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Committee for Examinations
Objective Structured Clinical Examination
Station 3
Sydney April 2018

The Royal
Australian &
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Psychiatrists

1.0 Descriptive summary of station:

In this station the candidate is to assess Nicole, a 22-year-old woman referred to the consultation liaison psychiatry team due to concerns regarding paranoid thoughts and periods of confusion. The candidate is expected to identify a possible diagnosis of delirium. Better candidates will identify that the investigations provided inform that the patient has an ovarian teratoma, and that the teratoma can be linked to the current clinical presentation.

1.1 The main assessment aims are to:

- Take a history that is mindful of the changes to the patient's mental state and the likely link to recent physical symptoms / diagnoses.
- Accurately conduct an appropriate range of focussed bedside cognitive tests, particularly for orientation and sustained attention.
- Establish that a primary psychotic illness is unlikely and differentiate the preferred diagnosis based on the history gathered and results of investigations.

1.2 The candidate MUST demonstrate the following to achieve the required standard:

- Focus on exploring the symptom of suspiciousness.
- Accurately assess orientation and sustained attention in the cognitive screening.
- Identify delirium as a key differential diagnosis.
- Propose the link between teratomas and encephalitis.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Medical Disorders in Psychiatry, Clinical Assessment Skills
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment - data gathering content; Assessment - physical - technique; Diagnosis; Diagnosis – investigation analysis).

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1.4 **Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female in 20s
- Pen for candidate.
- Timer and batteries for examiners.

2.0   Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

You are working as a junior consultation liaison psychiatrist. You are about to see Nicole, a 22-year-old woman referred by the neurology team with concerns regarding irritability, suspicious thoughts, and periods of confusion.

The neurology team report that Nicole presented following a generalised seizure with no previous history of a seizure disorder. Nicole was reluctant to accept that she had a seizure and refused any medication. At times she won't eat the food provided. She has yelled at the nurses on several occasions but then denies doing this and accuses the staff of lying about her.

She has also been drowsy at times and is often asleep during the day. Occasionally Nicole has wandered into other patients' rooms and tried to get into the wrong bed.

Nicole's fiancé, Luke, has provided the following information:

Three weeks ago Nicole had some sort of 'flu or gastro' – she had a temperature, headache, vomiting and diarrhoea.

The headaches continued for two weeks and Luke noticed a change in Nicole. There were times when she appeared to get her days mixed up, sometimes she forgets plans that they'd made, and this was not like Nicole who is usually very organised. She was irritable and questioning where he'd been and what he had been doing. She seemed unaware that there was any problem and would get angry at him if he suggested there was. Luke managed to convince her to return to her GP.

A week later, Luke noticed that Nicole's face was twitching. Three days after this she collapsed and had a fit and he called the ambulance and Nicole was admitted to hospital.

Your tasks are to:

- Take a relevant and focussed history from Nicole.
- Conduct relevant specific bedside cognitive screening, while providing commentary on rationale, and interpretation of tests **to the examiners**.
- Review the relevant investigation results that will be **provided by the examiners** at twelve (12) minutes.
- Based on your assessment and the investigations provided, explain your preferred and differential diagnoses **to the examiners.**

You are not required to conduct a physical examination.

At **twelve (12) minutes** you will receive the investigations results.

Station 3 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
  - Pens.
  - Water and tissues (available for candidate use).
- Do a final rehearsal with your simulated patient and co-examiner.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- **At twelve (12) minutes**, take note of the cue for one examiner to provide the 'Investigation Results' to the candidate
- If the candidate asks you for information or clarification say:

  'Your information is in front of you – you are to do the best you can.'
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate – e.g. 'Investigation Results'.
- Complete marking and place your co-examiner's and your mark sheet in **one** envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the <u>final task</u>:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?

  If so, you <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings.'

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.1   In this station, your role is to:

Observe the activity undertaken in the station and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

> *'There's no problem with my head.'*

This is your specific prompt: At **twelve (12) minutes** you are to provide a copy of the investigations results below to the candidate.

INVESTIGATION RESULTS

CT and MRI brain	**9 April 2018**
Both unremarkable	

EEG   **10 April 2018**
History - Generalised seizure. No history of epilepsy.
Patient status - The patient was drowsy during the recording

Factual Report
Background: diffuse generalised slowing present throughout the recording

Other: On two occasions there was a generalized spike lasting 4 seconds over the left posterior temporal region. There was no clinical change noted in the patient in these periods.

Pelvic Ultrasound   **11 April 2018**

Uterus – anteverted. Myometrium – homogenous. Endometrium – clearly visualised, thickness within expected limits. Right Ovary – clearly seen, normal morphology, outline smooth. Left Ovary – clearly seen, contains 6cm cystic mass with fluid levels and multiple thin echogenic bands. Findings consistent with dermoid cyst (mature teratoma) of the left ovary.

3.2   Background information for examiners

In this station the candidate is to interview a 22-year-old woman who presents, following a seizure with no history of epilepsy, with paranoia and periods of confusion. The candidate is expected to complete an assessment and focus on cognitive screening to elicit symptoms in keeping with a possible diagnosis of delirium and recognise that delirium is more likely than a primary psychotic illness. The candidate is provided with investigations that inform that the patient has an ovarian teratoma and should link the teratoma to the current clinical presentation.

In order to 'Achieve' this station the candidate **MUST**:
- Focus on exploring the symptom of suspiciousness.
- Accurately assess orientation and sustained attention in the cognitive screening.
- Identify delirium as a key differential diagnosis.
- Propose the link between teratomas and encephalitis.

A surpassing candidate may correctly identify a likely diagnosis of anti-NMDAR encephalitis and its implications for the presentation.

DSM-5 Criteria for Delirium

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition diagnostic criteria for delirium is as follows:

A. Disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment).

B. The disturbance develops over a short period (usually hours to days) and tends to fluctuate during the course of the day.

C. An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception).

D. The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal such as coma.

E. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a direct physiologic consequence of a general medical condition, an intoxicating substance, medication use, or more than one cause.

Bedside Cognitive Tests

The following is a summary of the common tests that may be undertaken by the candidate. Candidates are expected to prioritise testing of orientation, sustained attention, and memory. It is expected that the candidates should identify an acute confusional state and that assessment of domains other than orientation, attention and memory may not be currently appropriate. It would, however, be relevant for the candidates to conduct a screening test of global cognitive alibility such as a test of constructional ability.

Attention & Sustained Attention / Vigilance / Alertness

Given the history of fluctuating presentation and concerns regarding confusion it is expected that the candidate would assess attention and alertness.

Ability to sustain attention and keep track of events is an important day-to-day function. A disturbance in attention or alertness can lead to vulnerability to interference and difficulty in inhibiting immediate, inappropriate responses. Disorientation to time and sometimes place may occur if attention is grossly impaired. Maintenance of attention requires integrated activity of the pre-frontal cortex, thalamus and brainstem linked via the reticular activating system.

Alertness is commonly considered to be normal when the patient is awake and fully cooperative. All other tests are impacted if the person is not alert. The patient's basic level of attention can be readily assessed by using the Digit Repetition Test or Serial Sevens Subtraction Test (or months of year / days of week backwards) and his / her orientation (to time and place).

Tests like serial subtraction of 7s or spelling a familiar word backwards (WORLD – DLROW) and days of the week of months of the year recited backwards examines sustained attention i.e. concentration.

Serial Sevens: The candidate should instruct the patient to '***subtract 7 from 100 and keep subtracting 7 from what is left'***. Once they have started, the patient should <u>not</u> be interrupted until they have completed five subtractions. If they stop before the five subtractions the instruction should be repeated.

In recitation of days of week / months of year many of these are familiar and so people have over-learnt the sequence; therefore, capacity for fast and errorless reverse order recitation is a good measure of sustained attention.

Working Memory

Working memory is short-term memory and is critical for cognitive abilities such as planning, problem solving and reasoning. Working memory requires the information to be available and then the ability to manipulate it.

The amount of information that is readily accessible for individuals varies (working memory capacity / span) and so has a relationship to cognitive ability / general intelligence. Distraction, trying to hold too much information at one time, or engaging in demanding tasks can all affect working memory function.

Various components of working memory are responsible for immediate repetition of words, numbers and melodies as well as for spatial information. It works independent of and parallel to long-term memory and its central component is frontal lobe function (phonological memory in peri-sylvian language areas in dominant hemisphere: visuo-spatial in non-dominant hemisphere). Patients are asked to recall immediately after.

Verbal - orally administered test in which the respondent mentally re-orders strings of number and letters and repeats them to the examiner.

Digit span, especially reverse, depends on short-term (working) memory, which in turn depends on frontal executive and phonological processes. It is tested by asking the patient to repeat progressively longer strings of digits; usually starting with three. ***The numbers should be read at a speed of one per second (like telling someone your phone number).*** Two trials are given at each level if required, and the digit span is the highest level the person passes on either trial. Normal forward digit span is 6±1 depending on age and intellectual ability, and reverse is usually one less.

The bedside test is repetition and recall of a word list as described in the Folstein MMSE; or an address, after a short period of other cognitive activity. It is expected that repetition and recall would be assessed by the candidate.

Long-term Memory

Includes learning new information, retaining newly learned information over time and recognising previously presented material and recalling it when needed. Tests measure declarative (explicit) memory which are available to conscious access and reflection. This memory is responsible for the laying down and recall of personally experienced, and highly temporally specific events or episodes (episodic memory), and knowledge of facts and concepts (semantic memory). They both form components of long-term memory.

Constructional Ability

Constructional ability is a complex perceptual motor ability involving the integration of occipital, parietal, and frontal lobe functions. Both two- and three-dimensional drawings are used. The instructions can be: ***'Please draw a picture of a clock with the numbers and hands on it';*** followed by asking the patient to '***Set the time as 11:10 or 10:20'.***

Other tests of constructional ability include asking the patient to draw a daisy in a flowerpot; or a house in perspective so that you can see two sides and the roof. A perfect clock drawing test strongly suggests that delirium is unlikely but no specific abnormalities on the test confirm a diagnosis of delirium.

Bedside Cognitive testing in Acute Confusional States

The approach to this task will vary but should include assessment of the patient's orientation, attention, registration and recall. Overall expectation is that the candidate will perform screening for orientation, registration, attention and concentration, and short-term memory.

O'Regan et al found simple attention tests may be useful in delirium screening. 'Months of the year' backwards used alone was the most accurate screening test in older people.

The Confusion Assessment Method (CAM) Criteria

The CAM is a validated delirium diagnostic tool which can be considered the 'gold standard' tool for detection of delirium.

1. **Acute onset and fluctuating course**
   a) Evidence of an acute change in mental status from the patient's baseline; OR
   b) The abnormal behaviour fluctuates during the day, tends to come and go or increase and decrease

2. **Inattention**

   The patient has difficulty focusing attention, for example, easily distracted or having difficulty keeping track of what is said.

3. **Disorganised thinking**

   Patient thinking is disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject.

4. **Altered level of consciousness**

   Overall the patient's level of consciousness fits one of the below descriptors:
   a) Vigilant
   b) Lethargic
   c) Stupor
   d) Coma

A positive CAM result requires **both** 1 and 2 plus **either** 3 or 4.

Reference: Inouye SK, Van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI (1990) Clarifying confusion: the Confusion Assessment Method. Annals of Internal Medicine 113: 941-8

Potential causes of delirium

The mnemonic I-WATCH-DEATH is a useful tool that can be used to recall the common causes of delirium

- Infectious – in this case infective encephalitis or meningitis would be more likely than common causes of delirium such as pneumonia or urinary tract infection.
- Withdrawal state – in this case, given the recent seizure, alcohol or benzodiazepine withdrawal would be more likely than other withdrawal states.
- Acute metabolic disorder - electrolyte imbalance, hepatic or renal failure
- Trauma - head injury, postoperative
- CNS pathology - seizure disorder (including post-ictal state - in this case supported by recent seizure activity) stroke, haemorrhage, Parkinson's
- Hypoxia - anaemia, cardiac failure, pulmonary embolus
- Deficiencies - vitamin B12, folic acid, thiamine
- Endocrinopathies - thyroid, glucose, parathyroid, adrenal
- Acute vascular - shock, vasculitis, hypertensive encephalopathy
- Toxins, substance use, medication (anaesthetics, anticholinergics, narcotics)
- Heavy metals - arsenic, lead, mercury

Diagnosis and appropriate differential diagnosis

In the scenario is it expected that the candidate will provided the preferred diagnosis of delirium and a surpassing candidate will provide the correct diagnosis of anti-NMDAR encephalitis (see below).

An appropriate differential diagnosis would include:

- Encephalitis – either autoimmune or infective
- Meningitis
- Seizure Disorder – including post-ictal state or status epilepticus
- CNS tumour (given the ovarian mass, CNS metastasis would be more likely than CNS primary)
- Withdrawal state
- Autoimmune disorder such as SLE
- Psychotic disorder – however it is expected that the candidate will recognise that this is less likely than an organic course

Anti-NDMAR encephalitis

Braverman et al report that Anti-NMDA-receptor encephalitis was initially described in 1997, in two separate reports of young women presenting with an ovarian teratoma and symptoms that included psychiatric manifestations and altered level of consciousness. In 2005, a series of four women with ovarian teratoma, psychiatric symptoms, altered level of consciousness and central hypoventilation was described. It was hypothesised that the syndrome was a paraneoplastic process due to an antibody to an unknown antigen expressed in the hippocampus. The associated antibody was discovered to be anti-NMDA-receptor in 2007. In subsequent years, hundreds of cases have been reported in the neurology literature in both men and women, with approximately 80% of cases in females. The median age at onset of symptoms is 21 years old, although cases have been reported in patients ranging from 8 months to 85 years. Teratomas are found in large numbers of patients, most commonly in women between age 12 and 45 and in patients of Asian or African American descent.

Braverman et al also report that the syndrome often begins with viral-like symptoms including headache, nausea, vomiting, fever, and fatigue. The non-specific nature of these symptoms generally precludes diagnosis at this stage and is recognized as a prodrome only after the illness progresses with a spectrum of neuropsychiatric symptoms. These symptoms have been divided into early and late stage symptoms. Early stage symptoms generally present with two weeks of prodromal symptoms and include confusion, memory loss, paranoia, hallucinations, mood disturbances, anxiety, self-harming behaviours, seizures and movement disorders such as facial twitching and choreoathetosis. As the psychiatric symptoms are often the most prominent, 77% of patients are initially seen by psychiatrists and many patients are diagnosed with new-onset psychiatric disorders. However, these patients do not respond to anti-psychotics and progress to late stage symptoms, such as decreased responsiveness, hypoventilation, and autonomic instability including hypotension or hypertension, bradycardia or tachycardia, hyperthermia, and urinary incontinence.

According to Mark Oldham, prompt identification and management of autoimmunity are critical for optimal outcomes. The fact that undiagnosed and, therefore, untreated autoimmunity leads to debilitation demands vigilance for these conditions. Close attention to the unusual nature and course of neuropsychiatric symptoms, associated neurological features, and review of systems should guide the skilful clinician.

Autoimmune encephalopathy usually has a subacute onset, progressing over the course of 1–3 months. Computed tomography and magnetic resonance imaging are insufficiently sensitive to rule out autoimmune encephalopathy. In fact, reviews indicate that a single brain MRI may have less than 50% sensitivity for detecting several of these conditions. Viral prodromes are seen in more than half of patients with anti-NMDAR antibody encephalitis.

Oldman produced the following table of features suggestive of autoimmune encephalitis.

Clinical Features That Raise Suspicion for Autoimmune Cause	
Psychiatric symptoms	Personality change Multi-symptom presentations Non-auditory hallucinations
History	Viral prodrome Severe diarrhoea Fever Personal / family history of autoimmunity Personal / family history of neoplasm associated with paraneoplastic syndromes Current or significant history of tobacco use
Natural history	Abnormal age of symptom onset Abrupt or florid symptom onset Rapid symptom progression Changing neuropsychiatric symptoms Treatment resistance
Neuropsychiatric symptoms	Unexplained delirium Premature cognitive impairment Subacute anterograde amnesia Catatonic features REM sleep behaviour disorder
Neurological features	Seizures Unexplained stroke-like events, particularly multifocal Headache Localizing neurological signs including cranial nerve palsies Sensorimotor findings Movement disorder
Medical features	Hyponatremia Central sleep apnoea Dysphagia Dysautonomia

The group of Graus F, Titulaer MJ et al recommend the following diagnostic criteria for anti-NMDA receptor encephalitis (anti- NMDAR)

Probable anti-NMDAR

All three of the following:

1. Rapid onset (less 3 months) of at least four of the six following major groups of symptoms:
    - Abnormal (psychiatric) behaviour or cognitive dysfunction.
    - Speech dysfunction (pressured speed, verbal reduction, mutism).
    - Seizures.
    - Movement disorder, dyskinesias, or rigidity / abnormal postures.
    - Decreased level of consciousness.
    - Autonomic dysfunction or central hypoventilation.

2. At least one of the following lab study results:
    - Abnormal EEG (focal or diffuse slow, epileptic activity or extreme delta brush pattern).
    - CSF with pleocytosis or oligoclonal bands.

3. Reasonable exclusion of other disorders
    - Diagnosis can also be made in the presence of three of the above groups of symptoms accompanied by a systemic teratoma.

Definite anti-NMDAR

Diagnosis can be made in the presence of one or more of the six major groups of symptoms and IgG anti-GluN1 antibodies after reasonable exclusion of other disorders. Antibody testing should include CSF. If only serum is available, confirmatory test should be included (live neurons or tissue immunohistochemistry in addition to cell-based assay) (The NMDA receptor is a heterotetramer comprised of twoGluN1 subunits and two GluN2/3 subunits. **Detection of IgG antibodies against the GluN1 subunit is a signature of anti-NMDAr encephalitis**.)

Dalmau, Joseph, Lancaster, Eric et al reported the following information about diagnostic tests:

- Brain MRI is unremarkable in 50% of patients (Although, Barry et al subsequently reported that MRI may be normal in up to 70% of cases), and in the other 50%, T2 or FLAIR signal hyperintensity might be seen in the hippocampi, cerebellar or cerebral cortex, frontobasal and insular regions, basal ganglia, brainstem, and, infrequently, the spinal cord. Follow-up MRIs either remain normal or show minimum change despite the severity and duration of symptoms.

- Electroencephalograms are abnormal in most patients, usually showing non-specific, slow, and disorganised activity sometimes with electrographic seizures. Slow, continuous, rhythmic activity in the delta-theta range predominates in the catatonic-like stage. This activity is not associated with abnormal movements and does not respond to antiepileptic drugs. Monitoring with video EEG is important to diagnose and treat seizures appropriately.

- The cerebrospinal fluid (CSF) is initially abnormal in 80% of patients and becomes abnormal later in the disease in most other patients. Findings include moderate lymphocytic pleocytosis, normal or mildly increased protein concentration, and, in 60% of patients, CSF-specific oligoclonal bands. Most patients have intrathecal synthesis of NMDAR antibodies.

- Brain biopsy does not provide a diagnosis of anti-NMDAR encephalitis.

3.3   The Standard Required

Surpasses the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieves the Standard – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

i.   they have competence as a ***medical expert*** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).

ii.   they can act as a ***communicator*** who effectively facilitates the doctor patient relationship.

iii.   they can ***collaborate*** effectively within a healthcare team to optimise patient care.

iv.   they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.

v.   they can act as ***health advocates*** to advance the health and wellbeing of individual patients, communities and populations.

vi.   they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.

vii.   they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

Below the Standard – the candidate demonstrates significant defects in several of the domains listed above.

Does Not Achieve the Standard – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

4.1 This is the information you need to memorise for your role:

You are Nicole Carter, a 22-year-old primary school teacher. You live in a unit with Luke, your fiancé of one year.

Recent Events

You think that it was about three weeks ago you had a virus infection of some sort, where you had headaches, vomiting and diarrhoea. The headaches continued for some time.

Luke says he has noticed you having difficulty remembering things and he tells you that you seem confused at times but you know this isn't true. You don't understand why Luke is telling these lies or why your GP seem to believe Luke. You are certain that Luke has made the doctors in the hospital get a psychiatrist to see you and that he wants you locked away.

In the last week some time – you are not sure of the exact day - you know you fainted at home but have been told that you actually had a fit (seizure) - you are not convinced that you had a fit and feel that the medical tests being performed on you are unnecessary.

You don't like being in hospital and you don't want to take the medication they are trying to give you. You distrust the hospital staff as they are listening to Luke.

You are aware a psychiatrist was coming to review you. You think this is happening because Luke and maybe the hospital staff want you locked away. You know that Luke and the hospital staff have been lying to you but you don't understand why.

You do not believe there is anything wrong with your mental health. You can admit that you might be anxious, but you think this is understandable given your partner has been telling lies about you, and the hospital staff are doing what Luke tells them.

If you are asked, you have no previous history of mental illness and have never seen a psychiatrist before.

If you are asked about unusual or bizarre experiences, you become annoyed and say you're not crazy but will answer the questions.

If you are asked about your childhood or early life

You are not aware of any problems during the pregnancy with you or at the time of your birth. No one has mentioned that there were any issues with your early growth and development. You feel you had a good childhood and that you were a happy child.

You fell off a swing and broke your arm when you were six but other than this you have had no significant accidents, injuries or illness.

You didn't have any problems at school. You got on with other students and teachers and still see some of your friends from school.

Some people have unusual behaviours that start when they are young, for instance counting things or needing to have things in a certain order, but you do not have any issues of this nature.

If you are asked about your family

You are close with your parents, who are both teachers, and with your older brother, Pete. Your family try to have dinner together at least once a week which Luke finds a little frustrating as he doesn't see his parents anywhere near as much.

There is no family history of major health problems, apart from your mother having rheumatoid arthritis. All your grandparents are still alive. No-one in your family has ever seen a psychiatrist or, to your knowledge, had any problems with their mental health.

Your family members are social drinkers and your brother smokes cigarettes, but you are not aware of anyone having any problems related to drugs or gambling.

You met at university. You have been together for three years. You don't understand why he is saying that you are having memory problems and that you are confused. You are certain that he got the doctors to refer you to a psychiatrist and that he wants people to think you are crazy.

If you are asked about alcohol or drug use

You do not smoke. You drink one to two glasses of wine with dinner most nights. You tried cannabis a few times at parties in your first year of university but no other drugs and you do not smoke cannabis now.

You've never had any charges or been in trouble with the police.

If you are asked about unusual thoughts or experiences

You are adamant that you are not 'crazy'.

You have noticed a strange smell lately – like something is dead or rotting - and people keep telling you it isn't there but you know that they are lying to you.

You don't think you are safe in hospital.

You're been hearing people, including the staff, laugh at you and think Luke has made them do it.

You have seen people coming into your hospital room at night and you are frightened but everyone keeps lying to you and telling you no one was there.

You have noticed that the food tastes strange and believe that the nurses are trying to put the medication that you don't want to take into your meals.

4.2   How to play the role:

Dress in casual attire. Hair to be somewhat messy with rumpled or askew clothing as getting dressed has been difficult. You are to be suspicious and you fear that this doctor wants to lock you away.

The candidate is required to come to the conclusion that you are confused or 'delirious' to assist the candidate with this:

- You are to yawn frequently and tell the doctor that you're tired.

- You are to be vague on the timeline of events that have happened recently and you must not know the current date and time – see below for answers to be provided.

- You are to lose track of the conversation occasionally.

- You are to accuse the candidate of laughing about you when they have not been.

- You are to provide the responses below to the testing the candidate conducts.

- If you are asked about unusual or bizarre experiences, you become annoyed and say you're not crazy but will answer the questions.

Responses to Memory and Cognitive Testing – you will be trained in these tests

PLEASE PRACTICE THESE CAREFULLY

Tests for Orientation:

Your date of birth is ***1 May 1995***. Your address is ***1 King Street, Ashfield, Sydney***. You are to give a correct answer as to the hospital that you are at, and you must give the day as ***Saturday***; but give the date as ***30th January 2018*** and ***the time of day four hours ahead of what it is***.

Tests for Concentration:

The candidate should ask you to '**subtract 7 from 100 and keep subtracting 7 from what is left'** (serial 7's) you go wrong after 2nd number and then give up. You say: **93...88...70'**.

If the candidate does not give the full instruction (above) or asks for a different calculation start exactly as they tell you to but only get the first calculation correct and do not complete the sequence.

If asked to repeat 5 numbers forward you **can do 4 correctly but give the last wrong digit**.

If asked to repeat numbers backwards you **give only the first number correctly, the second and third numbers are wrong and then you stop**.

If asked to spell a word (like WORLD) backwards, you **give the first two letters correctly and then wrong letters after this**.

If asked to repeat the days of the week <u>or</u> the months of the year backwards, you **do this incorrectly – you give the days / months out of order and then stop (e.g. May, June, July)**.

Tests for Memory:

If asked to repeat a set of three separate words, you **will repeat two out of three immediately**. You should be asked what those words were again after a few minutes you are **only able to recall one, even if given clues**.

If asked to remember a name and address you **are only able to immediately repeat the name**. You **provide the street wrong number and you cannot recall the street name**. If asked again in the few minutes you **only recall the first name**.

Drawing:
You may be asked to draw interlocking pentagrams, a cube and / or a clock face. **Start to draw but have your hand shake and then stop** and say that you **can't do anymore**.

Writing:
If asked to write a sentence, **write one or two words and then stop**.

Fluency:
If asked to list as many words as possible in one minute starting with a particular letter – **say 2-3 words correctly and then give answers staring with the wrong letter**.

If asked to name animals, supermarket items, or something similar in one minute – **say 2-3 words correctly and then give incorrect answers**.

Similarities:
You may be asked to explain how X is similar to Y (e.g. how is an apple like an orange?) **Decline to do this**.

Proverb interpretation:
You may be asked to explain a proverb (e.g. 'A stitch in time saves nine' or 'Too many cooks spoil the broth') **Decline to do this**.

Physical tasks:
Decline to do any physical tasks or anything that has you copying the candidate's movements – say **you are too tired for this**.

Calculation:
You **can only perform very simple calculations. Otherwise give a wrong number** or say **you don't know**.

Language:
You cannot repeat a sentence back to the candidate correctly, you understand most questions and commands; you are able to solve simple problems but nothing complex or that has several steps.

General knowledge:
Answer as best you can but **do not know details of very recent news events** if asked about these.
If asked to do anything else decline to do them.

4.3   **Opening statement:**

   'There's no problem with my head.'

4.4   **What to expect from the candidate:**

There are two parts to the station for you. The candidate is to:

1.   take a history about what you think has been happening recently
2.   ask you to do some tests

The candidates should politely and sensitively ask you about your recent illness. They are expected to conduct some tests of your orientation, attention and memory (the responses you are required to provide are listed above). If they ask you to do a test not listed, decline to do the test of say you are too tired and decline.

The candidate should explain what they want you to do but will provide an explanation **to the examiners** of their reasons and findings as they examine you. If you do not understand how to do the test, please ask them to explain again.

Towards the end of each session the candidate will address the examiner about their findings and recommendations.

4.5   **Responses you MUST make:**

   'I shouldn't be here, there's nothing wrong with me.'

   'Why are you laughing at me? I knew you were in on it.'

4.6   **Responses you MIGHT make:**

   'No one is listening to me. You are all listening to Luke.'

   'You're just here because you want to lock me away.'

4.7   **Medication and dosage that you need to remember:**

You are not currently taking any medication.

STATION 3 – MARKING DOMAINS

The main assessment aims are to:

- Take a history that is mindful of the changes to the patient's mental state and the likely link to recent physical symptoms / diagnoses.
- Accurately conduct an appropriate range of focussed bedside cognitive tests, particularly for orientation and sustained attention.
- Establish that a primary psychotic illness is unlikely and differentiate the preferred diagnosis based on the history gathered and results of investigations.

Level of Observed Competence:

1.0   MEDICAL EXPERT

1.2   Did the candidate take appropriately detailed and focussed history (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
clearly elicits the recent physical symptoms / illness and associated mental state changes; achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication.

Achieves the Standard by:
demonstrating use of a tailored biopsychosocial approach; exploring the recent physical symptoms; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; demonstrating ability to prioritise; eliciting the key issues that the patient is paranoid (e.g. fears that medication is in her food, and doesn't trust her fiancé or the staff); completing a risk assessment relevant to the individual case; demonstrating phenomenology including multimodal hallucinations; clarifying important positive and negative features; assessing for typical and atypical features.

To achieve the standard *(scores 3)* the candidate **MUST**:
a.   Focus on exploring the symptom of suspiciousness.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2 Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.5   Did the candidate demonstrate adequate and accurate technique in the selected bed side cognitive testing? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
overall examination technique is accurate and well organised; references the Confusion Assessment Method (CAM) and explains its relevance.

Achieves the Standard by:
competently explaining and applying selected tests; prioritising testing of attention and sustained concentration, and memory, and recognising that due to disorientation and inattention more detailed cognitive testing is not appropriate.

To achieve the standard *(scores 3)* the candidate **MUST**:
a.   Accurately assess orientation and sustained attention in the cognitive screening.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
demonstrates incorrect technique is for most tests selected; prioritises inappropriate tests; fails to assess orientation.

1.5. Category: ASSESSMENT – Physical - Technique	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.9 **Did candidate formulate appropriate differential diagnoses? (Proportionate value - 25%)**

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; accurately identifies anti-NDMAR encephalitis as the most likely diagnosis; appropriately identifies the limitations of diagnostic classification systems to guide treatment.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; adequate prioritising of conditions relevant to the obtained history and findings, utilising a biopsychosocial approach; identifying relevant predisposing, precipitating perpetuating and protective factors, recognising that an organic cause is more likely than a primary psychotic illness.

To achieve the standard *(scores 3)* the candidate **MUST:**
a.   Identify delirium as a key differential diagnosis.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

provides an inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusions.

1.9 Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.10 **Did the candidate interpret the cognitive tests, EEG and ultrasound results correctly in formulating a diagnosis and differential diagnosis? (Proportionate value - 10%)**

Surpasses the Standard (scores 5) if:

demonstrates a superior performance linking relevant investigations with other diagnostic procedures / formulations.

Achieves the Standard by:

analysing findings of cognitive screening and identifying the significance of disorientation and impaired attention, accurately interpreting the results and incorporating them into the relevant formulation of the presenting problem.

To achieve the standard *(scores 3)* the candidate **MUST:**
a.   Propose the link between teratomas and encephalitis.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

does not link recent physical illness and abnormal EEG and ultrasound result with the patient's change in mental state.

1.10. Category: DIAGNOSIS - Investigation Analysis	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail