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Patient management problems: 'the vignettes'

In spring 2003, the format of the Patient Management Problems (PMP) part of the MRCPsych Part 2 will change. At present, examiners bring their 'vignettes' to the examination. The Examinations committee believes that the examination should be more structured, and that there should be a 'bank' of vignettes. The working group, which I chair, was set up to make recommendations about the best way forward.

The following points have been agreed:

- The examination will last 30 minutes.
- Each candidate will be given three vignettes, each of which will be discussed for 10 minutes.
- Not only will the vignette be read out to the candidates but they will also be given a written copy of it.
- For each vignette, the examiners will have three 'probes' which they should use to promote further discussion. For the examiners there will also be a list of five areas which will be relevant to the vignette, but will not necessarily be all-inclusive.
- The same vignettes will be given to all candidates who are being examined at the same time. Thus at, say, 10 a.m. on 5 May 2003, the vignette read out to a candidate in London will be the same as the vignette read out to a candidate in Glasgow.
- On the assumption that seven candidates will be examined each day, and that the examination lasts three days, $3 \times 7 \times 3 = 63$ different vignettes will be required for each sitting.

The PMP working group is now building up a bank of vignettes. This is how we are going about it.

1. Over the past year, examiners have been encouraged to submit their own vignettes to the working group. We now have over 1000.
2. Each vignette is read by myself and two other members of the working group. A vignette is graded 'probable', 'possible' or 'reject'. The ones that are rejected are usually either too vague or too specialised.
3. Vignettes that are graded 'probable' or 'possible' by all three group members are considered further.
4. Batches of 10 vignettes are then given to one group member, usually a psychiatrist with a special interest in the subject matter (e.g. general psychiatry, psychotherapy, etc.) He/she works on the vignette. Necessary improvements are made to the vignette itself, the probes and the range of the answers that might be given.
5. The vignettes are then read again by two different group members, working together, and further amendments made.
6. This version is then read by myself for final 'tweaking'.

This is a laborious process but we hope that the final version of each vignette will be fair but searching.

Below are 12 vignettes with probes and suggested areas that might be covered. There are six in general psychiatry and one each in old age psychiatry, forensic psychiatry, child and adolescent psychiatry, substance misuse psychiatry, learning disabilities and psychotherapy. The vignettes can also be found on the College website: www.rcpsych.ac.uk/traindev/exams/regulation/pmp.

Comments on them would be most welcome and should be sent to me at the College.

General psychiatry/child psychiatry

Vignette number: GAP02
10 October 2001

The accident and emergency department has asked you, as the duty psychiatrist, to assess a 32-year-old woman, who has presented in a dishevelled state and is behaving oddly. She is clutching an infant who appears to have a number of bruises.

How would you assess and manage this situation?

Suggested probes

(a) How would you tackle any risk to the child?
(b) Who else would you involve?
(c) What impact might the mother's clinical state have on the child?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Child protection issues – including issues around confidentiality and disclosure.
(b) Child protection procedures, involving social services and paediatrics.

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(c) Some knowledge of the nature and injuries in physical abuse.

(d) Likely diagnoses and management plans for the mother.

(e) The mother's ability to care for the child, including the impact of clinical features/diagnosis on the child.

General psychiatry

Vignette number: GAP014
10 October 2001

A 32-year-old man who got married 6 months ago has developed constant preoccupations about an incident which occurred when he was 16, babysitting a girl of 6. He thinks that he might have interfered with her sexually and caused her permanent psychological damage.

The actual incident consisted of him patting the girl on her bottom. He is now buying magazines, books and newspapers that relate to accounts of child molestation and is so distressed that he has contemplated suicide.

How would you assess and manage this man?

Suggested probes

(a) What psychological interventions might you recommend?
(b) How would you assess the risk of suicide?
(c) Is the timing of this presentation of any significance?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) The candidate will be expected to pay particular attention to the temporal sequence of events. These thoughts have started preoccupying the patient 6 months after marriage. Is there any trigger to their appearance, such as marital problems, sexual problems, etc.?
(b) The candidate should pay particular attention to eliciting the nature of the sexual interference. Was it real, imagined or exaggerated?
(c) The differential diagnosis should cover the possibility of depression, obsessive–compulsive order and psychosis.
(d) The management should address the issue of the underlying disorder and should look at both chemotherapy and psychological interventions.
(e) The candidate needs to assess the suicidality of the patient and also the possible risk to others and organise the management in accordance with the findings.

General psychiatry

Vignette number: GAP018
10 October 2001

A 19-year-old single man in his first year at university is referred for emergency admission by a general practitioner. The patient is perplexed, frightened and expresses ideas of persecution, but is willing to be admitted to hospital. He lives in a student flat.

Outline how you would assess and manage him in hospital for the next 48 hours, and what you would say to his parents who ask you what is wrong with him; they wonder if it might be schizophrenia.

Suggested probes

(a) How are you going to clarify the diagnosis?
(b) Would you prescribe medication?
(c) Would you see the parents on their own and what would you say to them?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) History to include academic performance and assessment from the university and anyone sharing his flat.
(b) Discussion of the physical assessment and drug screen.
(c) Discussion of ward management including pros and cons of withholding neuroleptic medication.
(d) Issues of consent for discussion with his parents.
(e) The only truthful answer to the parents' question is that it is too early to tell. The information should be given sensitively.

General adult psychiatry

Vignette number: GAP022
20 September 2001

In your out-patient clinic, you see a 25-year-old married woman who presents with symptoms of depressed mood and anxiety over a 2-year period. Her marriage is under stress. She discloses to you that she was repeatedly abused by her stepfather between the ages of 8 and 12. She has never told anyone about it and insists it is confidential.

How would you assess and manage her case?

Suggested probes

(a) Are there wider professional responsibilities than to the patient herself?
(b) How would you deal with the possible risk to other children from the alleged perpetrator?
(c) What treatment options will you consider in the short-term?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Disclosure has implications, other than merely those of the patient.
(b) Responsibility to protect children who may be at risk.
(c) Treatment options to include pharmacological and psychological therapies, including marital therapy.

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(d) Advantages and disadvantages of involving the partner.
(e) Risk of 'perpetuating' abuse by prolonged exploration by a male therapist.

General psychiatry

Vignette number: GAP032
10 October 2001

A 52-year-old man has been referred to you in the out-patient clinic by his general practitioner (GP), who is seeking advice with regard to further management. The GP has been advised by renal physicians that the patient should stop lithium carbonate because they believe it has caused renal impairment.

The patient has a long history of manic–depressive illness but has been maintained well on lithium. During his last episode of illness (about 15 years ago) he jumped off a bridge and broke his legs in a suicide attempt, while in a depressive episode.

Please tell me how you would assess and manage this situation.

Suggested probes

(a) What do you believe are the criteria that the renal physicians have used to give this advice?
(b) What factors would you take into account when thinking about his further drug treatment?
(c) Could the patient sue for medical negligence?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Evidence base for causing renal impairment.
(b) He may need an alternative mood stabilising drug.
(c) He could be treated with carbamazepine or sodium valproate.
(d) He will need close monitoring if he stops lithium as he may suffer from a rebound mania. Should the change of medication be on an in-patient basis?
(e) Medico–legal issues around medical negligence.

General psychiatry

Vignette number: GAP034
10 October 2001

You are asked to do a domiciliary visit by a general practitioner (GP). The wife of a 45-year-old man had attended the surgery earlier that day. She was concerned about her own safety. The previous evening her husband was angry and challenging – he accused her of sleeping with a neighbour.

How would you assess and manage this situation?

Suggested probes

(a) Where would you get important additional information?
(b) What factors might be relevant in a risk assessment in this case?
(c) What management options might be necessary?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Necessary to obtain comprehensive background from the wife – and additional information from the GP regarding past history in particular.
(b) The patient may refuse to be interviewed.
(c) Demonstrate awareness of risk/dangerousness to wife and perhaps others – psychodynamics within relationship.
(d) Must discuss and elaborate on factors such as drug and alcohol misuse, formal mental illness/delusional processes/pathological jealousy, cognitive impairment. Allegations may be truthful.
(e) Raise the possible need for involuntary admission and pre-discharge case conference, if necessary.

Learning disabilities

Vignette number: LD01
10 October 2001

A 40-year-old patient with Down's syndrome had been living in a residential home. Staff report a gradual deterioration in self-care and his ability to engage in everyday activities. He has become irritable when interacting with peers. Relatives visit regularly.

How would you go about assessing and managing this patient?

Suggested probes

(a) What investigations might be necessary?
(b) What difficulties might there be in mental state examination?
(c) What environmental factors might be important?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Need for comprehensive history to be taken from carers and family.
(b) Physical examination to rule out concurrent infections.
(c) Demonstrate awareness of affective/psychotic/organic aetiology including epilepsy, hypothyroidism and dementia in this group of patients.
(d) Highlight difficulty in mental state examination, presentation of illnesses and relevance of environmental factors.
(e) Need to convene case conference and consider management of underlying cause of deterioration.

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Old age psychiatry

Vignette number: OAP014
10 October 2001

You are asked to visit a 70-year-old lady at her home. Her husband died 6 months ago and she now lives alone. She has grown-up children, with whom she keeps in touch but who live in different parts of the country. She has been losing weight, neglecting herself and not doing the housework. Previously, she was a capable and house-proud woman.

Tell us how you would go about assessing and managing this situation.

Suggested probes

(a) What diagnoses might you consider?
(b) What are the risk factors in this case?
(c) What psychological treatments might you consider?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Differential diagnosis – depressive illness, dementia, grief reaction, alcohol or drug misuse, concurrent physical illness or a combination of these.
(b) Risk assessment – ability to care for herself, suicidality, available support.
(c) Need for admission to hospital.
(d) Meaning of loss of husband – precipitant of depression, loss of role as spouse/carer, loss of support reveals pre-existing dementia.
(e) Treatment – use of day care, use of antidepressants in the elderly – consider electroconvulsive therapy, role of psychological treatments.

Psychotherapy

Vignette number: PSYCH03
10 October 2001

You are asked to make a domiciliary visit to a 51-year-old widow whose husband died 3 months ago from cancer.

On two occasions in the past week she has 'come to' some distance from her home and she does not remember what has happened. She had similar lapses in memory 10 years ago after her mother's death.

How would you go about an assessment and management of this patient?

Suggested probes

(a) Would you consider further neurological investigations?
(b) What might be some predisposing factors?
(c) How would you assess and manage her bereavement responses?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) The differential diagnosis includes dissociative *v.* organic states.
(b) Discuss further neurological investigations.
(c) Be aware of predisposing factors, e.g. childhood, histrionic personality.
(d) Understand the stages of normal bereavement and what constitutes an abnormal grief reaction.
(e) Understand how to manage an abnormal grief reaction, reflect upon the use of antidepressants or not, benzodiazepines or not.

Substance misuse

Vignette number: SM05
10 October 2001

A 22-year-old woman, 12 weeks pregnant with her first child, has been referred to your clinic for treatment of her drug dependence. She has no previous psychiatric history but has taken drugs for 6 years. Currently, she takes heroin intravenously, temazepam and, occasionally, smokes crack cocaine. She has been with the child's father, who also takes drugs, for 4 years. She says she wants to sort herself out for the sake of the baby.

How would you go about the assessment and management of this case?

Suggested probes

(a) What are the issues with regard to her physical health?
(b) What thoughts would you have about the baby's safety?
(c) What medication is suitable for this patient?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Full assessment for dependence on stated drugs, other drugs and alcohol. Counselling concerning human immunodeficiency virus (HIV), hepatitis C and B.
(b) Adopt a harm-reduction approach – abstinence may be an unrealistic target.
(c) Stabilisation on methadone and, if indicated, benzodiazepines followed, if possible, by gradual reduction.
(d) Child protection issues. Seek advice from social services. Ensure antenatal care. Awareness of risks to foetus.
(e) Involvement of boyfriend.

Child and adolescent psychiatry

Vignette number: CAP017
10 October 2001

An 8-year-old boy is referred by his general practitioner. His parents complain that he will not do as he is told. He

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is very bright. His school complains that he will not sit still and is always moving about. He cannot stay doing one thing and moves from one task to another. His parents say he has no sense of danger – he has tried to get out of a moving car. He has no friends – no one will play with him because he is too rough and bossy.

Discuss the child's assessment and management.

Suggested probes

(a) What are the key criteria for attention–deficit hyperactivity disorder (ADHD)?
(b) Who would you involve in behaviour management?
(c) What other problems/disorders would you look for?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Must mention ADHD/hyperactivity disorder (overactivity, short attention span and impulsivity).
(b) Features are seen in 2 out of 3 situations (home, school, interview).
(c) Know role of medication, e.g. stimulants, e.g. methylphenidate – dosage, investigations and common side-effects.
(d) Involve family and school and the educational psychologist – behaviour management.
(e) Impact of comorbidity, especially conduct disorder, anxiety, developmental disorders, e.g. Asperger syndrome.

Forensic psychiatry

Vignette number: FOR013
10 October 2001

You are asked to write a court report on a 55-year-old man charged with indecent exposure. He has no previous convictions for this.

How would you approach the consultation and what psychiatric diagnosis would you have in mind?

Suggested probes

(a) Are there any clinical features which would increase your level of concern?
(b) What advice are you going to give the court with regard to the risk of re-offending?
(c) What information would you require to complete your report?

The following areas are relevant to this vignette but are not necessarily all-inclusive. This list is *not* exhaustive.

(a) Need to gather information from a range of legal and medical sources prior to completing the assessment.
(b) Be aware of the particular implications of a man in this age group presenting for the first time.
(c) Possible psychiatric diagnoses include organic brain syndrome, e.g. frontal lobe dementia, hypomania, depression and substance abuse.
(d) Possible association of indecent exposure with other more serious sexual offending (e.g. if penis is erect during exposure, if there is escalating behaviour).
(e) The low actuarial risk of an individual re-offending (low risk of re-offending if no previous offences of this nature).

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