

THE O.S.C.E. – ‘It’s a hard auld station!’
- A TRAINEES’ AND TUTORS INFORMATION CIRCULAR
Dr. Martin Mahon, Spring 2004

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UPDATED!
for Spring
2004

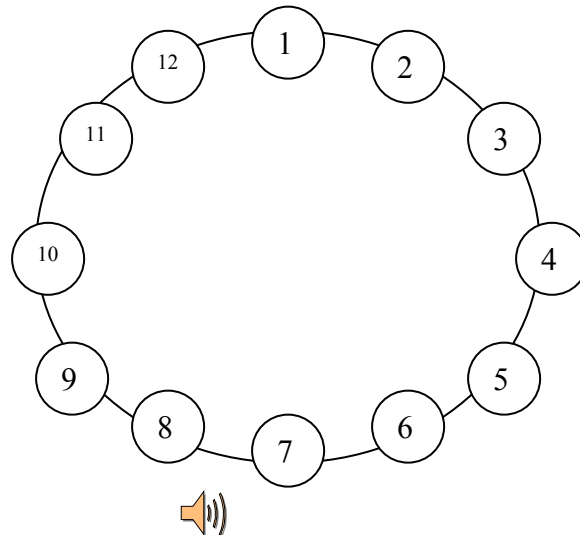
1. O.S.C.E-PURPOSE

- OSCE is an abbreviation for Objective Structured Clinical Examination and replaced the IPA/long case from the Spring 2003 Examinations. It is a more comprehensive and fairer assessment of your clinical abilities than the “long case”
- It reduces examiner subjectivity as your final mark will have been the product of 12 examiners.
- It examines your abilities over more areas (12 stations) than the traditional long case could achieve. The traditional assessment of a “real patient” perhaps with bipolar disorder in the long case might only examine your skills and knowledge with regard to this disorder, an area where you might be less knowledgeable than in, for example, schizophrenia if unlucky!!
- Standardised simulations of real-life situations can be presented in a controlled, relatively accurate and consistent but safe manner throughout the exam day to many candidates. In the old exam the patient may have been an inconsistent performer with different candidates and so a roleplayer or simulated patient as occurs in the new exam, will attempt to standardise the exam.
- Feedback from the actors (simulators) is possible and may some day become part of your score. This could involve asking the roleplayer to score you on how s/he felt you communicated or dealt with them.
- Stations can be adapted or tailored to the level of skill to be assessed.
- Scenarios that are distressing to real patients can be simulated and roleplayers can be expected to perform consistently with different candidates.
- Furthermore the long case really only tested assessment skills and theoretical knowledge. The emphasis of all OSCE examinations is to examine macroscopic skills in focused circumscribed clinical tasks potentially drawn from the breadth of your syllabus. There will be a focus on testing the application of knowledge not simply the theoretical knowledge itself. For example communicating a diagnosis of schizophrenia to the patient or a relative will require a candidate to relate through effective communication skills a theoretical knowledge of the aetiology of the disorder to a lay person.
- The subject matter or material covered will be made up of tasks that you all perform each day. They will merely be deconstructed into testable or **OSCEable** (amenable to being examined in an OSCE station!) tasks and a marking regime set along side them. Skills tested could be drawn from the following areas:
 - **basic clinical skills,**
 - **neurology,**
 - **communication skills,**
 - **clinical procedures**
 - **data interpretation etc.**

2. O.S.C.E - DESIGN

- Your exam will consist of twelve different “**stations**” organised into a “**circuit**” with more than one circuit at the exam centre each made up of different stations but you will only have to undergo one circuit. You will only need to complete one “**circuit**”. A circuit might possibly be housed in one large examination hall or some or all stations might be given individual rooms.
- Actors/role players will take the place of patients to simulate clinical situations. The advantage of this development is that perhaps unlike “real patients” the role players are professionals who seek to standardise their responses to questions from all candidates examined and they try to maintain a consistent psychopathology. You must assume that the actor or role player is a “real” patient and must be approached as you would approach a patient of your own at work. Many will be professional actors who have been coached to deliver a certain “scenario” for you at the exam.

- Observers, as always, will also be present at the College exam to further ensure standardisation.
- **NB (These are the timings proposed for Autumn 2003!)** At each station in the OSCE circuit there will be a set of “Instructions to candidates” which you will have about **1 minute** to read the “Instructions to Candidates” **BEFORE entering the station (and then 7 more minutes to perform the task of the OSCE. The first bell will occur 1 minute before the end of the station (i.e. 6 minutes after you first ENTERED the station) and the second bell will occur at the completion of the 7 minute period. You must then move to the next station. From start to finish the station will take 8 minutes.**



1 minute **Read Instructions at OSCE station! What do I have to do? Make notes!**



Enter station: Introduce yourself to patient and show your exam number to the examiner!

6 minutes **OSCE Task**

1 minute left bell



1 minute **Complete OSCE Task –Thank patient!**

Final bell move on to next station!



- A “rest” station or a “pilot” station may be included. A “rest” station will be just that; a chance to take a break within the circuit; a “pilot” station will be a station the College are testing with a view to including it in a future examination. Unfortunately, for some candidates the rest station may come first or last in your circuit! You should undergo the pilot in order to help the College in the exams process but it will have no bearing on your result.
- In total, your exam should take little over 1.5 hours. Bring your own watch to time your work.
- Different components of your performance at the station may be weighted differently e.g. the assessment of suicidality in a depressed patient might be weighted and so if you performed this aspect of the assessment of a depressed patient badly you might score poorly at this station or fail the station. Similarly, omitting the assessment of the possibility that a mother might harm her child when depressed post-natally would also be weighted. An examiner on the day may be blind to the weighting at the station and so may not know whether you have passed or failed that particular station.

3. EXAMPLES OF STATIONS

Here is an example of what might appear as an instruction to candidates at a possible station.

- **Title** - Auditory Hallucinations
- **No. 1**
- **Instruction** - Take a history from the following 30 year old man with a history of schizophrenia who presents to casualty complaining of hearing voices.

The corresponding information before the examiner at the station might be:

- **Title** - Auditory hallucinations
- **No. 1**
- **Construct** - This station aims to test candidates ability to elicit psychotic symptoms. The candidate should also be able to outrule other abnormal experiences.

The examiner may have a marking sheet like this to score your performance:

	A EXCELLENT	B GOOD	C AVERAGE	D FAIL	E SEVERE FAIL
Communication					
Systematic inquiry into hallucinations					
Systematic inquiry into other perceptual disorders					
Systematic inquiry into other abnormal experiences					
Global rating					

You can see that depending on the information given in the “Instruction to candidates” you will be asked to carry out a reasonable assessment of psychotic symptoms. Your ability to elicit a history from someone with psychosis is tested and there is a section where your global performance is assessed. This task is something you do almost every day. It is merely deconstructed into discrete areas/skills. You will also notice that as for all stations, you are not required to take a full psychiatric history (you will not have time).....instead you must take a relevant one.....practising OSCEs will focus your mind as to what is a relevant history or physical examination.

Another example of a station and the “instruction” to candidates might be:

- **Title** - Consent for ECT
- **No - 2**
- **Instruction** - Your consultant proposes to treat a depressed man who has not responded to adequate antidepressant therapy with ECT. Explain to the patient the nature and purpose of ECT and any beneficial or adverse effects in order for him to be able to consent for ECT.

And again the corresponding information before the examiner might be:

- **Title** - Consent for ECT
- **No - 2**
- **Construct** - This station aims to examine the candidate’s ability to explain to the patient the nature and purpose of ECT, the procedure, benefits and any adverse effects etc.

An example of the marking sheet before the examiner might be:

	A EXCELLENT	B GOOD	C AVERAGE	D FAIL	E SEVERE FAIL
Communication					
Nature & Purpose					
Benefits					
Adverse effects					
Global rating					

Another example of a station and the “instruction” to candidates might be:

- **Title** - Post partum depression (appeared in pilot examination)
- **No - 2**
- **Instruction** - Assess the following 25 year old woman for who presents with low mood one week after the birth of her baby boy.
- **Title** - Post partum depression
- **No-3**
- **Construct**-This station examines the candidates ability to establish a diagnosis of post natal depression and assess risk to self and infant.

An example of the marking sheet before the examiner might be:

	A EXCELLENT	B GOOD	C AVERAGE	D FAIL	E SEVERE FAIL
Communication					
History					
Risk to self					
Risk to infant					
Global rating					

Remember we said OSCEs could test basic clinical skills .Here is a grid to help you think of where to look for potential OSCEs!!!
 ... (This list is not exhaustive)

	History and Assessment	Collateral history taking	Physical examination	Investigations	Procedures	Communication with patients relatives or other professionals
Schizophrenia						
Affective disorders						
Anxiety disorders						
Eating disorders						
Old age psychiatry						
Substance misuse						
Organic syndromes etc.						

Apart from Basic Clinical skills I have listed other areas where OSCEs might be taken from..... I also note which potential OSCEs have been mentioned in discussions of the exam at workshops or pilots and others I think might be OSCEable! Those that have appeared in the exam are highlighted also.

4.1 BASIC CLINICAL SKILLS

- **Risk assessment** in suicidal or deliberate self harm patient settings.
 Here you would be required to take a relevant history which might include the context surrounding the self harm and it’s precipitants....assessing the existence of a mental illness, assessing risk to self and others e.g. a child or partner. You might look for evidence of depression etc....if an overdose...perceived lethality, quantity and type of medication consumed, altered/full consciousness(intoxication) at the time of the incident?, planned or impulsive? final acts? previous attempts? etc, remorsefulness after the event etc. etc.? If a wrist laceration or paracetamol overdose etc...ensure adequate surgical/medical assessment etc...When assessing suicide risk...emphasis will be placed on doing

so professionally...how you introduce the topic and the language you use is important....begin with open questions...
 "Sometimes when people are down or distressed they might feel life is too much for them....and might not want to go on...do you ever feel like this?....Explore passive death wishes e.g. "Sometimes people wouldn't mind if something happened and their life ended...do you ever feel like that? Explore active death wishes by asking "Have you considered doing anything to harm yourself? etc. This OSCE appeared in the pilot. Read up on assessment of suicide risk and homicide risk and prepare some stock phrases to use in the exam on the day.

- **FRS (first rank symptoms) of Schizophrenia**

Here you would be expected to competently examine for these symptoms. Much emphasis would be placed on what questions are asked so as to retrieve the correct information from the role player or simulated patient. One of the advantages of using role players for the exam is that the answers s/he will provide will be standardised. Use questions that can reliably discriminate between the sometimes trick psychopathology of schizophrenia. You will find well constructed questions in the SCID...(mentioned later)

- **Assessment of common illness.** Candidates in the Spring 2003 sitting of the OSCE were required to take a history in anorexia nervosa. One could foresee a station designed to test the candidates ability to take a history capable of supporting a diagnosis of depression, hypomania, panic disorder, heroin abuse, alcohol abuse etc. so be prepared to apply the appropriate diagnostic criteria through questions designed to do this. Practise this with colleagues and your tutors. These are discrete tasks that are possibly OSCEable (I think!). In the Spring 2003 sitting the assessment of PTSD comprised an OSCE station! The assessment of alcohol dependence syndrome appeared as a station at the spring sitting. Examiners were looking for evidence of dependence e.g. primacy, tolerance, compulsion etc. but also evidence of social, domestic, occupational, physical and psychological consequences of alcohol abuse. The assessment of a manic patient also appeared. In terms of approaching an OSCE on the assessment of a possible depressive episode the following points might be important in the allocation of marks:

Onset of mood problem, pervasiveness, precipitants, sadness or depression? Biological symptoms: e.g. sleep, appetite, concentration, libido, energy disturbances, Psychological symptoms: feelings of loss of self-esteem, guilt, hopelessness, Social: Work and home circumstances, Past psychiatric history, family history of mental disorder, Assessment of suicidality and other deliberate self harm, Communication, empathy.

- **MMSE in dementia (cognitive assessment)**

Here you might be expected to introduce and explain the nature and purpose of the test to a patient (setting the scene) and efficiently complete the task by controlling the interview with a cognitively impaired and possibly hearing impaired patient. (This is OSCEable but was not discussed as a possibility).

- **Assessment of decision making capacity** appeared as an OSCE in the Spring 2003 sitting of the OSCE's! The lady, according to the instructions in the OSCE was refusing surgical treatment for an intestinal tumour. You would need to assess her ability to understand the consequences of having or not having the operation, assess that she understands the nature of her physical illness, assess whether her decision is due to an illness process e.g. a delusion or nihilism if depressed etc.....ensure that she is not cognitively impaired i.e. that can register and recall information you give her....this suggests she has done so about the nature of her illness and the intervention suggested by the surgeons....finally it is important that the decision made is one she is certain about...that she is not suggestible or tempted to alter it in the near future.....etc...
- **Assessment of testamentary capacity in the elderly** could appear as an OSCE!! Know the questions to ask! It is similar to our last OSCE but in testamentary capacity the individual should know the extent of his estate.....
- **Assessment of possible NMS (neuroleptic malignant syndrome) or an adverse drug reaction or side effect.** Here you would be expected to explain to the patient what you are doing and perform a relevant physical examination etc. (These are possibly OSCEable?)

4.2 PROCEDURES

- **Performing CPR**

The College website discusses psychiatric emergencies....get a medical colleague to go through this with you and look it up...supposing a patient on the ward collapses one day.....

ABC

A - Airway

- Place victim flat on his/her back on a hard surface.
- Shake victim at the shoulders and shout "are you okay?"
- If no response, call emergency medical system - then,
- Head-tilt/chin-lift - open victims' airway by tilting their head back with one hand while lifting up their chin with your other hand.

ABC

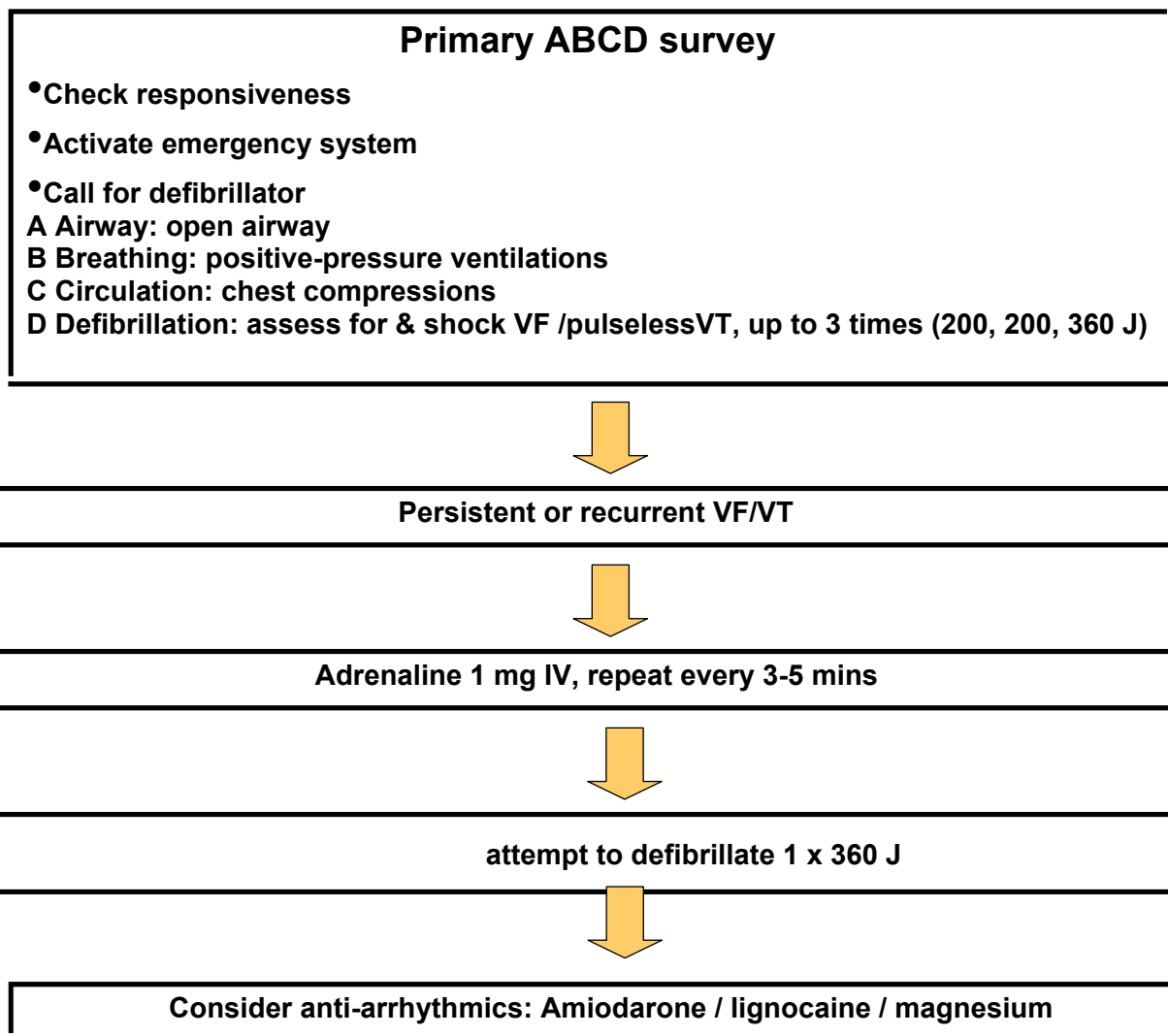
B - Breathing

- Position your cheek close to victims' nose and mouth, look toward victims' chest, and
- Look, listen, and feel for breathing (5-10 seconds)
- If not breathing, pinch victim's nose closed and give 2 full breaths into victim's mouth (use microshield).
- If breaths won't go in, reposition head and try again to give breaths. If still blocked, perform abdominal thrusts (Heimlich maneuver)

ABC

C - Circulation

- Check for carotid pulse by feeling for 5-10 seconds at side of victims' neck.
- If there is a pulse but victim is not breathing, give Rescue breathing at rate of 1 breath every 5 seconds Or 12 breaths per minute
- If there is no pulse, begin chest compressions as follows:
 - Place heel of one hand on lower part of victim's sternum. With your other hand directly on top of first hand, Depress sternum 1.5 to 2 inches.
 - Perform 15 compressions to every 2 breaths. (rate: 80-100 per minute)
 - check for return of pulse every minute.



- **Assessment of chest pain-placement of ECG leads**
Mentioned on the College website. You might be asked to apply ECG leads to a patient who has chest pain on the ward as part of its investigation.
- **Rapid tranquillisation**
Another possible station perhaps? What if you had to discuss with a nursing colleague how you planned to achieve this safely for an aggressive patient. See the College's guidelines on the Management of Imminent Violence and the Maudsley Guidelines regarding rapid tranquillisation. This is one I think might be OSCEable but was not mentioned at any discussion of the OSCE.
- **Administration of ECT**
Here is a possible OSCE where the application of your knowledge is tested. You might be given a mannequin and a clinical scenario e.g. a balding male aged 65 who requires ECT... You might be expected to administer ECT...so you would check...that he is the correct patient...is consented..., cannulated...that the anaesthetist, medical notes and prescription sheet etc....are present, ...introduce yourself to the patient and ensure s/he is happy to proceed and has previously had an explanation of the procedure....You would then administer the appropriate dose after setting the ECT machine and by placing electrodes correctly (bilateral or unilateral placements)...document the procedure professionally if required. You should familiarise yourself with the College's guidelines on ECT!!!! The only mention of the administration of ECT as an OSCE is on the College websiteit mentions the application of ECT electrodes. You need to know where to position the electrodes properly. In a mock OSCE we conducted recently, many candidates administered ECT to the mannequin's jaw!!!! The exact positionings of electrodes is a vital skill to learn. Do not forget that you should know about unilateral ECT also!!!!...(know the different lead placements!!)

4.3 COMMUNICATION

- **Telephone station**
Communicating your clinical findings to a consultant after assessing a patient might be an examinable skill. It might be envisaged that you would do so after assessing someone who is suicidal to seek advice on management/admission etc. This OSCE was discussed as a possible OSCE and appeared in Spring 2003. One should relate the demographics of the patient (age, gender etc...a patient of this service or not?... etc...) and the context of the assessment (seen in A/E etc...), whether the patient has a psychiatric history or not, why they presented today ...whether a psychiatric illness is present or not....and justify your findings!!.....you should also have made a risk assessment and relate those findings to the consultant.....you might also be asked to offer an opinion as to how the patient should be dealt withIn brief your telephone call with the consultant should give them the essential information or evidence to be able to make a decision about the patient you have assessed. . . . Appropriate, defensible, professional clinical notekeeping might also become an OSCEable task as in the MRCP (physicians) examinations.
- **Relating a diagnosis**
This is about giving information to a patient or their relative e.g. that they have a diagnosis of schizophrenia, bipolar disorder etc and giving advice on prognosis.....answering their questions. "What's wrong with my son...? ...What does schizophrenia mean doctor?" "How did he get it?" "Will he get better?" "Can he be cured?" "What are the chances his kids will get it?" "What can we do to keep it from coming back?" This station appeared at the spring sitting... so make sure you practise it....There will be a big emphasis on aetiology in the OSCE as it is appropriate territory for part I candidates and so this is an important station type as it demands mastery of communication and theory. You need to be able to give information to relatives or patients in plain language on to causes, symptoms, natural history and prognoses of schizophrenia, bipolar disorder, or dementias...etc....have a few phrases "stock phrases" prepared in advance. How about the following guidelines....tell the patient or relative the diagnosis, We feel, at this stage, that you are suffering from bipolar disorder or manic depression. It explains many of your symptoms. Establish their knowledge of the diagnosis. How much do you already know about schizophrenia? (a baseline from which to begin explanation), Establish their attitude to the diagnosis.....Had you suspected this yourself? Does it explain, for you, what has been happening or how you have been feeling? Educate the patient or relative about the diagnosis (aetiology and nature of the illness, natural history) and deliver advice on optimising outcome or prognosis. Explore other preventative opportunities...minimising substance misuse, stress etc. Allow the patient to ask questions. Do you want to ask me anything? Reinforce the information delivered. Provide takeaway information (leaflets... perhaps), Offer patient follow-up and the option of returning to discuss the matter again. Evaluate the patient's understanding of information imparted. Do you understand what I have told you so far?
- **Obtaining informed consent for ECT**
You will need to explain to the patient the nature, purpose and administration of the procedure, why it is being recommended by the treating psychiatrist now etc....(setting the scene) and its possible benefits and adverse effects, etc. This was used as an example of a communication OSCE by the Chief Examiner. (see dialogue later in handout)
- **Talking to relatives!** In the Spring 2003 sitting of the exam candidates were asked to speak to the mother of a man with schizophrenia who was non compliant with medication and had just relapsed. Communication with relatives could involve OSCE's focussing on taking collateral histories in dementia, anorexia, schizophrenia etc. or discussing aetiology or prognosis in various disorders. Suppose you had to meet the family of a patient of yours who had recently committed suicide? In most discussions with relatives you should have the consent of the patient to discuss his/her case.....so if this is not indicated in the "instruction to candidates"I think it is a good idea to say to the relative....

“I have just spoken to X and he is agreeable that I discuss some aspects of his illness with you...”...it shows that you know that you can't just talk to anyone about a patient without their consent.

- **Discharging someone from hospital-** Mentioned on the College website...consider arranging follow up...opd , day care.... , possible blood tests if on lithium etc...other investigations as an out patient etc...promoting compliance with new interventions e.g medications or attendance at a psychotherapy you will organise, proposing a visit from the community mental health nurse, letting the patient know that you usually contact the GP to let him/her know of changes...talk to the patient about recognising symptoms of relapse (relapse signature), their safety (if living alone) or social circumstances.....arranging allied health professionals to see them etc.....**crucial here is that you ensure the patient understands what is being explained to them**an OSCE on planning or discharging a patient might be dealt with by using the above ideas.....you may have more.....think of the different disorders and their needs.....again learn a few “stock phrases” that can be kept in store for such an OSCE.
- **Obtaining a collateral history** from relatives of a patient with vascular dementia.....(this appeared in the pilot examination!) Emphasis is placed on detailing the chronology of the illness and it's behaviours, memory loss etc...being able to discriminate between the major dementias by history (or their co-existence!)...a good knowledge of the symptoms of the dementias is vital but you will have to gather evidence to support a diagnosis from relatives...this will involve careful phrasing of questions to efficiently and effectively collect the correct data. The same OSCE could be replicated for a patient with eating disorder, schizophrenia or substance misuse.....etc....the OSCE tests your ability to interact with patients relatives and take a collateral history professionally and efficiently. In the recent exam candidates were asked to take a collateral history from a nurse regarding a patient with delirium on a medical ward. This would involve gathering information on his/her medical surgical history, investigations and current condition, behaviour, thought (look for sundowning, evidence of hallucinations, abnormal psychomotor behaviour etc.) and speech as experienced by staff and outlining to them the plan...that you will assess him and make recommendations (usually!) etc....
- **Commencing treatment (lithium, clozapine, depot, Cognitive behaviour therapy, systematic desensitisation etc.)**
Here you might be expected to communicate to a patient the recommendation of the treating team that this treatment be commenced, for various reasons..... (bipolarity or refractory schizophrenia, respectively)....e.g. “It's felt you should try clozapine as you have not achieved much benefit from the other medications you have tried” “We feel you could improve more on a different medication” “However like all medications it has some side effects....”. “And because of these side effects we would have to take blood tests regularly...” Phrases such as this might help to “set the scene”. You would be expected to answer the patient's questions and to inform them of benefits and possible side effects and the necessary monitoring involved....etc. Commencing Lithium was mentioned as a sample OSCE by the Chief Examiner...I feel commencing Clozapine or a depot medication are also possible OSCEs. How about having to explain to a patient that you would like her to have psychotherapy for her OCD? etc...or explain systematic de-sensitisation to an agoraphobic patient as appeared in the spring exam in 2003!!! One might use the following headings when explaining psychotherapies to patients...the **nature, purpose or indication for the proposed treatment and process** of the therapy should be explained. Similarly, the **benefits and side effects should be explained.** “We have been considering your case and feel that you could benefit from a different approach to treating your condition. Have you ever heard about systematic desensitisation before? It's a treatment for agoraphobia. It involves meeting a therapist and.....it might occur each week for an hour and could take a few months....It's a gradual process of slowly getting you used to crowds or places you avoid...it's done gently.....”It should gradually make you better able to cope with entering crowded places.....” Look up all the major psychotherapies and gather a few phrases using the above headings so as to be able to explain them to patients

4.4 NEUROLOGY

- Cranial nerve examination
- Fundoscopy
- CPR
- Extrapyrimal side-effects

Cranial nerves

- I Olfactory
- II Optic
- III Ophthalmic
- IV Trochlear
- V Trigeminal
- VI Abducens
- VII Facial
- VIII Vestibulo-cochlear
- IX Glossopharyngeal
- X Vagus
- XI Accessory
- XII Hypoglossal

Cranial Nerves examination

A basic examination can be done in 7 minutes!!! You will need to explain to the patient what you are doing, the purpose of it and perform it accurately and with finesse. It is an essential clinical skill for a doctor training in psychiatry. This appeared for many candidates at the Spring 2003 sitting of the OSCE. You may be told to leave out ophthalmoscopy or examination of certain reflexes e.g. the corneal reflex and the jaw jerk. Find a medical colleague and have her/him teach you good examination technique!!!

I Olfactory

- **Symptom: anosmia**
- **Test each nostril separately**
- **Coffee/vanilla/peppermint**
- **Do not use noxious stimuli**
- **Causes:**

- **URTI**
- **Meningioma**
- **Ethmoid tumour**
- **Basal skull or frontal #**
- **Kallmann’s syndrome**
- **Smoking/increasing age**

II Optic

- **Visual acuity**
- **Snellen’s chart**
- **Count fingers/POM/POL**
- **Causes:**
- **O neuritis/retinal v. thrombosis**
- **Cataracts/glaucoma/d. retinopathy**

● **Visual fields**

- **Keep head level with patient**
- **Hold pin midway between you and patient**
- **Homonymous or bitemporal hemianopia**
- **Quadrantanopia**

● **Fundoscopy**

III, IV and VI

● **Light reflex / Accommodation**

● **Eye movements**

● **III n lesion**

– **Ptosis**

– **Eye “down & out”**

– **Dilated, unreactive pupil**

● **VI n lesion**

– **Failure of lateral movement**

– **Convergent strabismus**

– **Diplopia**

● **Look for nystagmus / INO**

V Trigeminal

● **Ophthalmic, maxillary, mandibular divisions**

● **Sensory: corneal reflex, facial sensation**

● **Motor: temporalis, masseter, jaw jerk**

VII Facial

● **Look for facial asymmetry**

– **Wrinkle forehead**

– **Close eyes**

– **Show teeth**

– **Blow out cheeks**

● **UMN: preservation of forehead wrinkling**

– **(bilateral innervation)**

● **LMN: loss of forehead wrinkling**

– **Bilateral VII e.g. Guillain-Barre/Sarcoid/Lyme**

VIII Vestibulo-cochlear

- Cover one auditory meatus, whisper into other ear
- Rinnés test:
 - Vibrating tuning fork at mastoid, then meatus
 - If heard at meatus, then Rinné positive
 - Implies either normal or SN deafness
- Weber’s test
 - Vibrating tuning fork at centre of forehead
 - Normal = sound heard in centre
 - Sensorineural deafness = louder in normal ear
 - Conduction deafness = louder in abnormal ear

IX and X

- Inspect palate with torch
- Palatal elevation: deviates to side of lesion (X)
- Gag: IX afferent, X efferent
- Assess voice for hoarseness (RLn palsy)
- Assess swallowing

XI Accessory

- Shrug shoulders (trapezius)
- Turn head against resistance (sternocleidomastoid)

XII Hypoglossal

- Inspect
 - Wasting?
 - Fasciculations? (motor neuron disease)
- “Stick out your tongue”
 - Deviates to side of lesion

Fundoscopy/ophthalmoscopy

Diabetic retinopathy

- Rubeosis
- Red reflex / Cataracts
- Non-proliferative changes
 - Dot & blot haemorrhage
 - Microaneurysms
 - Hard & soft exudates
- Proliferative changes
 - New vessel formation
 - Vitreous haemorrhage/scar/retinal detachment
 - Laser scars

Diabetic retinopathy

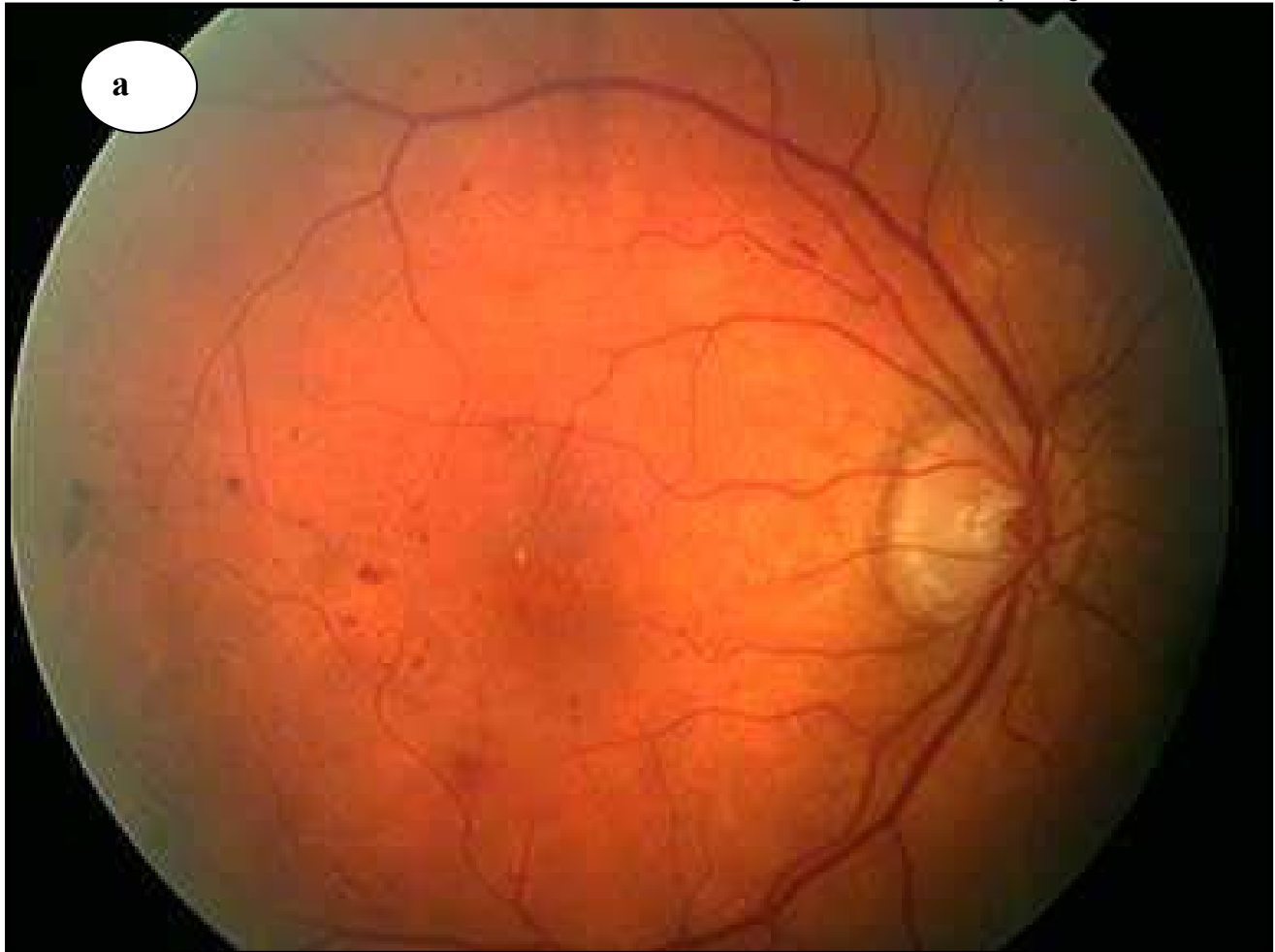
Diabetic retinopathy

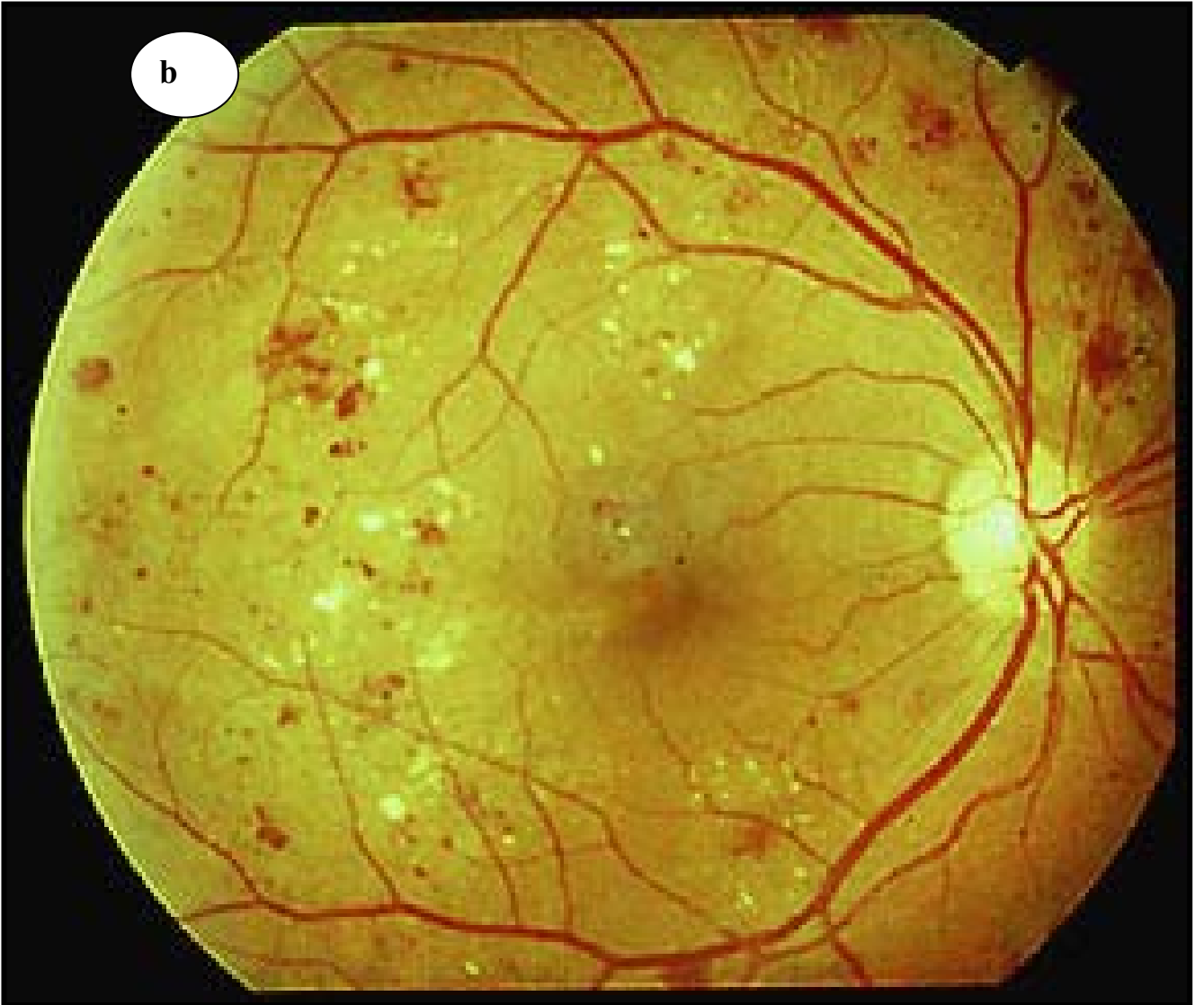
Diabetic retinopathy

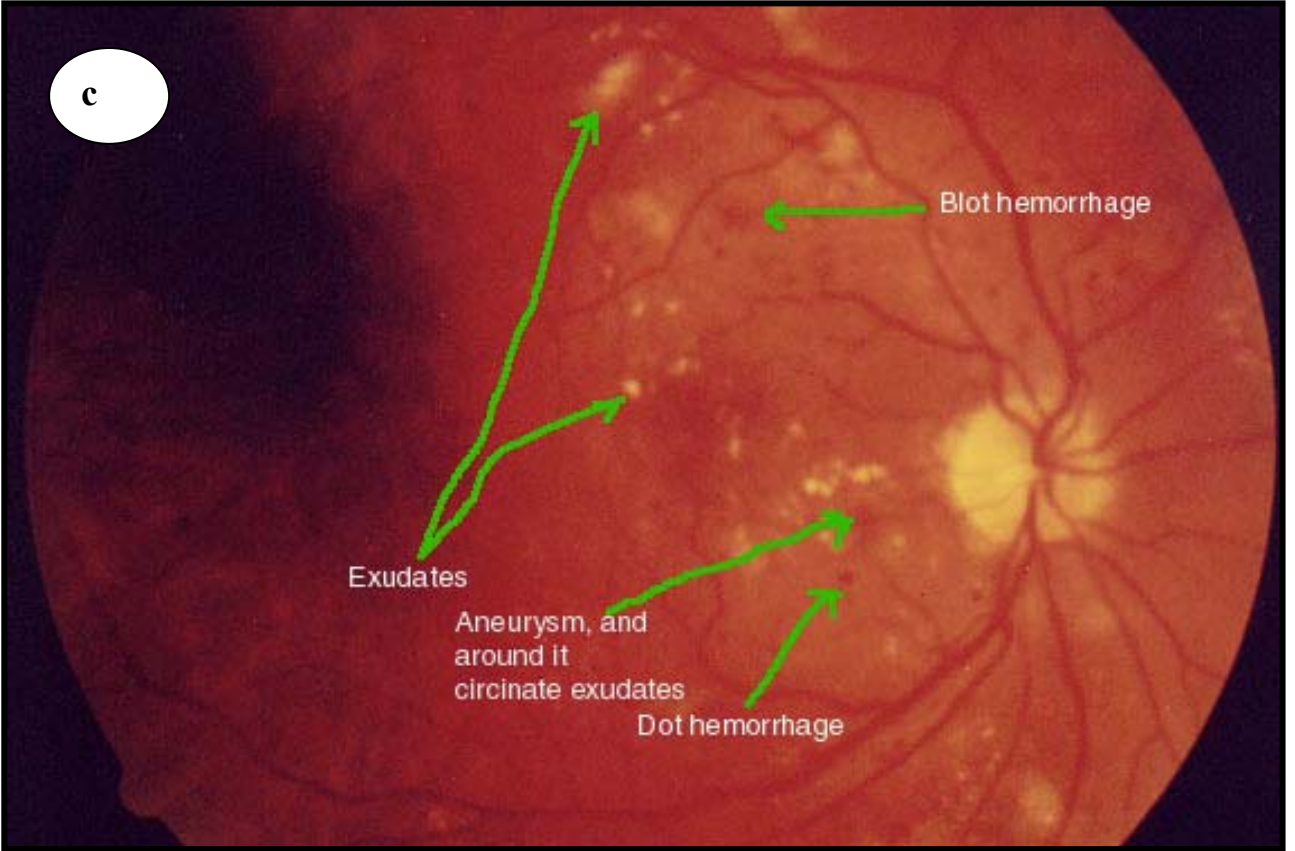
Hypertensive retinopathy

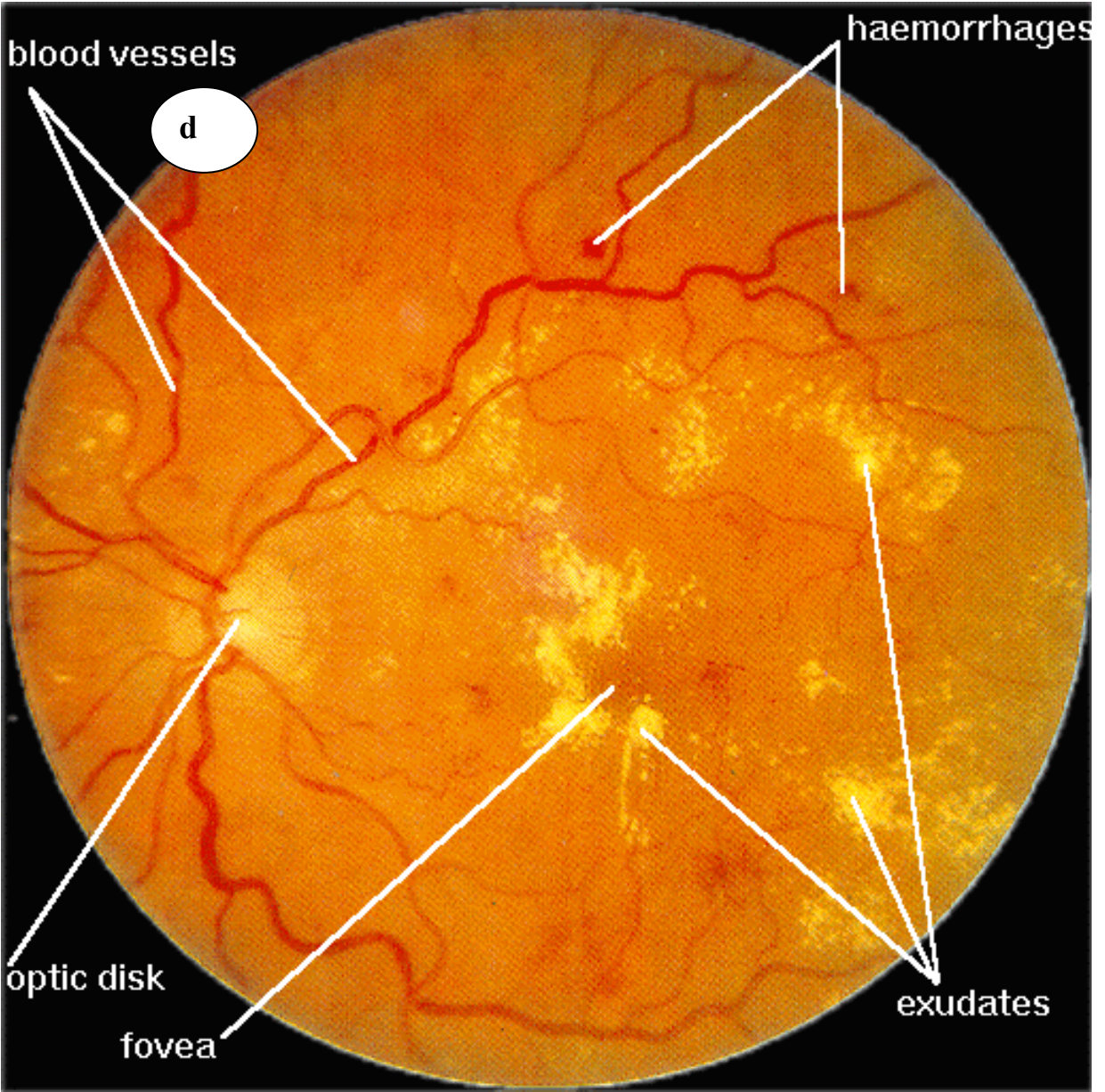
- I Silver wiring
 - II A-V nipping
 - III Haemorrhages & exudates
 - IV Papilloedema
- Hypertensive retinopathy
 II A-V nipping
 Hypertensive retinopathy
 Hypertensive retinopathy
 IV papilloedema

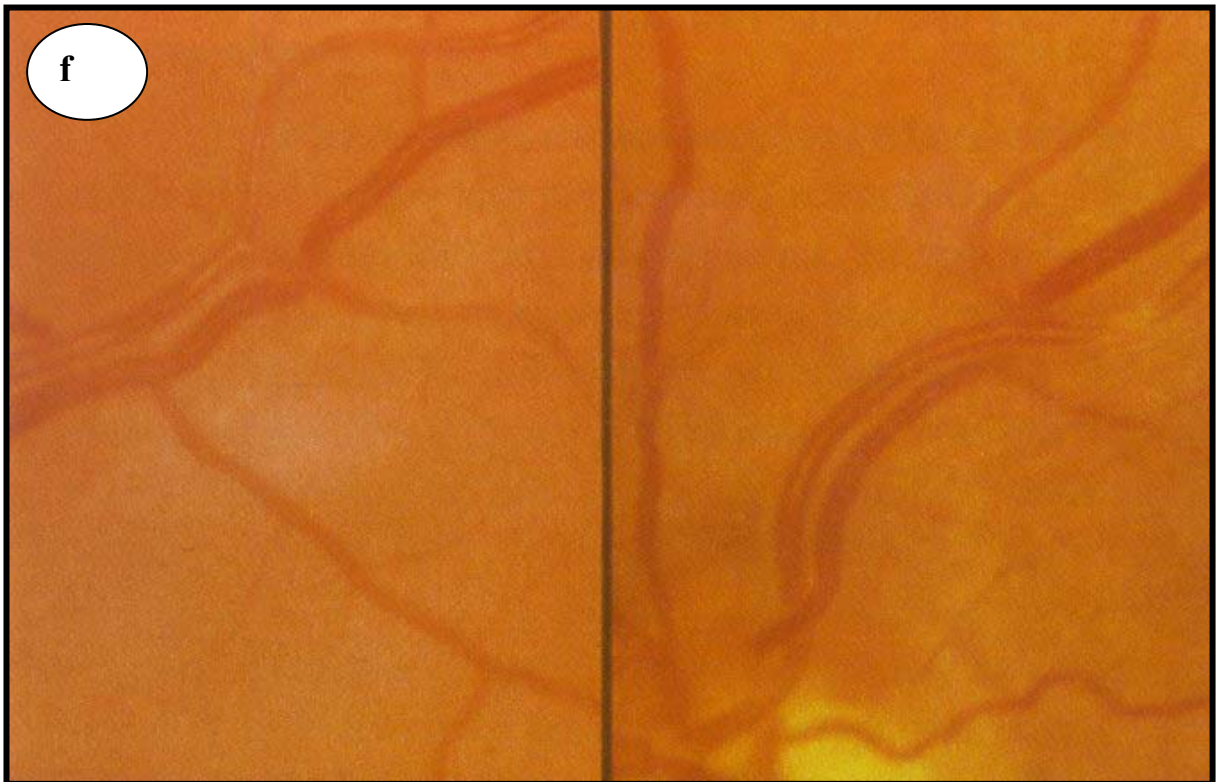
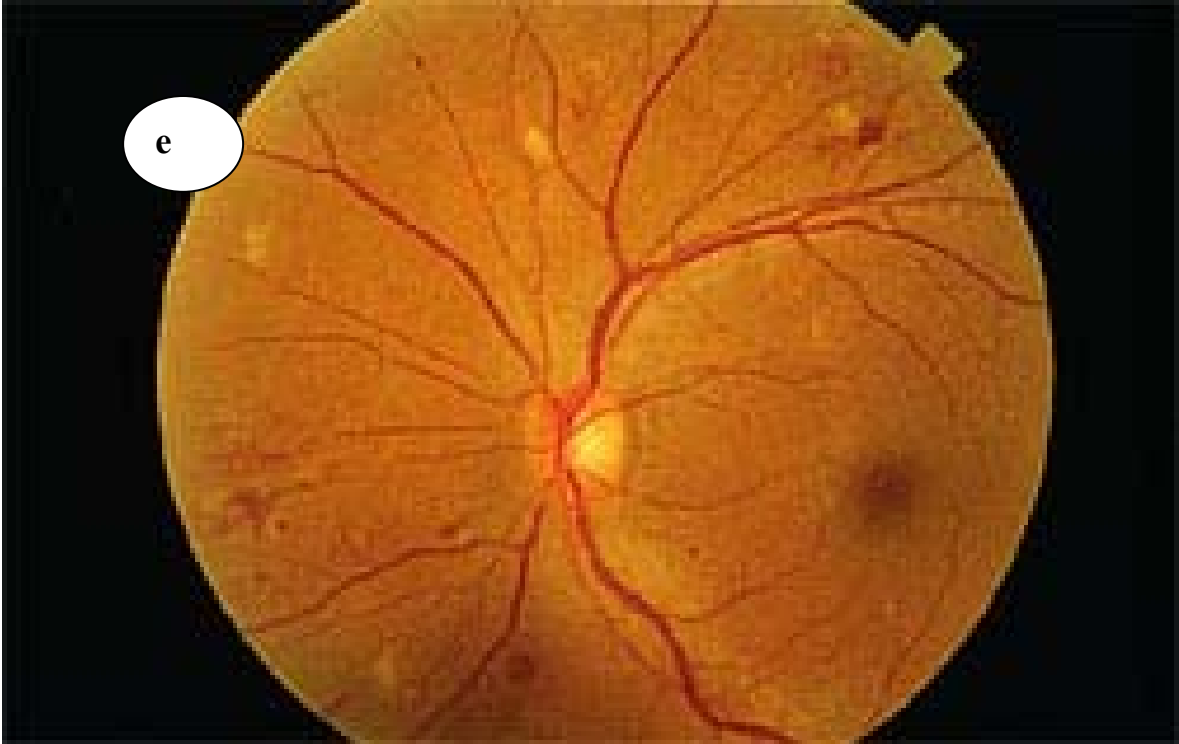
More than likely you will be presented with a mannequin in the exam and might reasonably be expected to recognise the following conditions; **hypertensive or diabetic changes**, perhaps evidence of glaucoma, papilloedema, optic atrophy etc.. Mannequins now exist where a range of such conditions can be mimicked on discs placed in the back of the mannequin's head. Much emphasis will be placed on the explanation to the patient (setting the scene) of the examination and on following the correct procedure in performing the task itself e.g. positioning the patient and configuring the instrument... "Mrs. Finch... as part of a thorough examination it is sometimes necessary to examine the eyes of our patients... for this I will have to use the ophthalmoscope (pointing to it)... essentially it's like shining a light into your eyes... I will ask you to sit in a certain position and to look at a particular spot on the wall for me while I look into your eyes... The light may be bright but it will not hurt you... you might find it a bit long and I may have to come quite close to you so as to look into your eyes during the examination ... I hope you don't mind too much...?.... (This is my own suggestion! You may come up with better...) Make sure you practise this OSCE as it attracted quite a deal of discussion at the workshops... look up the idealised depictions of the conditions in textbooks and learn what the features of each condition are...!!! I include a few characteristic images of familiar retinal pathologies.

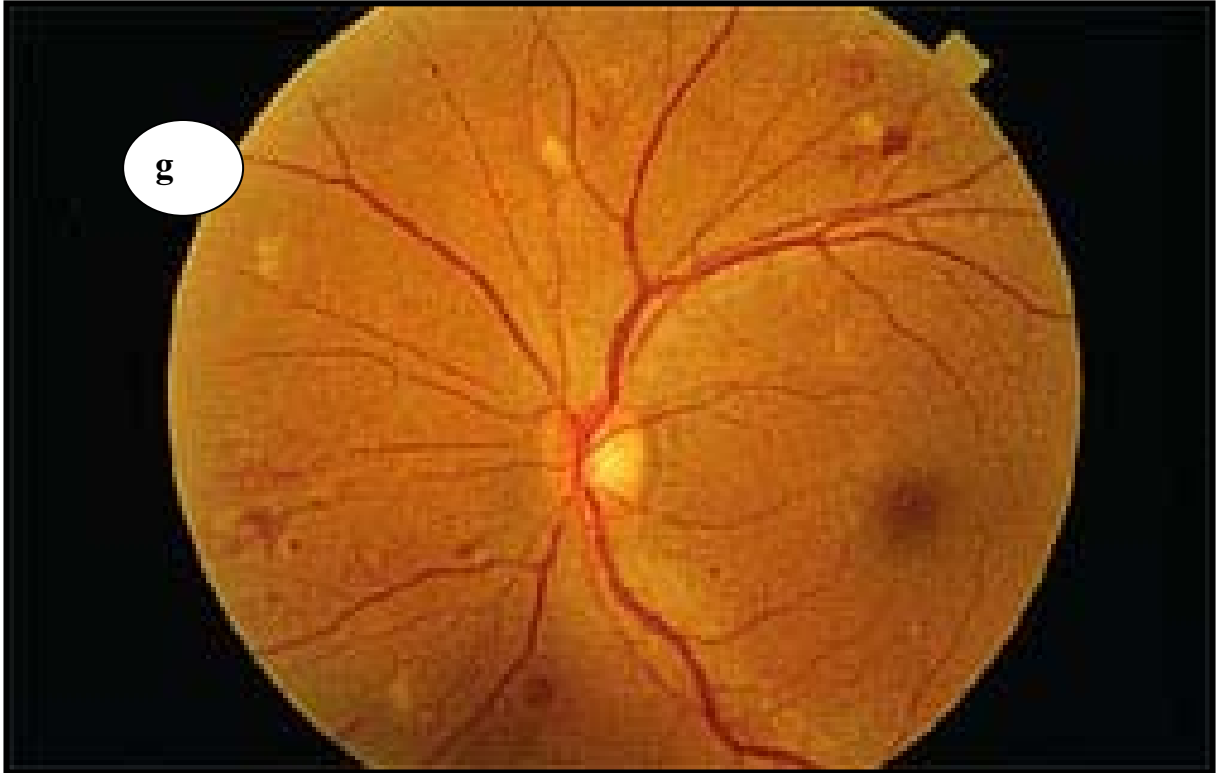












The above images are (a,b,c,d) diabetic retinopathy and hypertensive retinopathy (e,f,g) respectively.

Extrapyramidal side-effects

Extrapyramidal S/E

- Basal ganglia – striatum (caudate & putamen, g pallidus, substantia nigra, red nucleus) and others
- Exerts control over muscles independent of descending corticospinal tracts
- Neuroleptics block dopamine D₂ receptors, therefore S/E mimic Parkinson's disease.
- Symptoms usually reversible

Extrapyramidal side-effects

- Acute dystonia – abnormal face and body posturing and movements
- Akathisia (restlessness)
- Parkinsonism
- Tardive dyskinesia

Tardive dyskinesia

- Repetitive, involuntary, purposeless movements
- Often involving lips, tongue, face
- Risk greater with older typical anti-psychotics
- More common in females
- May be irreversible

Treatment

- Anticholinergic drugs are used to help control neuroleptic-induced EPS.
- Akathisia may require B-blockers or benzodiazepines

(see later section on pilot OSCE) Find a copy of the AIMS scale and construct some questions that would collect historical information to determine whether they have symptoms of EPSEs e.g. akathisia, stiffness etc.... Practise putting these questions to colleagues...practise examining your colleagues or patients for EPSEs... cogwheel rigidity... etc... Remember you will have to introduce this topic to the patient in the exam...." All medications have side effectsand the medications you are taking are no different....I wonder if in the next few minutes you would mind if I tried to work out whether your medications are causing you any side effects. This will help us to perhaps alleviate them. I would also like to do a brief physical examination of your arms if

that's ok with you...? This is my suggestion for perhaps "setting the scene" in this station....you might find a better option! (See the Maudsley guidelines which offers a good description of the side effects---have someone show you how to examine for cogwheel rigidity. It should look as if you do this regularly at your outpatients clinics.)

http://medlib.med.utah.edu/neurologicexam/home_exam.html This website contains videos of how to perform ophthalmoscopy and other cranial nerve examinations. You will need to download "Quicktime" to allow you to watch the videos.... luckily it's free!

- **Frontal lobe signs**

This is another possible station in that it is a discrete area that I feel is amenable to being examined for example you might be required to take a relevant history suggestive of such symptoms or perhaps perform a relevant examination for frontal lobe signs. The entire symptomatology and signs could not be examined in a 7 minute period but such discrete components might be OSCEable e.g. symptoms of frontal lobe disease, signs of frontal lobe disease, frontal lobe neuropsychological testing.

4.5 DATA INTERPRETATION

- **Biochemical/haematology lab reports**

You might be given lab reports relevant to a case of eating disorder or substance misuse (alcohol misuse) etc. perhaps a Brain CT scan report or an EEG report? Hyponatremia due to mood stabilisers or SSRIs etc...are other possibilities.....

4.6 O.S.C.E - EXAMPLES FROM THE PILOT EXAMINATION

The following are examples of OSCEs that were used at the Pilot examination in St Bartholomew's where I attended in October 2002.

- **Title** - Vascular dementia

- **N0** - 14

- **Instruction** - Mr B is 70 year old man referred for assessment of memory impairment. You are asked to take a history of the present symptoms from his wife and explain the diagnosis to her. You will not be expected to discuss treatment with her at this stage.

- **Title** - Assessment of risk

- **No** -

- **Instruction** - a 21 year old single mother took an overdose after a fight with her boyfriend where she sustained a bruise to her face. She is currently medically fit for discharge. Assess her current level of risk.

- **Title** - Extrapyramidal system

- **No** - 16

- **Instruction** - This station examines your ability to elicit EPSE's. Assess the patient for signs and symptoms of same. Examine, explaining to the patient what you are doing as you proceed. Examine the patient so as to demonstrate EPSE's. (ref- Maudsley Guidelines 2003)

4.1

- Doing an O.S.C.E is **like doing your driving test!**- It's not enough to know how to do it- you must demonstrate before the examiner that you can do the task of the O.S.C.E. It's a performance.....the candidate and the roleplayer are performingfrom OSCE'S to OSCARS!
- **You can do a lot of preparation in advance!** Think of possible OSCE's that have come up! And those suggested by your tutors. Get together with colleagues and do mock OSCE's together with a colleague playing patient or relative. Consider and prepare answers to questions that a roleplayer might ask you in the exam. This is "**troubleshooting**". Prepare "**stock phrases**" for initiating conversations with patients and relatives...e.g introducing yourself...introducing the topic of the discussion with the patient or relative, for asking about certain common symptoms. Have a few lines prepared on how you would explain the aetiology of schizophrenia in layman's language to a relative, how you would explain in layman's terms the advantages of commencing clozapine to a patient with schizophrenia. Your language and phraseology has to be about proposing the therapy, not being coercive and about telling the patient that you think it's in his or her best interests to do so. E.g. "Mr Browne my name is Dr Aziz and my consultant and the team have been thinking about your case and have asked me to discuss with you some treatment options for the future. We think clozapine would be a good choice for you as the medications we have tried so far have not got you as well as we think you could be. "They asked me to discuss a new medication with you today. It's called clozapine. I wonder if you already know something about this medication?It's a tablet that works like your olanzapine or risperidone only it can be more effective than them in getting people back to themselves sometimes. We would need to stop your current tablets slowly before starting it. Like all medications it has some side effects and it has different side effects to the tablets you have been taking so far. Some of these side effects are....."
- Read the instruction at the station carefully - **do the task** of the OSCE-you must decide what the important aspects of the OSCE are! What would a good assessment require? **Focus on where marks might be going!** Think of the possible **weighting** at each station!! What do I have to do in the next 7 minutes to get the most marks? What's important here e.g. in the assessment of risk in a depressed woman? What must I include and what can I afford to leave out if I don't have time?
- **Rapport! Empathy! Be professional!** Remember you are **NOT** communicating with the examiner.....Examiners will only very rarely intervene in your exam.....the exam is about you and the patient..... you are **communicating with the patient/roleplayer**you must assume that this is a real patient with a real illness- Don't use unnecessary **medical jargon** your patient may not understand... don't recite the textbook for the examiner...Instead, **your ability to apply knowledge** is being tested...you might know every fact in the book but if you can't communicate it to your patient it doesn't mean much.....e.g. your bipolar patient may ask you if he really needs to take his lithium.....you will need to explain the prognosis to him in a way he can understand. If your patient is difficult, wandering, demanding, rude or hard of hearing etc..... remain professional but firm in steering the interview to achieve results! E.g. get that MMSE or assessment of suicidality done! **Position yourself appropriately!!!** Arrange the seats appropriately. Don't sit with your arms folded if there is a depressed and tearful patient before you...you must be empathic.....your patient is in distress...that's why they have sought help! **Build rapport. Maintain good eye contact** throughout! Use phrases like, Can you tell me what has brought you here today?, "I wonder if you would mind talking about your illness a little? "That must have been distressing". "You must have felt very low then?" "That must have been difficult", "I think I can understand that", "That's very interesting can you tell me more about that?". "Thank you for bearing with me throughout the interview"
- "**Set the scene**" – This involves introducing yourself, confirming the patient's name and explaining the structure or purpose of the interview, examination or assessment, how long it will take etc. ...what you want them to do... - for example if you had an OSCE based on performing a MMSE in an elderly man with known dementia you might approach it as follows:

"Hello Mr. Smith my name is Dr. Day, I believe you have been having some difficulty with your memory recently so I would like to perform a brief test of your memory. I will be asking you to do some things that might appear a bit tedious or odd to you but try and bear with me... The test will help us to see what your memory is like and to see how we can help you. I have a few minutes to get through thisso try and give me your full attention...."

Already you have explained what will happen and what it's for and that it will take 7 minutes and that it may be tedious...you have enjoined your patient in the task and things should run smoothly.... Ask a non-threatening, open question to begin with and be careful not to use a lot of medical jargon. Jargon can often confuse the patient. They will end up asking you to clarify what you are saying and it will not impress the examiner. **Pitch the conversation at their level, modify your language, avoid jargon, provide clear explanations, give clear treatment instructions, evaluate the patient's understanding of what is being asked of or explained to them, summarise and repeat. Ensure the patient is satisfied with the interaction.** "I know that I am giving you a lot of information at once....feel free to ask me questions if you don't understand something". "Do you understand what I have said so far?" These are useful "**stock phrases**" to use in different OSCE's or if you get stuck for something to say while you are formulating your next question!!

- Be efficient!** Realise the time frame! The OSCE is a tough demand and you must **produce the goods in effectively no more than 7 minutes** ...e.g...take an alcohol history or do a cranial nerve examination....you must be focused and leave out extraneous questions or less relevant/ irrelevant aspects of physical examination. **Control the interview!**- you might have a manic/psychotic or cognitively impaired patient, a patient who is hearing impaired!! You have to get the information in 7 minutes so without being rude to your patient you must work efficiently!!! Don't let the patient wander too much.....set the agenda for the interview at the beginning so that the patient knows that you will cover certain areas....tell them that you will allow them to ask questions at the end and invite them to ask questions if they don't understand something! This is important! It should reduce the number of times the patient asks you questions as you are explaining material... which might divert you from getting the task of the OSCE done... You should take control of the interview but remain open to the patient or relative's needs throughout. E.g. Hello there! My name is Dr Ignatio and am I correct in assuming that you are Mr Ryan? Yes..... The brother of one of our patients? Yes. I think you have come to discuss your brother's illness with me today? Yes. I'd like to begin by asking you what you would like to know, and what you might be worried about.....(Allow relative to speak)...then outline your plan which incorporates their queries also...."Yes ...good ... I will try to address those concerns and also let you know something about his illness and it's outcome etc....You may know that we believe he is suffering from schizophrenia.....? You may have heard something about this but it is an illness that involves periods of wellness and unwellness that occur throughout someone's lifetime... When unwell some patients suffer unusual experiences and may behave or speak unusually....With time your brother will be able to recognise when he is becoming unwell and seek help. We will offer to see him regularly at outpatients after he is discharged from here.... This will seek to encourage him to keep taking the medication we have prescribed and to coordinate other supports or daycare for him...depending on what he needs. It may take time to find what medications suit him best...and it is important to emphasise that medication is important to keep him well and free from symptoms when he goes home. When unwell he may require admission to hospital...for brief periods so that he can be stabilised or his medications can be adjusted. Apart from medication there are other useful supports that are helpful in his illness. Can it be cured doctor? Schizophrenia is like most other medical illnesses...it can be treated...and kept at bay for long periods. Most illnesses e.g. high blood pressure or diabetes are not curable but can be kept under control with treatment and other measures....." Phrases like these might be useful to open such an OSCE...You should have some phrases on medication and high EE, rehabilitation, etc prepared so as to be able to discuss these aspects of treatment and prognosis with patients or relatives.
- Try and keep the interview interesting.** Remember the examiners are getting more and more tired as the day goes on! Also, one of the most striking features of the last sitting of the OSCE exam was the degree of noise present in the room as many candidates and role-players converse. You need to be able to focus on your task.
- Do you have a list of questions prepared which would be a help if you were asked to assess the presence of First rank symptoms of schizophrenia or Insight in someone with schizophrenia? All of this should be prepared in advance so you are not stuck on the day!! **Get your hands on a copy of the SCID questionnaire.....**it contains usefully phrased questions for asking about the presence of common discriminative symptoms e.g. auditory hallucinations, manic symptoms or features of social phobia or PTSD.....essential reading!!! It's important that the questions you ask are professional and able to discriminate between possible illnesses and illicit reliably the presence of certain phenomena e.g. delusional perception!!! It's a long document but many centres have it and it will be very useful for your part II exam also....e.g. in eliciting the phenomenon of thought broadcasting it suggests. "Did you ever feel as if your thoughts were being broadcast out loud so that other people could actually hear what you were thinking? "Did you ever believe someone could read your mind....?" In the social phobia section it suggests the following when assessing for it's presence..."Are there are things you are afraid to do in front of other people...e.g. speaking, eatingetc.....it provides good history taking questions for the common disorders.
- Consent and Courtesy!! Obtain consent for any examination or test even if only for eliciting extrapyramidal side effects! Explain what you are doing to the patient before you touch them!!** This will be important in all OSCEs but especially with physical examinations. Remember to ask the patient BEFORE you examine them... "Is your hand sore anywhere? (They may have an injury or arthritis and you might cause them pain if you don't ask) Do you mind if I take your hand and examine for stiffness or other movement problems? It won't hurt and just takes a minute." Don't just grab a limb and attempt to elicit cogwheel rigidity!!!! **Make sure you know how to examine for extrapyramidal side effects e.g. cogwheel rigidity!**
- Bring the interview to a close properly.** An abrupt unpolished ending to your station does not look well! When you have finished you should inform the patient courteously, thanking them for their co-operation before moving on to the next station....**Instill hope in your patient or their relative!** Your interaction with the patient or relative should leave them feeling a bit better about themselves...reassured and that they are in the hands of a good doctor! The interaction must not be discourteous or coercive! The examiners will be looking for this empathy and rapport. **Avoid uncertainty and avoid giving inappropriate reassurance.**
- Always remember risk assessment!** Consider it at every OSCE station! e.g. suicide, safety of the dementing patient (fire hazard if forgetful, safety to drive etc.), homicide.....ask the post natally depressed woman about any possibility that she might harm her child etc....remember homicide risk also constitutes part of risk assessment in certain scenarios.

- You may need to **respond to cues** - e.g. "I'm suicidal". Even if suicidality etc. is not mentioned in the instruction to candidates you should respond appropriately to such a response...or if your patient cries...respond appropriately. "I'm sorry if you find this distressing.....bear with me for a few more momentsI wont ask you too many more questions ...etc" ... Be aware of **non verbal cues**....if the patient looks very anxious....is wringing their fingers....it might be a way of introducing questions about anxiety symptoms....."You seem nervous...are you an anxious person?" Similarly if a patient is moving his legs a lot and the station is about the examination of extrapyramidal side effects...you could ask..." I notice that your feet seem restless.....do you find it difficult to sit still? Has this happened since starting this medication?.....here you are introducing a question on akathisia and showing the examiner that you are observant and capable of introducing this into the clinical situation.....a word of caution....
- **Be careful not to ALARM your patient** by, for example, commenting on "abnormal movements" in an insensitive way....."Have you noticed that your face is mask-like?"....or "Has anyone said that your mouth moves abnormally?" It might be more prudent to ask...."Have your friends commented on any differences in your appearance etc. recently?" This should also be borne in mind when you talk of the side effects of medications or when discussing ECT!!! DO NOT SAY "An electric shock will be passed through your brain and you will have a fit".....Try saying...."After you have had your anaesthetic and muscle relaxant and are fully asleep you will receive a tiny amount of electric current that is measured by a machine designed for the purpose. There will be a number of nurses and two doctors present, an anaesthetist and a psychiatrist. The anaesthetist puts you to sleep just like when you are having your appendix out and the psychiatrist will carefully administer the ECT. You will feel nothing and will remember nothing"... "It's similar to being put to sleep to have your appendix out, only quicker!" "You will then have a brief seizure which will be monitored by the doctors and nurses present and which tells us that the treatment has been successful". "In total the procedure takes no more than 5 minutes". The tone should be reassuring. The same applies when discussing medication or the symptoms of a relative's illness. Instead say...."Sometimes, in a very small number of cases, clozapine can cause difficulties with your blood cells that look after your defences against infection". "That's why there is such careful monitoring...so as to prevent this happening.....If it were to happen we would stop the medication and your blood cells would return to normal.**The information must be truthful...but shouldn't unnecessarily alarm your patient.**
- Make sure the **relevant physical examination** is performed and learn how to **use instruments properly**... ophthalmoscopes, tendon hammers...etc. you will not impress if you are seen to be shining the ophthalmoscope onto the forehead and insisting you see cotton wool spots! Position the patient or mannequin appropriately for each examination or assessment. e.g. the examination for EPSEs and fundoscopy... or the stigmata of alcoholism...request a chaperone if it is appropriate.....In the ophthalmoscopy station it is your approach to the patient, technique etc that comprises most of the marks. Getting the diagnosis correct is only a component.
- The standard required? –1 year in Psychiatry - what you might reasonably be expected to know or skills you might reasonably have mastered in this period.
- **If a patient/roleplayer asks you something you don't know the answer to?**...At the last sitting of the exam a candidate, when discussing medications for dementia, was asked by the patient if one of the medications contained dandelion extract as he was allergic to this!! If it's something you don't know ...say so....(unless it's something you really should know!!!)...be honest...agree to look it up or consult someone more experienced...and promise to get back to them on the topic....." With this you will have to judge whether it's something you really should know and you may have to make a stab at it!!
- **Troubleshooting!!!** If you managed to strike up a good rapport with the actor or if s/he is in charitable mood on seeing you struggle s/he may drop hints (sometimes by accident!) which might provide direction for the flagging interview!!!.....e.g. ..."the doctor said my eating problem was so bad it affected my periods".....This might remind you to ask about amenorrhoea in a station where you were assessing if the patient had anorexia nervosa.
- **If you draw a blank or start off badly, be honest, explain, apologise and ask if you can start again!** There was a copy of the "Instruction to candidates" inside the OSCE station at the last sitting so you may be able to refer to this if you forget what you were asked to do. The patient will show you respect for this decision and agree with your proposal. HOWEVER, you should do this only if necessary as it looks unprofessional.
- **If you get stuck** and have no idea what to ask next, reflect back on the interview and check what you have heard is correct. Perhaps you could repeat some of what has been said (be careful to get it correct!) This could lead to another area of questioning you may have missed out on earlier. Reflecting back, will suggest to the patient that you have been listening and also builds rapport. Their replies may give you clues as to what to ask next.
- **Be warned** that the OSCE stations examined in the morning at the exam centre may be different to those examined in the afternoon. It has been noted that although the title and much of the instruction to the candidate may appear the samesubtle differences in the instructions may occur. Similarly the ophthalmoscopy slides may change.
- **Sometimes it may be a good idea to spell out what you are doing or observing!** Don't assume the examiner will know that you know your stuff! E.g. when assessing the signs of extrapyramidal side effects of medication...it may be a good idea to say to the patient (for the benefit of the examiner!) "I have noticed since we began chatting that your feet seem restless....do you find it difficult to sit still?" or that "Your movements seem a little slowed up...." Although your hands don't seem to have a shake now...do you find they shake sometimes? These questions save time by getting you over the 1) eliciting of symptoms and 2) letting the examiner know that you have looked for these symptoms and 3) have observed them

accurately. This might also be relevant if you got an OSCE on assessing the stigmata or signs of alcohol abuse.....you could say..."Can I see your hands...I don't think you have a tremor there.....your face does not seem flushed or sweaty and your skin and eyes have a good colour (no jaundice).....your palms are clear (no palmar erythema or Dupuytren's contracture)....." Here you are incorporating your clinical observations into a dialogue with the patient which reassures him or her. It's like the artificial way we made certain that our driving test examiner saw that we had looked at the rear and side mirrors before we pulled off during the driving test!!!

- There are Videos of OSCEs and a lot of information on the College website www.rcpsych.ac.uk
- **Practise, practise**..... most clinical tasks can be deconstructed to OSCEable tasks ... discuss the possibilities with your tutors and consultants... practice examining for EPSEs, the examination of eating disorder clients etc...

5 **Article on OSCE's.**

Simulated Patients and Objective Structured Clinical Examinations: review of their use in medical education. J Wallace, R.Rao & R. Haslam. Advances in Psychiatric Treatment, Vol (8), Issue 5 2002.342-348.

6 **List of possible OSCE'S!**

Perhaps you could prepare these in advance and discuss them with your tutors.... You may wish to set up mock

OSCE's based on this list and those discussed above!!! Get together with your colleagues and practise these!!!

- Cognitive assessment of the elderly
- Physical assessment for the stigmata of alcohol abuse
- Assessment of possible depressive episode or manic episode
- Assessment of a patient with tremor
- Assessment of suspected pathological grief
- Assessment of chest pain and performance of ECG
- Assessment of physical complications of anorexia nervosa
- Physical assessment of substance misuser
- Discussion of abnormal haematology reports in clozapine treatment
- Discussion of abnormal lab reports in anorexia nervosa or alcohol excess
- Assessment of negative symptoms of schizophrenia
- Assessment of weight gain in neuroleptic treatment
- Assessment of panic disorder, OCD, PTSD, Social phobia, agoraphobia etc.
- Assessment of sexual dysfunction
- Assessment of suspected heroin addiction
- Taking a collateral history in anorexia nervosa
- Assessment of premorbid personality
- Assessment of akathisia
- Assessment of insight in schizophrenia

- Assessment of insomnia
- Assessment of patient with side effects on clozapine treatment
- Proposing depot medication to non compliant man with schizophrenia
- Assessment of benzodiazepine withdrawal symptoms
- Discussion of lab. reports demonstrating hyponatremia-differential diagnosis
- Discussion with patient starting methadone maintenance treatment
- Assessment of antidepressant discontinuation syndrome
- Assessment of an adverse drug reaction e.g. rash on carbamazepine...etc
- Discussion of commencement of RLAI (risperidone long-acting injection)

There are more possibilities but these seem like possible OSCEable tasks !!!

Remember! It's vital not to forget or lose sight of how to assess **common** things like whether someone is depressed or not before getting worried about being able to establish the presence of Korsakoff's psychosis in 7 minutes or the intricacies of systematic desensitisation!!!

Finally,

I am very grateful to Dr. Aisling Ryan, Neurology SpR, Mater Hospital for compiling much of the content on cranial nerve examination, ophthalmoscopy and cardiopulmonary resuscitation.

Your predecessors, doctors training in psychiatry in Ireland, performed better than other doctors during the first ever sitting of this exam, earlier this year, due in no small part to the efforts of your tutors and consultants. Most of the work will have to be done by yourselves and you have plenty material in this handout to focus on between now and the examination! Practise! Practise! Practise! Best of luck!

Dr. Martin Mahon

Research Fellow, Dept of Psychiatry and Mental Health Research, St Vincent's University Hospital, Dublin 4.

PS. The Royal College may at any time chose to alter aspects of the examination and you should continue to check for updates on such changes on their website....this handout is prepared on current information available.