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1. Descriptive summary of station:

In this station the candidate is expected to assess Gloria Fernandes, a 52-year-old woman who presented to hospital following an overdose on 10 tablets of temazepam, as she thought it was better to be dead than to face the shame of her husband's extramarital relationship with a television news reader. This belief is actually a manifestation of her delusional disorder. The candidate has to interview Gloria where she will reveal that she has a plan to hurt the newsreader in order to save her marriage. They then have to present the actions they need to take in response to this risk.

1.1 The main assessment aims are to:

- Evaluate the candidate's ability to assess delusional disorder.
- Evaluate the candidate's ability to present an accurate mental state examination.
- Evaluate the candidate's approach to assessment and investigation of the first presentation of psychosis (in this age group).
- Display knowledge of the Tarasoff case and the limits of confidentiality.
- Display knowledge of the duty to warn the potential victim in addition to informing the authorities.
- Evaluate the candidate's ability to assess dangerousness.

1.2 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator, Scholar, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Mental State Examination, Assessment – Investigations, Selection; Diagnosis; Management – Initial Plan), Communicator (Patient Communication – Data Gathering Process), Scholar (Participation in Learning & Feedback), Professional (Ethical Practice)

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1.3 Station requirements:

- Standard room with suitable IT equipment and internet connection for all participants.
- Accessibility to Zoom for all participants (examiners x 2, role player x 1, candidate x 1, observer x 1).
- A set of 'Instructions to Candidate'
- Role player: female in her 50s, looks tired, a little dishevelled.
- Pen for candidate.

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 Consultant Psychiatrist in a large general hospital. You have been called to the Emergency Department to assess Gloria Fernandes, a 52-year-old woman who has been assessed by your registrar after she presented to the hospital following an overdose on 10 temazepam tablets.

Gloria has been medically cleared. Your registrar has assessed her as having an adjustment disorder (with impaired sleep and anxiety for the past three months). He performed a MoCA (Montreal Cognitive Assessment) which was normal. He does not believe that she requires admission.

Your registrar is having difficulty formulating a management plan in relation to her difficulties with her husband and asks that you assess her.

Your tasks are to:

1. Interview Gloria to get a better understanding of the concerns that resulted in her overdose.
2. Present your findings of her mental state examination **to the examiners**.
3. Present the differential diagnoses **to the examiners**.
4. Based on your differential diagnoses, justify which investigations you would request.
5. Outline how you will manage the immediate and longer-term risks that arise from this situation **to the examiners**.

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.

When the candidate enters the station briefly check photo ID.

The role player opens with the following statement:

'I'm sorry I did this doctor – I would rather die than live without Gary.'

3.2 Background information for examiners

In this station the candidate is expected to:

- Evaluate the candidate's ability to assess delusional disorder.
- Evaluate the candidate's ability to present an accurate mental state examination.
- Evaluate the candidate's approach to assessment and investigation of the first presentation of psychosis (in this age group).
- Display knowledge of the Tarasoff case and the limits of confidentiality
- Display knowledge of the duty to warn the potential victim in addition to informing the authorities.
- Evaluate the candidate's ability to assess dangerousness.

In order to 'Achieve' this station, the candidate should be able to:

- Verify the delusional nature of Gloria's beliefs.
- Consider the likelihood of a delusional disorder.
- Take steps to ensure the safety of the newsreader.

A surpassing candidate should be able to:

- Provide a detailed list of well justified investigation.
- Present a well organised mental state examination.
- Explain the Tarasoff case and its limitations in relation to the current scenario.

Delusional disorder is an uncommon psychiatric disorder with an estimated lifetime risk of 0.05-1%.

The diagnosis of a delusional disorder occurs when a person has one or more non-bizarre (situations that can take place in real life, although not real but are possible) delusional thought for one month or more, that has no explanation by another physiological, substance-induced, medical condition or any other mental health condition. An individual's cultural beliefs merit consideration before coming to the diagnosis. Cultural beliefs also impact the content of delusions.

Delusional disorder is relatively rare, has a later age of onset as compared to schizophrenia and does not show a gender predominance. The exact cause of delusional disorder is unknown. Many biological conditions like substance use, medical conditions, and neurological conditions can cause delusions. Delusional disorder involves the limbic system and basal ganglia in those with intact cortical functioning.

Hypersensitive persons and ego defense mechanisms like reaction formation, projection and denial are some psychodynamic theories for delusional disorder. Social isolation, envy, distrust, suspicion, and low self-esteem are some of the factors which, when becoming intolerable, lead to a person seeking an explanation and thus form a delusion as a solution. Immigrants with a language barrier, deaf and visually impaired persons, as well as the elderly, are special populations who are more vulnerable to delusions.

DSM-5 diagnostic criteria for delusional disorder

- A. The presence of one (or more) delusions with a duration of one month or longer.
- B. Criterion A for schizophrenia has never been met.

Note: Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).

- C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behaviour is not obviously bizarre or odd.
- D. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
- E. The disturbance is not attributable to the physiological effects of a substance or another medical condition, and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

Subtypes

The subtypes of delusional disorder are categorised by central themes of the delusions observed in patients meeting criteria for delusional disorder. Many case reports and papers characterise their distinctness, as well as their connection to this group. Each subtype can be primary (an idiopathic disorder that meets diagnostic criteria) or secondary (arising from specific causes, such as general medical illness). The delusional themes and common consequences are described below. In each case, the central belief should be thoroughly reviewed and found to be false.

Erotomanic type — The patient believes that another person is secretly in love with them. That person may be famous or have some kind of higher status, usually not part of the patient's social circle, and not likely to be attainable. Affected individuals may attempt to communicate with the object of their affection and attempt to meet them in person. Such effort can lead to stalking in some cases, with some risk for assaultive behaviour. Expressions of love may be intense, and rejections by the loved person interpreted oddly as affirmations of love to deflect suspicions or jealousy from the loved person's spouse. Other names include De Clerambault syndrome, erotomania, and *psychose passionelle*.

Grandiose type — The patient believes they have special prominence or talent, unusual fame, or major achievements. Features of the patient's thinking may suggest the grandiosity associated with mania, but in the delusional disorder, the mood disturbance and behaviours characteristic of mania are not present.

Jealous type — The delusional theme is the patient believes that a spouse or lover is unfaithful and finds 'evidence' to support the delusion, accuses the spouse, and relentlessly tries to substantiate the offense. The delusion of jealousy can lead to aggressive, threatening, and possibly violent behaviour, including homicide and suicide. In some cases, delusional jealousy and its disruptive impact may only improve through separation from the suspected unfaithful partner. Other names include pathologic or morbid jealousy, Othello syndrome, and conjugal paranoia.

Persecutory type — The patient is typically preoccupied by a delusion that they are being persecuted, conspired against, or potentially harmed. Their resulting actions are generally consistent with these concerns; they are well-planned, executed, and carried out with emotional fervour and determined effort. These individuals may resort to the courts and even to violence to right the wrongs directed at them.

Somatic type — The patient believes that something awful is wrong with their body. There are several forms: that one is ill with undiagnosed disease; that one is infested with parasites or insects (delusional parasitosis); or that parts of the body are misshapen, ugly, or emanate a foul odour. Individuals generally go from one doctor to another, specialist to specialist, usually disappointed by the failure to detect and diagnose the medical problem that haunts them. Suicide may be a risk, thought to be due to frustration and lack of effective clinical intervention. Other names include hypochondriacal delusion and monosymptomatic hypochondriasis.

Mixed type — No one delusional theme predominates.

Unspecified type — The dominant delusional belief cannot be clearly determined or is not described by the subtypes above.

Differential Diagnosis

1. Obsessive-compulsive disorder: A person who remains convinced that his/her obsessions and compulsions are true convictions, should be given the diagnosis of obsessive-compulsive disorder with absent insight.
2. Schizophreniform and schizophrenia: Can be differentiated from delusional disorder by the presence of other symptoms of the active phase of schizophrenia.
3. Delirium/major neurocognitive disorder: Can mimic delusional disorder but distinguished based on the chronology of symptoms.
4. Depression or bipolar disorder: Delusions occur with mood episodes. A delusional disorder is diagnosed only when the span of delusions exceeds the total duration of mood symptoms.

5. Schizotypal or schizoid personality disorder.
6. Psychosis secondary to substance use.

Investigations

In this case, the assessment should be that of a middle-aged person with first episode psychosis. Thus, as per the RANZCP guidelines, in addition to the history and mental state examination investigations should include:

- Physical examination including neurological examination
- Full blood count and ESR
- Electrolytes, liver function tests
- Fasting glucose, cholesterol, triglycerides
- Thyroid function tests
- Hepatitis screen (with tests for other blood-borne diseases, for example, HIV if indicated), Anti-NMDAR (*N*-methyl-d-aspartate receptor), Anti-VGKC (anti-voltage-gated potassium channel), Anti-GAD (glutamic acid decarboxylase) antibodies
- Urine drug screening
- ECG
- EEG (if indicated)
- MRI scan of the brain
- Psychometric testing (if possible)
- Screening for sexually transmitted diseases (if indicated).

The Royal Australian and New Zealand College of Psychiatrists Code of Ethics - Confidentiality

Psychiatrists shall maintain the privacy and confidentiality of patients and their families:

1. Psychiatrists shall instil confidence in patients that whatever information they reveal will not be used improperly or shared.
2. Information about a patient obtained from other sources shall be shared with the patient by the psychiatrist unless it is judged that harm may result from sharing such information. Psychiatrists shall also acknowledge and manage the conflict that may prevail between serving the best interests of the patient and respecting the confidentiality of the source.
3. Psychiatrists shall be aware of and manage potential conflicts of interest when treating separate patients who have a close personal relationship with each other.
4. A breach of confidentiality may be justified where there are public interest considerations, in order to protect the safety of the patient or of other people.
5. Psychiatrists may need to share clinical information with colleagues and should take into account patient preferences of what can be shared.
6. If required to disclose clinical information, such as by subpoena, psychiatrists shall limit such disclosure to what is necessary.
7. Safeguarding confidentiality applies even if the psychiatrist–patient relationship has ceased or the patient has died, except in specific circumstances, such as a relative’s need to ascertain a hereditary risk or when required by law.
8. Psychiatrists shall maintain confidentiality when using clinical information about their patients for teaching or publishing; the information should be disguised so that the patient is not identifiable.
9. Psychiatrists shall respect a patient’s right to privacy. In the case of teaching, valid consent shall be obtained from patients and/or their families who are involved. Patients shall be informed that refusal to participate or a request to withdraw will not jeopardise their treatment in any way.

Australian Medical Association's Code of Ethics that deals with confidentiality states:

Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research or where there are overwhelming societal issues.

This may justify a doctor breaching confidentiality in the 'public interest' in order to protect third parties (such as warning the sexual or needle-sharing partner of an HIV positive patient), but does not impose an obligation to warn them. The Code of Ethics does not have the same legal validity as a statute or common law, but it is an indication of accepted medical practice that would provide some defence to a doctor who breached confidentiality in good faith to avoid harm to a third party.

However, the law is unclear in this area; it may equally be found that a doctor is liable for having made an unauthorised disclosure to a third party.

Tarasoff case

Tatiana Tarasoff was murdered by Prosenjit Poddar in 1969. Poddar had described his plan to murder Tarasoff to his psychologist.

Legal principle: When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.

The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case.

Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

The duty to warn was established in the Californian court in 1976 in the case of Tarasoff vs Regents of The University of California. This landmark case determined that a mental health care provider had a duty to warn authorities or a potential victim if a patient poses a threat to a third person. This responsibility overrides or outweighs the patient's right to confidentiality and privilege. In the Tarasoff case the court deemed that it was necessary for the (in this case) psychologist to warn the potential victim of the danger. It was not sufficient to notify the police. In this case the psychologist notified the police who detained the patient initially. They were unable to keep him as a crime had not been committed. He committed the murder after having been released from custody.

In New Zealand tort law, there is no general obligation to warn a potential victim. The Tarasoff ruling has not been tested in court in Australia or New Zealand. However, the duty to warn is accepted in Australia.

Assessment of dangerousness in clinical practice is a complex and difficult matter. There is a deficit of data to guide confidence. Factors associated with dangerousness include past dangerousness, antisocial personality, access to weapons. The NIMH study showed lifetime violence among people with serious mental illness was 16% compared with 7% in people who were not ill. The incidence went to 43% with comorbid substance abuse. The Macarthur Violence risk study followed 851 discharged patients prospectively, and found that patients who did not abuse substances were not more likely to commit an act of violence.

Psychotic symptoms including persecutory delusions, command auditory hallucinations and systematised delusions are associated with increased risk. Patients who respond to psychotic symptoms with anger, agitation, and excitement, or labile mood are at an increased risk for aggression.

Attempts to develop tools, such as the Violence Risk Appraisal Guide (VRAG), have not been successful enough to replace clinical assessment.

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.

Domain Not Addressed – the candidate demonstrates significant defects in all 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 Gloria Fernandes, a 52-year-old woman who lives in a home not far from the hospital. You live with Gary, your 44-year-old husband, who you describe as 'the most handsome, smartest, charming man' that anyone could ever meet.

You have been married for six years and neither of you have any children.

Reason for coming to hospital:

You called for the ambulance yesterday evening as you had changed your mind about wanting to die. About half an hour before that, you took 10 tablets of Temazepam with the intention of 'going to sleep forever'. These tablets had been prescribed to you by your family doctor (General Practitioner), Dr Webster, last week as you had gone to him to tell him that you were having difficulty sleeping. He did not ask you a lot of questions and gave you a prescription for these pills.

You had not been thinking of killing yourself, but got fed up with the way things were and took the pills impulsively. Very shortly after that, you realised that your life could be in danger and so called for help.

A very nice young doctor spoke to you after you were brought into hospital and did some blood tests. You have been told that all your results are normal. You were very sad and told the doctor how much you were hurting inside because of Gary's behaviour, and he suggested that you talk to a psychiatrist for some help.

Gary and you:

You met Gary seven years ago. He is a landscaper, and you met him when he was working in the units where you lived previously. Until then you had never really been in love. He was so kind and handsome, and caring that you found yourself attracted to him immediately. You had always found it difficult to trust men and this time felt different. If only you had not been so foolish!

You were married six months after you met. There were times when you had doubts and wondered if he was making a fool of you, but you convinced yourself that you were being silly and suspicious. He had after all promised to love you and care for you 'till death do you part'.

Gary and Angela:

Things changed around nine months ago when you discovered that Gary was in a relationship with Angela. You feel stupid now about how blind you had been, 'that is what love does to a woman'. But now you know, it's so obvious. The fact that he wants to see her every day, that he bought a new perfume when you went shopping two weeks ago, that he wears the same shirt to work every Thursday are evidence that he has been taken in by her charms. She is trying to steal him from you, and you will not let this happen.

If specifically asked:

Angela is the newsreader on the 6 o'clock news. Gary comes home from work and watches the news every day. Angela has replaced the previous news reader – prior to this she was a field reporter, but you never paid much attention till you realised how she was trying to take your husband away from you. There is no other possible explanation for Gary's behaviour. It is just so obvious.

You were struggling with this and felt sad and tearful, and were sleeping poorly and consulted your GP. You did not say anything about Angela to your GP or the nice young doctor that you saw last night, you only said that you were having trouble with your marriage.

However, you now know what to do. Angela is the cause of your trouble and so you must get rid of her. You do not know how, but you are sure there are ways this can be managed. You would not hurt her yourself, but have heard that people can be hired to do this for you. You waited outside the TV station and then followed her home a few days ago, so you know where she lives now.

If specifically asked:

You have never seen Gary and Angela together – they are discreet in their illicit relationship. But you know they are having an affair, 'A woman can sense these things.', and it is because she lured him away. He is a good man and would never have started this on his own.

If asked for proof, say:

- 'He watches the evening news that she presents and appears transfixed every day.'
- 'He has started wearing a white shirt on Thursdays to give her a sign.'
- 'He bought a new brand of perfume without asking me first, and he would never do that.'
- 'He smiles to himself at times.'
- 'He tells me he loves me more often than he did before, and that is a sign of guilt.'

You have not questioned Gary about his behaviour or told him about your doubts – he is as much a victim as you as he has been trapped by Angela.

If the candidate argues with you when you say any of these things or makes it obvious that they do not believe you, get irritable and say that you are only talking to them because you were told to do so in order to be allowed to go home.

If they appear to be sympathetic, thank them for their support and make them promise they will not tell your secret to anyone.

Other symptoms if asked:

1. You do not hear voices or see things that other do not.
2. No one else is against you.
3. You have not lost weight and are eating well.
4. You are sad about what is happening, but know how to solve your problems.
5. You have not lost interest in doing things and have enough energy.
6. Your sleep has been a little disturbed, but it is not too much of a problem.
7. Your sex drive is unchanged and you do not want Gary to suspect anything, so your sexual relationship is unchanged.
8. You have never been the opposite of depressed – that is, had excess energy, been impulsive or spent too much.
9. You are not feeling suicidal.
10. You do not want to harm Gary.
11. You do not hear voices when there is nobody around or hear a commentary about what is going on.
12. You do not get messages from the TV or Internet or radio or feel as if these things are directed towards you.
13. You do not feel as if people can read your mind or interfere with your thoughts.
14. Your thoughts are your own thoughts.
15. You have been able to do the things you normally do, run the household, plan a holiday for next year.
16. You do not have any problems with your memory, and have not been forgetful or confused.
17. You do not use drugs and never have. You are a social drinker – a couple of times a month. You prefer a nice Shiraz and never get drunk.
18. You do not smoke and do not gamble.
19. You have had no major physical illnesses and have no past mental health problems.
20. As far as you know, no one in your family has had psychiatric problems requiring medication or admission to hospital.
21. You have never had any problems with the police.

Past history:

You grew up in Melbourne. You are the third of four sisters. Your parents are both dead for many years now.

You do not have contact with any of your siblings. They never seemed to like you and you do not trust them. They are all married and live interstate.

You have not had any serious relationships prior to meeting Gary. Men just cannot be trusted. They only want one thing from a woman.

You do not have any close friends. Prior to meeting Gary, you worked full time in a department store and lived in a rented unit by yourself. You have never been very social. Even when you worked full time, you kept to yourself. You continue to work in the same store on a casual basis now, mostly selling cosmetics. You think the other women often gossiped about you. People in general cannot be trusted, they are out to get whatever they can from you.

4.2 How to play the role:

You are polite and easy to engage. You are keen to tell the doctor how much you love your husband.

You will look tired and dishevelled as you have just spent the night in the Emergency Department of the hospital. You know where you are 'in the Hospital', the day, date and time. If the doctor attempts to test your memory, refuse politely saying the nice young doctor did that a short while ago and said it was fine.

4.3 Opening statement:

'I'm sorry I did this doctor – I would rather die than live without Gary.'

4.4 What to expect from the candidate:

They will ask you questions about why you are in hospital and about your feelings towards Gary and Angela. They will explore in some details any thoughts you may have of wanting to hurt either of them, and your past friendships.

They will spend the last few minutes telling the examiner what they think your problems are. During this time, just sit still, and do not participate in the conversation.

4.5 Responses you MUST make:

'No woman should have to put up with what I am going through.'

'Things would all be ok if she was no longer here.'

'I went to the TV station last week and followed her home.'

4.6 Responses you MIGHT make:

If the candidate asks about if you have a plan on how you are going to harm Angela.

Scripted Response: There are many ways to do this, but I have not decided exactly what I am going to do.

If the candidate asks about more details of how you are going to harm Angela.

Scripted Response: I don't know you well enough to share that with you.

If the candidate asks whether you have a gun.

Scripted Response: No, I don't at the moment, but I have no record so it wouldn't be too difficult to get one.

4.7 Medication and dosage that you need to remember:

Temazepam 10 mg at night if you have difficulty sleeping.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate the candidate's ability to assess delusional disorder.
- Evaluate the candidate's ability to present an accurate mental state examination.
- Evaluate the candidates' approach to assessment and investigation of the first presentation of psychosis (in this age group).
- Display knowledge of the Tarasoff case and the limits of confidentiality.
- Display knowledge of the duty to warn the potential victim in addition to informing the authorities.
- Evaluate the candidates' ability to assess dangerousness.

Level of Observed Competence:

2.0 COMMUNICATOR

2.2 Did the candidate conduct an adequate assessment of the patient? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

clearly achieves the standard overall with a superior performance in a number of areas; demonstrates competence in overall management of the interview, superior technical competence in eliciting information; details in areas pertaining to risks and delusions.

Achieves the Standard (scores 3 or 4) by:

engaging the patient as well as can be expected; demonstrating flexibility to adapt the interview style to the patient, problem or special needs; prioritising information to be gathered; using an appropriate balance of open and closed questions; summarising; being attuned to patient disclosures, including non-verbal communication; recognising emotional significance of the patient's material and responding empathically; sensitively evaluating quality and accuracy of information; clarifying inconsistent information efficiently; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features.

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):

if the candidate does not meet the above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

if there are significant omissions affecting quality; significant deficiencies such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

Does Not Address the Task of This Domain (scores 0).

2.2. Category: PATIENT COMMUNICATION – Data Gathering Process	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (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"/>

1.0 MEDICAL EXPERT

1.2 Did the candidate proficiently present a mental state examination? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

the mental state examination is relevant to the patient's problems and circumstances; it is presented at a sophisticated level.

Achieves the Standard (scores 3 or 4) by:

demonstrating capacity to present a thorough, organised and accurate mental state examination; assessing key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; deciding on the importance of a cognitive assessment; succinctly presenting with accurate use of phenomenological terms; including appropriate positive and negative findings; including delusions of jealousy and excludes other symptoms of schizophrenia like thought insertion, broadcast and hallucinations.

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):

if the candidate does not meet the above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

if there are significant omissions affecting quality; significant deficiencies in technique, organisation, accuracy and/or presentation.

Does Not Address the Task of This Domain (scores 0).

1.2. Category: ASSESSMENT – Mental State Examination	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (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 describe relevant diagnosis/differential diagnoses? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; considers a range of possibilities with features that would help include and exclude the diagnosis.

Achieves the Standard (scores 3 or 4) by:

demonstrating capacity to integrate available information in order to formulate a diagnosis and differential diagnosis; adequately prioritising conditions relevant to the obtained history and findings, utilising a biopsychosocial approach, and/or identifying relevant predisposing, precipitating perpetuating and protective factors; presenting delusional disorder as the likely diagnosis and considering at least three differential diagnoses – OCD, schizophrenia and related psychoses, depression, personality disorder, substance induced psychotic illness or delirium/dementia.

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):

if the candidate does not meet the above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

if there are significant omissions affecting quality; inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusions.

Does Not Address the Task of This Domain (scores 0).

1.9. Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (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"/>

1.7 Did the candidate make an appropriate choice of investigations? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

sophistically considers the resource impact of choices; identifies any difficulties with access to investigations chosen.

Achieves the Standard (scores 3 or 4) by:

prioritising and selecting the optimal range of investigations; justifying selection of diagnostic procedures and investigations; identifying potential limitations of investigations; demonstrating consideration of cost-benefit reasoning; considering choice in relation to differential diagnoses; including and justifying some of the following investigations – FBC, electrolyte, kidney and liver functions, TSH, BSL, urine drug screen, HIV and syphilis screens, hepatitis panel, Anti-NMDAR, Anti- VGKC, Anti-GAD antibodies, neuroimaging, ECG, EEG, formal cognitive screening and neuropsychological tests.

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):

if the candidate does not meet the above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

if there are significant omissions affecting quality; incorrectly chooses even routine/standard range of investigations; unable to prioritise relevant investigations.

Does Not Address the Task of This Domain (scores 0).

1.7. Category: ASSESSMENT – Investigations, Selection	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (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"/>

1.11 Did the candidate develop and describe a relevant initial and longer-term risk management plan? (Proportionate value – 10 %)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key risks identified; clearly addresses difficulties in the application of the plan.

Achieves the Standard (scores 3 or 4) by:

demonstrating the ability to prioritise and implement evidence-based acute care skills; planning for risk management; prioritising and synthesising information; considering involuntary/inpatient/community modes; recommending medication and other specific treatments in accordance with evidence and guidelines; recognising limitations of medications in delusional disorders; record keeping and communicating to necessary others; recognising their role in effective treatment; identifying potential barriers; referring to the Tarasoff case and the longer term risk to the potential victim.

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):

if the candidate does not meet the above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

if there are significant omissions affecting quality; omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient’s immediate needs or circumstances.

Does Not Address the Task of This Domain (scores 0).

1.11. Category: MANAGEMENT – Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (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"/>

6.0 SCHOLAR

6.5 Did the candidate appropriately seek counsel from peer review, supervision or professional/organisational bodies as relevant? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

clearly articulates gaps in knowledge, generates new questions for review; acknowledges their lack of experience as a consultant; reflects on options like mentoring.

Achieves the Standard (scores 3 or 4) by:

demonstrating the capacity to appreciate the role of, and utilise, peer review and supervision; appreciating the role of, and maintaining, professional standards; undertaking quality assurance and continuing education; ensuring ongoing learning; demonstrating the capacity to appraise performance; considering consultation with their medical defence organisation.

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):

if the candidate does not meet the above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

if there are significant omissions affecting quality; insufficient recognition of importance of learning and/or feedback; does not incorporate professional/organisational standards into supervision.

Does Not Address the Task of This Domain (scores 0).

6.5. Category: PARTICIPATION IN LEARNING & FEEDBACK	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (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"/>

7.0 PROFESSIONAL

7.2 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value – 10%)

Surpasses the Standard (scores 5) if:

comprehensively considers all major aspects of ethical conduct and practice.

Achieves the Standard (scores 3 or 4) by:

demonstrating the capacity to: identify and adhere to professional standards of practice in accordance with College Code of Conduct/Code of Ethics and institutional guidelines; integrate ethical practice into the clinical/non-clinical setting; apply ethical principles to resolve conflicting priorities of confidentiality versus duty to ward the potential victim; utilise ethical decision-making strategies to manage the impact on professional practice/patient care; maintain appropriate personal/interpersonal boundaries; seek peer review in difficult countertransference situations; recognise the importance and limitations of obtaining consent and keeping confidentiality; consider involving the police.

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):

if the candidate does not meet the above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not appear aware of or adhere to accepted medical ethical principles.

Does Not Address the Task of This Domain (scores 0).

7.2. Category: ETHICAL PRACTICE	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (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 level of a junior consultant psychiatrist?

Cross (X) in ONE BOX ONLY	Clearly Proficient <input type="checkbox"/>	Marginal Performance <input type="checkbox"/>	Not Proficient <input type="checkbox"/>
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