RANZCP Auckland Training Programme

Mock Objective Structured Clinical Examination

Station No. 2

April 2006

Station No. 2 - Introduction and Aims

This station concerns the ability correctly to diagnose depression and to screen for this and other differential diagnoses so as to explain withdrawal and poor functioning in a patient with schizophrenia.

The main aim of this station:

- The candidate must assess a known non–acute patient with schizophrenia whose keyworker is concerned that the patient is coping poorly. The candidate must assess to determine the cause of the patient's withdrawn, low–functioning state. Screening is needed for negative symptoms, depression, extrapyramidal side-effect history and unresolved positive symptoms.

Candidate must demonstrate

- Ability to take a focussed psychiatric history regarding the symptoms of concern;
- Ability to assess mental state regarding the concerns about withdrawal and poor functioning;
- Knowledge of the main differential causes of such a state in such a patient, and of how to screen for these;
- Ability to diagnose a depressive episode correctly.

Requirements:

- Table and 2 chairs
- Actor for patient (male)
- Instructions for Candidate
- Copy of an AIMS test carried out by the keyworker

Station No. 2 - Instructions to Candidate

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

You are a community team registrar, seeing a patient Paul – a 34 year old single man living in a supported flat with 3 others, who is known to the team, and who has paranoid schizophrenia. You have not seen him before as you are new to the community team.

His keyworker Gail visits the flat each working day, to support the residents. She has arranged for you to review Paul, telling you that he is not coping well in the flat, is spending most of his time in his room, and is not helping with the cooking and chores. He has lived in this flat for four months, moving there after his second admission for a relapse of psychotic symptoms, due to non-compliance with risperidone. Gail cannot attend the appointment with Paul as she is away at a course.

Paul was previously admitted for the first time 18 months ago, and prior to that had a 7 month history of gradual deterioration in functioning and development of persecutory delusions regarding his ex-boss and workmates, 3rd person auditory hallucinations discussing him, and a belief that his boss was "messing with" his thoughts.

Paul responded well to risperidone 4mgs nocte with full symptom resolution, but took this erratically, finally ceasing it altogether after about 9 months. He was admitted for 2 months initially, then on the second occasion for 1 month. The records show that he is still being treated with risperidone, now 5mgs nocte since his second admission. He is on no other medication, is medically well and has no relevant medical history.

Paul had lived with his mother before this, but she was reluctant to have him back again as she had warned him that she would not allow him to stay unless he took his medication. She had also wanted him to find work again (he used to work for a printer), which he had not managed to do.

Your tasks are to:

- **Take a focussed psychiatric history and perform relevant aspects of mental state assessment**, so as to determine the reason why Paul is not coping well.

- **Read and utilise a recent AIMS test** completed by Gail, the keyworker, which is provided inside the Station. Do not repeat the AIMS. You may take the AIMS provided as being accurate, and that Gail has been trained in administering the AIMS and assessing EPSE.

- Do NOT attempt to do a full MMSE, as the time is limited.

- After 13 minutes (with 4 minutes remaining), present **a summary of your history, mental state assessment findings and provisional diagnosis** of his current state, to the examiners.

Station No. 2 - Instructions to Examiner

The examiner will introduce the candidate to the surrogate patient, and will hand them the *Candidate's Instructions* and *AIMS Test*.

"This is your patient, Paul. This is a copy of your instructions, and of a recent AIMS test. Please proceed."

If the candidate asks any other questions about their task, refer them back to the *Candidate's Instructions* 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 a summary of the relevant history and mental state assessment, and provide a diagnosis and differential diagnosis of the patient's current problems in coping."

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

"Are you sure that you have presented a summary of the relevant history and mental state assessment, and provided a diagnosis and differential diagnosis of the patient's current problems in coping?"

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 2 - Instructions to Simulated Patient

You are Paul Green, a 34 year old single man living in a supported flat with 3 other men, and currently on a sickness benefit. Your keyworker Gail has arranged for you to have this appointment with your new doctor (the candidate). Gail told you that she could not be here today however, as she is away at a course.

Gail visits the flat Monday to Friday, to support you and the other 3 residents. You have lived in this flat for four months, moving there after your second admission for a relapse of psychotic symptoms due to schizophrenia, due to not having taken your risperidone for a few months.

You were admitted for the first time 18 months ago, and prior to that you had a several month history of experiencing delusions regarding your ex-boss (Mr Saturn, a printer) and some of your workmates. At that time you became convinced that Mr Saturn was deliberately trying to drive you "crazy" (and that a few of the workmates were helping him) and thought that he was "messing with" your thoughts. You felt that he was taking thoughts out of your head, and felt confused and frightened, finding it hard to think clearly. You also heard several people unknown/invisible to you discussing you and talking about what you were doing, and at times heard the TV newscasters mentioning your business. You were not sure why this was happening but were suspicious that Mr Saturn was actually "Mr Satan", and was trying to take your soul.

You were admitted after your mother became very concerned, by which time you had lost the job at the print shop. You never threatened Mr Saturn or anyone else, nor did the voices tell you to harm anyone or yourself. In the past you have not been depressed or suicidal at any point, until the last 1-2 months.

During your 1st 2-month admission you responded well to risperidone 4mgs nocte and became free of symptoms and insightful about the symptoms being "not real". You decided that the whole incident was due to "stress" and didn't really listen to the explanations of the ward staff, who mentioned the term "schizophrenia". You were sure that you did not have this however, as you believe that people with schizophrenia are violent, and you are not a violent person. You did not notice any special problems with the risperidone except mild sedation, but after a few weeks you took this erratically, feeling that you didn't really need it. You finally ceased it altogether about 9 months after discharge.

You began to relapse about a year after discharge, and struggled on at home (after discharge you had returned to live with your mother), increasingly preoccupied that Mr Saturn had done some sort of permanent damage to your brain, because again you could not think properly. You again began to hear voices discussing you and arguing between themselves. Finally your mother again arranged admission, this time for 1 month. Again, treatment with risperidone was very effective, and you were free of symptoms after 2-3 weeks. The staff spent a lot of time on this admission explaining about your diagnosis of schizophrenia, and this time you accepted this diagnosis. You are still being treated with risperidone, now 5mgs nocte since the second admission. You are on no other medication, and you are medically well with no medical history.

You had lived with your mother until recently, but she was reluctant to have you back again as she had warned you that she would not allow you to stay unless you took your medication. She had also wanted you to start work again as a printer, but you had not been able to find work, and when getting unwell, had not tried to do so. The ward staff and your mother felt that flatting with others in similar circumstances would be good for you, and you reluctantly agreed to try this.

You grew up locally and are close to your mother who is aged 60. Your father died of cancer when you were three and you barely recall him. You are the youngest of 3 and your 40 year old twin sisters are living in London and Sydney. Your schooling was uneventful and you had several friends and were an average student. You used to like soccer but have not played this since leaving school at age 17 with School Certificate. You and your mother attended the local Baptist church, and you have never used alcohol or street drugs. After school you had several semi-skilled jobs then did a printing apprenticeship, and have worked in this trade since age 25. You had a couple of girlfriends in the past, but somehow these relationships never worked out, and you have not had a girlfriend for a few years.

Since you left the ward 4 months ago and moved to the supported flat, you have not coped very well. You found yourself brooding about having schizophrenia, and now feel that your life is basically over, and that your mother has rejected you. You had drifted away from friends across the years and do not really have anyone else that you are close to. This sadness and negative attitude to the future has worsened across the last month, and you have felt unhappy almost every day. You have taken to spending most of your time in your room, feeling unable to socialise with the others in the house, and in the last month you have not helped much with the cooking and chores. This has led to your flatmates getting irritable, but they also seem worried about you.

You tend not to show your feelings, rather you withdraw and hide how you are feeling, and avoid interactions. You say little to the flatmates, and also say little to Gail when she tries to talk with you. You are not looking after yourself and are taking fewer showers, and Gail had to speak to you about body odour. You feel that there's no real point, and cannot be bothered. You are trying to make yourself eat but are not hungry at all. You are not sure if you have lost any weight. You initially tended to sleep more, as there seemed nothing to get up for. Now you cannot sleep well, tending to lie awake much of the night, and being unable to sleep after about 4am. You lie in bed anyway in the mornings, even though you cannot sleep. Usually you get up in the afternoons, but you still don't do much. You used to go for long walks but now feel tired and unable to manage these. You don't do much of anything, except to watch TV in your room (your mother gave you a small TV) – but you cannot concentrate on this. You cannot concentrate on reading (used to like reading thrillers) and now have no interests. You cannot imagine ever getting back to work, as your life seems ruined and hopeless. You have thoughts of wanting it all to just end, but no suicidal plans, as this would take too much energy.

You have no EPSE, and no akathisia. You don't notice any side-effects from your risperidone. You do take this every night, as you are now fearful of having another relapse. You have not missed any doses since discharge, but are finding it harder to remember to take the tablets. Your psychotic symptoms have not returned since discharge. Overall, you feel very despondent, but tend not to tell Gail or your mother as you fear they might put you back into hospital. When your mother visits you try to make an effort, but she has been concerned about you "drifting" and tries to "motivate" you when she comes round. This tires you.

Things that you must say at some point:

At the start of the assessment, when the registrar asks how you are:

- **"The medicine's working OK, none of those voices."**
- **"I guess I'm OK…"**

Then a bit later, if you are asked about your moods or how you are "in yourself"

- **"I don't know, I just can't seem to see my way forward …"**
- **"I just feel there's no point to it all …"**

How to Play the Role: (casual clothes, slightly scruffy, please)

- Don't immediately indicate that you're depressed. Don't offer much and let these symptoms be drawn out. Be a bit reluctant at first to admit to depressive symptoms, but if the registrar asks direct questions to assess this, tell the truth. You can admit that you've been covering this up due to fear of readmisison.
- Appear flat and expressionless, rather than distressed. Look down, make little eye contact. Don't move much. Sigh at times and rub your face tiredly. Allow a little latency after questions and try to answer briefly, but don't do this to excess (re the limited time available in the OSCE). Occasionally miss a question and ask for it to be repeated (again, not more than once or twice though).
- If they test you for tremor or tone, all this is normal (no EPSE). If they ask about anything not in the script, say **"I don't know…"** and let it trail off vaguely.

Objective Structured Clinical Examination
Mock Exam Auckland April 2006

Candidate No.:

MARKSHEET

Station 2

1.0 APPROACH

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

Category : Approach to patient, interview technique	**Surpasses Standard**	**Achieves Standard**	**Just below required standard**	**Standard Not Achieved**
▪ Introduces self properly, explains role. ▪ Supportive manner, tries to be empathic with patient ▪ Does not badger or interrogate patient and is patient with their mild latency and relative poverty of speech ▪ Directs interview appropriately to key areas ▪ Assesses for depression in a systematic way, mix of open and closed questioning	Manages this particularly well, with excellent ability to engage a withdrawn patient and encourage them to talk. Good mix of screening & systematic questioning.	Manages this quite well. May not quite get the balance exactly right between accepting the patient's state and extracting information, but does reasonably well.	Manages this somewhat poorly but is clearly trying to engage. However, may interrogate too brusquely or be too passive and not seek specific information systematically	Manages this very poorly. Attitude is unprofessional brusque or rude. Not systematic in clarifying Sx, and may not elicit the history in all key areas. Patient may become upset and close off.
ENTER GRADE (X) IN ONE BOX ONLY				

2.0 HISTORY

Did the candidate collect <u>appropriately focussed history from the patient</u>?
(Proportionate value - 35%)

Category : Information gathering	**Surpasses Standard**	**Achieves Standard**	**Just below required standard**	**Standard Not Achieved**
▪ Relevant history taken covering the key areas: – for *psychotic* Sx – for *depressive* Sx (and they are likely to cover screening for *negative* Sx here re motivation, interest, activities) – for *EPSE* history – for substance abuse ▪ MUST ask about risk of suicide, once they grasp patient is depressed	Manages this very well, gathering a lot of useful information in a brief time. Covers all the key areas. Rapidly homes in on depression assessment.	Manages this quite well. Possibly does not take a complete history about all the key areas, but coverage is adequate. Checks suicide risk.	Manages this somewhat poorly. Misses out some aspects (e.g. current psychotic Hx or EPSE), but does do some depressive Sx screening. However, this is not systematic. Suicide risk is not assessed adequately.	Manages this very poorly. Misses out important aspects (e.g. current psychotic Hx or depression). Is not systematic. Suicide risk is not assessed. Wastes time on less relevant aspects of history. Misses cues.
ENTER GRADE (X) IN ONE BOX ONLY				

3.0 PHYSICAL EXAMINATION

Did the candidate carry out a relevant, focussed <u>mental state examination</u>, demonstrating adequate technique? (Proportionate value - 20%)

Category : Mental State Examination	Surpasses Standard	Achieves Standard	Just below required standard	Standard not Achieved
▪ Asks about subjective mood ▪ Asks about suicidal thoughts and plans and what might stop patient acting on these ▪ Asks about thoughts/plans to harm others ▪ Asks about psychotic symptoms – runs through the main ones from past and screens for these at least ▪ Brief cognitive assessment – concentration/attention and orientation, short-term memory, 1-2 frontal tests.	Covers all these areas well and systematically. Asks specific and relevant questions to clarify MSE, does not waste time on less relevant assessments.	Any errors or omissions are minor and do not materially adversely impact on the assessment overall.	Does not clarify these areas well – may miss out some aspects, e.g. psychosis screening Qs. Poor assessment of suicidal ideas. Little or no cognition assessment.	Disorganised assessment, not systematic –misses out key aspects, e.g. re suicidal ideas. Little or no cognition assessment, or starts full MMSE despite instructions not to do this.
ENTER GRADE (X) IN ONE BOX ONLY				

4.0 DIFFERENTIAL DIAGNOSIS

Did the candidate <u>present a summary of their findings, and give an accurate diagnosis and differential diagnosis of the patient's problems coping</u>? (Proportionate value - 35%)

Category : Summary and Diagnosis	Surpasses Standard	Achieves Standard	Just below required standard	Standard Not Achieved
▪ Presents adequate summary of the assessment, focussing in on the key issue of why patient is failing to cope in the flat ▪ Alongside main Dx of Paranoid Schizophrenia, correctly diagnoses current *depression* ▪ Is clear that depression rather than EPSE, unresolved psychosis or substance abuse is current cause for poor functioning ▪ Understands that in current state, negative Sx cannot be ruled out as yet – needs review once not depressed	Formulates & presents well. Excellent grasp of key issues, is clear about depression and aware neg. Sx cannot yet be excluded as an additional factor. Is clear re no EPSE or psychosis. Suicide risk is definitely mentioned in summary.	Summary is reasonable, diagnosis is correct – i.e. that patient is depressed. Presentation may be a bit clumsy but standard's reasonable overall. Negative Sx are given as a differential - may not say they can't be excluded yet.	Summary is not well organised or presented. Diagnosis of current problems is not clearly presented – may laboriously slog thru DSM-IV axes rather then homing in on the main issues. May not give any differentials for depression, or may be vague about whether this is the diagnosis.	Presentation & summary are poor. Diagnosis may be incorrect or off the point – e.g. may miss that patient is depressed. May not be able to give any possible differentials. Suicide risk is not mentioned in presentation.
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

AIMS **PATIENT NAME: PAUL GREEN** **DATE: 29/3/06**

Complete the examination procedure before making ratings.
For the movement ratings (the first three categories below), rate the highest severity observed.
0 = none, 1 = minimal (may be extreme normal), 2 = mild, 3 = moderate, and 4 = severe.

Facial and Oral Movements
Muscles of facial expression,
e.g., movements of forehead, eyebrows, periorbital area, cheeks. Include frowning, blinking, grimacing of upper face.
(0) 1 2 3 4

Lips and perioral area,
e.g., puckering, pouting, smacking
(0) 1 2 3 4

Jaw,
e.g., biting, clenching, chewing, mouth opening, lateral movement.
(0) 1 2 3 4

Tongue.
Rate only increase in movement both in and out of mouth, **not** inability to sustain movement.
(0) 1 2 3 4

Extremity Movements
Upper (arms, wrists, hands, fingers).
Include movements that are choreic (rapid, objectively purposeless, irregular, spontaneous) or athetoid (slow, irregular, complex, serpentine). Do **not** include tremor (repetitive, regular, rhythmic movements).
(0) 1 2 3 4

No tremor seen, no tone either

Lower (legs, knees, ankles, toes),
e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.
0 (1) 2 3 4

Trunk Movements
Neck, shoulders, hips,
e.g., rocking, twisting, squirming, pelvic gyrations. Include diaphragmatic movements.
(0) 1 2 3 4

Global Judgments
Severity of abnormal movements.
(0) 1 2 3 4
based on the highest single score on the above items

at No restlessness

Incapacitation due to abnormal movements.
(0) = none, normal
1 = minimal
2 = mild
3 = moderate
4 = severe

Dental Status
Current problems with teeth and/or dentures.
(0) = no
1 = yes

Patient's awareness of abnormal movements.
(0) = no awareness
1 = aware, no distress
2 = aware, mild distress
3 = aware, moderate distress
4 = aware, severe distress

Does patient usually wear dentures?
(0) = no
1 = yes

Final Score: 1

Staff Member involved: Gail Edwards