

**RANZCP Auckland Training Programme**  
**Mock Objective Structured Clinical Examination**

**Station No. 2**

**April 2007**

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**Station No. 2 - Introduction and Aims**

This station concerns the ability to assess a patient with somatic concerns.

The main aim of this station:

The candidate must assess a patient with somatic concerns about body odour, and determine the likely diagnosis and recommended treatment. The station is aimed at ensuring that candidates can distinguish between somatoform disorders such as hypochondriasis, obsessive compulsive disorder and delusional disorder.

Candidate must demonstrate

- Ability to carry out a focussed assessment regarding somatic preoccupations
- Ability to formulate a preferred diagnosis and to present this
- Ability to present a recommended treatment plan

Requirements:

- Table and 2 chairs
- Actor for patient (female)
- Instructions for candidate

## Station No. 2 - Instructions to Candidate

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

You are working in a consultation-liaison service. A local GP Dr Caroline Meadows has sent the following referral:

*Please can you assist with Mrs Susan Mee, aged 45. She has developed worries that she has a bad body odour and has seen me repeatedly about this. She has had extensive investigations (all normal) and specialist consultations including dermatology, gastroenterology and dental opinions, but no medical basis for her concerns has been found. I am somewhat concerned about her repetitive skin-cleansing, which is beginning to cause mild abrasions in places. I am not sure what the problem is - ?hypochondriasis ?OCD*

*Susan has become quite distressed and anxious about these concerns, so I commenced her on citalopram 20mgs mane 2 months ago, but with no real benefit to date. I would appreciate your assessment and recommendations as to how best to help her. She is not very keen to see a psychiatrist, but I have persuaded her to see you on the basis of the considerable distress her concerns cause her.*

### **Your tasks are to:**

- Carry out a focussed assessment with the patient regarding her main complaints, in thirteen minutes
- Your key assessment focus should be on the patient's main complaints, with additional background history explored as relevant
- At thirteen minutes, turn to the examiners and present to them your differentials and preferred diagnosis and the key points of your recommended treatment plan

Please Note:

- You may assume that the patient has been very fully medically investigated and that no further investigations are warranted
- Cultural factors are not an issue in this case and do not need to be explored

## Station No. 2 - Instructions to Examiner

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

***“This is your patient, Mrs Susan Mee. This is a copy of your instructions. Please proceed with your assessment.”***

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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.”***

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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.”***

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At **13 minutes** if the candidate has not started to discuss diagnosis and treatment with you, say ***“Please now present your differentials and preferred diagnosis and the key points of your treatment plan”***

At **17 minutes**, on the final bell, finish the examination immediately

### Station Operation Reminders – for Examiners

Prior to examination / between candidates: (3 minutes)

- Clear any used writing paper from last candidate into the rubbish bin
- Ensure that water & tissues are still available for candidate's use on table
- Ensure that the Candidate's traytable has on it:
  - Laminated copy of 'Instructions to Candidate'.
  - Paper copy of the patient Case Summary from the Bye station for reference
  - Writing paper on clipboard, pen

During examination: (17 minutes)

- At the first bell, ensure fresh mark sheets are ready (candidate is now outside reading - so careful to keep any noise down in the OSCE room)
- At the second bell, the examiner keeping track of timing notes time on clock (for the 15 minute prompt)
- The other examiner directs the candidate to their task

At conclusion of OSCE: (3 minutes)

- Retrieve writing paper clipboard and pen from the candidate (don't let them carry these off) and clear away used pages into bin
- Complete marking and get a fresh mark sheet ready for next candidate
- Ensure room is set up again for next candidate (as above)

## Station 2 - Instructions to Simulated Patient

You are a 45 year old married woman living in your own home with your husband, a bank manager. You have no children. You do not now work outside the home although up to 2 years ago you worked part-time at a florists. Your GP has referred you as she is concerned about your degree of distress and preoccupation with concerns that you constantly give off a foul odour.

You have noticed this problem for the past approximately three years since noticing that someone had scrawled "wash me" in dust on the back window of your SUV. When you saw this you began to wonder what they meant, and to doubt that they were just referring to the car. You rapidly became convinced that they were telling you to wash yourself as you had a bad body odour which passers-by could notice.

Since then this conviction has caused you a great deal of distress. You suspect that it may be your bowels or your digestion, but the gastroenterologist could find nothing wrong. You don't see how that can be the case, but think perhaps it is a skin problem – maybe with your "glands". You know that a dermatologist has reassured you that your skin and sweat are normal and your dentist said that you do not have halitosis, but you are not reassured. Despite all these consultations and many investigations, including stool samples and skin scrapings, you remain completely convinced that you have a very bad body odour and that the specialists have missed the medical cause for this. No amount of investigation or specialist consultation has reassured you at all, not even briefly.

At the time that this concern developed you were somewhat stressed as you had recently lost a clerical job at a real estate agents when the office downsized and reduced staff numbers. You managed to find part-time work at a florists as you have always enjoyed flower arranging, but these changes did knock your confidence considerably.

You are completely convinced that this odour exist – in fact you can smell it clearly. It smells something like bad flatulence and causes you great embarrassment. Your husband has chronic hay fever so you feel that he is not troubled by the smell (he says he cannot smell it) and can relax around him. However, over the past 3 years you have more and more avoided going out in public where you would have to have contact with others, because of the smell. You make only very brief trips to do essential shopping, and tend to apologise to salespeople you encounter. You avoid most of your prior friends – some have tried to keep in touch but you mostly interact with them on the phone. Your family of origin are all overseas so you have phone contact with them. You continued working at the florists for 6 months after these concerns developed, hoping that the scent of the flowers would mask your body odour, but finally you could not bear this any longer and resigned, despite the owner protesting that she could not smell anything.

If you do go out, you occasionally hear passers by in the street or in shops or the supermarket saying things like "that's bad!" and "what's that?" etc. and you know that this definitely refers to your odour. You believe that people are very aware of the smell but that most of them are too polite to say anything. You are more inclined to hear such things when passing people you believe to be "rude" (teenage youths, for example). You know that people can smell the foul odour when you pass them by, by the expressions on their faces and as you think you can see that they are holding their breath. If asked about these facial expressions you cannot describe them, you **"just know"** that passers by can smell the odour and are trying not to breathe when you are near. You have no other delusions or ideas of reference re TV, radio, newspapers, etc.

You have no psychotic symptoms other than this focal delusional system about your odour and the associated hallucinations. You sleep about 6 hours/night, mostly as you stay up doing laundry and washing. You eat enough to maintain your weight but are fussy about what you eat and lost some weight 3 years ago, due to concerns that the "wrong foods" might be the cause. You now doubt that foods cause the smell and think it is "medical". Your energy, concentration and motivation are all normal. You have never had a panic attack.

You keep yourself scrupulously clean and wash your clothes and bedding very frequently. You shower 4 times a day and spend a lot of time scrubbing your skin with special washcloths, a nail brush and antibacterial soap. You also gargle with mouthwash frequently and brush your teeth 3 times a day. Your gums often bleed. You know that you are developing raw skin areas but feel that you must do this, as the smell is so bad. This cleaning takes all your time, even keeping you up at night so that you don't get enough sleep. The cleaning gives you no relief as you can still smell the bad smell even after doing so. Your husband is worried about you and has for some time had to sleep in a separate bedroom.

These concerns are so troubling that you sometimes feel you can't go on. You feel very guilty about these thoughts, but when you imagine smelling this bad for the rest of your life, you do not think that you could bear it. Your love for your husband is the main thing that has prevented you from acting on these despairing thoughts. You have currently no definite suicidal plans or intent and have never made an attempt. You blame no-one for your problems and are sure it's a health issue of some unusual sort. You are no risk to others and do not blame any of the doctors you've seen for not sorting out your problem. You would give anything to have it treated. You appreciate your GP trialling citalopram and have been taking this properly (with no side-effects) but it has made no difference to how you feel. You never expected that it would help with the smell.

### **Brief Background History:**

You were raised in a “normal family” with 2 younger brothers (all in your country of origin – you emigrated with your husband Tony many years ago), and with a rather strict and rigid religious (Anglican) mother who left you with some self-esteem and confidence issues lifelong. Your father was a quiet man – your mother ruled the roost at home. Your mother was very houseproud and made you do a lot of cleaning in your youth “Cleanliness is next to Godliness”. You see yourself as “a bit inhibited”, even before the problems with the smell. There is no abuse history at all. You were an average student at school and had a few close friends but were not very sociable or popular. You left school at age 17 with University Entrance but went to work as your mother felt that you needed “a proper job”. You did secretarial training then worked in clerical jobs until the real estate office closed, as above. You met your husband Tony in one such post and have been married for 20 years – you love your husband and are close to him but you have never much enjoyed “the physical side” of the relationship (the topic embarrasses you). It is a sadness to you that you have no children – you had investigations when you were 35 and your husband had a low sperm count, probably due to mumps as an adult. You decided not to adopt - “we’re happy as we are, really.”

There is no psychiatric history in your family at all that you know of – no history of schizophrenia, depression, suicide, or substance abuse. You yourself have no past psychiatric history, and no current medical history, but you did have a significant head injury aged 5, in a fall from a tree. You were told you were knocked out for several minutes and had “concussion” afterwards, and that this delayed your starting school by a year.

You have never abused drugs and have just a glass of wine occasionally with dinner.

You are on no medication other than the citalopram. You are not opposed to a trial of alternative psychiatric medication or psychotherapy if asked about this, but do not see how it would help with the smell. You can accept that it might help your distress but feel **“that’s not really the point”**.

### **Things that you must say at some stage:**

At the start of the assessment, when the registrar introduces themselves, say **“Hello doctor, I really don’t think that you can help me with this....It’s not a psychiatric problem, but it is very stressful”**

You will apologise repeatedly to the candidate for the way you smell **“I’m terribly sorry about this doctor – I know my B.O. is terrible – I just can’t help it – I’m very embarrassed by it”**

Feel free to ad lib on this theme with various heartfelt apologies - e.g. checking the candidate can bear the smell.

**“I do hope the smell isn’t too distressing for you doctor”** and

**“I’m so sorry doctor, I try not to go out these days and bother other people with my problem”** etc.

### **How to Play the Role:**

- You are to let the candidate introduce themselves and start the assessment, as you are bit dubious about seeing a psychiatric doctor, given that you feel you have a physical health problem.
- Be well organised and polite. You are a nice middle-aged woman who is very troubled by this inexplicable health problem. Be a little hesitant in explaining the issue at first, and mention that it is embarrassing. e.g. **“I expect that you’ve noticed my problem already...it’s quite embarrassing”**
- Apart from this initial reluctance, you will give the history reasonably freely (especially if they manage the interview well and are empathic), but with occasional apologies for the nature of the issue **“sorry doctor, it’s not nice to talk about these things”** etc.
- You are to appear very intense when discussing the bad smell – you are *absolutely* humourless about this issue, and are quite distressed by it. If asked about suicidality you are to put your face in your hands and seem briefly close to tears, but overall you are not depressed. There is no slowing, you talk freely and you do NOT see yourself as at all depressed. You see yourself as stressed by a very real problem that no-one can help you with. When discussing any history *not* related to the delusions, you can show humour, and your affect is normally reactive.
- These worries about your body odour are NOT like obsessions – you are totally convinced that you smell very bad, and do not have any insight into them as unwanted or unrealistic thoughts.
- There is no true compulsive behaviour – no checking, counting or rituals that calm your anxiety. The washing is a direct result of your conviction that you smell very bad, and it does not help your concerns.
- You don’t have any anxiety symptoms that are not directly linked to your conviction that you smell very bad. You worry about going out in public and seeing people – but only because of the smell. You have no somatic or hypochondriacal concerns that are not directly linked to your beliefs about the bad odour.
- Away from the encapsulated area of your delusional beliefs about the smell, you are much less intense and can talk normally about other areas of history. But if the topic impinges on your beliefs about your body odour you once again become fixed and intense.

**MARKSHEET**  
**Station 2**

**1.0 APPROACH**

**Did the candidate demonstrate an appropriate professional approach to the patient?**  
(Proportionate value - 25% )

**Achieves standard by:** Demonstrating the following:

- Development of empathy and being able to form a relationship using appropriate language tailored to the patient
  - A systematic approach, including an appropriate mix of open and closed questions
  - Being attuned to patient disclosures including non-verbal communication
  - Containing distress and handling the patient's hesitancy and reluctance to see a psychiatrist
- Errors or omissions are minor and do not seriously impact on the therapeutic alliance.

**Surpasses standard if:**

Manages the above unusually well, at a better standard than that expected of an advanced trainee and without any significant errors.

**Does not achieve standard if:**

- Candidate adopts an interrogative approach or is very disorganised and unsystematic
- Candidate uses jargon that the patient does not understand
- Candidate fails to pick up on important cues, and fails to establish reasonable rapport.

Category: Approach to patient, interview technique	Surpasses Standard	Achieves Standard	Just below standard	Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY				

**2.0 HISTORY AND PHENOMENOLOGY**

**Did the candidate take an appropriately focussed history of the main complaint?**  
(Proportionate value - 40% )

**Achieves standard by:**

- Demonstrating a prioritised approach focussing on clarifying the main complaint.
- Specific details required to determine the differential diagnosis are elicited
- Elicits history of despair and suicidal ideas due to her beliefs
- Brief, relevant background history is elicited – e.g. personal and family psychiatric history and patient's medical history, perhaps premorbid personality

Any omissions or errors are relatively minor.

**Surpasses standard if:**

Manages the above unusually well, at a better standard than that expected of an advanced trainee and without any significant errors or omissions.

**Does not achieve standard if:**

- Fails to identify the main presenting features and details of phenomenology
- Leaves significant gaps in the history e.g. insufficient details about differential diagnoses so as to exclude these
- Misses the history of despair and suicidality – no adequate assessment of risks due to her beliefs
- Does not prioritise history taking well so as to focus on the key issues and also elicit some brief background details

Category: History and Phenomenology	Surpasses Standard	Achieves Standard	Just below standard	Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY				

### 3.0 DIAGNOSIS

Did the candidate present accurate differentials and preferred diagnosis?

(Proportionate value - 15% )

**Achieves standard by:**

- Adequately presenting their preferred diagnosis and briefly explaining why the main differentials are excluded or very unlikely
- Accurately diagnosing Delusional Disorder ( $\pm$  "somatic type")  
(section 3.0 cannot be an "achieved" if this is not given as the preferred diagnosis)

Any omissions or errors are relatively minor.

**Surpasses standard if:**

Manages discussion of the differentials and diagnostic formulation unusually well, incorporating possible risk factors e.g. head injury or personality structure. No significant errors or omissions.

**Does not achieve standard if:**

- Candidate fails to identify the correct diagnosis as Delusional Disorder
- Candidate appears unaware of possible differentials or is unable to select a preferred diagnosis and just presents a list of possible differentials

Category : Diagnosis	Surpasses Standard	Achieves Standard	Just below standard	Standard not Achieved
ENTER GRADE (X) IN ONE BOX ONLY				

### 4.0 TREATMENT PLAN

Did candidate present key points of treatment plan adequately? (Proportionate value - 20%)

**Achieves standard by:**

- Emphasising the need for treatment with antipsychotic medication long term (type not so important but likely an atypical such as risperidone, quetiapine, etc. May mention pimozide but this is no longer available of course). (May mention ceasing citalopram but this is not essential)
- Discussing (briefly) the need to develop a good therapeutic relationship, so as to engage the patient despite her delusional lack of insight. Sensible to persuade patient to try medication on basis of helping her with the distress, initially.
- May mention the need for further follow-up
- May mention liaison with patient's husband and with the GP
- May mention referral for psychotherapy (e.g. CBT) once medication effect is evaluated.

**Surpasses standard if:**

Manages presentation of key points of the treatment plan unusually well, at a better standard than that expected of an advanced trainee and without any significant errors or omissions.

**Does not achieve standard if:**

Candidate fails to present the key treatment options – the main two being antipsychotic medication and the importance of engagement and the therapeutic relationship.

Category : Treatment Plan	Surpasses Standard	Achieves Standard	Just below standard	Standard Not Achieved
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	Marginal Performance	Definite Fail
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