Committee for Examinations
Objective Structured Clinical Examination
Station 8
Adelaide September 2017

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is required to assess a 69-year-old woman, Valerie, who presents with a history of panic disorder and long-term benzodiazepine use. They are to then make recommendations for her GP regarding ongoing care.

1.1 The main assessment aims are:

- To evaluate the symptoms of panic attack as the therapeutic necessity for continuation of benzodiazepines.
- To demonstrate knowledge of the evidence base of long-term benzodiazepine use, and alternative treatments in the management of chronic anxiety.
- To weigh the risks and benefits of long-term use of benzodiazepines in this patient.

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

- Demonstrate engagement skills with an anxious patient worried about benzodiazepine cessation following long-term use.
- Explore panic attack symptoms with regards to frequency, duration and precipitating factors.
- Cover a range of adverse effects and misuse of diazepam.
- Conclude that continued use of diazepam is appropriate for this patient, based on the risk-benefit analysis.
- Provide recommendations to the GP rather than providing a prescription for a benzodiazepine.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Anxiety Disorder
- **Area of Practice**: Psychiatry of Older Adults
- **CanMEDS Domains**: Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Data Gathering Content, Management **–** Initial Plan); Communicator (Patient Communication **–** To Patient / Family / Carer)

References:

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- Schweizer E, Rickels K, Weiss S, Zavodnick S. Maintenance drug treatment of panic disorder. I. Results of a prospective, placebo-controlled comparison of alprazolam and imipramine. Arch Gen Psychiatry. 1993; 50(1):51-60.
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1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female, with the appearance of being in her 60s, tidy and conservatively dressed.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in your private clinic rooms.

You have received the following referral letter from a General Practitioner for a woman you have not met before.

02/09/2017

Dear Doctor,

Thank you for seeing Valerie Willmot, a 69-year-old married woman who has a long history of anxiety disorder and has been on diazepam for ages. I think she needs a treatment review especially in view of 'benzodiazepine addiction' and the precautions we are required to take when prescribing this.

Your opinion in this regard will be highly appreciated.

Regards,
Dr. Christopher White
Wertoga Medical Clinic

Your tasks are to:

- Clarify the diagnosis of an anxiety disorder.
- Explore the concerns raised in the General Practitioner's letter.
- Present your findings and treatment recommendations **to the examiner.**

You will receive a time prompt at **six (6) minutes** if you have not commenced addressing the third task.

You **DO NOT** need to take developmental or personality history. No physical examination is required.

Station 8 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' and any other candidate material specific to the station
  - Pens.
  - Water and tissues 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.
- TAKE NOTE of the cue for the scripted prompt you are to give at **six (6) minutes**.
- DO NOT redirect or prompt the candidate unless scripted – 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 **six (6) minutes**, as indicated by the timer, if the candidate has not commenced addressing the third task, provide the following prompt:

  '*Please proceed to address the third task.*'
- 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 the next candidate. (See 'Prior to examination' above.)

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

- You are to state the following:

  'Are you satisfied you have completed the task(s)?
  If so, you <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings.'

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

3.0 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.

The role player opens with the following statement:

'My GP sent me to you. I hope everything is okay.'

There is a prompt at **six (6) minutes** if the candidate has not commenced the third task.

'Please proceed to the third task.'

3.2 Background information for examiners

Detailed Assessment Aims

This station seeks to establish the candidate's skill in clarifying a diagnosis of panic disorder as a clinical indication for benzodiazepine use. Candidates are expected to demonstrate the ability to engage a patient who is worried about ceasing diazepam, the medication that has controlled her anxiety over many years; conduct a brief targeted assessment of panic disorder; and present the evidence-based opinion of the long-term use of benzodiazepines.

The candidate is expected to use deductive reasoning in order to be successful in this station: they must apply their knowledge about various treatments to the patient in front of them; elicit prior treatment effectiveness in this patient; and use an evidence-based approach to arrive at appropriate individual recommendations for the GP.

In order to 'Achieve' this station the candidate **MUST:**

- Demonstrate engagement skills with an anxious patient worried about benzodiazepine cessation following long-term use.
- Explore panic attack symptoms with regards to frequency, duration and precipitating factors.
- Cover a range of adverse effects and misuse of diazepam.
- Conclude that continued use of diazepam is appropriate for this patient, based on the risk-benefit analysis.
- Provide recommendations to the GP rather than providing a prescription for a benzodiazepine.

A surpassing candidate may demonstrate more advanced skills (e.g. exploring patient's concern regarding social stigma of benzodiazepine use; exploring how patient's fear about 'addiction' can be used to explore alternate remedies etc.). They will be able to demonstrate ability to prioritise history taking in a more sophisticated manner, and explore a wide range or relevant treatment options for anxiety disorders. Their assessment and recommendations for the GP will demonstrate awareness of the evidence-base and literature regarding long-term use of benzodiazepines.

Diagnosis

Panic Disorder is common in clinical practice. According to DSM-5 the essential features of Panic Disorder are: persistent fear or concern of inappropriate fear responses with recurrent and unexpected panic attacks. Panic Disorder has physical and cognitive symptoms (although it is important to note that individuals with Panic Disorder can also experience expected / triggered panic attacks).

A panic attack is an abrupt surge of intense fear or discomfort that reaches a peak within minutes, and during which time, 4 or more of the following symptoms occur:

1. Palpitations, 2. Sweating, 3. Trembling, 4. Shortness of breath, 5. Feelings of choking, 6. Chest pain, 7. Nausea, 8. Dizziness, lightheaded, faint, 9. Chills or heat sensations, 10. Numbness or tingling, 11. Experience derealisation or depersonalisation, 12. Fear of going crazy or losing control, 13. Fear of dying.

ICD-10 characterises a panic attack by all of the following:

(a) it is a discrete episode of intense fear or discomfort;

(b) it starts abruptly;

(c) it reaches a crescendo within a few minutes and lasts at least some minutes;

(d) at least four autonomic symptoms (similar to the DSM-5).

Most commonly used exclusion criteria are: not due to a physical disorder, organic mental disorder or other mental disorders such as schizophrenia and related disorders, affective disorders or somatoform disorders (F45).

Differential Diagnosis

Candidates may assess for specific medical co-morbidities like asthma, respiratory disease, and obstructive sleep apnoea. A better candidate may briefly screen for alternative medications (e.g. beta-adrenergic agonist agents like salbutamol) and organic conditions (e.g. hypoglycaemia, myocardial infarction, asthma, hyperthyroidism and pheochromocytoma) that could cause panic attacks.

Treatment options

Historically benzodiazepines have been prescribed for anxiety disorders, including Panic Disorder. While benzodiazepines are powerful anxiolytics that provide significant benefits, their use also poses a range of challenges: various side effects like sedation; memory impairment; psychomotor impairment and falls; potentially dangerous interactions with other CNS suppressing drugs including recreational substances (e.g. alcohol) and potential for misuse and dependence. There is recent but debatable links between benzodiazepines and dementia (Gray et al 2016).

Concerns about dependence and misuse have become widespread but despite these fears that are prevalent among the patients and practitioners alike, an evidence-based appraisal of the literature suggested that primary misuse of benzodiazepines is rare among legitimate users (Rifkin, et al 1989) who take medications as per a therapeutic prescription. While benzodiazepine misuse does exist, it is more common among those who misuse other drugs and procure benzodiazepines from illegal sources. Misuse of benzodiazepines has become a major public health problem that has forced regulatory agencies to restrict the use of these medications.

However, considering the prevalence of anxiety disorders the use of benzodiazepines could be seen to far outweigh their misuse. Although most guidelines suggest restricted short-term use of benzodiazepines, some patients may require long-term use of this group of medications on a favourable risk-benefit ratio (see RANZCP guidelines and other references below).

Benzodiazepines are considered to be relatively safe in overdose and some of the side effects subside with continued use. Interestingly tolerance does not tend to develop to the anti-anxiety effect of benzodiazepines. Studies have shown that most patients who use benzodiazepines for anxiety disorders maintain stable doses without dose escalation, and discontinuation of these medications is possible under therapeutic guidance.

The dependence of benzodiazepine can be difficult to ascertain because it is not easy to disentangle actual withdrawal symptoms (appearance of new symptoms upon drug dose reduction and discontinuation) from rebound symptoms (reappearance of the original symptoms for which drug was given). It is also difficult to define tolerance because some patients may need higher doses in the range for adequate control of anxiety. Nonetheless, Fleischhacker, et al (1986) implied that the rate of dependence among legitimate users of benzodiazepines is rare (1-7%).

To ensure safe and continued prescription of benzodiazepines the candidates should screen for signs of misuse, which include, but are not necessarily limited to:

1. Consumption of more doses than prescribed;
2. Reporting of increasing anxiety symptoms despite prescription of doses that are reasonably thought as sufficient to control anxiety;
3. Frequent changing of GPs and history of doctor shopping;
4. Procurement of medications from multiple and often illegal sources; and
5. Discrepancy between pill count and prescriptions.

The use pattern of diazepam including the dose, frequency and indications should be established. Enquiry about dose escalation is essential. Candidates should consider assessing for a history of concomitant intake of alcohol and other recreational substances / substance misuse, as well as elicit a driving history and impact of medications on driving skills. This is an elderly patient and therefore falls risk and cognitive decline are particularly important to consider in the context of benzodiazepine prescribing.

The candidate is not expected to do a formal cognitive examination; a screening for symptoms of cognitive decline may be considered sufficient.

The first line treatments for this disabling disorder include Cognitive-Behavioural Therapy and Serotonin Specific Inhibitors (SSRI). Other antidepressants (e.g. venlafaxine and tricyclic antidepressants) have also been approved for the long-term treatment of chronic or recurrent anxiety disorders.

Although antidepressants are recommended as the first line treatments there are only a few head to head comparison trials between benzodiazepines and antidepressants. These trials and available data show that benzodiazepines and antidepressants had equal efficacy in alleviating anxiety symptoms, and benzodiazepines were better tolerated (Schweizer, et al 1993).

The patient described in this station has a long history of panic disorder. In considering the possibility of benzodiazepine misuse the candidates must establish a genuine diagnosis of Panic Disorder. All or most of the common symptoms of Panic Disorder must be elicited, without utilising leading questions. In order to arrive at a reasonable treatment option the candidate must obtain the history of previous treatments tried. This particular patient has had a trial of CBT and SSRI without adequate improvement, a scenario that is not uncommon in clinical practice.

The candidates are expected to tailor application of the guidelines to this particular patient who had a trial of a SSRI. At the end of consultation, a reasonable recommendation is continuation of diazepam for time being, while alternate treatments are explored. Previous history of substance misuse is not in itself a contraindication for benzodiazepine use.

General practitioners play a vital role in the management of anxiety disorders. In this instance, as the candidate is seeing a GP referred patient they need to respond to the GP. The candidates are therefore expected to demonstrate the skills of collegial communication. Considering the limitations of the first-time consultation in the assessment of a new patient, the candidates must explicitly say that they will liaise with the GP, and encourage the GP to use his knowledge of the patient, particularly drug seeking behaviour, medication consumption history and doctor shopping, rather than merely agreeing to prescribe a benzodiazepine following a short consultation. The relationship between a psychiatrist and a GP should be demonstrated as supportive and collaborative.

3.3 The Standard Required

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

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

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

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

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

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

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

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

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

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

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

4.0 Instructions to the Role Player

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

You are Valerie Willmot, a 69-year-old married woman happily living with your husband, Mark. You have come to the private psychiatric rooms because your General Practitioner (GP) asked you to see a psychiatrist for an opinion about your medication. You have been taking a medication called DIAZEPAM for many years to keep you well.

You find this appointment to be an intrusion into your wellbeing because you feel fine. You are worried this psychiatrist will interfere with your medication treatment for your anxiety.

About your mental health symptoms:
You have a history of feeling excessively anxious; this anxiety comes in episodes as sudden explosive outbursts. You had these '*very bad attacks*' many times in the past, but currently they are less intense and they occur much less frequently. To you they are reasonably under control and manageable.

History of these anxiety symptoms:
The attacks started in your late 40s. The first attack happened when you were thinking of your new job and you still remember that '*nightmare'*: sudden sweating and rapid breaths with a feeling that you '*couldn't breathe'*. You couldn't breathe deep enough. You had thought you were going to choke, you felt dizzy, your heart started beating fast (called palpitations), you had feelings of tightness in your chest, and you thought you were going to collapse.

At that time, you remember running out for fresh air and frantically looking for help. You felt it was the worst experience a human being could ever have. However, the symptoms just stopped in about an hour. Since then you have always worried about the possibility of the next attack especially when you faced challenging situations. Sometimes they didn't occur, but at other times when you thought of the horrible attack another would develop instantaneously. For the next few months, the attacks occurred almost daily and you had to stop working and going out, because your worst worry was how you would manage if you were out and no help was available.

Your husband was really understanding and encouraged you to seek help. You first saw a psychologist who informed you that you were suffering from panic attacks and taught you several relaxation techniques: deep breathing and muscle relaxation. You applied these techniques when you became anxious and when you felt an attack was about to commence. They helped a little bit to reduce the intensity, but the attacks occurred with the same frequency. The psychologist also did a therapy known as Cognitive-Behavioural Therapy (CBT).

Cognitive behaviour therapy is an effective treatment for a range of mental health issues including anxiety and depression. CBT is a form of 'talking therapy' that aims to assist a person to identify and challenge unhelpful thoughts, and to learn practical self-help strategies to manage them. CBT helps people to better understand links between their thoughts, feelings and behaviours, and how their thinking affects their mood. The learned strategies try to bring about positive changes in the person's quality of life by teaching them to think in a less negative way about life and themselves. It is based on the understanding that thinking negatively is a habit that, like any other habit, can be broken. It includes regular homework and practising a thinking style that does not lead to anxiety. You had been encouraged to take physical symptoms, like sweating, to not necessarily mean that you are having a breathing arrest. You tried your best and the attacks were much less for a while, but only to recur on a later date.

As the agony of intense anxiety continued you saw your GP who made a diagnosis of panic attacks, and he prescribed a medication called SERTRALINE. You recall taking up to 200 milligrams a day. You tried this medication for three months but without satisfactory improvement. After approximately one year of the diagnosis of panic attacks, the doctor then added another medication by name DIAZEPAM with a dose of 5 milligrams twice a day. Diazepam brought prompt relief from anxiety attacks. You became happy that the medication worked and continued both these medications.

Diazepam is a medication that belongs to a group of medications called BENZODIAZEPINES. You heard about 'benzodiazepine addiction' from your friends and TV. After five years of starting DIAZEPAM your GP left the practice that you attended. Your new doctor wanted to cease diazepam and continue sertraline. You just followed your doctor's advice and continued to practise techniques of CBT. He slowly reduced the doses and eventually stopped diazepam. The consequences for you were disastrous. Your anxiety symptoms returned and they were much worse than before. He therefore reinstated diazepam and ceased sertraline nearly 15 years ago. You have been reasonably well ever since then, and your anxiety symptoms are under control with just diazepam. You have been taking DIAZEPAM for approximately 15 years.

You have never gone above the prescribed dose of diazepam, as you were also worried about addiction and being dependent on this medication: you tried to limit its use. When the dose was reduced you did not notice any symptom other than the anxiety. If asked, you did not have any seizures / fits when the dose was lowered. You had no intention to use this medication for other purposes, and have never given it to others even if they complained of feeling anxious. You have not noticed sedation during the day after taking the medication, and you have driven a car as usual without any untoward incidence.

Your general mental health:

Your mental health is otherwise unremarkable. You never suffered depression or strange experiences like paranoia or hearing or seeing things, which were not there. You are not '*mad'*. You never had an episode of confusion or memory impairment and if asked, your husband is not concerned about your memory or orientation. You have never felt suicidal.

Substance use:

You drink one or two glasses of wine during social occasions, and you never thought this was a problem. However, you were a heavy drinker in your youth and at one stage you are ashamed to admit you needed inpatient detoxification in your 20s (for 10 days) to help you stop the excess drinking. You have never smoked or taken recreational drugs.

Your physical health:

You have high cholesterol, and you take a medication called ATORVASTATIN 10 milligrams a day. You have no other medical conditions; for instance, you do not have asthma or heart disease. If asked, you have never had any falls.

About your personal life and your family:

Your childhood was unremarkable, though your father was a strict man. School life was tough because of financial restraints at home, but there were no traumatic experiences. You have been married for 45 years and your husband, Mark, is very supportive. You worked as a children-crossing supervisor for many years, but retired now. You have two adult children, Adam (43) and Emma (41), who live locally and you see regularly and they have two children each. All of you get along well.

You continue to manage day-to-day affairs at home, and manage your finances with your husband. You are a social person, and interacting with people was never a problem for you. You can drive just like any other ordinary person, you haven't noticed any impact of diazepam on your driving.

You remember your mother was an anxious person, but there was no formal diagnosis made. There is no other mental illness in the family.

You are clear that diazepam is the best medication for your anxiety although you are worried about 'addiction'. You try to reach a balance by limiting its use. You are afraid today that the new doctor, a psychiatrist will stop your diazepam.

4.2 How to play the role:

Overall pleasant, but **slightly anxious occasionally (about changing diazepam).** Your responses must be clear and precise.

DO NOT volunteer information about anxiety symptoms, previous treatments you had, and the use pattern of medications unless the candidate asks.

4.3 Opening statement:

'My GP has sent me to you. I hope everything is okay.'

4.4 What to expect from the candidate:

The candidate needs to establish which anxiety disorder you have, namely panic disorder. They may ask about the anxiety symptoms, and the detailed history of what medications you have been on.

They may also ask you about your personal life like your relationships and work history (answer as above). They may also ask you about your mental wellbeing like thoughts of self-harm, feeling anxious in social settings, and any symptoms of your dependence on medication.

4.5 Responses you MUST make:

Nearer the end of the interview:

'I think diazepam has worked best for me.'

'Do you think I could have a script of diazepam now?'

4.6 Responses you MIGHT make:

If the candidate asks you about your own view of continuing the medication then say:

'I want to continue, but sometimes I am afraid this medication might make me an 'addict.'

'You don't think I'm addicted, do you?……. like the youngsters on the streets.'

4.7 Current medication and dosage that you need to remember

- DIAZEPAM 5 milligram - twice a day – for anxiety
- ATOR-VA-STATIN 10 milligrams a day – for high cholesterol
- Previous medication was SIR-TRA-LEEN 200 milligrams a day – for anxiety.

STATION 8 – MARKING DOMAINS

The main assessment aims are

- To evaluate the symptoms of panic attack as the therapeutic necessity for continuation of benzodiazepines.
- To demonstrate knowledge of the evidence base of long-term benzodiazepine and alternative treatments in the management of chronic anxiety.
- To weigh the risks and benefits of long-term use of benzodiazepines in this patient.

Level of Observed Competence:

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to patient? (Proportionate value – 10%)

Surpasses the Standard (scores 5) if:
clearly achieves the standard with a superior performance in sensitively exploring concerns regarding social stigma of benzodiazepine use; utilising patient's expression of addiction fears to explore alternate interventions.

Achieves the Standard by*:*
Engaging the patient while acknowledging patient's anxiety in changing a medication that brought substantial improvement; effectively tailors interactions to maintain rapport within the therapeutic environment; listening to patient's concerns; not providing premature reassurance; using open ended questions rather than leading questions; discussing the patient's preferences about ongoing medication.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Demonstrate engagement skills with an anxious patient worried about benzodiazepine cessation following long-term use.

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

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

Does Not Achieve the Standard (scores 0) if:
approach materially adversely impacts on alliance; unable to maintain rapport; being insensitive or critical of benzodiazepine use; inadequately reflects on the information obtained and jumps to premature conclusions.

2.1 Category: PATIENT COMMUNICATION – To Patient	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.0 MEDICAL EXPERT

1.2 Did the candidate take an appropriately detailed and focussed history related to <u>panic disorder</u>? (Proportionate value – 30%)

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 screening for alternative causes of anxiety symptoms; identifies therapeutic outcomes of all interventions trialled for panic attacks; assesses timing of application of CBT techniques on a regular basis.

Achieves the Standard by:
demonstrating use of a biopsychosocial approach; conducting a tailored and focussed assessment orientated to the symptoms of an anxiety disorder; exploring specific symptoms of panic attacks with appropriate depth and breadth; completing a risk assessment relevant to the particular case; obtaining further information about relieving factors; exploring prior psychological and pharmacological treatment options; exploring alternative causes.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explore panic attack symptoms with regards to frequency, duration and precipitating factors.

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

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

Does Not Achieve the Standard (scores 0) if:
omissions adversely impact on the obtained content; significant deficiencies such as no attempt to explore symptoms of panic attacks or duration of the disorder.

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

1.2 Did the candidate take an appropriately detailed and focussed history related to benzodiazepine use? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; obtains specific detail about prior discontinuation attempts of diazepam.

Achieves the Standard by:
demonstrated use of tailored and focussed approach addressing previous therapeutic interventions and their outcomes; obtaining a substance use history relevant to the pattern of benzodiazepine use; screening for features of misuse; eliciting key issues relevant to elderly patients particularly enquiring about falls and cognitive impairment; completing a risk and safety assessment; enquiring patient's preferences regarding ongoing treatment.

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

a. Cover a range of adverse effects and misuse of diazepam.

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

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

Does Not Achieve the Standard (scores 0) if:
key aspects of benzodiazepine history are ignored; risks and safety not adequately assessed; omissions adversely impact on obtained content.

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

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
achieves the overall standard and provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan; demonstrates awareness of evidence-base and literature regarding long-term use of benzodiazepines including recent but debatable links between benzodiazepines and dementia.

Achieves the Standard by:
presenting findings and management options; advising of absence of benzodiazepine misuse or dependence; recommending periodic review of ongoing use, benefits and adverse effects; demonstrating knowledge of evidence-base for long-term use of benzodiazepines in panic disorder; recognising the limitations of a one-off assessment while making longer term recommendations; identifying the importance of GP's knowledge of the patient in assessing the likelihood of diazepam misuse; suggesting slow tapering of the dose if discontinuation is attempted in the future.

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

a. Conclude that continued use of diazepam is appropriate for this patient, based on the risk-benefit analysis.
b. Provide recommendations to the GP rather than providing a prescription for a benzodiazepine.

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

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) 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:
Errors or omissions will impact adversely on patient care; concludes benzodiazepine misuse or dependence; recommends cessation of diazepam.

1.13 Category: MANAGEMENT – Initial Plan	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	**Definite Pass**	**Marginal Performance**	**Definite Fail**