

1.0 Descriptive summary of station:

This is a viva station following an active bye in which the candidate will watch the DVD of an interview. Their junior registrar, for whom they are the supervisor, has interviewed a patient with depression and psychotic symptoms. The registrar involved is inexperienced, does not have good interview skills and is insensitive at times. The station involves assessing the candidate's ability to assess patient's mental state, formulate differential diagnoses and provide an initial management plan based on their observations. They are then required to present the feedback they would provide to the junior registrar on his interview.

1.1 The main assessment aims are:

- To identify and present important features of a mental state examination, formulate and provide an appropriate differential diagnosis and initial management plan.
- To identify and present strengths and deficiencies of interview technique observed on the DVD.

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

- Identify the presence of psychomotor retardation, auditory hallucinations and poor insight.
- Recognise the role of unresolved grief in the presentation.
- Acknowledge the potential significance of unexplored personality factors.
- Present at least three of the most likely possible diagnoses.
- Recognise that high expressed emotions or appropriate accommodation are significant factors in his management.
- Include some strengths of the interview as part of the feedback process.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders, Core Clinical Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - Mental State Examination, Formulation, Diagnosis, Management - Initial Plan); Scholar (Training & Supervision)

References:

- RANZCP *All about the OCA and How to rate an OCA*
- Kumar V. *Getting started in psychiatry: A guide for junior registrars: Sydney West and Greater Southern Psychiatry Training Network, 2017*
- *Teaching on the Run – feedback, assessment and evaluation UWA 2009*

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- DVD player.
- Role players for the DVD: patient should be a Caucasian male in their late 20's, who is unkempt and not overweight. Doctor should be a professionally dressed male.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after a further **five (5) minutes** of preparation time.

This is a VIVA station: there is no role player in the examination room.

You are working as a junior consultant psychiatrist, and your Stage 1 Trainee has conducted an interview of a patient named Jackson Daniels as an Observed Clinical Activity (OCA).

You are expected to present your responses to the questions based on the DVD.

Your tasks are to:

- Present a mental state examination of the patient who was interviewed.
- Present your formulation and justify the differential diagnoses you would consider in this case.
- Present an initial management plan.
- Outline the feedback you would provide to the registrar on his interview during his next supervision.

You have **twelve (12) minutes** to complete the first three tasks and **three (3) minutes** for the last task.

You will receive a prompt at **twelve (12) minutes** to present the feedback you would provide the registrar if you have not already begun this task.

Station 1 - 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' specific to the station.
 - Pens.
 - Water and tissues are available for candidate use.

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 there is a scripted prompt at **twelve (12) minutes** if the candidate has not commenced the final task. You are to say:
'Please proceed to the feedback you would provide the registrar.'
- DO NOT redirect or prompt the candidate at any other time.
- 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 **fifteen (15) 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 co-examiner's and your mark sheet in **one** envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early:

- You are to state the following:
***'Are you satisfied you have completed the task(s)?
If so, you must remain in the room and NOT proceed to the next station until the bell rings.'***
- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the 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.

This is a VIVA station. Your role is to keep to time and to mark the candidate.

When the candidate enters the room briefly check ID number.

There is no opening statement.

At **twelve (12) minutes**, if the candidate has not already commenced the final task say:

'Please proceed to the feedback you would provide the registrar.'

3.2 Background information for examiners

This station has an Active Bye where the candidate will watch a DVD of an interview with a patient by a Stage 1 registrar for whom they are the supervisor. The station is made up of two distinct parts: the initial major part is to provide comment on the clinical features of the patient in the DVD and the second is to provide feedback to a trainee – as per the expectations of the Observed Clinical Activity (OCA).

The station aims to evaluate the candidate's ability to identify and present important features on a mental state examination and then to present a formulation, differential diagnoses and an initial management plan. The candidate is then expected to identify and present strengths and deficiencies of an interview.

In order to achieve this station the candidate **MUST**:

- Identify the presence of psychomotor retardation, auditory hallucinations and poor insight.
- Recognise the role of unresolved grief in the presentation.
- Acknowledge the potential significance of unexplored personality factors.
- Present at least three of the most likely possible diagnoses.
- Recognise that high expressed emotions or appropriate accommodation are significant factors in his management.
- Include some strengths of the interview as part of the feedback process.

In the DVD the patient presents with features in keeping with a major depressive disorder with psychotic features (DSM-5) on a background of persistent depressive disorder. Other major differential diagnoses that the candidate could consider include:

- Mood disorder secondary to substance use,
- Schizoaffective disorder,
- Depression secondary to a medical condition (hypothyroidism),
- Dysthymia (persistent depressive disorder),
- Pathological grief / Persistent complex bereavement disorder (condition for future study in DSM-5), Personality disorder, e.g. schizotypal, borderline.

It is less likely to be a complicated grief reaction as the principal issue, rather than any of the above.

Formulation

In psychiatric literature, the term 'formulation' is utilised by different authors in quite diverse ways. In the United States, it often implicitly means psychodynamic formulation. Sperry, L, Gudeman, JE, Blackwell, B, Faulkner, LR (1992) use it to mean a comprehensive overview of the case encompassing phenomenology, aetiology, management and prognosis. Formulation is an explanatory hypothesis to provide a structure to further management.

According to Kumar V. (2017), the psychiatric formulation tries to 'make sense' of the information that you have gathered. A formulation tries to answer the question of:

'Why has this person presented with this problem, at this point in time, and in what context?'

Or, put another way:

'What is going on with this person for them to be here now, and how is the past relevant?'

The formulation often goes a step further, as we try to 'project forwards' and see what the future holds for this patient:

'What are the challenges that this patient faces, and what strengths do they have to tackle these challenges?'

Why is it important?

There is the danger in psychiatry to purely base management upon the history and mental state i.e. to treat symptoms:

e.g. To diagnose a patient with mania as part of a bipolar disorder, start mood stabilisers, and discharge them back home when they are euthymic only to find that they re-present to hospital soon after.

Diagnosis is important, but formulating is just as important. Without a formulation you may never know:

- i. Why the patient keeps presenting to hospital (the 'revolving door' situation commonly seen on acute wards)
- ii. What is happening in their life and how this is relevant to their presentation (e.g. why is it that a patient continuously abuses substances?)
- iii. What challenges they face and, importantly, what strengths and resources they have to tackle those challenges

Formulating a patient is a very 'humanising' exercise. It makes the patient a 'person' and not a diagnosis, and it gets you thinking about their life. It also assists in managing the patient, and may assist you in 'breaking' the revolving door scenario.

What models are there that can help formulate a case?

There is no such thing as the 'perfect' formulation. To some extent it is one of the main reasons why psychiatry is both an art and a science. Two psychiatric doctors may formulate the same person's predicament in two seemingly different ways. These two perspectives may both have their merits, and together contribute to a richer understanding of the patient.

That being said, there are some basic models that can help to construct a formulation. These include:

1. The '5 P' model

a. This model uses a 'temporal' (i.e. time based) approach to formulation, under the headings of:

- i. **P**resenting problem (how did the patient come to clinical attention?)
- ii. **P**recipitating factors (what was the immediate cause of their presentation?)
- iii. **P**redisposing factors (what in the patient's past seems relevant and linked to what is happening now?)
- iv. **P**erpetuating factors (what seems to be driving the patient's ongoing problem?)
- v. **P**rognosis (how does the future seem, and what strengths does the person have to tackle these?)
- vi. It is also worth considering the patient's **P**ersonality, as this is the core of the patient's identity
It isn't enough to simply list information under each heading; ideas need to be linked together in a coherent way which takes practice.

b. Why think about a person's strengths?

- i. We spend a lot of time thinking about a patient's 'weaknesses', or poor prognostic factors, such as medication non-compliance. It is just as important to think about a patient's strengths, as these are what you can work with to help the patient. For instance, a strong therapeutic relationship may be present which, over time, can reduce the person's mistrust over medications.

2. The 'biopsychosocial' model (you might also add 'cultural and spiritual' aspects)

a. This is a well-known way of looking at a patient's presentation from a variety of perspectives:

- i. Biological perspectives
 - o E.g. A 24-year-old male patient with depression may have a strong family history of affective disorders, and prednisone they were prescribed for a series of asthma attacks may have precipitated their illness, along with alcohol misuse.
- ii. Psychological perspectives
 - o The same patient's girlfriend may have died prior to presentation. This may have awakened the trauma of previous losses to the patient, and may be contributing to certain emotional ('transference') reactions to health professionals, thereby impacting upon their care.

- iii. Social perspectives
 - This same patient may be coping with homelessness, social isolation, as well as difficulty with finances that compounds his problem.
 - iv. Cultural perspectives
 - The patient may be of from the Philippines originally, and recently migrated to Australia. He may be adapting to a new lifestyle, missing friends, places from home, and familiar customs, while also adapting to a new home.
 - v. Spiritual perspectives
 - The patient may be of Christian background, and finds that his faith in god and support from his church community are a comfort to him amidst all the difficult things that he has faced recently.
- b. Psychological factors are internal factors that impact upon the person's emotional state, whereas social factors are more external and in the patient's environment (although they are closely linked).
3. Psychological models
- a. A patient's internal world can be thought of using a variety of psychological models, which can assist in developing a formulation. The following is a brief review of some useful theories:
- i. *A psychodynamic perspective (based upon the work of Sigmund Freud):*
 - This model is based upon a belief that an individual's behaviour is affected by both conscious thought processes as well as unconscious experiences which they may not be aware of.
 - There is a focus on linkages between a patient's past, and how this contributes to an understanding of their current difficulties:
 - a. Themes often tend to recur throughout an individual's life without them consciously being aware of it, and some of these patterns can be unhelpful, and cause the individual to face similar problems throughout life. For instance, a patient who enters a series of abusive relationships which have a striking resemblance to their own parent's relationship.
 - Emphasis is placed upon the relationship between the therapist and patient, including:
 - a. Issues of transference and counter-transference:
 - i. Transference refers to unconscious feelings that the patient has towards their therapist, which reflects previous relationships in their lives. For instance, a patient who has negative reactions to male doctors because of early life abuse they suffered from a male carer.
 - ii. Counter-transference reactions are similar, but involve unconscious feelings that the therapist, or doctor, has towards their patients.
 - b. The nature of the relationship itself is seen as important:
 - i. If a patient develops a secure and safe relationship with their therapist, they, hopefully, will be able to generalise this to other relationships in their life.
 - ii. *An attachment theory perspective (born of the ideas of John Bowlby):*
 - This theory provides a model of thinking about the ways in which human beings form attachments with one another.
 - Key ideas:
 - a. After birth, a baby is vulnerable and, in order to survive, needs to develop a strategy to obtain care and have needs met (material and emotional).
 - b. The relationship between an attachment figure (such as the patient's mother) and child (or 'dyad'-a relationship between two people) early in life has profound impact upon the child's future ways of relating with others.
 - c. Depending upon the nature of this early attachment the child may develop one of several attachment strategies or 'styles':
 - i. Secure attachment
 - 1. When the mother is able to attend to the needs of the child and provide warm, consistent care, the child later in life is more likely to be able to be emotionally available to others, whilst also being comfortable in their own company.

- ii. Insecure attachment
 1. If the mother is emotionally available at times to the child, but not consistently, an ambivalent attachment style may occur. Individuals with this style find it difficult to settle their own emotions, or to be comforted by others.
 2. If the mother is rarely available and emotionally distant, the child may develop an avoidant attachment style. Such an individual may prefer to be on their own, and find it uncomfortable to have emotional closeness with others.
- iii. Disorganised attachment
 1. Seen in cases of severe trauma, and includes reactions such as dissociation. The individual has no set template of how to form attachments with those around them.

iii. *The Eriksonian stages of development (developed by Erik Erikson):*

Erikson describes 8 developmental stages. Each stage describes a conflict that the individual strives to resolve and, if achieved, leads to a series of 'virtues'. The following are some of the stages which are particularly useful when formulating a case:

- i. Trust versus mistrust (birth to 18 months)
 1. The emotional and physical care that a baby received from its early attachment figures (typically the mother) leads to an ingrained sense of safety and security which is carried throughout life. Without this, an individual may face ongoing emptiness and sadness throughout life.
 2. Virtue of hope.
- ii. Identity versus role diffusion (ages 13-21)
 1. With the onset of puberty, the individual embarks upon the task of establishing an identity and discovering 'who they are'. The individual develops a sense of identity by exploring romantic relationships, developing a circle of friends, a sense of direction in terms of the future, dress-sense, interests, and other domains. By exploring these aspects of themselves, the individual develops a sense of their identity and values. Difficulties with this stage leads to a 'role diffusion' in which the individual has a poor sense of self and belonging.
 2. Virtue of fidelity (a sense of authenticity).
- iii. Intimacy versus isolation (ages 21-40)
 1. The individual sets upon the task of forming meaningful relationships with others, in terms of friendships, relationships with family, and romantic relationships. Difficulties with this stage may lead to isolation and difficulties with intimacy.
 2. Virtue of love.
- iv. Generativity versus stagnation (ages 40-60 years)
 1. The individual finds ways to contribute to society in meaningful ways. This may occur through raising children, having a job that one finds fulfilling, as well as having creative interests. The individual feels as though they have contributed to the world in a meaningful way. Difficulties with this stage may lead to a 'mid-life crisis' as well as substance misuse.
 2. Virtue of care.
- v. Integrity versus despair (ages 60-death)
 1. As the individual gets older they begin to contemplate mortality, and to look back on their life with acceptance (the 'good and the bad'). The individual comes to accept their mortality and feels that they have led a meaningful life. Difficulties with this stage can lead to profound despair, and possibly depression.
 2. Virtue of wisdom.

These stages are particularly useful in thinking about potential challenges that a patient may be coping with in the long-term after they leave hospital.

Some basic tips to formulating a case:

- i. A formulation is not a 'summary', it is about 'linking ideas' together
- ii. Psychological theories can help with formulating, but always be practical and say what you actually think is going on (i.e. don't use 'fancy theories' unless you think they are applicable)
- iii. Always keep in mind a patient's personality style and strengths (as these generally guide management)

A formulation can be conceptualised as having 3 sections:

Section I

This is usually a brief introductory statement that places the patient and their problems in context. The notion of the patient's 'predicament' may sometimes be helpful in presenting this section. Example: 'Ms Jones, currently a patient on an acute medical ward, has a ten-year unremitting history of anorexia nervosa. Her condition has become life-threatening in the context of a breakdown in the treatment alliance with her usual psychiatric treating team'.

Section II

This section highlights the important biological, psychological and socio-cultural aspects of the history which have potential explanatory power. In contrast to the preceding section, this section provides a more 'longitudinal' perspective.

The concept of 'vulnerability' (or predisposing factors) can often be usefully invoked in this section.

It is crucial in this section (and also in the preceding section) to exercise judgment as to which aspects of the history are selected and to convey an appropriate sense of emphasis and priority.

Section III

The task in this section is to make linkages between the material of Section I and Section II using hypotheses derived from an acceptable model or framework. Thus, the patient's vulnerabilities are juxtaposed with current stressors (and / or environment) to provide a plausible explanatory statement. In many cases, only a small number of linkages may be appropriate.

The formulation is almost invariably hypothetical. In other words, it would usually involve a set of 'educated guesses'. It is the plausibility of these speculations which makes the difference between a good and a poor formulation.

Although many cases lend themselves to formulation according to the above structure, this should not be interpreted as providing a 'formula' which will fit every case. In some cases, formulation may take the form of describing factors such as:

- the possible impact of the illness upon the patient and his / her lifestyle (in both its early phases and currently);
- the possible relevance of the premorbid personality to the present picture;
- the possible impact upon the family;
- possible ways in which the patient's current environment may be impinging upon the symptoms.

Occasionally, patients are seen in whom one would anticipate finding linkages of various kinds, but these appear to be perplexingly absent. In such cases, the candidate should describe the kind of linkages he / she has sought, remark upon their incongruous absence and speculate about what factors might underlie this.

As per the feedback, assessment and evaluation module of the Teaching on the Run program from UWA: Feedback (or appraisal) is a confidential process where judgments about performance contribute to make educational plans to help progress. Feedback is usually immediate and should occur on a daily basis and often in the clinical environment. It should be seen as confidential and non-threatening.

Assessment involves making cumulative judgments about people's performance against defined criteria and counts towards progress.

Evaluation relates to judgments by the learner of the trainer or the program. In the clinical setting, because of the 'power differential' between the trainee and the supervisor, there may be an unwillingness to provide an honest evaluation.

In the clinical setting with trainees, assessment and feedback often use the same tools like observations and standard forms, but it is the purpose to which the data is used that determines whether this is an assessment or feedback. Feedback should be confidential but assessment cannot be.

Effective feedback includes:

- a clear statement of objectives to be achieved
- planned time set aside
- input from the trainee.

Input from the trainee at the outset is helpful as they are often aware of their areas of strength and weakness. They often tend to be harder on themselves than senior staff. If they do not recognise their own strengths and weaknesses, this often indicates a problem.

Participant driven critiquing allows the learner to reflect on their performance and includes what the trainee thought went well and opportunities for improvement that they have identified during the experience

As an assessor, positive critiquing is very valuable to a trainee's outcome. It is useful to have three specific items when critiquing a performance, as the trainee is unlikely to remember more than 3 points. Words like but and however can prove confusing as they reverse the message given previously.

Feedback should be timely, relevant, precise, firsthand, constructive and supportive.

Additionally, doctors rarely give feedback when professional behaviour is poor, e.g. being rude or disrespectful. They are more likely to look disapproving or grim or walk away, or ignore it and use humour, rather than point out that it is bad for the patient or patient care. It is important to give a clear message that they think it is wrong, and an example of how to do it better.

Diagnostic Criteria:

DSM-5 – Major Depressive Disorder

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation.)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiological effects of another medical condition.

Specify:

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia.
- With peripartum onset
- With seasonal pattern (recurrent episode only)

ICD 10 - F32.3 Severe depressive episode with psychotic symptoms

- A. The general criteria for depressive episode (F32) must be met.
- B. The criteria for severe depressive episode without psychotic symptoms (F32.2) must be met with the exception of criterion D.
- C. The criteria for schizophrenia (F20.-) or schizoaffective disorder, depressive type (F25.1) are not met.
- D. Either of the following must be present:
1. delusions or hallucinations, other than those listed as typically schizophrenic in F20, criterion G1(1) b, c, and d (i.e. delusions other than those that are completely impossible or culturally inappropriate and hallucinations that are not in the third person or giving a running commentary); the commonest examples are those with depressive, guilty, hypochondriacal, nihilistic, self-referential, or persecutory content;
 2. depressive stupor.

A fifth character may be used to specify whether the psychotic symptoms are congruent or incongruent with mood:

F32.30 With mood-congruent psychotic symptoms (i.e. delusions of guilt, worthlessness, bodily disease, or impending disaster, derisive or condemnatory auditory hallucinations)

F32.31 With mood-incongruent psychotic symptoms (i.e. persecutory or self-referential delusions and hallucinations without an affective content)

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

STATION 1 – MARKING DOMAINS

The main assessment aims are:

- To identify and present important features of a mental state examination, formulate and provide an appropriate differential diagnosis and initial management plan.
- To identify and present strengths and deficiencies of interview technique observed on the DVD.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.3 Did the candidate demonstrate adequate proficiency in presenting the mental state examination, including a cognitive assessment? (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; includes observations of body language displayed by the patient.

Achieves the Standard by:

demonstrating capacity to present a thorough, organised and accurate mental state examination (MSE); assess key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; commenting on the lack of a cognitive assessment; succinctly presenting MSE with accurate use of phenomenological terms; inclusion of appropriate positive and negative findings.

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

a. Identify the presence of psychomotor retardation, auditory hallucinations and poor insight.

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:

significant deficiencies in presentation, organisation, and / or accuracy.

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

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 20%)

Surpasses the Standard if: provides a superior performance in a number of areas; demonstrates prioritisation; applies a sophisticated biopsychosocial and cultural formulation.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history, observation and examination; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient's predicament; accurately describing recognised theories and evidence; commenting on missing or unexpected data; accurately linking formulated elements to any diagnostic statement; analyses vulnerability and resilience factors.

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

a. Recognise the role of unresolved grief in the presentation.

b. Acknowledge the potential significance of unexplored personality 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) or (b) above, or covers other aspects as outlined in the additional factors above; significant omissions affecting quality or failure to question veracity where this is important scores 1.

Does Not Achieve the Standard (scores 0) if:

significant deficiencies including inability to synthesise information obtained; providing an inadequate formulation or diagnostic statement.

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

1.9 Did candidate formulate and describe relevant diagnosis and differential diagnoses? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; adequately prioritising of conditions relevant to the obtained history and findings.

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

a. Present at least three of the possible diagnoses.

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:

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

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

1.13 Did the candidate describe a relevant initial management plan? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

demonstrating the ability to prioritise and implement evidence based treatment; identifying need for more detailed history; planning for risk management both for the patient and his family; considering risk of absconding; consideration of involuntary / inpatient / community modes; selection of treatment environment; recommending medication and other specific treatments as appropriate; skilful engagement of appropriate treatment resources / supports, particularly the family; taking a multidisciplinary approach; safe, realistic time frames / risk assessment / plan review; communication to necessary others; recognition of their role in effective treatment; identification of potential barriers.

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

a. Recognise that high expressed emotions or appropriate accommodation are significant factors in his management.

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:

errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

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

6.0 SCHOLAR

6.5 Did the candidate demonstrate an appropriately skilled approach to training and supervision? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

provides a well-structured approach to the supervision session and systematically works through the process; recognises the opportunity that teaching and learning present; seeks the trainee’s opinion about their interview skills; provides tailored strategies to work on the areas for improvement.

Achieves the Standard by:

demonstrating the capacity to identify the weaknesses in the interview and present these to the trainee; including effective educational strategies to encourage learning; communicating at a level and in a manner appropriate to a trainee; clearly see their role in the delivery of supervision; seeking advice as required; allowing the trainee time to respond to the feedback provided; referring to relevant RANZCP resources; suggesting areas for improvement like aspects of attitude and professionalism in interaction with patient and failure to pick up cues during the interview.

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

- a. Include some strengths of the interview as part of the feedback process.

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:

does not apply any structure to their approach; does not demonstrate understanding of RANZCP expectations for supervision; does not see provision of comprehensive feedback as part of their role.

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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