

Objective Structured Clinical Examination

Mock Exam Auckland Sept 2005 - Station 3

Introduction and Aims

In this station, a known patient treated for schizophrenia with olanzapine, gives a history of the development of obsessions and compulsions. The candidate's main task is to take a detailed history of this specific problem, distinguishing these symptoms from other differentials such as psychotic symptoms, and to present their findings.

An empathic approach to the patient must be demonstrated.

The station aims to:

- Assess candidate's ability to take a focussed history (obsessive-compulsive symptoms)
- Assess candidate's ability to empathize with the patient.
- Assess candidate's ability to integrate their findings and present a diagnostic formulation and brief plan

Station Requirements:

- One simulated patient, aged 30-40, casually dressed and neatly groomed.
- Pen and paper.

Station 3

Instructions to Candidate

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

You are a psychiatry trainee, in a Community Mental Health Centre (CMHC). You are about to see a patient Greg who you have known for the last three months, and who has a known diagnosis of schizophrenia (paranoid type), with a 10 year history of this condition. He is a 35 year-old man who works in a garden centre, is unmarried and living in his own rented flat. A month ago you altered his medication from risperidone to olanzapine as he had developed gynaecomastia on risperidone. Prior to that he was taking trifluoperazine but complained of akathisia on this. He has in the last 2 weeks been taking 15 mgs olanzapine daily and is on no other medications. He is medically well and does not abuse alcohol or drugs. You last saw him 2 weeks ago, just after he commenced olanzapine, and at that stage he had mild sedation on 10 mgs olanzapine and was tapering off the last 2 mgs of risperidone, but seemed otherwise to be coping well with the change. He had no psychotic symptoms when last seen. When unwell in the past, he became deluded that "special forces agents" were bugging his phone and watching his flat, filming him with hidden cameras. He also developed auditory hallucinations. When in relapse, he has never been a significant risk to others or regarding self-harm, but did in the past become preoccupied and stressed and unable to maintain employment. Today's interview is a routine follow-up session.

Your task is to:

1. Take a focused history of the main presenting problems today and any relevant other history. You are *not* required to take a full developmental history.
2. After 14 minutes, you will be asked to present your diagnostic formulation and a brief action plan to the examiners.

Station 3

Instructions to Examiner

As candidate enters the room, check their name-badge then ask them to proceed:

“Please proceed with your tasks as outlined.”

If the candidate asks for clarification at any stage, repeat:

“You have your information. Please proceed with your tasks as outlined.”

If the candidate has not already commenced this, at 14 minutes interrupt the assessment and ask them to present their findings:

“Thank you. In the final 3 minutes, please present your diagnostic formulation and a brief action plan focussed on the presenting problems.”

If the candidate says they are finished and wants 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 3

Instructions to Simulated Patient (Greg)

You are Greg, a 35 year-old man who works in a garden centre. You are unmarried and live in your own rented flat. You have a 10 year history of schizophrenia (paranoid type). When unwell in the past, you have become deluded that “special forces agents” were bugging your phone and watching your flat, filming you with hidden cameras. You also developed auditory hallucinations of two men commenting on your actions, which you experienced as a normal conversation, but when no-one was around. When unwell you interpreted this to be “agents” who were bugging you.

Recently and when in remission, you have good insight and understand that you have a mental illness, schizophrenia, and that this caused your past symptoms. You tend to refer to your condition as “**my paranoia**” “**those worries about the agents**” and “**the voices**”. You no longer believe that “agents” are bugging or watching you, and have not heard any voices for 3 years, since your last relapse. You are medically well and do not abuse alcohol or drugs.

That relapse occurred as you had developed akathisia on trifluoperazine and had ceased your medication. You were treated for this relapse in the community, with risperidone, and did well on this overall, but gradually developed gynaecomastia (you call this “chest swelling”), which you found very embarrassing. As a result, your current registrar (who you have known for 3 months since run-change) changed your medication to olanzapine a month ago. You tapered the risperidone across 2 weeks while on 10 mgs of olanzapine, and last saw this registrar 2 weeks ago. At that time you were coping quite well with the change, apart from some mild sedation at night. In the last 2 weeks you have just been taking 15 mgs olanzapine at bedtime and are on no other medications.

You have continued working at the garden centre throughout these medication changes. When in relapse in the past, you have never been a significant risk to others or to yourself regarding self-harm, but you did in the past become so preoccupied and stressed with the “agents” that you were unable to maintain employment. Today’s interview is a routine follow-up session. The registrar is your main case-manager within Mental Health Services, and you do not routinely have a nurse assigned as part of your follow-up. You also have a good relationship with your GP but have not seen him for several weeks.

Your main concerns today are that across the last 2 weeks you have developed thoughts and behaviour which are new and bothersome, and which you have not experienced before. You describe the following problems freely to the registrar:

- **“I’ve started having these weird worries doctor, in the last couple of weeks”**
At work, you find yourself continually thinking that you’ve left the hose taps running, and have to keep returning to the taps and checking and re-checking that you have turned these off. You are clear that you have turned off the taps, and that these worries are “silly”, but you cannot stop these thoughts coming into your head. You wish they would stop, as it is beginning to affect your work and to slow you down.
- **You also find that at home you are having thoughts that people might get into your flat and rob you.** There was a break-in about 6 weeks ago in a nearby flat, but at the time you didn’t have these worries, they started in the last 2 weeks. Due to this you find that you have to keep checking the doors to make sure they are locked. You have to keep checking repeatedly even though you know “rationally” that the doors are locked. This has made it harder to go to bed and sleep and you are feeling somewhat stressed and having initial insomnia and reduced sleep. This is also not helping you to cope at work and you got a telling-off by the boss recently for forgetting to do some tasks.

Other details are (only give these if you are asked about them):

- You will be clear, if asked, that the unwanted thoughts as above are definitely your own thoughts, inside your head, and that they are not in any way like the “voices” you experienced in the past. You have no “voices” at all. But you cannot control these unwanted thoughts and they keep happening even though you wish they would stop.
- You will be clear that the fear of a break-in at home is quite different to the past concerns about “agents”. None of your worries about “agents” watching or bugging you have returned - this is something different. You have no other abnormal thought content.
- You will be clear that these recent symptoms are totally different from your past relapses and that they do not feel to you like a relapse of your schizophrenia.
- You will be clear if asked that you have no ideas of being controlled by anyone/anything.
- You are no longer sedated on the olanzapine and think that this medication seems to be OK for you. You think the “chest swelling” is a bit reduced, and are pleased about that.
- You have no mood or vegetative symptoms of depression or hypomania, no panic symptoms, but are experiencing mild generalised anxiety about the problems as above.

How to play the role

You are mildly anxious, but overall are pleasant and cooperative. You are in general coping OK, but are worried about these new problems and don’t want them to continue – **you should say you are afraid you may lose your job** if they don’t get better. You offer the initial information, then allow the registrar to check details and elicit further information. Don’t offer all the details at once, but respond to questions freely as above, when asked to clarify your experiences.

MARKSHEET

Station 3

1. APPROACH

**1 Did the candidate demonstrate an appropriate professional approach to patient?
(Proportionate value - 10%)**

Category : Approach	Surpasses Standard	Achieves Standard	Just Below	Standard Not Achieved
Demonstrates appropriate manner <ul style="list-style-type: none"> • Empathic • Professional manner • Responds appropriately if patient seems distressed 	Handles the approach to the patient very well. Empathic and supportive yet sensible manner.	Handles the approach to the patient quite well – reasonable blend of empathy and objectivity. A little less polished at times.	Handles the approach to the patient poorly – somewhat insensitive, seems not to be aware of distress. May be rather interrogative.	Handles the approach to the patient very poorly – may be rude or abrupt in responses. No support given, seems insensitive, interrogates.
ENTER GRADE (X) IN ONE BOX ONLY				

2.0 HISTORY and MSE

**2.1 Did the candidate collect appropriate history of current problems?
(Proportionate value - 40%)**

Category : History taking and MSE	Surpasses Standard	Achieves Standard	Just Below	Standard Not Achieved
<ul style="list-style-type: none"> • Gathers history of current presenting problems re thoughts & behaviour • Checks details well re exact nature of phenomena and thinking, so as to distinguish between OCD and psychosis 	Manages this particularly well, gathers a lot of useful information in brief time. Detailed checking of both OCD and psychotic symptoms.	Manages this quite well. Possibly does not take quite enough history about all these aspects, but gets enough to grasp the main details.	Manages this poorly. Does not get enough information or misses out large parts. Variable follow up of cues and may not “drill down” much for details.	Manages this very poorly. Misses out important aspects. Does not follow up cues or “drill down”. May be focussed only on psychotic symptoms.
ENTER GRADE (X) IN ONE BOX ONLY				

**2.2 Did the candidate collect other relevant history from the patient?
(Proportionate value - 10%)**

Category : Other key information	Surpasses Standard	Achieves Standard	Just Below	Standard Not Achieved
<ul style="list-style-type: none"> • Checks additional history re mood changes, general coping, sleep, work situation • Checks compliance with medication and side-effects 	Manages this particularly well, gathering a lot of useful information in a brief time.	Manages this quite well. Possibly does not take quite enough history about all these aspects, but gets enough to grasp the main issues.	Manages this poorly. Does not get enough information or misses out large parts. Variable follow up of cues.	Manages this very poorly. Does not follow up cues or remember to ask about these aspects. No or poor general screening Qs.
ENTER GRADE (X) IN ONE BOX ONLY				

3.0 DIAGNOSTIC FORMULATION

**Did the candidate present an appropriate diagnostic formulation?
(Proportionate value - 20%)**

Category : Plan re the gambling and debts	Surpasses Standard	Achieves Standard	Just Below	Standard Not Achieved
<ul style="list-style-type: none"> • States that patient has developed obsessive-compulsive symptoms (NOT a psychotic relapse) • Understands that these are superimposed on his schizophrenic illness which remains in remission • Postulates that olanzapine may be causing the OCD symptoms. • Discusses concern that if they continue, OCD symptoms may jeopardise patient's job and may further stress him such that his psychosis does start to relapse. 	Manages this particularly well, with sophisticated grasp and ability to formulate and integrate the information well.	Manages this quite well. May not quite pull the formulation together quite as competently, but does a reasonable job. Gets the key issues right re OCD vs psychosis.	Manages this poorly. Does not really integrate the information and make sense of it in formulation. May not link the OCD symptoms to olanzapine use, or state concerns re prognosis if Sx continue.	Manages this very poorly. Seems to have no real grasp of OCD Sx as opposed to psychosis. May entirely misinterpret patients complaints and diagnose psychotic relapse.
ENTER GRADE (X) IN ONE BOX ONLY				

4.0 MANAGEMENT

**Did the candidate present an appropriate brief management plan?
(Proportionate Value - 20%)**

Category : Mangement Plan	Surpasses Standard	Achieves Standard	Just Below	Standard Not Achieved
<ul style="list-style-type: none"> Plans to change medication so as to try to reduce symptoms. OK options would be: <ul style="list-style-type: none"> - Reduce olanzapine dose - Change back to risperidone (in interim) - Change to another atypical antipsychotic Plans either extra support for patient via increased team contacts, or an urgent follow-up appt. and PRN phone contact meanwhile 	Manages this particularly well, touching on both these aspects efficiently and in an organised manner.	Manages this quite well. Possibly does not cover both these aspects quite as fully, but plan is reasonable and touches on both issues.	Manages this poorly. May suggest half of this but forget the other half. May be indecisive or plan to consult supervisor before deciding.	Manages this very poorly. Does not really have a plan for either of these aspects. May not cover plan at all in time allowed, or plans to do nil or to ask supervisor what to do.
ENTER GRADE (X) IN ONE BOX ONLY				

Global Proficiency Rating

Did the candidate demonstrate adequate overall knowledge and performance of the task?

<i>Circle One Grade :</i>	Definite Pass	Just Below	Definite Fail
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