

1.0 Descriptive summary of station:

The task is to assess Harold, a 69-year-old man with Parkinson's Disease. His wife and GP are concerned about him due to his progressively increasing lack of enthusiasm despite good control of his illness. The candidate is expected to identify a range of differential diagnoses and specifically consider depressive disorders and apathy.

1.1 The main assessment aims are:

- To assess the ability to explore the medical condition of Parkinson's Disease and identify the psychological and psychiatric symptoms.
- To evaluate ability to explore a range of psychiatric complications of Parkinson's Disease.
- To assess competence in interpreting depressive and apathy symptoms.
- To evaluate ability to generate and present a broad differential diagnostic statement.

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

- Clarify the impact of Parkinson's Disease on the patient's functioning (physical, psychological and social).
- Explore at least three of the psychological, cognitive and psychiatric symptom complexes.
- Ask about both psychological and biological symptoms of depression.
- Explore the phenomenon of apathy.
- Explain at least one depressive disorder as a possible differential diagnosis.
- Offer at least two other diagnoses of non-depressive illnesses.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Old Age Psychiatry
- **CanMEDS domains of:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis)

References:

- Rao, SS, Hofmann LA, Shakil A (2006) Parkinson's Disease: Diagnosis and Treatment, American Family Physician, 16 Dec 2006
- Weintraub D, Stern MB (2009) Recognizing psychiatric and cognitive complications in Parkinson's Disease. Medscape Neurology: Parkinson's Disease Expert Column
- Slaughter JR, Slaughter KA, Nichols D, Holmes SE, Martens MP (2001) Prevalence, clinical manifestations, aetiology and treatment of depression in Parkinson's Disease. J Neuropsych Clin Neurosc 13:2, Spring 2001 187-196
- Shulman LM, Taback RL, Rabinstein AAQ, Weiner WJ (2007) Non-recognition of depression and other non-motor symptoms in Parkinson's disease, J Neurol Neurosurg Psychiatry 78: 36-42
- Starkstein SE, Leentjens AFG (2008) The nosological position of apathy in clinical practice, J Neurol Neurosurg Psychiatry 79: 1088-1092
- Ferreri F, Agbokou C, Gauthier S (2006) Recognition and management of neuropsychiatric complications in Parkinson's disease, CMAJ, 175 (12), 1545-1552
- Marsh L, McDonald WM, Cummings J Ravina B (2006) Provisional diagnostic criteria for depression in Parkinson's disease: Report of an NINDS/NIMH Work Group, Movement Disorders, 21 (2), 148-158.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, roleplayer x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – male, late 60s, casual rather untidy dress.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are a junior consultant working in the outpatient setting. You are about to see Harold, a 69-year-old retired schoolteacher, referred by his GP for your opinion.

Harold was diagnosed as suffering from Parkinson's Disease six months ago and his movement disorder responded well to medication. However, his wife, Marg, now reports, '*He's not the man he used to be*' and his GP agrees, saying Harold doesn't seem depressed but has '*lost his sparkle*'.

A Geriatrician could find no cognitive impairments and no physical problems other than the movement disorder associated with Parkinson's Disease.

Your tasks are to:

- Obtain a relevant focussed history from Harold about his illness and presenting symptoms.
- Outline the most likely diagnosis plus important differential diagnoses with Harold.

You are **not required** to examine Harold physically, to test his cognition or to discuss management.

You will not receive any time prompts.

Station 5 - 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 e.g. investigation results.
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

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 – the simulated patient has prompts to use to keep to the aims.
- 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 **eight (8) 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.
- Complete marking and place your mark sheet in an 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 final task:

- You are to state the following:
***'Are you satisfied you have completed the tasks?
If so, you must remain in the room and NOT 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 tasks.

3.0 Instructions to Examiner

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.

You have no opening statement or specific prompts in this station.

The role player opens with the following statement:

'I'm not sure why Marg wanted me to see you. Everything is going OK with me.'

3.2 Background Information for Examiners

In this station the examiner is to assess the candidates' ability to understand the background of the diagnosis of Parkinson's Disease. They are to explore a range of psychological, cognitive and psychiatric complications of Parkinson's Disease: the patient presents with decreased activity, energy and interest following the diagnosis and management of Parkinson's Disease.

In order to 'Achieve' in this station the candidate **must**:

- Clarify the impact of Parkinson's Disease on the patient's functioning (physical, psychological and social).
- Explore at least three of the psychological, cognitive and psychiatric symptom complexes.
- Ask about both psychological and biological symptoms of depression.
- Explore the phenomenon of apathy.
- Explain at least one depressive disorder as a possible differential diagnosis.
- Offer at least two other diagnoses of non-depressive illnesses.

The candidate should try to assess the range of other psychological, cognitive and psychiatric symptom complexes evident in Parkinson's Disease:

1. **Cognitive** symptoms (apathy and decreased initiative, impaired memory and concentration, indecision);
2. **Psychotic** phenomena (hallucinations, illusions, paranoia, persecutory ideas, thoughts);
3. **Anxiety** disorders (panic, generalised anxiety, social phobia, obsessive compulsive);
4. **Impulse Control** disorders (gambling, sexual, buying, eating behaviours, stereotyped movements);
5. **Sleep and Wakefulness** disorders (insomnia, hypersomnia, sleep fragmentation, sleep terror nightmares, nocturnal movements, REM behaviour disorders);
6. **Emotional Expression** disorder (pseudobulbar affect, affective lability, uncontrolled crying or laughter).

The candidate is expected to elicit symptoms best described as of 'indifference' or 'flattening of affect' (decreased range and reactivity), together with deficits in activity and interest, in a passive and hard to engage historian. As part of understanding the presentation the candidate is expected to enquire about depressive symptoms specifically mood, affect, motivation, interest, energy, suicidal thoughts and biological features (sleep, appetite, weight, diurnal variation, concentration) as well as to specifically assess for apathy.

The examiner is to then judge the adequacy of diagnosis and differential diagnoses presented. The candidate should demonstrate competence in interpreting depressive and apathy symptoms and in presenting a broad differential diagnostic statement. Harold, the patient in this station, has been scripted to provide a range of deficit-type symptoms that can occur in either Parkinson's Disease or Major Depression (see table on next page).

The key knowledge for the candidate to display is awareness that the intrinsic manifestations of Parkinson's Disease often include a range of symptoms that can mimic depressive disorders. This overlap in symptoms makes the diagnosis of a Depressive Disorder problematic in patients with Parkinson's Disease. In light of this the candidate must consider at least one likely primary diagnosis to be an affective/mood disorder (minor or major). Each of the disorders listed below could count as a separate differential diagnosis:

1. Adjustment disorder with depressed mood.
2. Depressive disorder due to Parkinson's Disease.
3. Primary depressive disorder (major depressive disorder).
4. Depressive disorder due to another medical disorder, substance or medication.
5. Dysthymic disorder.
6. Apathy.

Non-depressive differential diagnoses may include:

1. Bipolar disorder.
2. Frontal lobe impairment.
3. Early cognitive decline (mild neuro-cognitive disorder in DSM-5) – possibly due to cerebral ischemia.
4. Organic personality syndrome.
5. Undetected substance abuse or other anxiety disorders.
6. Occult malignancy.

Symptoms common to Parkinson's Disease and Major Depression

Symptom category	Parkinson's Disease	Major Depression
Motor	Bradykinesia	Psychomotor retardation
	Masked facies	Restricted/depressed affect
	Dyskinesia	Agitation
Cognitive	Apathy & decreased initiative	Decreased interest & enjoyment
	Impaired memory & concentration	Impaired memory & concentration
	Indecisiveness	Indecisiveness
Vegetative	Fatigue & decreased energy	Fatigue & decreased energy
	Impaired sleep	Impaired sleep
	Weight & appetite changes	Weight & appetite changes
Somatic	Physical discomforts	Physical complaints

Depression in Parkinson's Disease

Despite this difficulty and symptom overlap, clinically significant depression is one of the most common psychiatric disturbances reported by patients with Parkinson's Disease. A review of 44 studies involving almost 6,000 patients with Parkinson's Disease found that 31% were diagnosed with a depressive disorder (Slaughter, Slaughter et al 2001). Applying the DSM criteria of the time revealed that 24.8% suffered from Major Depression and a total of 42.4% experienced a DSM Depressive Disorder (Dysthymia plus Major or Minor Depression).

However, depression is often not recognised and under-diagnosed. One study found that less than half of the patients with clinically diagnosed depression were recognised by their treating neurologists as depressed (Shulman, Taback et al 2007).

Depression can be particularly difficult to diagnose in patients with Parkinson's Disease because of the overlap between the two illnesses. Psychomotor slowing, concentration and sleep difficulties occur frequently in Parkinson's Disease, as do diminished appetite and sexual desire. Social withdrawal is common in Parkinson's Disease as patients become less able to participate or more uncomfortable with their appearance, tremor or dyskinesia.

Varying authorities present different characterisations of the symptoms suffered by patients with Parkinson's Disease. Some claim that Parkinson's patients experience more anxiety, brooding, irritability, cognitive deficits, pessimism and suicidal ideation without suicidal behaviour, although lower rates of guilt and self-blame (Shiffer, Kurlan et al, 1988). Symptoms favouring depression that may help in the differential diagnosis include early morning awakening, pervasive (more than two weeks) low mood, diurnal mood variation, and pessimistic thoughts about oneself, the world and the future (Rickards, 2005).

Apathy in Parkinson's Disease

It has become increasingly recognised that 'apathy' is a distinct psychiatric syndrome (Starkstein, Leentjens, 2008) and one that is frequently found in patients with Parkinson's Disease. There is a significant overlap in the symptoms attributed to apathy and those of a depressive disorder. Several authors have proposed diagnostic criteria for apathy as shown below from Starkstein (2000).

- A. Lack of motivation relative to the patient's previous level of functioning
- B. Presence during most of the day of at least one symptom from the following domains
 - i Diminished goal directed behaviour
 - Lack of effort or energy to perform everyday activities
 - Dependency on prompts from others to structure everyday activities

- ii. Diminished goal directed cognition
 - Lack of interest in learning new things or in new experiences
 - Lack of concern about one's personal problems
- iii. Diminished concomitants of goal directed behaviour
 - Unchanging or flat affect
 - Lack of emotional responsivity to positive or negative events

C. Causing distress or impairment

D. Not due to substances or diminished consciousness

It can readily be seen that the 'Apathy' diagnosis has much in common with the Depressive Disorders we most commonly see in psychiatric practice. In the current station, the patient Harold has been scripted and counselled to present as more apathetic than depressed. This does not mean that a Depressive Disorder should not be considered by the candidates. In point of fact, a joint working group of the American National Institute of Neurological Disorders and Stroke, and National Institute of Mental Health has reported on the Diagnosis of Depression in Parkinson's Disease (2003). They recommended a broad, inclusive diagnostic approach be taken when confronted with depressive symptoms in Parkinson's patients. It was the consensus that the clinician should count every symptom, rather than try to determine whether a symptom is due to depression or due to some other aspect of Parkinson's Disease. For example, patients with problems sleeping would get points on the rating scales or diagnostic criteria for sleep disturbances, regardless of whether their insomnia was perceived to be due to worrying or tremor.

That is, rather than attempting to tease out the underlying cause of the symptom (e.g. depression or Parkinson's), it may be more prudent to consider all symptoms at face value when applying DSM IV-TR or 5 Depression criteria. Such an inclusive approach will ensure that depression is not missed or under-diagnosed in patients with Parkinson's Disease.

Other psychiatric conditions that could be considered

Parkinson's Disease is primarily a movement disorder characterised by rest tremor, bradykinesia, rigidity and postural instability. However, the high prevalence of psychiatric complications suggests that it is more accurately conceptualised as a neuropsychiatric disease (Ferreri, Agbokou Gauthier, 2006). Neuropsychiatric disturbances include not only depression, apathy and cognitive impairment but also psychosis, anxiety, sleep and weight disturbances, fatigue, addictions and affective lability. These may result from complex interactions between the progressive pathological changes of the disease, emotional reactions and treatment side effects. Neuropsychiatric complications are estimated to occur in more than 60% of patients with Parkinson's Disease at some time during their illness.

The candidates in this station are expected to enquire about the presence of the some of the more common neuro-psychiatric complications.

Psychotic phenomena

These can be mild and relatively benign or complex and disturbing. The milder form includes illusions, 'passage' and 'sense of presence' phenomena or stereotyped visual hallucinations of human figures or animals. Patients often have insight into the hallucinations and do not find these 'benign hallucinations' troubling. The more severe psychosis involves vivid hallucinations, elaborated persecutory delusions and little insight. In this station, the patient denies all psychotic phenomena.

Cognitive impairment

Cognitive deficits tend to be of a 'sub-cortical' nature characterised by poor memory retrieval, psychomotor slowing, amotivation and slowed thinking (bradyphrenia). Executive impairment may be more pronounced and language deficits less prominent compared to early Alzheimer's Disease. In this station a Geriatrician has found no cognitive impairment and the candidates are instructed not to examine cognition.

Anxiety

Anxiety symptoms can be more upsetting and disabling than depressive symptoms and occur in up to 40% of patients with Parkinson's Disease. Discrete episodes of anxiety are sometimes related to motor symptom 'off' periods. Disorders include Generalised Anxiety Disorder, Panic Attacks, Obsessive-Compulsive symptoms/ Disorder and Social Phobia.

In this station, the patient has not suffered any specific anxiety disorder but does experience anxiety at the time of medication troughs.

Sleep and Wakefulness disturbances

Disturbances of sleep are common in Parkinson's Disease and include insomnia, hypersomnia, sleep fragmentation, sleep terrors, nightmares and nocturnal movements (restless leg syndrome) and REM Behaviour Disorder. Excessive daytime sleepiness and fatigue are common. The patient in this station reports initial insomnia, broken sleep and drowsiness on awakening.

Impulse control and related disorders

Behaviour addictions including compulsive gambling, buying, sexual behaviour and eating have been reported associated with dopamine agonist medication. Patient may under-report these problems due to ambivalence or embarrassment. The patient in this station does not report any impulse control behaviours.

Involuntary emotional expressions

Pseudobulbar affect with episodes of involuntary crying or laughing can occur in patients with Parkinson's Disease. The expressed emotion may be excessive and incongruent with the patient's underlying mood. This is not reported by the patient in this station.

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:

Personal Circumstances

You are Harold, a 69-year-old man. You have been happily married to Marg for the past 44 years. You have two grown children; Mary aged 40, who is also a schoolteacher, lives interstate and John aged 38 who works as a building inspector lives in a nearby suburb. Both Mary and John are married and both have two children.

You retired 9 years ago from teaching Year 7 at a local public school. You just felt you'd had enough and had adequate superannuation to live comfortably. You did not have any difficulties teaching but just felt it was time to retire.

You have had a full life in retirement. You used to play golf twice weekly and volunteer at the local Meals on Wheels kitchen three times a week. In retirement, you and Marg have gone on caravan holidays for up to a month, two to three times each year. You used to take a keen interest in rugby league (Brisbane Broncos' supporter), gardening and current affairs, through newspaper reading and viewing ABC television. Your daughter Mary phones Marg all the time and they talk for hours. Your son phones every week and visits **'when he can'**. You do not belong to any clubs or go out socially on a regular basis.

Past Medical History

You have always been fit and healthy. You have never had any medical illness or allergies. You did not take any medication until the diagnosis of Parkinson's Disease. You don't like to take tablets, but do take the Parkinson's medication **'to keep Marg happy'**.

Specifically, you do not have high blood pressure, diabetes, heart trouble, or arthritis. You have never had an operation or hospital admission.

There are no illnesses that run in your family. Your mother died at age 89 years of **'old age'** and your father died of stomach cancer at age 81 years.

No one in your family has ever suffered Parkinson's Disease, dementia or any psychiatric condition.

You have never smoked cigarettes. You don't like the effects of alcohol and have never been intoxicated. The last drink you had was at New Year's Eve and then only to keep company with the others. You have never used any illicit drugs.

Parkinson's Disease

You first noticed a shake of your right hand when drinking tea about a year ago. This gradually worsened but you thought nothing of it. Marg told your GP about the shake last year and he sent you to see an 'old age doctor' who diagnosed Parkinson's Disease. Your GP has prescribed a medication called Sinemet that you take three times a day. At first, you felt a bit of nausea, but that settled in a few weeks. Sinemet worked well to decrease the shake so that it is now barely noticeable. You feel **'right as rain now'**.

On reflection, you may have had some stiffness and stumbles when walking, and some trouble arising from a chair, but these symptoms have improved on the tablets.

If the candidate specifically asks, you have noticed the following:

- Small handwriting (**'But that's better now'**)
- Trouble sleeping (trouble getting off to sleep, waking through the night, feeling groggy first thing in the morning - see below)
- Soft voice (**'Marg kept asking me to stop mumbling, but not recently'**)
- Change in your facial expression (**'Marg used to say I looked sad, but I didn't feel sad'**)
- Constipation (see below: **'I thought it was the Parkinson's or the tablets'**)

If asked any other physical symptoms (faints, falls, dizziness, stooping posture, loss of smell) either answer in the negative or say **'I don't think so'**.

You were never worried about the shake or about the diagnosis of Parkinson's Disease because you know it can be treated. You don't recall being particularly upset with having to take these tablets. You have friends who have Parkinson's and they seem all right to you. You don't think the diagnosis has had any impact on you at all. Say **'It's no problem to me'**.

If the candidate asks about your leisure activities, reluctantly admit that you don't go to golf much any longer. To further specific enquires, admit you stopped helping out at Meals on Wheels and you rarely leave the house these days.

Now that you are on medication, you feel your movements are **'back to normal'** and say, **'I don't know what the fuss is all about'**. You think Marg worries too much, but you have gone to the doctors to put her mind at ease.

PSYCHOLOGICAL SYMPTOMS – responses to be provided only on direct questioning

Depression

You do not think you are depressed, and do not feel sad, downcast or tearful. You have never wondered if life is worth living. The thought of suicide or self-harm has never entered your mind. (If asked, you do not have any weapons). You look forward to a long and peaceful life with Marg. If asked, you do not feel hopeless or negative about anything. You feel 'OK' about the future, but say this with little conviction.

If asked, you don't go out as often as you used to do. You have only played golf **'about once a month this year'** and stopped going to Meals on Wheels about eight months ago **'because I was embarrassed about that shake in my hands'**.

Interest: You admit that you may have lost interest in the footie, garden and reading the newspaper. You still watch ABC television but often forget what you've just watched. You aren't sure why your interest has waned, but you just say:

'I can't be bothered with all that anymore.'

You have noticed that when the grandchildren visit, you feel irritated by their noise and questions and say:

'I do love them but I can hardly wait for them to leave.'

Motivation: You spend most days just sitting in the living room, listening to talkback radio. You don't really feel like doing anything anymore. When Marg suggests outings or activities, you put her off by saying:

'I don't feel like doing that today, maybe tomorrow.'

Memory: You have not noticed any problems with your memory or thinking ability. You could say any or all of the following:

'I can still do cross word puzzles, when I feel like it.' (but admit you haven't done one this year)

'I can remember the names of most of the kids I taught years ago.'

'I've got Parkinson's not Alzheimer's.'

If the candidate asks or starts to test your memory or any other mental abilities (drawing, making hand movements, naming animals in sixty seconds), say:

'I did that with that old age doctor. He said my memory's fine.'

If the candidate asks or starts to examine you physically, similarly say:

'My GP and the other doctor have done all that.'

Concentration: You're not sure how to judge that, but maybe it's 'not so good'.

'My mind does wander a bit like when I'm watching television.'

'I don't read books anymore. Don't know why. Just lost interest, I guess.'

The candidate may ask questions about the physical effects of depression.

Sleep: You have trouble getting off to sleep and awaken several times during the night. **'Marg says I thrash about in the bed at night.'**

Appetite: You don't look forward to meals, saying: **'Food's lost its taste, maybe that's Parkinson's?'**

Weight loss: You may have lost weight in the past year **'now you mention it, my pants do seem a bit loose.'**

Constipation: You have noticed that, but **'I thought it was the Parkinson's or the tablets.'**

Energy: You do get tired easily **'I only spend ten minutes in the garden before I want to go inside and lie down.'**

Anxiety

- Just before taking your Parkinson's medication you do feel '**a bit edgy**' but this settles thirty minutes after taking the noon and night tablets.
- In general, you do not worry about things.
- You have never been a nervous, highly-strung or worrying person.
- You do not have any particular fears or phobia and have never had a panic attack.

Psychosis

- You do not hear voices, have visions, experienced illusions or suffer from any other form of hallucinations.
- You do not feel paranoid, watched, spied upon or under surveillance.
- You do not feel that things have a special meaning for you, that media reports refer to you (TV talking about you), or that other can read or influence your thoughts or feelings.

Sleep & Wakefulness

As noted above: You have trouble getting off to sleep and awaken several times during the night.

'Marg says I thrash about in the bed at night.'

You do awaken feeling a bit groggy and sometimes have an afternoon nap of half an hour.

However, you do not feel particularly drowsy during the day or fall asleep without warning.

You do not experience nightmares, sleep walking or strange behaviours in your sleep.

You do not have restless legs or stop breathing during the night (sleep apnoea).

Impulse Control

You do not suffer compulsive gambling, buying, eating or sexual behaviour.

Emotional Expression

You have never experienced episodes of uncontrolled crying or laughing.

4.2 How to play the role:

Your clothing is casual leisurewear with little attention to cleanliness or matching. You are generally unconcerned about your condition and slightly resistant to questioning. You offer only sparse spontaneous conversation of your own, and only answer questions with brief responses.

Your mood is best described as 'flat' with little emotional reaction, either positive or negative; and you are self-contained, showing minimal interest in what the candidate is asking.

You have come along to please Marg, your wife, and can barely wait to end the interview.

4.3 Opening statement:

'I'm not sure why Marg wanted me to see you. Everything is going ok with me.'

4.4 What to expect from the candidate:

The candidate should clarify your personal circumstances and then enquire about the diagnosis of Parkinson's Disease and its impact on you.

The candidate may ask you questions about your general health (medications, other illnesses) before focussing on psychological symptoms. They may ask a range of questions about depression including your energy, concentration, interest, appetite, sleep, activities, etc. They should also enquire about anxiety, memory, psychotic symptoms (hallucinations, delusions, disordered thoughts).

4.5 Responses you MUST make:

'Don't know why, but I just can't be bothered anymore.'

'Have I answered all your questions? Can I go home now?'

4.6 Responses you MIGHT make:

'You sure ask a lot of questions.'

STATION 5 – MARKING DOMAINS

The Main Assessment Aims are:

- To assess the ability to explore the medical condition of Parkinson's Disease and identify associated psychological and psychiatric symptoms.
- To evaluate ability to explore a range of psychiatric complications of Parkinson's Disease.
- To assess competence in interpreting depressive and apathy symptoms.
- To evaluate ability to generate and present a broad differential diagnostic statement.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take a focussed history of the symptoms, diagnosis and impact of Parkinson's Disease? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication.

Achieves the Standard by:

obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; using a tailored biopsychosocial approach; eliciting longitudinal history of Parkinson symptoms (onset and how symptoms developed over time) and current symptoms; clarifying how diagnosis was made, patient's attitude to illness, medication and side effects; checking for medical illnesses (past and current); exploring the concerns of patient's wife; clarifying important positive and negative features; assessing for typical and atypical features.

To achieve the standard (**scores 3**) the candidate **MUST:**

- Clarify the impact of Parkinson's disease on the patient's functioning (physical, psychological and social).

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; 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 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

1.2 Did the candidate take a history of other psychological, cognitive and psychiatric symptoms found in patients with Parkinson Disease? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication including ability to explore at least five (5) psychological, cognitive and psychiatric symptom complexes.

Achieves the Standard by:

obtaining a history relevant to the patient's problems and presentation; integrating key sociocultural issues relevant to the assessment; considering risks associated with the presentation; demonstrating the ability to prioritise and elicit key issues related to the psychological, cognitive and psychiatric symptoms of Parkinson's Disease.

To achieve the standard (**scores 3**) the candidate **MUST:**

- Explore at least three of the psychological, cognitive and psychiatric symptom complexes.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; 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; no psychiatric complications of Parkinson's Disease other than depression/apathy are explored; other significant deficiencies in the history taking.

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 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

1.2 Did the candidate take an appropriately focussed history of depressive spectrum and apathy symptoms? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard and attempts to differentiate apathy from depressive symptoms, particularly anhedonia; demonstrates prioritisation and sophistication.

Achieves the Standard by:

conducting a detailed but targeted assessment; including brief assessment of recent stresses, family context, past/family psychiatric history, medication and general medical history; history taking is hypothesis-driven; assessing for important positive and negative features; checking for typical and atypical features.

To achieve the standard (**scores 3**) the candidate **MUST**:

- Ask about both psychological and biological symptoms of depression.
- Explore the phenomenon of apathy.

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

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) or (b) 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 enquire about suicide; 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 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.9 Did the candidate explain the relevant diagnosis and differential diagnoses to the patient? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard and attempts to differentiate apathy from depressive symptoms; presents more than four diagnostic possibilities with well-reasoned explanations; identifies any limitations of the diagnoses prioritised.

Achieves the Standard by:

integrating available information in order to formulate a diagnosis/differential diagnoses; presenting the patient with a broad range of possible diagnoses or explanations for his symptoms; adequately prioritising possible diagnoses relevant to the obtained history and findings; utilising a biopsychosocial approach; communicating in an appropriate language and detail; checking the patient's understanding.

To achieve the standard (**scores 3**) the candidate **MUST**:

- Explain at least one depressive disorder as a possible differential diagnosis.
- Offer at least two other diagnoses of non-depressive illnesses.

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

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) or (b) 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:

inaccurate diagnostic formulation; does not provide any diagnostic possibilities or provides only names of conditions without any explanation of the reasoning behind this; errors or omissions are significant and do materially affect conclusions.

1.9 Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

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
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