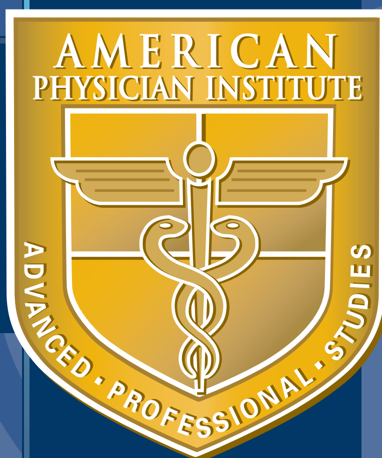
Avoid These Oral Board Mistakes!

A Special Report for Psychiatry International Medical Guidelines



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Special Report for Psychiatry International Medical Graduates: Avoid These Oral Board Mistakes!

A Frank Discussion of the Problems that International Medical Grads Confront & Ways to Overcome Them

Dear Colleague,

Thank you for taking the time to download this report. I believe that you'll be glad you did. Preparing for the psychiatry oral boards can be a time when you wish you had a trusted advisor to turn to with questions and, perhaps, with private concerns. This is where I come in. My job is to get psychiatrists to pass their oral board exam. I've worked with hundreds of International Medical Grads just like you and I am not shy about talking to you about sensitive issues that no one else will.

Your Accent is Not a Problem, I Mean It.

I know that for many foreign-born oral board candidates a major concern is their accent in English. It is easy to fret about it. "Will the patient understand me?" "Will I understand the patient?" And of course in no time you can end up having short "video clips" of worst case oral board scenarios playing in your head.

I have good news for you. The issue of not being understood by an oral board patient is very nearly a total non-issue. I categorize the problem of accent as having the highest ratio of imagined fear to real problem. Each year four hundred psychiatrists attend a Beat The Boards! Course and, out of these, only one or two doctors have a way of pronouncing certain words that truly leads to problems of communication. Hundreds worry. One or two actually have a reason to. And even for this very small number of psychiatrists, the problem with their accent in English is circumscribed. Let me give you an example.

A recent Beat The Boards! Course participant's first language was Spanish. She pronounced the word 'psychiatric' with the initial 'p' sounded out audibly, the way one would pronounce the word in Spanish. I noticed that two patients in a row did not understand her when she used this word. One asked her to repeat herself and still struggled to make sense. The other patient apparently misunderstood her and answered off topic. I pointed this small problem out to her and asked her to just drop the initial 'p' sound because that seemed to be the main source of confusion for listeners.

She could alter her pronunciation as I suggested when she was seated with me, but when she was in the heat of a patient interview, she reverted back to her original confusing pronunciation. When this occurred she became flustered. It seemed to me that this small problem led to large consequences for her because it inspired hesitation and self-consciousness. So I suggested an alternative.

I asked her to refrain from asking patients about their 'psychiatric problems' and 'psychiatric treatment' and instead substitute the phrase 'mental health' as in 'mental health problems' and 'mental health treatment.' This permitted her to side-step the use of the word 'psychiatric'

entirely. Knowing that she did not need to use the word 'psychiatric' at all and having an alternative phrase to substitute for it, relieved her anxiety.

During her mock-exams she used her 'mental-health' alternative term and avoided focusing on what was in reality a very minor isolated issue. And how did she do on her oral board exam? She passed. And passed with the confidence that was rightfully hers.

If I still haven't convinced you that problematic accents are over-rated, let me ask you to try this exercise. Ask yourself, "Do I have a problem communicating with patients in my practice?" The answer is most probably "No" or "Hardly ever." If you do have a problem contact me and we'll put our heads together on how to solve it.

But Will You Understand the Patient?

The problem that mirrors the problem of the patient not understanding you is you not understanding the patient.

Over the years we've held Beat The Boards! Courses all over the country from coast to coast.

This is what I learned. Only a handful of participants at each course told me that they had any major issue in understanding the patient they interviewed in their mock-exams. And of the number who did have a problem? It was unsurprising to me that these candidates had trouble understanding some patients because I had trouble understanding those very same patients.

Some patients simply have dysarthria or very specific regional accents that neither you nor I may be familiar with. In such cases, you are not responsible for the communication gap although you need to accommodate to it.

So what do you do? Here are a couple of specific tips.

- Do not be shy about asking the patient to repeat something you didn't understand. If you think this is rude or disruptive, I would argue that letting the patient continue speaking when you have no understanding of what is being said is much more rude. And not only that, ignoring missed communications may be dangerous because you may miss crucial information.
- Another technique is to repeat back what you thought you heard the patient say and ask the patient if you understood correctly. Now, I realize that you may be concerned that these techniques take time. They do. However, what is the alternative? To continue without comprehending and making no effort to clarify? In my judgment if a doctor is pretending to understand and doesn't AND I as a mock examiner catch something he is pretending to understand but doesn't, it is in such a case that I will evaluate that candidate negatively. You can't help it if you didn't understand something. It happens. But if this occurs you need to take steps to clarify the communication. Of course, a rare patient may mumble so incomprehensibly that you can hardly understand anything. In these extreme cases make sure you at least clarify the fundamental pieces of information. Then let go for you have done the best you could.

Beyond Politeness to Effective Guidance of the Patient

Although the US is a land of many peoples and cultures, it is in general a much less traditional culture than is present in many parts of the world. In many cultures there are much stricter cultural rules on the correct way of interacting with strangers. In those cultures one needs to follow very clear rules of politeness. For instance, in many cultures it is impolite to interrupt or question or challenge another person.

While these same rules apply in the US, they apply less strictly and one is permitted to bend these rules, especially in certain professional interactions. It is often more difficult for an International Medical Graduate to interrupt and redirect a patient than for someone raised since childhood in the informal atmosphere of the US. Let me share an example with you.

At one of the first Beat The Boards! Courses I worked with a course participant who was a female psychiatrist from India. She was an excellent candidate. But she had one problem. She was too deferential to the patient. No matter how off track the patient's responses became, she just couldn't find it in herself to redirect the patient.

Especially with disorganized or talkative patients, she often ran out of time. She admitted that it just wasn't something she felt comfortable doing because of her cultural upbringing. Her success was at stake.

What were we going to do? Well, I showed her a way to interrupt the patient that was much less intrusive than verbally interrupting the patient. I call it the "Little Hand-Raise." Let me explain.

Normally when you are interviewing a patient at the oral boards, your hands are either resting on or near your lap, or you are writing with a notepad resting on your lap. With the Little Hand-Raise when you wish to interrupt the patient, you do so by raising your hand slightly off your lap or off your notepad and gently dorsiflexing your wrist to bring your hand into a semi-vertical position, in a halfway gesture of 'stop.'

Make this gesture as gentle as possible, not lifting your hand any higher than necessary. Most patients respond to quite subtle forms of this gesture. Usually this gentle gesture lasts a mere second before you bring your hand back into resting position. Usually, the patient will stop talking immediately and as he does so, you interject your question without hesitation, redirecting or clarifying as necessary. Patients who require your hand to be raised higher, sometimes as high as chest level like a crossing guard, in order to stop speaking are usually hyperverbal and / or pressured.

This is what you do NOT do. You do not interrupt by talking over a patient. Let me say that again. Do NOT speak over a patient. Get the patient to stop talking by either saying their name and / or by using the "little hand-raise" to get them to stop. If they continue speaking, then repeat the above, each time slightly more forcefully. The vast majority of patients stop speaking immediately. Those who don't usually have some form of psychopathology that interferes with their ability to do so.

As I show in one of our video examples at The Premium Beat The Board! Course, speaking right over the patient appears quite disruptive and disrespectful to an outside observer, such as your examiner. It can also be quite disruptive to the interview flow and to the rapport with the patient.

Two board examiners who viewed the video clip I'm referring to, stated independently of each other that they would have failed the candidate because he talked over the patient. Precisely because they found it disrespectful and disruptive to the therapeutic alliance.

Let's now return to the course participant I was telling you about. She tried the Little Hand-Raise and it worked. In fact, she mastered it to the point that patients and other observers didn't even notice it when she made use of it. You can probably guess the end of the story. Since she solved her only real problem, she passed her exam.

Be Prepared for the Personal Question

(This section reprinted from *The Ultimate Guide to the Psychiatric Oral Board Interview*)

Most of us Americans have immigrated to the United States or are descended from forbearers who have. (My parents arrived from Poland.) We are all different. We have differing physical characteristics and clothing that suggests a specific cultural or religious affiliation. Don't be surprised if your patient is curious about your national, cultural or religious background. Don't be caught off-guard if your patient asks about your background. These are the questions I have heard patients ask interviewing psychiatrists in a single recent Beat The Boards! Course.

- "Are you from Afghanistan?" Of a doctor whose name suggested this was her country of origin.
- "Are you Jewish?" Of a doctor wearing a Yarmulke.
- "Are you from Iraq?" Of a doctor from India.
- "Where are you from?" Of a doctor from Des Moines, Iowa. But of course the patient meant, "Where are you from originally?" The doctor was from Egypt.

When asked a question from this category of questions I find it best to respond with a simple, short, and informative answer such as, for instance, "Yes, I'm from Afghanistan." or "Yes, I'm Jewish." One of our Blue Tower Institute faculty members, Dr. Venu Depala, has an elegant way of phrasing his response, "I'm an American of Indian descent."

Here is some more advice on handling this type of personal question:

- Answer and move on without hesitation. For instance, "Yes, I'm from Afghanistan. Now, Mr. Smith, I want to ask, 'Are you receiving psychiatric treatment at this time?'" And continue unless stopped by another question from the patient.
- Don't explore the psychological meanings of the question for the patient at this point in the interview. Avoid, for instance, "Yes, I'm from Afghanistan. Why do you ask, Mr. Smith?" I think it more important to proceed with the interview and hold the patient's question in abeyance. Of course, keep it in abeyance, but do keep it. During the rest of the interview, listen for hints, if any, of why that question came up.
- Delay exploring the psychological meaning of the question with the patient until later in the interview, if at all. This is what I call the "Delay Opening a Can of Worms" approach. Rather than exploring the source of the question before the formal interview even begins, I would

recommend returning to this question late in the interview when you already have a relationship established and you have achieved some understanding of the patient's areas of concern. Then you can proceed something like this, "Mr. Smith, when I first told you my name you asked me where I'm from. Can I ask you why you asked? …. Do you have any thoughts regarding the fact that I'm from Afghanistan?" This is what the doctor who emigrated from Afghanistan did. The patient told her that since she was from Afghanistan he feared that she was a terrorist. She responded without defensiveness that she had never been a terrorist and that she always was and remains a doctor. This reassured the patient. Some patients, however, may be so paranoid or misinformed, that they will not allow you to proceed without further questions or discussion at the start of the interview. In those cases, you have no choice but to explore and address further details of the patient's concerns right then.

- Avoid not answering. Most patients have a simple curiosity that is easily quieted. Many of us may have the same type of question about a person we meet – "What type of accent does she have?" – but are socially appropriate enough not to ask this of a stranger. Remember that our patients may not have the same level of social inhibition that we do. Answering is the quickest way to get beyond the patient's query. Rue the day if you avoid answering and instead respond with, "Why do you ask?" or "Where do you imagine I'm from?" This is not the time to be Freud Junior and reflect back a question with another question. That is the type of response that will turn a molehill into a mountain. The paranoid patient is now suspicious. And just about any patient is put off by your withholding, "I was just curious, doctor. Just don't start analyzing me." So answer the question simply and move on. Note, however, that my advice to answer a "Where are you originally from?" question does not necessarily apply to The Highly Personal Question, the category we cover next.

The Highly Personal Question

If you are confronted with a clearly highly personal and inappropriate question (e.g., "Are you gay?"), do what anyone else would do, decline to answer. I would say something like, "I'm sorry, I don't want to discuss my sexual life. It's private." Then I would move on with the start of the interview as I normally would and, as I suggested, delay opening the can of worms until later if at all. Of course, my eyes and ears would be perked to catch any clue that would shed light on the source of the patient's inappropriate question.

Some questions that patients ask lie somewhere in between the mildly personal and the highly personal. The most common ones I can think of are, "Are you married?" Or "Do you have children?" With these questions, I tend to give the patient the benefit of the doubt and answer the question briefly and, without hesitating, move on with the interview. And again, if it seems appropriate, I may return to the question towards the end of the interview.

The Question About Your Religion

This is a case of the highly personal question. You have three options. Answer. Refuse to answer. Answer halfway.

In most circumstances, I advocate Answer Halfway. For instance, a patient who is a "Born Again Christian" may ask, "Doctor, have you let Jesus into your heart?" What do you say? Here is one suggestion for a response, "Sir, like you I am a person of faith. However, I'd rather not go into

that right now. Since our time is short, I'd like to focus on learning about you. Now, Sir, how old are you?"

Consistent with my advice that NOT answering can turn a small problem into a larger one and my advice NOT to answer highly personal questions, this answer walks the middle ground. It gives the patient some information about you (You are a person of faith) but avoids a conversation you don't need to engage in. Notice also how after you respond, you move right along without hesitating to ask for information about the patient. This approach places the burden of stopping the interview momentum onto the patient, something most people will choose not to do.

Handling the Racist or Bigoted Patient

OK. Now let's move into even tougher interview territory, dealing with the racist or bigoted patient. What do you do if confronted with one? One of our recent course participants who is Jewish told me she had just such an experience. The patient said, "I don't like Jews." The doctor handled it well. She said, "I'm a doctor. I'd like to go ahead with our interview. Are you OK with that?" The implicit message was something like this, "I'm a doctor and as a doctor I assess and treat patients. I will maintain my professional duty towards you and treat you with the same respect and concern for your condition as I do for all my patients DESPITE your feelings about me and my group." The patient assented to the interview.

Here's another approach suggested by another Premium Beat The Boards! Course participant, "Given your strong feelings, I appreciate your agreeing to be interviewed. Now, how old are you sir?" Notice that this psychiatrist assumed the patient would agree to the interview without the patient ever having stated that. This is an effective and well-known move used by salespeople the world over. It even has a term associated with it, "Assume the Sale." Notice again that then she, without hesitating, moved quickly into the interview questions. Both approaches suggest this: Don't start exploring the source of the bigoted beliefs. Not at this point. Try hard not to be offended by the patient and continue the interview as best you can.

If a patient makes a clearly racist or bigoted statement, as this patient did, it probably should not be ignored. I would, however, address it later in the interview, after I have obtained the needed psychiatric, medical, social and family history. And, further, I would not seek an open-ended discussion of the sources of or justifications for these racist beliefs but, rather, take a narrower approach, focusing on how these beliefs have affected this patient's life and treatment. These are some areas I would want to clarify. Have the patient's bigoted / racist beliefs ever:

- Interfered with the patient's ability to work with his treatment team?
- Led to legal or work problems?
- Led to fights or other violent acts?
- Might lead to future violence?

Now let's move to another area of concern.

Examiners Can Be Nasty to Anybody

This tip comes from one of our best-loved faculty members, Dr. Venugopal Depala. He shared with me that many foreign–born candidates believe that examiners are against them, that they are, to put it bluntly, racists or bigots.

Now, I don't think this is true. I have heard several stories about examiners taking overly aggressive stances with the candidates. However, these unpleasant experiences were shared with me as frequently by native-born as by foreign-born candidates.

But whether I am right or wrong about the examiners is, frankly, not that important. The real reason for you to reject a belief that the examiners are racists or bigots is this: holding that belief hurts no one but you. It will damage your chances of passing. When interviewing your patient, your full attention needs to be squarely on the patient (and not on you or on the examiners). And when presenting the case your focus needs to be firmly on the presentation itself and on any questions that are put to you (and not on what the examiners might be thinking of you).

Focusing on trying to divine whether or not the nasty examiner is a bigot is a powerful distraction to you from your appointed task. You just cannot know what that person is thinking or imagining since you are not in his head. You must have the discipline to let it go.

And let me add another point. This may not make me popular with you, but as I said earlier, I have a single goal and that is to get candidates to pass their oral board exam. So let me go ahead and say this.

Sometimes believing that the examiner was a bigot and that was why the candidate failed, is an excuse. It can keep a candidate from reviewing their own performance and figuring out what went wrong. Often very good candidates have one area of weakness that could be fixed. Rather than fixing it, they get discouraged and give up. If you haven't done so, please read my downloadable manuscript, "12 Mistakes that Will Sink Your Oral Board Exam and How to Avoid Them." It is free, my gift to the profession. It's at www.BeatOralBoards.com. It has helped many doctors figure out what may have gone wrong at their exam.

Will you get an aggressive examiner? Perhaps. I had one myself – and failed and deservedly so. What will you do if you do get such an examiner? The answer is focus on getting your job done and done as well as you possibly can. And then it is out of your hands.

A Personal Word

Dear Colleague, thank you for downloading this report. I hope you found this frank discussion helpful. I wish you to remember that you are not alone. Many candidates face the same challenges that you do. Please review our website at www.BeatOralBoards.com for the extensive resources that are available to you.

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We have released a new version of the Beat The Boards! Psychiatry Oral Board Preparation Course that is so comprehensive, so detailed, and so organized in step-by-step training techniques that it makes all other preparation approaches obsolete – including our previous version of this course!

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Take care and ….
Happy Studies.

Jack Krasuski, MD

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- "Are you from Iraq?" Of a doctor from India.
- "Where are you from?" Of a doctor from Des Moines, Iowa. But of course the patient meant, "Where are you from originally?" The doctor was from Egypt.

When asked a question from this category of questions I find it best to respond with a simple, short, and informative answer such as, for instance, "Yes, I'm from Afghanistan." or "Yes, I'm Jewish." One of our Blue Tower Institute faculty members, Dr. Venu Depala, has an elegant way of phrasing his response, "I'm an American of Indian descent."

Here is some more advice on handling this type of personal question:

- Answer and move on without hesitation. For instance, "Yes, I'm from Afghanistan. Now, Mr. Smith, I want to ask, 'Are you receiving psychiatric treatment at this time?'" And continue unless stopped by another question from the patient.
- Don't explore the psychological meanings of the question for the patient at this point in the interview. Avoid, for instance, "Yes, I'm from Afghanistan. Why do you ask, Mr. Smith?" I think it more important to proceed with the interview and hold the patient's question in abeyance. Of course, keep it in abeyance, but do keep it. During the rest of the interview, listen for hints, if any, of why that question came up.
- Delay exploring the psychological meaning of the question with the patient until later in the interview, if at all. This is what I call the "Delay Opening a Can of Worms" approach. Rather than exploring the source of the question before the formal interview even begins, I would

recommend returning to this question late in the interview when you already have a relationship established and you have achieved some understanding of the patient's areas of concern. Then you can proceed something like this, "Mr. Smith, when I first told you my name you asked me where I'm from. Can I ask you why you asked? …. Do you have any thoughts regarding the fact that I'm from Afghanistan?" This is what the doctor who emigrated from Afghanistan did. The patient told her that since she was from Afghanistan he feared that she was a terrorist. She responded without defensiveness that she had never been a terrorist and that she always was and remains a doctor. This reassured the patient. Some patients, however, may be so paranoid or misinformed, that they will not allow you to proceed without further questions or discussion at the start of the interview. In those cases, you have no choice but to explore and address further details of the patient's concerns right then.

- Avoid not answering. Most patients have a simple curiosity that is easily quieted. Many of us may have the same type of question about a person we meet – "What type of accent does she have?" – but are socially appropriate enough not to ask this of a stranger. Remember that our patients may not have the same level of social inhibition that we do. Answering is the quickest way to get beyond the patient's query. Rue the day if you avoid answering and instead respond with, "Why do you ask?" or "Where do you imagine I'm from?" This is not the time to be Freud Junior and reflect back a question with another question. That is the type of response that will turn a molehill into a mountain. The paranoid patient is now suspicious. And just about any patient is put off by your withholding, "I was just curious, doctor. Just don't start analyzing me." So answer the question simply and move on. Note, however, that my advice to answer a "Where are you originally from?" question does not necessarily apply to The Highly Personal Question, the category we cover next.

The Highly Personal Question

If you are confronted with a clearly highly personal and inappropriate question (e.g., "Are you gay?"), do what anyone else would do, decline to answer. I would say something like, "I'm sorry, I don't want to discuss my sexual life. It's private." Then I would move on with the start of the interview as I normally would and, as I suggested, delay opening the can of worms until later if at all. Of course, my eyes and ears would be perked to catch any clue that would shed light on the source of the patient's inappropriate question.

Some questions that patients ask lie somewhere in between the mildly personal and the highly personal. The most common ones I can think of are, "Are you married?" Or "Do you have children?" With these questions, I tend to give the patient the benefit of the doubt and answer the question briefly and, without hesitating, move on with the interview. And again, if it seems appropriate, I may return to the question towards the end of the interview.

The Question About Your Religion

This is a case of the highly personal question. You have three options. Answer. Refuse to answer. Answer halfway.

In most circumstances, I advocate Answer Halfway. For instance, a patient who is a "Born Again Christian" may ask, "Doctor, have you let Jesus into your heart?" What do you say? Here is one suggestion for a response, "Sir, like you I am a person of faith. However, I'd rather not go into

that right now. Since our time is short, I'd like to focus on learning about you. Now, Sir, how old are you?"

Consistent with my advice that NOT answering can turn a small problem into a larger one and my advice NOT to answer highly personal questions, this answer walks the middle ground. It gives the patient some information about you (You are a person of faith) but avoids a conversation you don't need to engage in. Notice also how after you respond, you move right along without hesitating to ask for information about the patient. This approach places the burden of stopping the interview momentum onto the patient, something most people will choose not to do.

Handling the Racist or Bigoted Patient

OK. Now let's move into even tougher interview territory, dealing with the racist or bigoted patient. What do you do if confronted with one? One of our recent course participants who is Jewish told me she had just such an experience. The patient said, "I don't like Jews." The doctor handled it well. She said, "I'm a doctor. I'd like to go ahead with our interview. Are you OK with that?" The implicit message was something like this, "I'm a doctor and as a doctor I assess and treat patients. I will maintain my professional duty towards you and treat you with the same respect and concern for your condition as I do for all my patients DESPITE your feelings about me and my group." The patient assented to the interview.

Here's another approach suggested by another Premium Beat The Boards! Course participant, "Given your strong feelings, I appreciate your agreeing to be interviewed. Now, how old are you sir?" Notice that this psychiatrist assumed the patient would agree to the interview without the patient ever having stated that. This is an effective and well-known move used by salespeople the world over. It even has a term associated with it, "Assume the Sale." Notice again that then she, without hesitating, moved quickly into the interview questions. Both approaches suggest this: Don't start exploring the source of the bigoted beliefs. Not at this point. Try hard not to be offended by the patient and continue the interview as best you can.

If a patient makes a clearly racist or bigoted statement, as this patient did, it probably should not be ignored. I would, however, address it later in the interview, after I have obtained the needed psychiatric, medical, social and family history. And, further, I would not seek an open-ended discussion of the sources of or justifications for these racist beliefs but, rather, take a narrower approach, focusing on how these beliefs have affected this patient's life and treatment. These are some areas I would want to clarify. Have the patient's bigoted / racist beliefs ever:

- Interfered with the patient's ability to work with his treatment team?
- Led to legal or work problems?
- Led to fights or other violent acts?
- Might lead to future violence?

Now let's move to another area of concern.

Examiners Can Be Nasty to Anybody

This tip comes from one of our best-loved faculty members, Dr. Venugopal Depala. He shared with me that many foreign–born candidates believe that examiners are against them, that they are, to put it bluntly, racists or bigots.

Now, I don't think this is true. I have heard several stories about examiners taking overly aggressive stances with the candidates. However, these unpleasant experiences were shared with me as frequently by native-born as by foreign-born candidates.

But whether I am right or wrong about the examiners is, frankly, not that important. The real reason for you to reject a belief that the examiners are racists or bigots is this: holding that belief hurts no one but you. It will damage your chances of passing. When interviewing your patient, your full attention needs to be squarely on the patient (and not on you or on the examiners). And when presenting the case your focus needs to be firmly on the presentation itself and on any questions that are put to you (and not on what the examiners might be thinking of you).

Focusing on trying to divine whether or not the nasty examiner is a bigot is a powerful distraction to you from your appointed task. You just cannot know what that person is thinking or imagining since you are not in his head. You must have the discipline to let it go.

And let me add another point. This may not make me popular with you, but as I said earlier, I have a single goal and that is to get candidates to pass their oral board exam. So let me go ahead and say this.

Sometimes believing that the examiner was a bigot and that was why the candidate failed, is an excuse. It can keep a candidate from reviewing their own performance and figuring out what went wrong. Often very good candidates have one area of weakness that could be fixed. Rather than fixing it, they get discouraged and give up. If you haven't done so, please read my downloadable manuscript, "12 Mistakes that Will Sink Your Oral Board Exam and How to Avoid Them." It is free, my gift to the profession. It's at www.BeatOralBoards.com. It has helped many doctors figure out what may have gone wrong at their exam.

Will you get an aggressive examiner? Perhaps. I had one myself – and failed and deservedly so. What will you do if you do get such an examiner? The answer is focus on getting your job done and done as well as you possibly can. And then it is out of your hands.

A Personal Word

Dear Colleague, thank you for downloading this report. I hope you found this frank discussion helpful. I wish you to remember that you are not alone. Many candidates face the same challenges that you do. Please review our website at www.BeatOralBoards.com for the extensive resources that are available to you.

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