RANZCP Auckland Training Programme

Mock Objective Structured Clinical Examination

Station No. 3 (2)

April 2008

Station No. 3 - Introduction and Aims

This station concerns the ability to conduct a joint assessment with another doctor, focussing on the assessment and management of extrapyramidal side effects and tardive dyskinesia.

The main aims of this station:

The candidate must carry out a joint assessment of a known patient with their consultant present. Candidate must assess for adverse effects of medication - extrapyramidal side effects (EPSE) and tardive dyskinesia (TD) - while explaining the assessment findings to the patient and their colleague, and finally discuss treatment options with the patient.

Candidate must demonstrate

- the ability to engage with the patient and to conduct a joint assessment sensitively without objectifying the patient
- the ability to assess for EPSE and for TD
- the ability to discuss their assessment findings with the patient and a colleague
- knowledge of treatment options to reduce EPSE and TD

Requirements:

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

Station No. 3 - Instructions to Candidate

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

You are based in an inpatient unit and are about to carry out a joint assessment with your consultant present, with a patient, Susan. Susan is a 40 year old unmarried Chinese woman who has a 20 year history of paranoid schizophrenia and you met her 3 days ago when you admitted her.

She emigrated two years ago from Hong Kong and now lives locally with her sister and family. She has been treated with traditional antipsychotic medication, which for the last 10 years has been fluphenazine decanoate 25mgs IMI monthly. She also takes benztropine 2mgs BD. She is medically well and is on no other medication.

Susan is from a wealthy family with a business both here and in Hong Kong and on her arrival two years ago her family arranged follow-up and continuing injections from their GP, so she only presented to mental health services recently when the GP became worried about possible side effects and felt that she needed a review. Susan works part-time in the family business and is supported by the family.

Susan is well and stable at present. When unwell she develops persecutory delusions that her family want to kill her, and she once attacked her brother in Hong Kong in the past, hitting him on the head with a jade statue and causing a concussion. She also develops tormenting voices when unwell, which tell her that family members are plotting against her. She recalls her past symptoms and behaviour well and is ashamed about what happened in the past, and very much wants to remain well.

Susan currently has no positive symptoms and has moderate insight into her past episodes. She accepts the diagnosis of schizophrenia. She is slightly blunted in affect, and you previously elicited mild deficits in executive functioning – largely somewhat concrete thinking and reduced verbal fluency.

Your tasks are to:

- **Engage with the patient and conduct a focussed assessment for extrapyramidal side effects and tardive dyskinesia**
- **Discuss the results of the assessment either during the assessment, or immediately afterwards, with the patient and your consultant**
- **Discuss treatment options to reduce or avoid any side effects, with the patient**

Note:

You are NOT expected to conduct a mental state examination, and can assume that this would show no positive symptoms, just the deficits mentioned above.

You are not expected to conduct any neurological examination, and there is no equipment available for this.

The role of your consultant will be played by one of the examiners.

Station No. 3 - Instructions to Examiners

Instructions for examiner roleplaying the candidate's consultant:

When the candidate enters and comes across to the chairs, you and Susan will stand up and you are to say:

"Here (s)he is Susan - you remember my registrar from when you were admitted? (s)he's going to do the assessment and then talk about what we can do. It's for your treatment, but it's also a good training practice."

You can direct the candidate briefly back to their tasks if they ask what they are to do next, but keep any interaction to a minimum and do not offer suggestions or tell them to do any assessment details they may have missed. You can ask them if they have finished, if they seem to have completed the assessment, and can chat normally with the patient, e.g. **"thanks for helping us with this Susan" "Thanks Susan, you managed that fine"** (after the assessment).

If candidate has finished the assessment they should then move to present their findings to you and the patient. If not, prompt them to do so. **"So can you tell Susan and me what you've found from examining her?"**

The candidate should then move on in the final few minutes to discuss how to manage the side-effects identified via treatment changes.

When **13 minutes** have elapsed, if they have not already done so, say: **"So at this point** (ideally use candidate's first name)**, why don't you explain to Susan what you recommend to help her with these side effects, in terms of any treatment changes."**

If the candidate says they are finished and want to leave the room, the non-roleplaying examiner is to 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 trayltable has on it:
    - Laminated copy of 'Instructions to Candidate'.
    - 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 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 3 - Instructions to Simulated Patient - Susan Hing

You are a 40 year old unmarried Chinese woman with a 20 year history of paranoid schizophrenia and you were admitted to the ward for a medication review 3 days ago. You were educated in English and speak this well, so no interpreter is needed.

Across the years, you have been treated with traditional antipsychotic medication, initially oral medications like chlorpromazine and haloperidol, and for the last 10 years your medication has been "modecate" - fluphenazine decanoate 25mgs IMI monthly. You do get side-effects from this so you also take benztropine 2mgs BD, which helps a little. You are on no other medication. You are medically well and have no medical or surgical history.

You emigrated here two years ago from Hong Kong and now live locally with your sister Sarah and her family. You are from a wealthy family with an import-export business here and in Hong Kong and on your arrival two years ago your sister arranged follow-up and continuing injections from her GP. This is the first time you have had contact with the local mental health services and at first you were anxious about being admitted, but you now realise that this ward is very different from the large institution you were admitted to in Hong Kong previously, so you are feeling OK about it now. You work part-time in the family business in a clerical position. You don't drink or use any drugs, and are a non-smoker.

You accept the diagnosis of schizophrenia and are well and stable at present. You were admitted in the past on 3 occasions, but not for the last 10 years since on the depot. In the past you did not fully recover on oral medication and took it erratically, hence the relapses. When unwell in the past you developed persecutory delusions that family members wanted to kill you, and several years ago you attacked your brother in Hong Kong, hitting him on the head with a jade statue and causing a concussion. You also developed unpleasant voices in the past when unwell, which told you that family members were plotting against you. Since then you have done a lot better on the depot, with full resolution of delusions and hallucinations (you call these "my voices and paranoia"). You recall your past symptoms and behaviour well, are ashamed about what happened then, and very much want to remain well. This means that you will be anxious about any medication change suggested, and will want reassurance that you will not get sick again.

Things that you must say at some point (in some similar form of words):

At the start of the assessment, when the registrar enters and is introduced:
"Hello Doctor, please call me Susan."

Other than that, you can just chat normally with both the doctors (but don't interfere with the assessment too much). Be guided by the candidate as to what to do – they should give you instructions. You can ask for clarification and be curious in a normal manner (try to imagine yourself as a patient unfamiliar with anything that the registrar does). Don't hold up the assessment too much, but it's OK to say things like **"what does that tell you, doctor?" "did I do OK at that?" "is that right?" "like that?" "OK"** etc.

You can also drop little comments about your treatment such as: **"I'm glad you're looking at my treatment – I heard there are better things you can take now?"** or **"I hope we can find something better for me that doesn't cause this shakiness"** (or stiffness, etc.)

How to Play the Role:

Be keen to be examined and to discuss treatment options, but maintain a somewhat blunted affect – i.e. don't be very reactive or show much facial expression. You are reasonably intelligent but have not really had any psychoeducation and have not looked things up on the internet so you are relatively lacking in knowledge about different treatment options. You will be baffled by any technical terms and will ask what they mean.

As above, you are very keen not to relapse, so you will want reassurance that any change will not cause this. **"I don't want to upset the family again – it was very bad before when I was sick in Hong Kong"** Once reassured, you will want to try a change of treatment that might reduce or get rid of your side-effects. It is the shakiness and stiffness that you notice most. You will be prepared to have blood tests if these are mentioned.

Signs and Symptoms you will display and describe on examination:

On history-taking:

If asked to grade these say they are **quite bad, not just mild - moderate to severe** (in terms of how much they bother you).

- You are aware of **shakiness** especially in your hands. You are right handed and it affects your writing and holding a tea cup etc.
- You are aware of **stiffness** affecting all your body when you move about. It's an effort to get up and start to walk. You are a little unsteady on turns but have never fallen.

The family also tell you that **you make odd movements with your mouth**, but you don't notice these much – if grading them say they are **mild and don't really bother you.**

On examination, display these signs:

- A **fine tremor of the hands** at rest and when asked to hold out arms and hands. Try to maintain this at least off and on during the OSCE, esp. when being examined
- A **"lead-pipe" type of increase in tone in all limbs when tested**. Allow the candidate to bend your elbows and wrists, but hold these stiffly. If the candidate tells you to "relax" or "go loose" say: **"I am relaxed, that's my stiffness doctor"**

You do not have any signs or experience of akathisia. You don't need to simulate a tremor in your legs and feet as this would be difficult to maintain.

There are no dystonic or dyskinetic movements affecting your neck, trunk or limbs. Your power and sensation are normal. They probably won't try to examine your legs much as there is no plinth. You can tell them your legs feel stiff as well.

You have signs of oro-buccal tardive dyskinesia. Throughout the OSCE, you will intermittently **purse your lips as though about to kiss someone**, and occasionally **push your tongue slowly out into one or the other cheek in the "bon-bon" sign**. It should be possible for the candidate to see your cheek being pushed out from the inside. If the candidate tries to activate your symptoms by getting you to do hand movements etc., then do more active lip pursing and bon-bon movements, but seem to be unaware of these while concentrating on your hand movements.

When your mouth is examined, make your **tongue writhe a little from side to side** when it is resting in your open mouth, but not when you are actively sticking it out.

Whenever walking, do not swing your arms, and be a little slow and stiff, but you don't have to actually festinate. **When turning, be slightly unsteady** but don't fall. If the candidate gets you to hold out your arms and shut your eyes, your arms will drift off a bit to one side, and you would become **more unsteady with eyes closed, with poorer balance,** if the candidate pushes you gently. Just stumble slightly then correct yourself, don't fall over.

You might be asked to write a sentence – if so, try to write small and comment that writing is harder than it used to be and the letters seem smaller.

Practice all this using a mirror, before the mock exam!

Objective Structured Clinical Examination
Mock Exam Auckland

Candidate Initials:

MARKSHEET
Station 3

1.0 APPROACH and ENGAGEMENT

Did the candidate demonstrate an appropriate <u>approach to the patient and engage them</u>? (Proportionate value - 20%)

Achieves the standard by managing the necessary tasks while maintaining empathy and engagement. Candidate should demonstrate respect, acknowledgment and understanding of the patient's concerns. Despite demonstrating the assessment to their consultant, candidate needs to avoid treating patient as an object, i.e. to avoid talking across them repeatedly as though they were not present. Throughout the assessment the process needs to be explained sensibly, with clear instructions and permission asked to touch patient's limbs etc.

Surpasses the standard if this is carried out especially well, with full inclusion of the patient in the process and clear instructions, well-explained.

Does not achieve the standard if – lacks empathy, is insensitive to the patient's concerns, repeatedly talks across them as though they were an object or gives instructions which are hard to follow or abrupt and not well explained.

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 ASSESSMENT OF EXTRAPYRAMIDAL FEATURES AND TARDIVE DYSKINESIA

Did the candidate competently <u>assess patient for EPSE and TD</u>? (Proportionate value - 30%)

Achieves the standard by a tailored approach focussing on EPSE and TD. Key areas that need to be covered are history from the patient of the nature and severity of their side-effects – i.e. screening questions for Parkinsonian effects, akathisia, dystonias (incl. oculogyric symptoms and blepharospasms) and TD. Examination (as far as possible with no plinth or equipment) should cover general observation, examination of the arms and hands, examination of the head, neck, mouth and tongue and of patient's balance and ability to walk and turn. Leg tone might be assessed to some degree, but is not really expected. Any omissions should be relatively minor.

Surpasses the standard if the above is especially well and fully covered, and the candidate is clearly well aware of how to assess for EPSE and TD, ideally including checking activation of oro-buccal movements by hand activity, glabellar tap and a writing sample.

Does not achieve the standard if – the main symptoms and signs needed to clarify the extent of EPSE and TD are not adequately covered, or if inadequate history is taken about these or the examination is confused and/or incomplete. Candidates are not expected to carry out any neurological examination or to check reflexes without a tendon hammer or other equipment. In the absence of a plinth, a full AIMS is not expected.

Category: Assessment of EPSE and TD	Surpasses Standard	Achieves Standard	Just below standard	Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY				

3.0 DISCUSSION AND EXPLANATION OF FINDINGS

Did the candidate adequately discuss and explain the findings of the assessment? (Proportionate value - 20%)

Achieves the standard by correctly recognising and naming some EPSE (oro-buccal TD and reduced balance/coordination, some tremor and increased tone - i.e. Parkinsonian effects). These are explained both to the consultant and to the patient and any technical terms used are also explained in lay terms. Appropriate responses to any questions by the patient are required. The identification and explanation of findings can be provided during or after the examination. Any omissions should be relatively minor.

A candidate who surpasses the standard will cover all these aspects particularly fully and clearly and will handle the explanation and discussion with the patient sensitively. It should be evident that the candidate is well aware of EPSE and TD symptoms and signs.

Does not achieve the standard if the discussion is inadequate, explanations are hard to follow or overly reliant on jargon, or if the symptoms and signs are not accurately recognised and named.

Category : Discussion and Explanation of Findings	Surpasses Standard	Achieves Standard	Just below standard	Standard not Achieved
ENTER GRADE (X) IN ONE BOX ONLY				

4.0 DISCUSSION AND EXPLANATION OF TREATMENT OPTIONS

Did the candidate adequately discuss and explain treatment options? (Proportionate value 35%)

Achieves the standard by sensibly discussing alternative treatments to the depot medication. More recent "atypical" antipsychotic medication should be suggested, particularly olanzapine and clozapine. Brief explanations of possible benefits and risks of each should be given, particularly for clozapine, where key risks need to be covered but not *all* details of possible side-effects are required. There should be some coverage of the process of changing over – e.g. that the depot would self-taper while new treatment is commenced and titrated. Immediate reduction of benztropine might be suggested but is not essential, although there should ideally be some mention of it not being needed after the depot side-effects are considerably diminished. Any omissions should be relatively minor.

A candidate who surpasses the standard will handle discussion of treatment options very well, taking into account patent's anxiety not to relapse, with good coverage of key details especially of the relative risks and benefits and the changeover process. Ideally some awareness that TD might worsen after cessation of the depot, unless clozapine was started.

Does not achieve the standard if the candidate does not appear to have adequate knowledge of the best treatment of EPSE and TD and of managing a medication changeover to atypicals in chronic psychosis, or if this seems confused and is not well explained. Failure to include clozapine would be a serious omission, as would recommendation of risperidone/Consta (not likely to prevent further TD).

Category: Discussion of Treatment Options	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