

**RANZCP Auckland Training Programme**  
**Mock Objective Structured Clinical Examination**  
**Station Number 2**  
**September 2007**

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**Introduction and Aims**

The Main Task is to:

Assess and manage a person with a sleep disorder (a parasomnia).

The Main Aims are:

- To interview a young man who has a sleep disorder
- To outline an approach to the management of this sleep disorder.

The Candidate Must Demonstrate

- The ability to take a comprehensive sleep history in a professional and empathic manner
- Knowledge of common primary and secondary sleep disorders
- Knowledge about the more commonly associated co-morbid psychiatric disorders
- An understanding of the biopsychosocial sequelae of sleep disorder
- The ability to suggest a treatment plan for a patient with long-standing and complex sleep disturbance.

Station Requirements:

- Standard consulting room, no physical examination facilities required
- Simulated patient – young, “trendy looking” male
- 2 chairs, paper and pen on desk.

## Instructions to Candidate

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

You are working in a Community Mental Health Centre. Dr Burdett, a local general practitioner, has referred a patient Tony Parker for psychiatric assessment. The referral states:

*Please could you assist with the diagnosis and treatment of Tony, a 30 y.o. single man who works as a barman and waiter, and who has longstanding problems with nightmares and sleepwalking that is causing him significant distress and disruption. I have tried him with low dose amitriptyline and more recently we tried a little thioridazine but he has not found them useful. He is rather afraid of addiction given his previous history with alcohol.*

**Your tasks are to:**

- **Interview the patient about his main complaints in 13 minutes**
- **At 13 minutes, provide the patient with your diagnosis and a recommended initial treatment plan**

Note - You are *not* expected to take a personal or developmental history from the patient.

### Station No. 3 - Instructions to Examiners

When the candidate enters the room, introduce them to the patient, hand them the *Candidate's Instructions* sheet and say

***“Please proceed with your task”***

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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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At 13 minutes, if the candidate has not already begun this task, you are to say

***“In the last 4 minutes, please explain to the patient your diagnosis and your recommended treatment plan.”***

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If the candidate says they are finished and want to leave the room, you are to say

***“You may leave the room, but please make sure that you have completed the station 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'.
  - 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 13 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)

## Instructions to Simulated Patient

You are Tony Parker, a 30 year old gay, single man who has worked as a barman/waiter for the past two years in a busy city pub. You presented to your current GP about 6 months ago because of sleep disturbances but also discussed your concerns with your family GP about 3 years ago - however he was unsure about dealing with it. You are keen to talk to the assessing doctor as you are worried about your sleep problems. You have made some notes to remind you what to tell the doctor (use this script and refer to it at times as though to notes).

You experience “*nightmares*” although you can’t recall the content of any dreams. You are apparently restless in your sleep and then wake up “*in a state*” often after calling out or screaming, which startles anyone sleeping with you. Your previous partner reported that he would find it difficult to wake you even though you had sat up and yelled (often it took several minutes to wake you) and you’d be disorientated for the next few minutes. You hurt him at times (punches and kicks) while in this state between sleep and waking and your partner eventually moved into another bedroom because of the risk. You have also walked in your sleep quite often as well, sometimes having these disoriented episodes when people try to wake you, and all of these sleep problems happen in the first few hours after you go to sleep. You have never come to harm while sleepwalking but are afraid that you might, so you always sleep on the ground floor and lock the outside doors. The relationship with your prior partner ended about 18 months ago, and you believe that the sleep problems partly led to its ending. You’ve avoided further relationships and have been single since then.

You would never sleep away from your flat and you never go on weekends away or feel able to travel, and this bothers you as you feel you’re missing out. You’re comfortable staying with your parents as they’re aware of these problems which started in childhood, around age 6. In fact the problem “runs in the family”, as your mother used to sleepwalk when she was a child, as well. You’d hoped you might grow out of it like your mother did, but although it does settle down at times for a few weeks, it tends to recur again. You currently flat with Marcia, a pleasant, easy-going, recently divorced 50 year old woman. She locks her bedroom door at night as she is afraid that you could injure her, but she occasionally comes through to help if you’ve had a bad night – you tend not to remember this clearly however. You are not, to your knowledge, a snorer and no-one sleeping with you has ever described periods during sleep when you stop breathing for a few seconds. You’ve never had restless legs or any other abnormal movements during sleep. You experience about 1-2 of these “nightmares” or sleepwalking episodes per month but they can increase to weekly experiences. You’re not sure if the episodes get worse with stress – they may do, but when you’re not stressed they don’t go away. You thus tend to worry about going to sleep, wondering whether you will have a bad night. It takes you 2 hours to fall asleep – in the past you tried different types of low-dose sedative medication from your GP for a month solidly each time but this did not help and you didn’t like the idea of being on medicines for depression or psychosis – “I’m not crazy”. In the past after your relationship broke up you drank about 1 bottle of wine and sometimes a few beers each day but your GP warned you that this was harmful so you limit your alcohol intake now – not more than 1-2 standard drinks daily, and not before bed. It never helped with the sleep problem anyway, which got worse if anything across that time. You’re worried not to get “*addicted*” to any tablets, as you think you got into trouble with the alcohol.

You are often tired during the day and feel compelled to nap at about 3-4 pm but you resist this. You habitually drink 2-3 espressos first thing, to wake up – you’ve got your own espresso machine. You frequently feel “*crap*” – tired and irritable - in the mornings but your mood improves as the day progresses. By the time you start your shift at 6 pm, you feel energetic and positive. Your shift at work is from 6 pm to about midnight, five days a week and you seldom get to bed before 3am. Most days you sleep in to about 11am although the traffic and noise in the units can disrupt your sleep. At other times when you feel “*flat*” you smoke 2-3 cigarettes (you smoke about 25 per day since age 16).

Occasionally you have taken a party pill when other pep ups haven't worked effectively. You've only called in sick on three occasions in the past 6 months due to fatigue.

Your mood is generally "OK" - you have periods when you feel rather down about your sleep problems but you don't consider yourself depressed and you feel that you will "*overcome it*". You've tried to remedy your sleep disorder by going to the gym regularly to tire yourself out but this hasn't helped for a sustained period. Work and your family and friends distract you from your problems but you've noticed that it can be worse after vivid movies, especially late night double-bills. You can get anxious and worried about the possibility of the "nightmares" or sleepwalking but this anxiety only comes when you're alone at home and preparing for sleep – there's no generalised anxiety, no panic attacks and no OCD. You've never had any suicidal ideas or plans. Your appetite is normal but you monitor your weight with daily weighing as you were a chubby teenager and were teased. Your weight has been stable for the past 6 months. You have never had symptoms to suggest that you had an eating disorder and you don't see yourself as overweight. Memory and concentration have never been impaired. Your libido and sexual functioning are normal but you are not currently sexually active and nor have you been since your partner left. You will make an unhappy joke about this - "*maybe I should join a monastery and just be celibate!*"

Your health is otherwise normal - you're a healthy person. You have never had any "*funny turns*", seizures, collapse, periods of paralysis (particularly on waking), etc. You have never experienced any other unusual experiences like visual, auditory or other sensory hallucinations. You want help with the sleeping problem as you feel it's destroying your social life and impacting on you emotionally. You're willing to take medications if it will help but are wary of anything "*addictive*".

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

You are a young, trendy, sociable guy who likes to keep fit. You should appear euthymic, open and frank and wanting help. You have a good sense of humour and are at times self-deprecating.

### **What to Expect from the Candidate**

The candidate should question you about your sleep as they have been instructed to do so for 13 minutes. After this time, expect the candidate to discuss a working diagnosis and possible differentials. They have also been instructed to discuss treatment options with you and may include the need for further assessment and investigations. Don't prompt the candidate to cover diagnosis or treatment options – the examiners will remind them if need be. If a hypnotosedative at night is suggested you won't be keen and will say that you really don't want to "*get dependant*".

### **Responses you must make**

Must mention at some stage about the *degree of disruption to your social life and close relationships* which the sleep problems cause, *and the degree to which you worry about it, especially before bed*. These are your main concerns.

### **Issues to Avoid**

Don't talk about your sexuality (e.g. earlier adolescent sexuality or process around "coming out") – if asked, state that you don't believe it's relevant to the assessment. If the candidate pushes you on this, it wasn't traumatic, your parents are pretty liberal and supported you when you announced you were gay at age 18. Restate that you really don't want to discuss this further as it's not relevant. The candidate has also been instructed not to take a personal developmental history so again, say this is not relevant in your opinion. If they insist exploring this then everything was normal – nice parents who run a furniture shop, 1 younger sister, good ongoing relationships with the family, no family psychiatric history. Liked school but not keen on university – went waiting age 18 then learned bar work instead. You like cooking, going to the gym and movies, and have a number of good friends.

**Objective Structured Clinical Examination  
Mock Exam Auckland**

***MARKSHEET***

**Station 2**

**1. APPROACH**

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

Achieves the standard by demonstrating the following – development of empathy, a supportive yet professional manner, endeavouring to form a partnership using language and explanations appropriate for the patient, and a reasonably systematic approach with a mix of open vs closed questions. Any errors or omissions are to be minor and not to significantly adversely impact on the therapeutic alliance and process of the assessment.

Surpasses the standard if the process of the assessment is especially well-managed.

Does not achieve the standard if – the candidate adopts an interrogative or brusque approach, uses technical language or jargon that the patient does not understand, fails to identify important emotional and verbal cues, displays lack of rapport appears not to register the patient's main concerns.

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

**2. HISTORY**

**Did the candidate take appropriately detailed and focussed history? (Proportionate value 40%)**

Achieves the standard by a tailored approach focussing on the area of sleep disorders – any omissions are to be minor and not to materially adversely impact the content obtained. Key areas that need to be covered are the elicitation of symptoms of the parasomnia in some detail so as to distinguish it from other sleep disorders, and questioning to screen for common differentials and exacerbating factors such as stress, substance abuse, mood and anxiety disorders, and other sleep disorders like restless legs syndrome and sleep apnoea.

Surpasses the standard if the above is especially well and fully covered, and the candidate is clearly well aware of how to assess sleep disorders.

Does not achieve the standard if – the main symptoms needed to clarify the parasomnia are not enquired about, or if there are significant gaps in the history such as insufficient screening for the more common co-morbid psychiatric and medical disorders related to sleep disturbance e.g. mood and anxiety disorders, complex partial seizures (TLE), sleep apnoea, etc.

Category: Adequacy of history taking	Surpasses Standard	Achieves Standard	Just below standard	Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY				

### 3. DIAGNOSIS

#### Did candidate formulate & describe relevant diagnosis/differential diagnoses? (Proportionate Value 15%)

Achieves the standard by adequately prioritizing conditions relevant to the obtained history and findings, using a biopsychosocial approach, and/or identifying relevant predisposing, precipitating perpetuating and protective factors. Any errors or omissions are to be minor and not to materially adversely affect the conclusions. The correct diagnosis is of a parasomnia: Sleepwalking disorder. There are aspects of Night Terrors as well and this can be given as a differential but candidates who do better will be aware that this can be part of Sleepwalking. It is adequate if these are given as differentials, and if no preferred diagnosis is given overall.

Surpasses the standard if - the above is managed very well, with a good formulation of likely factors that may be worsening the problem, and the role of anticipatory anxiety.

Does not achieve the standard if – the candidate does not identify diagnosis as a sleep disorder, or if the parasomnia of Sleepwalking is not given as a major differential. Or if candidate includes very unlikely differentials such as depression or an anxiety disorder, for which there is no real history.

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

### 4. MANAGEMENT

#### Did the candidate formulate and describe a relevant initial management plan? (Proportionate Value 25%)

Achieves the standard by a sensible discussion of possible management for such a sleep disorder including further referral for assessments (EEG, sleep laboratory with polysomnogram, sleep diary). Candidate must make sensible recommendations about avoiding situations that worsen the parasomnia such as stress, alcohol and sleep deprivation, and about continuing to manage the sleep environment such as sensible preventative measures to avoid harm if sleepwalking, as he is doing. The possibility of low dose clonazepam to help patient's sleep switch remain switched can be raised, but if the patient is not keen this should not be pushed.

Surpasses the standard if the above is handled especially well and sensibly, with good explanations tailored to suit the patient, a good grasp of the management of this type of sleep disorder being apparent, and assistance with the anticipatory anxiety ideally also covered.

Does not achieve the standard if – the candidate talks only of referral on to some other “expert”, fails to provide the patient with information about further treatment options or explains these poorly, or if only pharmacological options are considered (these are rarely of much help in fact). If “CBT” is recommended without a good rationale as to why this might help (only for the anticipatory anxiety, really) then this is below standard.

Category: Initial 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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