

RANZCP Auckland Training Programme
Mock Objective Structured Clinical Examination
Station No. 1
April 2009

Introduction and Aims

This station involves an interview with a patient treated for depression, and the need to collaboratively discuss management options.

The main aim of this station:

The main aim of the station is to demonstrate the ability to carry out an interview with a patient being treated for depression who is having doubts about continuing treatment, and to discuss the pros and cons of treatment options with them collaboratively.

Candidate must demonstrate

- Ability to carry out a follow-up review with an out-patient
- Ability to engage and reassure the patient, while informing them honestly about the pros and cons of treatment options
- Ability to discuss material provided by the patient and to use evidence-based research findings in the discussion

CANMEDS competencies assessed in this station

- 1) Medical expert/Clinical decision maker
- 2) Communicator
- 3) Collaborator
- 4) Scholar

Requirements:

- Table and 2 chairs
- Actor for patient (male, late twenties to thirties)
- Instructions for Candidate

Station No. 1 - Instructions to Candidate

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

You work at a community mental health centre and are today seeing a patient known to you, Stuart Williams, who is being followed-up after several episodes of recurrent major depression. You have reviewed him once before, about 3 months ago, since you started working at the community team. You have just refreshed your memory of his psychiatric history from the records, and have seen several articles from the internet that he sent to you when asking for the appointment.

You are aware that Stuart has concerns about his treatment with venlafaxine medication, and wants to discuss this with you.

Shortly before your appointment with him, you take a phone call from his wife, Liz, who expresses considerable concern that Stuart might ask to stop his medication. She tells you that it is very important that he keeps taking it, as they “can’t go through all that again” (referring to his past major depressive episodes). She wanted to come in with him today but was unable to get away from work. She tells you he is now very well on the venlafaxine and that they have argued about the articles he has been reading. She says that the only problem on the venlafaxine is that he is not as interested in sex as he used to be. She says that this does not bother her, as long as he is well otherwise.

Liz asked that you not tell Stuart she had called, as it would upset him to think she had been “interfering”. You told her that you understood her wishes but that you could not promise to keep her call confidential, depending on how the interview with Stuart went. She accepted this, reluctantly.

Your tasks are to:

- **Meet with Stuart for a follow-up review, focussing on his treatment for recurrent major depression and any side-effects**
- **Discuss the material provided by Stuart and use your knowledge of the evidence-base on this issue to discuss his concerns, and the pros and cons of treatment**
- **Formulate an ongoing management plan with Stuart, based on this discussion**

Station No. 1 - Instructions to Examiners

The examiner will indicate to the candidate where they should sit, and will point out the Candidate's Instructions by their chair.

“This is your patient, Stuart. This is a copy of your instructions. Please proceed with your appointment.”

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.”

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 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 tray/table has on it:
 - Laminated copy of 'Instructions to Candidate'
 - Clean copy of prior Bye Station (remove anything they bring in with annotations)
 - 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 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 notes 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 1 - Instructions to simulated patient Stuart Williams

Background history to be aware of: (you'll have this with you as a laminated sheet as well)

You are Stuart Williams, a 30 year old man living locally, in your own home. You are originally from the UK, but came here as a adolescent. You are married to Liz and are the sales manager at a local Woolworths supermarket branch. You have 1 child - a boy, Harry, aged 3. Liz works part-time as a caregiver at a nearby rest home.

You have had 3 episodes of major depression since you were aged 20. The first happened when you were at University doing your MBA, before you met Liz. At that time you became stressed by your final examinations. The second episode occurred after Harry's birth, three years ago, when he was 3 months old and you were not getting much sleep, and the third episode occurred a year ago when your job was threatened due to financial problems affecting the company. You did not in fact lose your job. On each occasion you were treated with antidepressants - initially fluoxetine in the initial two episodes, but this was ineffective a year ago, however you eventually responded to venlafaxine. You currently take 225mgs venlafaxine daily (75mg with breakfast and 150mg with your evening meal).

You have had intermittent out-patient follow-up with the community mental health team since the episode 3 years ago. You were referred back to your GP 2 years ago, then re-referred to mental health services for follow-up a year ago when the depression recurred. Following the most recent episode you have also had a course of CBT with the community team's psychologist. You had 12 sessions and found this useful. You use the techniques if you feel that you are getting stressed.

You are not aware of any side-effects with venlafaxine except for a tendency to sweat a little more, and some reduction in your libido (refer to this as "*my interest in sex*"). This does worry you somewhat although your wife has reassured you that it's not important. The problem is mild and does not cause impotence or any other sexual dysfunction. (Describe this as "*it's all in working order, I'm just not as...you know...keen as I used to be.*") Overall, you can live with this problem.

When depressed, you develop classical melancholic features with slowing, low energy, poor concentration, hopelessness, anxious and guilty thoughts, anhedonia, early waking and lack of appetite with weight loss. You do develop suicidal ideas when depressed and although you only ever acted on these initially, at age 20, they worry your wife a great deal. At age 20 you took a moderate overdose of sleeping pills and were briefly medically admitted. When you relapse, you deteriorate quite fast, across 1-2 weeks.

Recently, you were searching the internet and discovered the articles that you sent to the doctor (the Bye Station with these is attached). They have caused you concern and you now wonder whether the medication is really necessary and suspect that you would now be fine off venlafaxine, especially given the sexual side-effects and as you had the CBT course. You think you are probably now "cured". Because of this you arranged an appointment a little earlier than had been planned. You have seen this doctor once already, for routine follow-up. You have a basic Relapse Prevention Plan, last revised a year ago.

Other Relevant Background History: As above, you live in your own home with your wife Liz and your 3 year old son Harry. Your father also suffers from recurrent depression, worse since he retired at age 60, Rxd with fluoxetine & 2 ECT courses. Your parents also live locally & you have a younger sister living with her husband in Nelson. You like to be active & go jogging regularly. No drug use, min. social alcohol only.

How to Play the Role - and things that you must say at some point:

Start by just asking about the articles, saying that you wanted to find out more about this research.

Early on, you must say that you want to try coming off the medication. You think that having done the CBT, you don't need it any more. You will consider continuing the medication if the doctor can give you sensible reasons for this, but keep coming back to your wish to try reducing the dose "*to see if I do need it*".

If the doctor tells you about Liz calling, you'll react initially with mild irritation at her "*fussing*", but will calm down and say that you know she worries, and admit that the depressions are "*really tough on her too*". You don't think you'd ever commit suicide, but you don't want to have a relapse. If a plan to meet again with Liz included before making a final decision about your treatment is raised, you will be happy to agree to this.

You are well at present so you will be calm and not anxious or dysthymic. You should express considerable mistrust of "*Drug Companies*" and their motives (you know about advertising & sales), but will not mistrust the treating team and appreciate their help. If the doctor discusses the issues sensibly you will be inclined to trust their judgement rather than the news articles you've read. If they don't discuss it well, feel free to be dubious and more inclined to believe the articles. If they're condescending or manage the interview poorly, get irritable and repeat firmly that you intend to stop your medication as it's "*probably not doing anything*".

You'll be a bit embarrassed to talk about the sexual side-effects of venlafaxine and won't raise this unless specifically asked about it by the doctor. Just talk about the sweating, and maybe say something vague e.g. "*side-effects? Not really, just it makes me sweat a bit more than usual, especially in summer, you know. Yeah, that's...um...that's all really.*" etc.

Once/If the doctor raises the possibility of sexual side-effects, then describe these as above. You'll be uncomfortable but will be able to talk about the problem briefly.

MARKSHEET
Station 1

1.0 APPROACH TO PATIENT DURING INTERVIEW

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

Achieves the standard - by an empathic and professional approach to the patient, developing reasonable rapport. Candidate needs to be appropriate in their use of language, avoiding technical terms the patient would not be likely to understand. Candidate needs to be tactful regarding the call from patient's wife, but honest with the patient if it is necessary to mention her concerns. Candidate needs to manage the eliciting of sexual side-effects sensibly and empathically.

Surpasses standard if they manage these interactions particularly well.

Does not achieve the standard if – candidate is condescending or brusque, inadequately empathic regarding the sexual side-effects, or is rigid and formulaic in their approach and does not tailor it to this particular patient's needs and concerns.

| Category: Approach to patient during assessment | Surpasses Standard | Achieves Standard | Just below standard | Standard Not Achieved |
|---|--------------------|-------------------|---------------------|-----------------------|
| ENTER GRADE (X) IN ONE BOX ONLY | | | | |

2.0 INFORMATION GATHERING AND ASSESSMENT OF PATIENT

Did the candidate gather sufficient information from the patient, and adequately assess their current state and coping? (Proportionate value - 20%)

Achieves the standard if - there is an adequate review of recent problems, symptoms and coping. There must be assessment of any side-effects, especially the sexual problem reported. Past and current suicide risk must be covered. Symptoms and timeframe of relapse should be checked. The usefulness of the CBT course should ideally be touched on.

A candidate who surpasses the standard will cover these issues fully, with a better than average exploration of the risks of a relapse, and of the benefits and side-effects of treatment to date.

Does not achieve the standard if - these issues are covered poorly and the risks of relapse are not addressed. If suicide risk is not covered the standard will not be achieved. There must be some evaluation of the patient's coping and symptoms since they were last reviewed, not just reliance on past history as provided in the previous Bye station.

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

Station 1:

3.0 DISCUSSION OF TREATMENT OPTIONS AND THE ARTICLES

Did the candidate discuss the articles and other relevant research, and discuss treatment options and risks/benefits appropriately? (Proportionate value - 35%)

Achieves the standard if - candidate is able adequately to discuss the articles with the patient, and to place these in context of other research and the overall evidence-base regarding treatment for depression. The evidence-base must be discussed in context of *this particular patient's* type of depression and his pattern of relapses and family history. The usefulness vs side-effects of treatment (and the usefulness of CBT as well as its limits in relapse-prevention) need coverage.

A candidate who surpasses the standard will interact professionally and with sensitivity regarding the articles provided, neither dismissing them out of hand or accepting them unquestioningly. There will be a sophisticated grasp of the need to put critical reviews of the literature into context regarding an individual patient's pattern of illness and risks, and a good ability to explain the issues to the patient.

Does not achieve the standard if - candidate's attitude regarding the articles is either too naively accepting or entirely dismissive, or they seem to have no real grasp of the evidence-base in this area. Or if candidate is unable to explain and discuss the evidence-base with the patient sensibly and to place this in context for *this particular patient's* pattern of depression and risks.

| Category : discussion of treatment and articles | Surpasses Standard | Achieves Standard | Just below standard | Standard not Achieved |
|---|--------------------|-------------------|---------------------|-----------------------|
| ENTER GRADE (X) IN ONE BOX ONLY | | | | |

4.0 FORMULATION OF ONGOING MANAGEMENT PLAN

Did the candidate adequately formulate an ongoing management plan with the patient? (Proportionate value - 25%)

Achieves standard by - a collaborative approach to the formulation of a management plan, arising from a reasonable discussion with the patient. Candidate is expected to recommend continuation of medication or at least close monitoring if patient insists on a trial of discontinuation. If discontinuation is to be trialed, candidate *must* mention the Relapse Prevention Plan, close monitoring, and recommend a tapering off of dosage not sudden cessation. Ideally, a further meeting with the patient's wife Liz included should be recommended, before making a final decision.

A candidate who surpasses the standard will manage a particularly good collaborative partnership with patient, handling the issues sensitively and formulating a plan involving the patient's wife as well in the final decision. Ideally they might offer to provide other articles/information for the patient to read.

Does not achieve the standard if - the candidate does not take a collaborative and balanced approach - e.g. is insensitive and dictatorial regarding best management, or is ineffective and accedes to patient's request inappropriately.

Standard is not achieved if no real management plan is developed during the OSCE.

| Category : formulation of 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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