Candidate Instructions

Role:
You are a FY1 in the GP surgery. Mandy Taylor, a 15 year old girl, has come in today and is worried about her eating pattern.

Candidate instructions:

1. 0-15 minutes: take an appropriate history and mental state examination. You are NOT required to physically examine the patient.
2. 15-20 minute: answer the examiner's questions.

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Simulator Instructions 1/3 - History

Patient Demographics
You are Mandy Taylor, a 15 year old girl. You have either:
- come to the GP discuss your eating habits.

Presenting Complaint:

History of Presenting Complaint
- Onset & Duration: 9 month history
- Severity: been on a 3 month diet – she has 1 small meal a day, which she forces herself to vomit up. Vigorously exercise every day.
- Triggers: Bullying at school for being overweight.
- Functional Impairment (Job, Family, ADLs): Not able to concentrate at school. Her periods have stopped. She is anxious and is too tired to carry out everyday activities.
- Associated Symptoms (Physical, Cognitive): Periods have stopped. Hair is thinning. Bruises over knuckles from repeated vomiting
- Overdose: NONE
- ICE: concerned about bullying and periods stopping

Past Psychological History
- No previous psychiatric history

Past Medical History
- Hayfever, eczema

Family History
- Family hx of diabetes
- Mum has generalised anxiety disorder (GAD)

Social
- Lives at home with Mum and Dad – supportive but she finds it difficult to open up to them regarding the bullying going on at school.
- Does not have many friends at school.

(If relevant) Personal History
Not relevant

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Simulator Instructions 2/3- Mental State Examination

Appearance
- Distinguishing features: looks tired
- Weight/ Physique & Hygiene: visibly very thin
- Stigmata of disease: lanugo hair, bruising over knuckles
- Clothing & Objects: loose clothing

Behaviour
- Engagement + Rapport (Difficulty establishing): engaged but Mandy is reluctant to open up at first.
- Eye contact: reduced
- Facial expression
- Body language: closed off
- Psychomotor activity: nil
- Abnormal movement/ posture: none

Speech
- Rate: normal
- Quantity: normal
- Tone: normal
- Volume: low
- Fluency + Rhythm: normal

Mood + Affect
- Describe Mood: low mood
- Affect: flat, in keeping with patient's mood

Thought
- Form: coherent
- Content: no delusions, no negative thoughts of self
- Ideation: nil
- Possession: none

Perception: NO Hallucinations

Cognition:
- Orientated to Place, Person, Time
- Difficulty concentrating for prolonged periods of time

Insight & Judgment: partial insight, poor Judgment

Risk
- To Self - none
- To Health – worsening physical health
- To/ From Others none
- Driving – none as she is a child

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Examiner Marksheet 1/2

Opening

- Introduces themselves
- Confirms Patient demographics
- Explains and gains consent from patient about consultation
- Demonstrates Professionalism & Empathy throughout consultation
- Demonstrates strong Communication skills, allowing clear conversation throughout

History

- Establish clear chronology of events
- Fully explores:
  - History of Presenting Complaint
    - Onset, Duration, Severity, Function impairment, Associated Symptoms
    - Overdose (How, Events before/ during/ after, Feelings about event)
    - ICE
  - Past Psychiatric History
    - Mental health issues (Treatments in Community/ Hospital?)
    - Mental health admissions (Voluntary? Lengths, Diagnoses)
    - Self-harm/ Suicidal thoughts or behaviour
  - Past Medical History
  - Family History
  - Social History (Drugs, Alcohol, Accommodation, Finances, Support
  - Eating Disorder assessment, if appropriate
    - History (Time, Weight changes, Restrictions, Ideal weight)
    - Current diet (Quantity, Frequency, Rules, Avoidances, Hunger)
    - Weight Control (Fasting, Binges, Purging)
    - Attitude (Feelings, Weight/ measure selves, Do others know?)
    - Associated Symptoms (Fatigue, Pale, Hair, Periods, Chest)
  - Personal History, if appropriate
    - Infancy- Birth, Development, Milestones
    - Adolescence/ Education- Relationships, Qualifications, Authority
    - Forensic

Mental State Examination

- Appearance (Distinguishing features, Physique, Clothing, Hygiene)
- Behaviour (Eye contact, Facial Expression, Body language, Psychomotor activity)
- Speech (Rate, Quantity, Volume, Fluency, Rhythm)
- Mood & Affect (Asks mood)
- Thought (Form, Content, Ideation, Possession)
- Perception (Hallucinations)
- Cognition (Orientation, Concentration)
- Insight & Judgment (Illness, Medication)
- Risk (Self-harm, Suicide, Neglect, To others, Driving)

Ending Consultation

- Summarises and clarifies any points
- Thanks patient

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- Signposting

Examiner Marksheet 2/2

Examiner Question examples

What is the most likely diagnosis?

Bulimia nervosa

What is the main management option for bulimia nervosa?

CBT

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