

RANZCP Auckland Training Programme
Mock Objective Structured Clinical Examination

Station No. 3

April 2007

1. Introduction and Aims

The Main Task is to:

Observe the candidate interviewing a man who has suffered Traumatic Brain Injury (TBI) and discuss a treatment plan tailored to the presenting complaints.

The Main Assessment Aims are:

- To interview a man who suffered a head injury 2 years ago and who continues to experience residual and long-term symptoms
- To demonstrate an understanding of the long term sequelae of Traumatic Brain Injury (TBI) and common co-morbid psychiatric and neuropsychiatric syndromes.

The Candidate Must Demonstrate

- The ability to take a comprehensive history in a professional and empathic manner
- Knowledge of common indices used to determine severity of Traumatic Brain Injury
- Knowledge about the common sequelae of Traumatic Brain Injury including secondary mood disorders, post traumatic stress disorder (PTSD), generalised and social anxiety, secondary sleep disturbance, etc.
- An understanding of the biopsychosocial impact of head injury
- The ability to tailor a treatment plan for a patient with long term and residual symptoms of a significant head injury, with a focus on vocational and cognitive rehabilitation

Station Requirements:

- Table and 2 chairs, no physical examination facilities required
- Simulated patient – male, aged about 30-40
- Clipboard with paper and pen

Station 3: Instructions to Candidate

You have seventeen (17) minutes to complete this station

You are working in a community team. A local GP Dr Luke Taylor has sent the following referral:

Please can you assist with Mr Jim Walker, aged 38. He suffered a serious head injury 2 years ago in an accident at a building site where he worked as a carpenter and was struck on the back of the head by a beam. He lost consciousness after the accident for 5 minutes; Glasgow Coma Scale (GCS) at the site was 13/15. On arrival at the Emergency Department the GCS dropped to 11/15; he was intubated and ventilated and admitted to the ICU where he stayed for 8 days. CT scan confirmed fractured base of skull and a small intracerebral bleed (treated conservatively). He was given intravenous antibiotics.

He did not experience any obvious neurological problems after the accident, but he has found it very difficult to return to work. He got very stressed about this 18 months ago and I started Prozac, which has had a reasonable effect. However, Jim is easily distressed and he remains worried and anxious.

Please can you advise about the diagnosis and treatment options, particularly rehabilitation options.

Your tasks are to:

- Interview Mr Walker about his main complaints in thirteen minutes
- After thirteen minutes, discuss your diagnosis and a recommended treatment plan with Mr Walker
- You are *not* expected to elicit Mr Walker's personal history
- You are NOT expected to perform cognitive testing such as the MMSE
(you may assume that his MMSE is normal apart from minor deficits in concentration)

Station No. 3 - Instructions to Examiner

One examiner notes the start time of the OSCE on the clock.

The other examiner introduces the candidate to the patient, and hands the candidate the *Candidate's Instructions*.

“This is your patient Mr Jim Walker. This is a copy of your instructions. Please proceed with your tasks.”

If the candidate asks any other questions about their task, refer them back to the *Candidate's Instructions* by saying

“Your information is in front of you – you are to do the best that you can”

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.”

At **14 minutes** if the candidate has not already started to discuss diagnosis and treatment with Mr Walker, say **“You have three minutes left – please complete all your tasks”**

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)

Briefing Information for Examiners:

Indices Used to Determine the Grade (severity) of Traumatic Brain Injury (TBI)

Mild TBI is called “Concussion” in lay terms.

It is most commonly due to acceleration or deceleration (shear) forces or a direct blow, but not generally caused by a penetrating head injury.

Grading Systems for Mild TBI vary but a commonly accepted version is as below.

Recent research is showing that the period of Post-Traumatic Amnesia (PTA) is the best correlate with more severe longer-term deficits and sequelae.

Grades of mild TBI:

- I. The mildest, grade I, involves only confusion**
- II. Grade II involves anterograde amnesia that lasts less than five minutes as well as confusion**
- III. Grade III involves the symptoms above, as well as retrograde amnesia and unconsciousness for less than five minutes**
- IV. Grade IV involves all of the above symptoms, as well as unconsciousness that lasts between 5 and 10 minutes.**
- V. Grade V is the same as grade IV, with unconsciousness lasting longer than ten minutes.**

‘Achieved Standard’: In terms of what it is reasonable for an “achieved” standard advanced trainee to know, we would expect knowledge that:

- there is a grading system for Mild TBI**
- Mild TBI is the same as Concussion**
- the length of Loss of Consciousness is important**
- the length of Post Traumatic Amnesia is also important**

‘Surpasses Standard’:

If the candidate understood and discussed the following details they would be at the “surpasses” standard if all else was at a good standard.

- Mr Walker would meet criteria for Grade III of Mild TBI**
- His length of PTA is not completely clear, as it is unknown whether his coma for 5 days post-accident was medically induced or not**

Station 3: Instructions to Simulated Patient

You are **Jim Walker**, a 38 year old married man. You live with your wife of 4 years, Lisa, and your 2-year-old son, Sam, in a rented 2-bedroomed apartment. You are unemployed and receive insurance payments. Lisa works 30 hours a week as a dental assistant. You last worked 2 years ago, as a carpenter on a building site. You were struck on the back of the head by a wooden beam while at work, suffering a serious head injury.

You have no memory of most of the day of the accident but your workmates saw it and has told you what happened. You remember having breakfast with your wife who was at full-term in her pregnancy; and you wondered whether this would be the day. You lost consciousness for about 5 minutes; when you woke up you were dazed. You cannot recall the ambulance arriving but you understand that you became confused and were taken to the local Emergency Department. You were admitted to the Intensive Care Unit and remained there for 8 days - for 5 of those days you were in a coma (you're not sure if it was medically induced). You have patches of recall from about 5 days, continuous memories start after about 7-8 days, and you recall hearing that Lisa had given birth to a healthy son. You understand that you had a fracture at the base of your skull and that you had a small bleed inside the brain but did not need surgery. You have not been able to play any contact sport for the past two years which has been a significant blow as you used to play rugby.

You were discharged home from the ward after 2 weeks and were told that you could restart work in 3 months. You were told that you had had a head injury and were referred to an Occupational Therapist to assist with rehabilitation. This period remains a bit of a blur, and mostly you were adjusting to having a newborn son.

Since the accident you have had significant short-term memory problems - you have to write everything down in a notebook or your wife has to remind you. Your attention and concentration are reduced - you can focus for about 20 minutes and then you feel "mentally tired". Your energy levels dip as day progresses. You care for your son at home and take naps when he does. At night, you go to bed early but wake up after nightmares, usually for about 2-3 hours in the middle of the night (you usually get up, have a cigarette and watch TV or DVDs). You don't have any 'flashbacks' about the accident however, and you don't avoid things that remind you of the accident - but you've lost contact with your old workmates. You find it hard to plan and rely on your wife to organise your day. You can only handle little bits of information and often feel overloaded. At these times, you get bad headaches - generalised, crushing and radiating into your neck. You can't do anything when you have a headache, you have sensitivity to noise and your son's crying is intolerable. On bad days, your mother comes to fetch Sam, and your wife stays home when he is sick. Codeine, Brufen and Panadol combinations help with the headaches.

Three months after the accident you tried to return to work but could not cope. Everything was difficult and you think that you had a panic attack or some sort of breakdown. Your GP told you that you couldn't return to work and that you had Post Concussion Syndrome. After another 2-month period, your wife took the job as a dental assistant. Both sets of grandparents live nearby and help out intermittently.

After about 6 months you became depressed. You were very low and irritable - your wife was often the target of your anger. She endured this however, understanding what was happening. You felt low in spirits, gloomy and that your life had ended. You felt useless because your wife had to work and you couldn't provide for your family. You never thought of killing yourself (and you say you never would) - you felt that you owed it to your family to survive. You saw your GP and he started Prozac. It eventually helped and you now take 40 mg in the morning. You feel much better on it: your wife suggested that it might be time now to stop the medication but you're afraid the depression will come back if you do stop.

You still have occasional down days but they are not as bad. Sleep is still a problem but your appetite is better (however you've gained some weight because you sit around all day and don't play sport). Your libido is still poor - it's linked, you believe, to your low self-esteem. You are worried about returning to work (but have not had any more panic attacks since and don't have general hypervigilance). Two years have now passed and you lack the confidence to return to work. You have always worked as a carpenter and have no other formal training. You continue to feel like a "leech"; but too much time has passed now and you doubt that you will ever return to work. The Insurance Company keep asking you to have repeated assessments and this really stresses you. They threaten to stop the payments, which would cause serious financial hardship for your family. You sometimes feel that you are at the end of your tether.

Apart from your immediate family, you tend to avoid groups and crowds. You cannot manage shopping without your wife going with you. You're a "quiet bloke" generally. Your relationship with your wife is stable now, as you're not so irritable. You continue to worry a lot, mostly about the future.

You have no previous psychiatric history. You have always been an energetic, fit person who grew up in a "normal home" and who was much more interested in sports than in academic achievement. Your parents were disappointed that you never got qualifications like your two older brothers (an accountant and a teacher), but you preferred working with your hands and making things. You smoke about 10 cigarettes per day and on bad days up to 20. You plan on quitting "one day" and Lisa hates your smoking. You have about 2-3 beers, usually on weekends. You drive, but never after taking alcohol. You are more sensitive to alcohol's effects now, since the head injury. You don't use any illicit substances. You have no other relevant medical or surgical history.

How to Play the Role

About 5 minutes into the interview, say that you are getting a headache.

You are to appear quite open and helpful – a "nice bloke". You will seem a little worried and may be unhappy at times, but not frankly depressed. Answer as fully as you can recall, from the script. From time to time, especially when asked something more difficult, squint as though suffering from a headache, and rub your brow or temple **"sorry, it's this headache again"**.

From time to time you will lose concentration and need to ask for a question to be repeated. You will be somewhat anxious about rehabilitation plans, but are prepared to "try anything".

If the candidate does not handle the interview well – e.g. if they are abrupt or they interrogate you, become more irritable, complain more of the headache worsening, and be less forthcoming and grumpy.

When the candidate is explaining about the diagnosis and treatment, if they do not explain this clearly and simply you will become more stressed. If they use medical jargon and complicated sentences your headache will worsen and you will get irritable and say **"I don't understand, slow down would you?"** and **"I can't handle this"**.

The candidate has been asked not to take a history of your past personal life. If the candidate asks about this, tell them **"I don't see how knowing that would help the assessment"**.

What to Expect from the Candidate:

The candidate should question you about the symptoms of head injury - they have been instructed to do so for 13 minutes. After this time, expect the candidate to discuss treatment options with you. You are not to prompt the candidate to discuss the diagnosis and treatment options – they should remember to do this.

**Objective Structured Clinical Examination
Mock Exam Auckland April 2007**

**MARKSHEET
Station 3**

Candidate Initials:

1.0 APPROACH

Did the candidate demonstrate an appropriate professional approach to the patient?
(Proportionate value - 20%)

Achieves standard by: Demonstrating the following:

- Development of empathy and being able to form a relationship using appropriate language and explanations tailored to the patient's needs and level of coping
 - A systematic approach, including an appropriate mix of open and closed questions
 - Being attuned to patient disclosures including non-verbal communication
 - Containing any distress or irritability and modifying their approach appropriately.
- 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 technical language or 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 and engagement | Surpasses Standard | Achieves Standard | Just below standard | Standard Not Achieved |
|--|--------------------|-------------------|---------------------|-----------------------|
| ENTER GRADE (X) IN ONE BOX ONLY | | | | |

2.0 HISTORY

Did the candidate take appropriately detailed and focused history?
(Proportionate value - 40 %)

Achieves standard by:

- Demonstrating a tailored bio-psycho-social approach.
- Specific details required to determine the severity of the TBI are obtained.
- There is adequate screening for the more common co-morbid psychiatric and neuropsychiatric disorders of head injury e.g. secondary depression and anxiety disorders - particularly PTSD, symptoms of Post-Concussion Syndrome, etc.

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 reasons for the presentation
- Leaves significant gaps in the history e.g. insufficient details about indices used to determine the severity of the TBI
- Fails to adequately screen for the more common co-morbid psychiatric and neuropsychiatric sequelae of head injury as above.

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

3.0 DISCUSSION OF DIAGNOSIS WITH PATIENT

Did candidate discuss the diagnosis and differential diagnosis adequately?
(Proportionate Value - 10%)

Achieves standard by:

Achieves the standard by adequately explaining the likely diagnoses to the patient.
Covers the fact of the TBI itself, Post-Concussional Syndrome, and the treated Depression.
Any omissions or errors are relatively minor.

Surpasses standard if:

Manages the discussion of the diagnostic formulation unusually well, with good skills in explaining the sequence of events and sequelae to patient. No significant errors or omissions.

Does not achieve standard if:

Candidate fails to identify the diagnosis and the impact of Traumatic Brain Injury. Or if the candidate fails to identify and explain the common co-morbid neurocognitive sequelae and the subsequent depression to the patient.

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

4.0 MANAGEMENT PLAN

Did the candidate formulate and describe a relevant initial management plan?
(Proportionate Value - 30 %)

Achieves standard by:

- Covers need for ongoing treatment for depression at this point in recovery
- Covers rehabilitation planning adequately – e.g. vocational and cognitive rehabilitation
- Discusses the need for further testing (e.g. Neuropsychological testing) and for referral for further assessment e.g. an Occupational Therapy assessment
- May mention a possible referral for psychotherapy (CBT)
- Discusses the need for further follow-up with patient
- Discusses arranging a meeting with patient's wife as well.

Surpasses standard if:

Manages the discussion of the management 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 provide the patient with adequate information about treatment options.
Fails to identify the core role of rehabilitation especially vocational rehabilitation.

| Category: Management 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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