RANZCP Auckland Training Programme

Mock Objective Structured Clinical Examination

Station No. 1

April 2006

Station No. 1 - Introduction and Aims

This station concerns medicine in relation to psychiatry, and the assessment of alcohol abuse or dependancy.

The main aim of this station:

- The candidate must assess a known out-patient with social phobia where a minor accident occurring while patient was intoxicated with alcohol has exposed that alcohol abuse is an issue. The candidate is asked to assess the severity of the alcohol abuse, take relevant medical history and conduct an examination to detect physical sequelae of alcohol abuse.

Candidate must demonstrate

- Ability to take a relevant psycho-social history regarding severity of the alcohol abuse and to differentiate between abuse and dependance;
- Ability to take relevant medical history regarding physical sequelae of alcohol abuse;
- Knowledge about the signs of alcohol abuse/dependance and expertise and technique in performing a focussed physical examination relevant to this issue;
- Capacity to interpret relevant investigations provided and to state what others are needed.

Requirements:

- Table and 2 chairs
- Physical examination equipment box on table, labelled as though from a CMHC
- Actor for patient (male)
- Instructions for Candidate on table
- Summary of past psychiatric records on table (as was available in Bye for Station 1)
- Copy of ED Record of assessment and physical, noting normal ECG and CXR (as was available in Bye for Station 1)
- Brief referral covering note from ED houseofficer, giving serum ethanol result and apologising that several blood test results have been mislaid.

Station No. 1 - Instructions to Candidate

You have seventeen (17) minutes to complete this station.

You are a community team registrar, seeing a patient David – a 35 year old single man living in his own apartment who is known to the team, and who has social phobia. You have seen him twice before (about 4 months ago), primarily to lower his dose of fluoxetine from 40 to 20mg mane, as he had complained of tremor and numbness of fingers on 40mg which interfered with his work at home as a software developer. He has now been referred from the local Emergency Dept (ED) after being slightly injured by a car while crossing the road when intoxicated, sustaining a bruised thigh, At the ED he was found to be intoxicated with alcohol. No history of him abusing alcohol or other drugs is documented in his psychiatric records. A brief Report from the ED houseofficer has been provided.

No proper examination couch is available at the CMHC, but there is a converted table with a padded top, which is sometimes used by nursing staff to give IMI injections. This can to some degree be used as a couch, at least for the patient to sit or lie upon.

You may assume that a risk assessment has been done and that the patient is not suicidal or aggressive. Do not repeat this.

Your tasks are to:

- Take a focussed history of David's alcohol use regarding severity and sequelae, especially physical sequelae (do NOT cover other drugs – you can assume that he does not abuse any other substances).
- Perform a relevant, focussed physical examination while engaging with the patient.
- After 13 minutes (with 4 minutes remaining), present your **history, physical findings and provisional diagnosis** to the examiners.
- Include your interpretation of the findings and investigations from ED, and state which **additional investigations** you would want to arrange at this point.

You are NOT to test for pain. You can assume that response to pain is normal.

You are NOT to do any aspects of physical examination which require disrobing, but are to act as a registrar carrying out as thorough an assessment as possible within the limited facilities provided by a CMHC. You may assume that the ED houseofficer's report on the patient's abdominal examination is accurate. Do NOT repeat any abdominal examination.

Station No. 1 - Instructions to Examiner

The examiner will introduce the candidate to the surrogate patient, will hand them the *ED Houseofficer's Covering Note and* another copy of the *Candidate's Instructions for Station 1* - and will indicate the the *ED Record* and *Summary of Psychiatric History* on the table.

"This is your patient, David. You have your instructions, please proceed."

If the candidate spends too long on the history (allow up to 7 minutes), prompt them to move on, by reminding them of the whole task:

"Please remember that you are required to perform a physical assessment as well as taking the relevant history."

At any stage, if the candidate asks about or attempts to perform a more intrusive physical assessment (e.g. testing for pain, disrobing, examination of the chest underneath clothing, or of the abdomen), redirect them:

"Please do not test for pain. You can assume the response to pain is normal."
"Please do not attempt any part of the physical examination that requires disrobing, including examination of the chest and abdomen."

If the candidate asks any other questions about their task, refer them back to the *Candidate's Instructions for Station 1* by saying ***"You have your instructions, please proceed."***

At 13 minutes, if the candidate has not already started, prompt them to present their findings:

"Please cease your assessment now and present your history, physical findings and provisional diagnosis, and state which additional investigations you would want to arrange at this point."

If they forget aspects of this task, repeat these instructions: e.g.

"Are you sure that you have covered your history, physical findings and provisional diagnosis, and stated which additional investigations you would want to arrange at this point?"

If the candidate says they are finished and want to leave the room, say:
"You may leave the room, but please make sure that you have completed the tasks to your satisfaction, as you cannot come back in again."

Station 1 - Instructions to Simulated Patient

You are David – a 35 year old single man living in your own apartment in a quiet suburb of the city. You work as a software developer, and do not go out very much socially, as you suffer from social phobia. You are a quiet person, not in a close relationship for some years as you find it hard to meet women, although you do have a number of internet "chatroom" friends.

You were always shy socially, were teased and bullied at school as a child, and from adolescence onwards have had to force yourself to engage in social situations. This worsened when you were 17, after an embarrassing incident at a school dance when your girlfriend argued with you then danced with another boy. You have never had a panic attack, but you do worry that people will see that you are anxious in public, or will think that you seem odd.

You are an only child and your parents live within walking distance of your flat. You see them for dinner each Sunday lunchtime. You have only had one girlfriend about 5 years ago, for 2 years. You met her at work and had a low–key relationship, but in the end she left the company for a job in Wellington. You have only a small no. of friends, mostly chess partners or workmates. You like chess, reading, classical music and computer gaming.

There is no history of psychiatric disorders or substance abuse in your family but your mother is an anxious, rather timid person who also avoids social gatherings.

You have no other psychiatric symptoms – no depression (mood is "fine"), no panic attacks and no real agoraphobia as it is social gatherings you fear, not generally going out. No OCD symptoms. You've never been depressed or suicidal.
In your twenties (about 25), you found that having a few drinks helped manage your anxiety in social settings. You have never abused or experimented with other drugs, and in general regard street drugs as dangerous and linked with crime and violence. However, you regard alcohol as different, and tend to think of in a phrase you once heard, as a "social lubricant".

When you began more regular drinking in your later twenties, you had begun working at your current software company, and found their occasional social sessions difficult to cope with. You began to have a few glasses of white wine before going to the company get together, and found that this helped quite a lot. From this you delevoped a habit of regularly having several glasses of white wine to manage anxiety – this built up until you were drinking a 750ml bottle of white wine daily (2 glasses before work, the rest afterwards). You are aware that this is probably a bit much, but prefer not to think about this, as you do not see how else you can cope.

You saw your GP then the CMHC psychiatrist a year ago after taking 3 weeks leave, at a time when you had ceased your alcohol use as you were not really going out anywhere and had decided to try to stop using this. After a few days you felt very unwell, with sweatiness, shakiness, nausea, headaches and poor sleep. You attributed this to "stress" at the time, and eventually saw your GP who made a referral to the CMHC. As you did not want your GP or the CMHC psychiatrist to think badly of you, you did not admit to your drinking, nor did any signs show up on routine blood tests at that time. A dignosis of social phobia was made and you were started on fluoxetine 20mg mane. This helped a little, but not enough, so you gradually began drinking again, and are again drinking one 750ml bottle of white wine daily. You have not had any CBT to date, as you feel unable to take time off from work and the CMHC cannot offer this after hours.

Your initial CMHC psychiatrist left the service, and you have seen your current registrar twice across the last 4 months. This registrar initially tried you on 40mgs fluoxetine mane, but you got shakiness and your hands felt numb (tricky for you as someone who has to use a computer keyboard a lot). Two months ago the fluoxetine was reduced to 20 mgs again.

You have now been referred back to the CMHC from the local ED after being hit a glancing blow by a car, when you misjudged crossing the road after a work drinks session at which you had 5–6 glasses of wine. You have mild bruising to your right thigh and are limping a little, favouring this leg, but no serious injury was done. A colleague from work insisted on taking you to the ED, which you would have preferred to avoid. At the ED your blood alcohol was quite high and the houseofficer got some of the history from you of your CMHC follow–up and of the amount of wine you use regularly. The houseofficer thus referred you back to your CMHC doctor for follow–up, especially of the drinking.

When asked questions about your drinking, these are the responses you will give:

- You drink about 2 glasses from a 750ml bottle of relatively cheap white wine before work so as to calm yourself before going out and also as if you don't have this in the morning you really miss it, and feel quite sweaty, sick and shaky. Then you drink the rest of the bottle after work **"so it doesn't go to waste".**
- As above, you started age 25, gradually increased to the level of use as above, ceased for 6 weeks about a year ago, then resumed drinking back to this extent again. There are no other times when you have tried to cease drinking. You are a non–smoker.
- You don't drink spirits or other alcohol as you are **"not an alcoholic!"** You are aware that it's not good for you physically and would like to cease it, but cannot see how you would cope without it.
- You don't drive or own a car – you get the bus to work or to see friends (so no driving offences)
- You have never been in trouble with the police or been aggressive or arrested – you will be somewhat shocked to be asked questions of this sort, and deny this vehemently
- No friend or family member has ever criticised your drinking or advised you to cut back. You concealed the extent of your drinking from your girlfriend. You also conceal this from your friends, and your parents.
- Your work has not been especially affected by your drinking, as you only have 2 drinks in the morning. You find it harder to concentrate as the day wears on, however, and find that you are craving the rest of the bottle and starting to feel more irritable and sweaty again. You tend never to go to things straight after work, but go home and have 1–2 glasses of wine before going out again. Generally you don't go out. Overall, you are starting to feel that your drinking is a bit out of control as you are aware of needing more to get the same effect, and that your daily amount is creeping up. You have been considering getting cask wine as it would be **"more economical"**
- You have only occasionally (maybe once a year) been intoxicated, as you were recently when you were grazed by the car. Past intoxication was after staff parties when you had had more than usual so as to cope with the larger gathering. You have had one or two falls when intoxicated which caused bruising or sprains, but no head injuries. You have not had any fits that you know of.
- You have never:
    - Vomited blood or passed bloody or black stools
    - Been jaundiced
    - Had pancreatic or liver–area pain
    - Had any symptoms of gout
    - Had any symptoms of cardiac failure, chest pain or shortness of breath (but you are not fit and take little exercise other than some walking)
    - Had any memory problems, especially not with short–term memory. Your concentration is reduced at the end of each working day, as above, otherwise you think this is fine.
- You have:
    - Had some numbness and tingling in your hands. But this was only after fluoxetine was increased to 40mgs and has not recurred. No other NS symptoms, and none in the legs.
    - Had an episode of wrist–drop (left side) 3 years ago, with loss of feeling and weakness. This happened after you had drunk too much and slept in a chair with your arm dangling across the armrest, but you did not admit this to your GP. It resolved fully.
    - Currently got a painful bruise on your lateral mid thigh on the right. There is no nerve damage from this. It will make it a little hard for you to perform any tests of muscle power in your right leg – you will wince and complain **"ow – that hurts"** on moving the leg. If the candidate is testing tone and reflexes here, be a bit anxious **"OK, but watch my bruise"**
- Apart from your leg, respond normally to the physical. You have no neurological deficits. Be anxious if they go to test pain in any way and refuse this **"no, I'd rather not do that"**. Be particularly anxious if they do not explain themselves and reassure you. If the candidate is too rough or brusque, you can refuse to cooperate with aspects of the examination, and if they don't explain what they are doing, ask them anxiously about this **"why are you looking at my hands?" "are my eyes OK?"** (after ophthalmoscope or torch) etc. Do not let them examine your stomach/groin or examine under your shirt.
- You are generally medically well, with no other past medical history or symptoms, and no allergies.

Objective Structured Clinical Examination
Mock Exam Auckland April 2006

Candidate No.:

MARKSHEET

Station 1

1.0 APPROACH

Did the candidate demonstrate an appropriate <u>professional approach to the patient</u>?
(Proportionate value - 10%)

Category : Approach to patient	**Surpasses Standard**	**Achieves Standard**	**Just below required standard**	**Standard Not Achieved**
▪ Introduces self clearly ▪ Listens well and is empathic ▪ Explores alcohol history without being judgemental or critical that patient concealed this previously ▪ Explains physical examination aspect well to patient ▪ Reassures patient about aspects of examination appropriately (e.g. that there will be no examination of abdomen or chest, and no sharp pins used.)	Manages this particularly well, with sophisticated ability to empathise and explain, particularly during physical examination.	Manages this quite well. May be a little clumsy with some aspects of their approach, but overall this is acceptable.	Manages this somewhat poorly but is clearly trying to engage with patient. May be a bit judgemental. Physical assessment stage is not well explained	Manages this very poorly. Attitude is unprofessional, curt or critical. Poor explanation about physical examination tasks / fails to reassure about these.
ENTER GRADE (X) IN ONE BOX ONLY				

2.0 HISTORY

Did the candidate collect <u>appropriately focused alcohol use history from the patient</u>?
(Proportionate value - 30%)

Category : Information gathering	**Surpasses Standard**	**Achieves Standard**	**Just below required standard**	**Standard Not Achieved**
▪ Alcohol use (timeframe, amount) and sequelae explored fully and in a systematic manner ▪ Makes reasonable attempt to clarify whether abuse or dependancy ▪ Main areas re sequelae are covered – psychological, physical, work, relationships, legal	Manages this very well, gathering a lot of useful information in a brief time, in a systematic manner. Covers all the required areas.	Manages this quite well. Possibly does not take quite enough history about all bio, psycho -social & legal sequelae. Reasonable try to clarify abuse vs dependancy.	Manages this somewhat poorly. Misses out some aspects (e.g. social or legal sequelae) or some aspects are not adequately explored. Does not make a good attempt to clarify abuse vs dependance.	Manages this very poorly. Misses out some aspects (e.g. past physical, social or legal sequelae) and some aspects are not explored. Does not seem to know how to clarify issue of abuse vs dependance.
ENTER GRADE (X) IN ONE BOX ONLY				

3.0 PHYSICAL EXAMINATION

Did the candidate carry out a relevant, focussed physical examination, demonstrating adequate technique? (Proportionate value - 40%)

Category : Physical Examination	**Surpasses Standard**	**Achieves Standard**	**Just below required standard**	**Standard Not Achieved**
▪ The examination should commence with greeting the patient and explanation, general inspection and observation, head and neck examination, then peripheral limb examination. ▪ Candidate needs to examine for stigmata of heavy alcohol use (spider naevi, palmar erythema, dupuytrens, jaundice) and do neurological examination, esp. peripheral NS, co-ordination & gait.	Performs an organized and systematic physical examination, covering all the essential aspects and demonstrating good technique. No errors or omissions.	Any errors or omissions are minor and do not materially adversely impact on the examination overall. May cover aspects which are less likely to be abnormal in alcohol abuse	The approach is somewhat disorganised, and some key aspects are missed. e.g. no NS examination, or no mention of checking for jaundice. May cause patient discomfort.	The approach is not systematic. Technique is poor. Many key aspects are missed. Patient is not treated with respect. May cause patient unnecessary discomfort.
ENTER GRADE (X) IN ONE BOX ONLY				

4.0 DIAGNOSIS & INVESTIGATION PLAN

Did the candidate present an accurate summary of their findings, diagnosis and plan for investigations? (Proportionate value - 20%)

Category : Diagnosis and Investigations Plan	**Surpasses Standard**	**Achieves Standard**	**Just below required standard**	**Standard Not Achieved**
▪ Competently presents a summary of their findings on history and physical examination. ▪ Correctly concludes that patient has additional Axis I diagnosis of likely Alcohol Dependance (vs Abuse), alongside Social Phobia. Plans for sensible investigations: ▪ Liver enzymes (esp. GGT, AST) ▪ Urea & Electrolytes, S. Creatinine and S. Glucose ▪ FBC/diff –macrocytosis screen ▪ Hepatitis A, B, C screening to rule out diff. Dx for liver disease ▪ Mention of the CDT (carbohydrate–deficient transferrin) test is icing on the cake, not an essential ▪ Others (bilirubin, amylase) don't contribute unless are *justified* – e.g. bilirubin only if jaundiced, amylase if history or symptoms of pancreatitis.	Summarizes well. Links the diagnoses – i.e. that the alcohol use developed to cope with the social phobia - Mentions excluding diff. diagnoses e.g. viral hepatitis. – *Justifies* the investigations planned – knows about the CDT test	Summary is reasonable, diagnosis is correct overall. May not quite get all the relevant tests but does plan for the most important of these and can justify their purpose.	Summary is not well organised. Diagnosis is not clearly presented re the comorbid Axis I issues. May not be specific about the most important liver function tests needed (GGT especially). Misses out many investigatns (or lists non-relevant ones) or doesn't justify need for tests.	Presentation & summary are poor. Diagnosis may be incorrect (eg. abuse not dependnce.) Comorbid diagnoses on Axis I are not clarified. Investigations are partial or excessive, and are not justified.
ENTER GRADE (X) IN ONE BOX ONLY				

Global Proficiency Rating

Did the candidate demonstrate adequate overall knowledge and performance of the task?

Circle One Grade to Score	Definite Pass	Just below required standard	Definite Fail