychosocial & functional impact

TRAINEE 10 – History Summary

Reminder – ask trainee: *"What would you cover next?"*

Facilitator checklist – what to listen for:

- Delivers structured verbal summary back to the patient
- Names the timeline: nasal symptoms first (18 mo ago) → chest symptoms (10 mo ago) → acute episode (6 wks ago)
- Confirms work-relatedness, names the likely exposure (latex gloves, powder)
- Acknowledges patient's concerns empathically
- Asks: 'Is there anything important I haven't asked about?'

Phase: Summary – demonstrates synthesis

SECTION 2

Examiner Questions

Section 2 | ~8 min | 3 questions | Full model answers in Clinical Reference document

FACILITATOR – Read aloud before Question 1

Additional findings now available:

Physical exam: Boggy nasal turbinates bilaterally; faint expiratory wheeze; mild eczema on dorsum of hands; RR 16, SpO2 98% RA

Spirometry: FEV1 78% predicted (was 62% at presentation six weeks ago); reversibility +15% post-salbutamol – positive

Specific IgE: common aeroallergens – negative; Latex – elevated (Class 3)

Section 1 is now complete. Move to examiner questions.

TRAINEE 10 – EXAMINER QUESTION 1

"Based on the history and the findings just provided – what is your diagnosis, and how confident are you in it?"

Key discussion points:

- Diagnosis 1: Occupational allergic rhinitis (Phase 1, 18 months ago) – the sentinel event
- Diagnosis 2: Probable occupational asthma – IgE-mediated latex sensitisation
- The rhinitis-to-asthma progression (~8 months) is clinically significant: earlier identification could have prevented asthma
- Confidence: probable – specific inhalation challenge is the gold standard but rarely performed in practice
- Differentials acknowledged: irritant-induced asthma (RADS), non-occupational asthma – less likely given clear work-rest pattern and positive IgE
- Strong candidates name both diagnoses, explain the temporal relationship, and discuss what confirmation would require

TRAINEE 12 – EXAMINER QUESTION 2

"What can Sarah do now, and what would a return to theatre require?"

Key discussion points:

- Currently unfit for any latex-exposed environment – certify clearly and specifically
- Fit for latex-free clinical duties: redeployment to ward or outpatient clinic is possible now
- Theatre return requires: 100% latex-free gloves for ALL staff on her lists – not just Sarah
- Elimination of powdered latex gloves from the department (powder aerosolises the protein)
- Formal occupational hygiene assessment of theatre air quality before return
- Medical: commence inhaled corticosteroid; optimise intranasal steroid; spirometry review in 6-8 weeks
- WorkSafe Victoria notification required – occupational disease under WIRC Act 2013
- Strong candidates explain WHY colleagues' gloves matter – aeroallergen, not contact allergy

TRAINEE 13 – EXAMINER QUESTION 3

"How would you manage this case going forward – medically, in the workplace, and at a system level?"

Key discussion points:

- Medical follow-up: spirometry every 3-6 months; adjust ICS; consider allergen immunotherapy (specialist decision)
- Workplace: hospital-wide latex management policy; powdered glove elimination; occupational hygiene assessment
- Health surveillance: symptom questionnaire + spirometry for all theatre staff; follow up the two symptomatic colleagues
- Legal: disability discrimination considerations – employer must provide reasonable adjustment before considering redeployment
- Education: managers and staff on early symptom recognition; building a reporting culture
- GP liaison: ensure treating GP and respiratory physician are aligned on management plan
- Strong candidates take a population view – this is one case; the department has a systemic problem

SECTION 3

Conflict Scenario

Section 3 | ~4 min | With the patient

TRAINEE 14 – CONFLICT SCENARIO – Context

Facilitator sets the scene:

You have explained the diagnosis and the return-to-work recommendation. Sarah has been quiet. Now she responds.

Actor cue (Sarah says):

I'm sorry, but I don't really understand what you're telling me. I feel completely fine now – I've been resting for six weeks, the steroids worked, and I want to go back to my job. Theatre nursing is what I do. I've done it for ten years and I'm very good at it. You're telling me I can't go back now? On what basis? I've never had asthma in my life before I started this job – and now you're saying I might lose it?

TRAINEE 14 – CONFLICT – Facilitator checklist

Reminder – ask trainee: *How do you respond to Sarah?*

What to listen for:

- Acknowledges her frustration and confusion before responding to the content – empathy first
- Does NOT immediately re-state the recommendation or become defensive
- Explains the diagnosis clearly: feeling fine now ≠ safe to return – sensitisation is permanent
- Validates her professional identity: names her 10 years, her expertise, her attachment to theatre
- Explains the clinical reality without catastrophising: this is a constraint, not an end
- Presents options honestly: what she can do now; what theatre return would require and when
- Holds the clinical position – does not soften the recommendation under pressure
- Closes with a path forward: ‘Let’s work out together what this can look like’

SECTION 4

Group Debrief

~8 min | Facilitator-led

DEBRIEF – STRENGTHS TO REINFORCE

- Opening with consent and dual-role explanation – non-negotiable in occupational medicine
- Asking about nasal symptoms before chest – recognising rhinitis as the sentinel event
- Establishing the work-rest pattern – the most discriminating question in occupational lung disease
- Naming the rhinitis-to-asthma timeline: 8-month gap – clinically and preventively critical
- Asking about colleagues – triggers health surveillance obligation and population thinking
- Empathy first in the conflict: acknowledging Sarah’s distress before addressing the content
- Holding the clinical position without becoming cold or dismissive

DEBRIEF – COMMON GAPS

- Jumping to chest symptoms without asking about nasal symptoms first
- Not establishing the rhinitis-to-asthma timeline – the most important teaching point of this case
- Superficial workplace history: glove type, task breakdown, hours – not just ‘works in theatre’
- Missing latex-fruit syndrome foods (banana, kiwi, avocado, chestnut)
- No explicit fitness-for-work statement – must certify fit or unfit, for what specific duties
- Vague return-to-work plan: ‘light duties’ is not a plan – name the specific role
- Responding to Sarah’s anger by immediately repeating the recommendation – skipping empathy
- Not mentioning WorkSafe Victoria notification

Key Exam Reminders

- Structure reading time: HPC → Occ Hx → PMHx → Social/Lifestyle → Psychosocial → Summary
- The occupation is not a label – it is the mechanism. Visualise the job.
- Work-rest pattern is the most discriminating question in occupational lung disease
- RTW plan must name specific modified duties – never ‘light duties’
- Consent + dual-role explanation: always, even under time pressure
- Conflict: empathy first, always – then hold the clinical position without apology

Good luck – the OSCE tests who you are as an occupational physician, not just what you know.