

ACTIVE BYE STATION NOTES

This station has an Active Bye station.

You may make notations on your notepad and take these notes with you into the station.

- You have **twenty (20) minutes** in this Active Bye Station in which you will watch a DVD of an interview with a patient and start working on the responses to the tasks based on the DVD.
- After you leave the bye station you have **five (5) minutes outside the examination room** to continue working on the responses you will present to the examiner.

Instructions to Candidate

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 will view a DVD recording of this interview in this active bye station.

Your tasks are to:

- Present a mental state examination of the patient who was interviewed in the DVD.
- 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.

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 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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1.0 Descriptive summary of station:

The candidate is expected to meet with Jennifer, the mother of 19-year-old Kate who was recently admitted with first episode of mania. The candidate has not met Kate or Jennifer previously as it is Monday morning, and the events have taken place over the weekend. Kate was admitted on Saturday evening, and then overnight had been moved to the High Dependency Unit (HDU) / Psychiatric Intensive Care Unit (PICU) after which she has been injured by another patient. Jennifer was not informed of the change at the time, and was notified of these events when she arrived on the ward this morning. Jennifer has requested a meeting to discuss the incident and ongoing management. The candidate must address Jennifer's concerns, while getting some background history, provide education about manic presentations, and discuss the short-term management while providing reassurance to Jennifer.

1.1 The main assessment aims are:

- To listen to the concerns of a parent of a patient who has been injured, and address these concerns appropriately.
- To gather history about a patient with a first episode of mania.
- To provide psychoeducation regarding mania and the associated risks.
- To discuss an immediate management plan that encompasses the ongoing risk.

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

- Apologise to Jennifer that she was not informed of the incident.
- Respect the confidentiality of the other patient involved in the incident.
- Conduct a risk assessment specific to mania.
- Provide details of both the incident and complaint management process.
- Confirm the mother's understanding of the psychoeducation provided.
- Explain the purpose of HDU / PICU.
- Justify the current use of practice that is not least restrictive.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Governance Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Manager
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Initial Plan); Communicator (Conflict Management, Patient Communication – To Patient / Family / Carer, Synthesis); Manager (Governance)

References:

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- Australian Clinical Guidelines for Early Psychosis (2nd ed). 2016 Orygen Youth Health <https://www.orygen.org.au/Campus/Expert-Network/Resources/Free/Clinical-Practice/Australian-Clinical-Guidelines-for-Early-Psychosis/Australian-Clinical-Guidelines-for-Early-Psychosis.aspx?ext=>.
- Australian Commission on Safety and Quality in Health Care (September 2011): National Safety and Quality Health Service Standards, ACSQHC, Sydney.
- Bassett, Darryl L. Risk Assessment and Management in Bipolar Disorders. MJA 2010; 193: S21–S23.
- Health Complaints Commissioner (Victoria) <https://hcc.vic.gov.au/>
- New Zealand Ministry of Health. Health and Disability Service Standards (2008). <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards>.
- Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders. Dec 2015. <https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Mood-Disorders-CPG.aspx>

Committee for Examinations
Objective Structured Clinical Examination
Station 2
Adelaide September 2017



1.4 Station requirements:

- Standard consulting room; no physical examination facilities required
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: woman in her early to mid-40s, neatly dressed in professional work attire.
- Pen for candidate.
- Timer and batteries for examiners.

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 an acute inpatient setting.

You have arrived at work on Monday morning, and have been informed that Jennifer, the mother of a 19-year-old patient called Kate, is waiting for you and that you need to see her right away as she is quite angry. You have not seen or assessed Kate, and have not had a chance to review her file either.

The nursing staff have informed you that Kate wants you to talk with her mother.

You know that Kate was admitted to the ward two days ago (on Saturday night) with first episode mania with psychotic features. Jennifer arrived on the ward today, and learnt that Kate had been moved from the open ward to HDU / PICU overnight. Jennifer was not informed of this at the time it happened. She was also told, this morning, that while in HDU / PICU, Kate has been injured by a male patient after she went into his room, and tried to lay hands on him to 'save him'. Jennifer has been told that Kate is not hurt, and only has some scratches on her arm.

Jennifer has requested an immediate meeting with you to discuss her concerns about Kate's management.

Your tasks are to:

- Listen to Jennifer's complaint and address her concerns.
- Gather relevant information about Kate's illness from Jennifer.
- Provide psychoeducation regarding the acute management of mania.
- Discuss the short-term management plan for Kate in light of Jennifer's concerns.

You will not receive any time prompts.

Station 2 - 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 that there are no cues / time prompts for you to give.
- DO NOT redirect or prompt the candidate – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can,'
- At **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 after the final task:

- 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.

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'What happened to Kate is unacceptable, and I want to know how this was allowed to occur.'

There are no time prompts.

3.2 Background information for examiners

This station aims to assess the candidate's ability to respond to a complaint made by the mother of a young woman admitted with a first episode of mania. Candidates are expected to be able to demonstrate that they are aware of how to manage a complaint, undertake clinical disclosure, and outline the process that takes place to investigate an incident of minor assault and associated complaint.

The candidate needs to take the mother's complaint seriously, and validate the mother's concerns. The failure of staff to notify the patient's mother about a significant change in management should be recognised and addressed. This could include a decision to discuss with the nurse-in-charge, care to avoid apportioning of blame without natural justice, as well as recognition of the impact of the incident on patient, family and staff wellbeing.

The candidate is expected to outline how they would manage the immediate situation with the individual patient including safety, and any medical response needed.

The candidate should be aware of the impact of the environment / setting on the incident: review of clinical matters (mental state, management, containment of patient), and evaluation of patient factors like illness process, substance use, or personality issues. The candidate is expected to undertake a brief risk assessment during the interview, and this should cover important aspects of the recent history, for instance:

- Any risk taking or impulsive behaviour
- Any incidences of aggression
- Any risk of self-harm or suicide.

A better candidate may also incorporate the other patients' acuity, distress, safety and de-escalation needs; the environment including staffing levels and experience, other activities etc.

The candidate should outline their plan of action to restore a safer environment. The candidate is also expected to manage the clinical situation by explaining the preference of a least restrictive environment, and associated treatment, but to recognise the risks associated with mania, and explain why least restrictive practices are not safe in this case.

Education should be provided to the mother on the reasons for utilisation of a HDU / PICU, and why the risks associated with mania might warrant such management.

It is critical that the candidates acknowledge that the mother is upset about both the incident and not being informed, and that they work in a non-judgemental, collaborative manner while recognising and acknowledging the mother's distress.

Questions about the co-patient / perpetrator should be dealt with sensitively, and with a respect for that patient's privacy.

The explanation of the initial management plan should recognise the ongoing risks associated with the patient's illness, and that ongoing management as an inpatient is required.

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

- Apologise to Jennifer that she was not informed of the incident.
- Respect the confidentiality of the other patient involved in the incident.
- Conduct a risk assessment specific to mania.
- Refer to both incident and complaint management.
- Confirm the mother's understanding of the psychoeducation provided.
- Explain the purpose of HDU / PICU.
- Justify the current use of practice that is not least restrictive.

A surpassing candidate may separate out the need to review the incident as well as the review of the mother's complaint, may provide information on the formal complaint process (this may include providing information about the consumer liaison officer, and accurately elaborate on open disclosure for incident management) or offer assistance from a consumer / carer worker.

Explanation about the diagnosis

DSM-5 Criteria for Mania

1. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalisation is necessary).
2. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree, and represent a noticeable change from usual behaviour:
 - a) Inflated self-esteem or grandiosity.
 - b) Decreased need for sleep (e.g., feels rested after only three hours of sleep).
 - c) More talkative than usual or pressure to keep talking.
 - d) Flight of ideas or subjective experience that thoughts are racing.
 - e) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
 - f) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
 - g) Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
3. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.
4. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.
 - **Note:** A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

ICD 10 Criteria for Mania

F30 Manic episode

All the subdivisions of this category should be used only for a single episode. Hypomanic or manic episodes in individuals who have had one or more previous affective episodes (depressive, hypomanic, manic, or mixed) should be coded as bipolar affective disorder (F31.-).

Incl.: bipolar disorder, single manic episode

F30.2 Mania with psychotic symptoms

In addition to the clinical picture described in F30.1, delusions (usually grandiose) or hallucinations (usually of voices speaking directly to the patient) are present, or the excitement, excessive motor activity, and flight of ideas are so extreme that the subject is incomprehensible or inaccessible to ordinary communication.

Mania with:

- mood-congruent psychotic symptoms
- mood-incongruent psychotic symptoms

Risks Associated with Mania

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) clinical practice guidelines for mood disorders states that acute mania is a medical emergency, and often necessitates use of mental health legislation. Care should be provided in a low stimulus environment with support from health professionals.

According to Darryl Bassett (MJA 2010) - the manic state carries a particular set of potential risks, which can be summarised as follows:

- Heightened risk-taking behaviour which follows a belief of being invulnerable. This may include erratic or high-speed use of a vehicle, crossing roads without due care, swimming in unsafe situations or attempting to fly by jumping from a high place.
- Excessive spending of substantial sums of money or inappropriate generosity. The direct financial impact of such behaviour can be severe, and the indirect effect on credit ratings can be significant.
- Excessive use of alcohol or other psychoactive substances.
- High levels of irritability and aggression with risks to self or others, particularly if the patient is opposed in their intentions. This is especially evident in mixed states, where heightened energy combines with dysphoric mood to produce a potentially explosive mixture.
- Disinhibited behaviour such as uncharacteristic sexual behaviour (promiscuity, unprotected sex, socially inappropriate propositions, exhibitionism) or other socially inappropriate behaviour. This can be particularly damaging in the workplace and in personal relationships, and potentially damaging to health.
- Socially disruptive behaviour derived from grandiosity, such as trying to take over piloting an aircraft that is in flight or inappropriately approaching a political leader.
- Excessive and personally offensive sarcasm and rudeness that can damage interpersonal relationships.

Least Restrictive Treatment in Early Psychosis

The recommendations from the Australian Clinical Guidelines for Early Psychosis are as follows:

- People with early psychosis should receive treatment in the least restrictive manner possible. Whenever possible, the location of the initial assessment should be community-based and at a place that is convenient to the person and their family.
- A range of treatment settings should be available to people, including home-based support, supported accommodation, rooming in, outpatient services, and inpatient care.
- The levels of risk (to self and others), the available resources (including community support) and the needs of the individual and their family should be assessed to determine whether the individual can be managed at home.
- Where hospitalisation is required, people should be admitted to a facility that can cater for, and is appropriate to, their age and stage of illness. Where streaming is not possible, a special section may be created in a general acute unit for young people with recent-onset psychosis.

Specific Issues for Families in Early Psychosis

Australian Clinical Guidelines for Early Psychosis states that the heightened emotional impact of a young person experiencing mental health difficulties for the first time, possibly maximised if the family's pathway to receiving appropriate psychiatric assistance was not straightforward, requires sensitive responses from services and clinicians.

There are special needs for information and education as families:

- Deal with possibly severe psychiatric illness for the first time
- Cope with diagnostic ambiguity and variable outcome
- Are faced with unfamiliar and often bewildering symptoms.

Complaints and Incident Management

With regard to complaint and incident management, the candidate should be able to demonstrate that they have a basic working knowledge of patient safety systems during their interaction with the mother.

Better candidates may incorporate the knowledge of these systems in their explanation to the mother, and their reassurance that the service will provide adequate care to her daughter.

Complaints management:

The Australian Charter of Health Care Rights states – 'I have a right to comment on my care and have my concerns addressed'. This is further elaborated to 'I can comment on or complain about my care and have my concerns dealt with properly and promptly'.

In New Zealand, complaints management is under the Consumer Rights Standard (Standard Number NZS 8134.1.1.13) of the Health and Disability Services Standards. The standard recognises the right of the consumer to make a complaint that is understood, respected and upheld.

The Victorian Health Complaints Commissioner provides the following recommendations for handling complaints (which are similar to other state/territory expectations):

1. Your complaint process should be easy and straightforward.
2. Complaints should be acknowledged promptly, and the complainant should be told how their complaint will be handled.
3. Complaints should be triaged appropriately.
4. Communication should be clear, using minimal jargon and technical terms. Make sure the complainant understands the information you are sharing.
5. Treat your complainants fairly, and with objectivity and respect.
6. Make sure your response to the complaint is clear and informative, and that it addresses the specific issues raised in the complaint.
7. If the complainant is not satisfied with the response, you should provide information about any available internal or external review options.
8. If the complaint highlights any systemic issues, these should be considered and acted on.

Clinical Incident Management:

In general, a clinical incident is defined as an event or circumstance resulting from health care which could have, or did lead to unintended and / or unnecessary harm to a patient. Clinical incident management is the process for effectively managing clinical incidents with a view to minimising preventable harm. It occurs in a similar manner in all health sector settings, and includes the identification and entry of an incident onto an incident management system (e.g. AIMS, IIMS, PRIME, CIMS, Riskman). Corrective actions or recommendations are actions that are then taken in the immediate, short, medium or long term to rectify or minimise the risk of harm to patients.

In Australia, the management of incidents is accredited under Standard 1 (Governance for Safety and Quality in Health Service Organisations) of the National Safety and Quality in Health Service Standards. This standard describes the quality framework required to implement safe systems; to set, monitor and improve performance of the organisation in providing quality patient care.

In New Zealand the Organisational Management Standard (NZS 8134.1.2.) of the Health and Disability Services Standards requires that the organisation has an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles and that all adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family / whanau of choice in an open manner.

Services undertake different types of formal review, and discussion and feedback to patient and family is critical, and can be done at the time (e.g. clinical disclosure) to explain what will be happening, and once the review has occurred (open disclosure). Open disclosure is the open discussion that takes place when health care does not go according to plan. The process acknowledges that an event has occurred, and provides information about what happened in an open and honest manner. It is not an admission of liability or an apportioning of blame.

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 Jennifer, age 45, a secondary school teacher and single parent of Kate, age 19, who is a student doing a science degree at the local university, and lives at home with you. You have asked to meet urgently with the doctor to raise concerns about your daughter's care.

Background:

Kate was admitted to a psychiatric ward two days ago on Saturday evening. You have heard that overnight she was moved to a more secure, locked area, sometimes called PICU (psychiatric intensive care unit) or HDU (high dependency unit), and you were not informed of this at the time it occurred.

It is now Monday morning. You arrived at the ward to visit, and you have been told this move took place because Kate was too unwell to be managed elsewhere in the ward. You're not clear what the exact reasons for this were, but you have been told that there were concerns about her behaviour. You find this strange as you assumed that she would get better once she was in hospital, but the nurse seemed to imply that her behaviour was getting more difficult to control.

Today you have also been informed that Kate was injured by another male patient late last night. The nursing staff have advised that Kate went into the other patient's room, and was trying to lay hands on him to save him, and she was scratched on the arm when the other patient attempted to stop her from touching him.

You've been told that Kate was examined but the doctor on duty after the incident, and that her injuries are minor but there are scratches on her arm, and you are very concerned for her safety.

You want an explanation of how this could have been allowed to happen. You are worried that Kate is not safe in hospital, and don't want to leave her there, but you are also worried that she was not safe at home either.

Kate had been depressed, and her GP started her on a medication that seems to have made things worse.

Kate has never been admitted to hospital before, and you've never visited a mental health ward before, and feel overwhelmed and distressed by the situation.

How you feel about the admission and recent events:

- You are very worried about Kate's safety – hospital is supposed to be a safe place!
- You are angry that you were not told about Kate being moved to the more secure area or about Kate being injured until you came to visit her today. And if it is a more secure area, it seems strange that she was injured there, because it should keep her safer.
- You are having difficulty coping with how quickly things have changed – Kate went from being depressed, and spending all her time in bed to acting strange like walking around naked in the yard with a knife, and saying odd things and is now in hospital.
- You are not convinced that she needs to be in the more secure, locked area of the ward, and you are not happy that you've not been clearly told the reasons why this move occurred.
- You are feeling distrustful of doctors as Kate has been injured in hospital, and it was also a doctor (your GP) who started Kate on the medication that you think might have made things worse.

If you are asked about Kate's recent history please provide this information to questions:

You were worried that she has been depressed. Kate broke up with her boyfriend, Tim, a few months ago, and she seems to have struggled with this. She had been spending most of her time in her room (mainly in bed), and she had not been attending her university classes or seeing her friends. So you encouraged her to see her GP. She was very quiet for a few weeks, and you think she would cry when she was alone (red eyes, puffy face). She had been eating poorly, and looked like she had lost some weight, but you are unsure how much. She lost interest in things she enjoyed, like spending time with friends and cooking. If asked if she was ever suicidal, deny this. She has never tried to self-harm, overdose or cut herself.

Kate was started on an antidepressant (you are unsure of the name of this) about six weeks ago, but it seemed to make little difference.

When Kate returned to see her GP, two weeks ago, the medication was increased, and you were pleased to see that Kate had started going out and seeing her friends again, and you believe she'd been attending university.

You had noticed that Kate had not been sleeping well in the last week or so – on a few occasions she'd woken you in the night playing music loudly, but she had turned this down or used her headphones when you told her it was too loud. So, you had not really thought too much further about it, as she had previously been spending so much time in bed that you were pleased to see a change.

She had started speaking quickly at times, and she decided to try out for several sporting teams. You now realise that these things were quite unusual for Kate, but at the time you were not overly concerned. It was nice to see that she was back to her normal self again.

On Saturday night, the night of admission, you were woken by Kate yelling out. You found her naked in the yard with a knife in her hand. She was talking about comets passing, and that she needed to die to save humanity. She was speaking very fast. If questioned, you will say that you have never heard her talk about having super powers, or say anything like the TV talks about her or refers to her. She has never voiced any fears about anything specific. She has not reported increases in her energy levels. You have not noticed risk-taking behaviour like driving too fast or being sexually overactive. She has not been spending excessively.

You called the ambulance and Kate was taken to hospital, and admitted under the Mental Health Act – the junior doctor who admitted her informed you of this.

You visited Kate on the ward yesterday (Sunday). You were able to spend the day with Kate, and she was not in the locked area. She did not appear any better or worse than she was the previous day. You were told that you would be able to meet the doctor who would be managing Kate on Monday, so you came to the ward to see Kate and to meet the doctor.

If you are asked about Kate's development / upbringing or home life:

Development - there were no problems with the pregnancy or delivery. There were no concerns about her development, and in fact she walked and talked earlier than many other children. She was a placid baby, and a timid child. Kate has always been a worrier. She performed well at school, and has been doing well at university. You would not describe her as outgoing, and she tends to avoid parties and larger gatherings. She is considerate and caring, and has always had a close group of good friends.

Family environment - you separated from Kate's father, John, when she was two years old, and she has had limited contact with him or his side of the family. Although you have had other relationships, you have not remarried or lived with any other partner as you were worried this would be difficult for Kate. You are close with your family, and your mother and sister assisted with looking after Kate when she was younger, and you had to work. Although Kate has no siblings, she is close with her cousins.

You worry at times that your divorce and the lack of contact with her father have been difficult for Kate, but overall you feel she has had a loving extended family. You are not aware of any other adverse events in her life (no abuse, no bullying).

Kate had a stable group of close friends through high school, and they have remained friends. Two of them are studying science with her at university. She was with her boyfriend for two years before they broke up – this was Kate's first serious relationship.

If you are asked about Kate's past psychiatric / mental health history or about use of drugs and alcohol:

You have been aware that Kate was depressed, and you have been quite worried about this. In the past she had periods of being withdrawn for a week or so at a time, but she always just seemed to "*snap out of it*". In retrospect you think she has been depressed in the past, but never as bad as she has been recently. Prior to this episode you have never seen her over-talkative or with excessive energy or needing less sleep.

You do not think Kate has been into drugs or alcohol. She has only ever had one glass of wine at dinner, and only at special family occasions. She doesn't smoke and to the best of your knowledge, Kate and her friends are against the idea of using drugs.

If you are asked about any family history of illness:

You suspect there is a history of anxiety and depression in your family (your mother's brother), but you are not aware of anyone being diagnosed with a mental illness or receiving treatment. There is also no history of substance abuse or issues with gambling.

You know little of the history of your ex-husband's family, but he did mention that his mother had had a nervous breakdown. You do not know any details regarding this.

4.2 How to play the role:

You are to be neatly dressed in professional work attire. You are angry (but not aggressive) and upset. You are worried that Kate has been injured, and have concerns about whether she will be safe if she remains in this environment. You are distrustful of doctors as Kate has been injured, and the medication her GP gave her seems to have made her worse.

However, your primary concern is for Kate, and you will become calmer if the candidate listens to your concerns in a respectful manner without trying to dismiss your concerns or down-play the incident or the fact that staff did not ring you.

You are willing to accept apologies and / or explanations, and listen to discussions regarding the reasons she was placed in the more secure, locked area. You are keen to be told about her future management, and what will be done to protect Kate. You will work with the doctor if they listen to you, and show concern and remorse over what has happened to Kate, but are not prepared to be pushed around.

4.3 Opening statement:

'What has happened to Kate is unacceptable, and I want to know how this was allowed to occur.'

4.4 What to expect from the candidate:

The candidate should listen to your complaint, and take your concerns seriously. They should be empathic and apologise for the fact that you weren't informed of events, and that Kate was injured. Explanations should be provided in non-technical language, and lots of reassurance should be given.

The candidate should be clear that Kate remains very unwell, and needs to stay in hospital but provide assurance that steps will be taken to prevent further injury. If the candidate starts to tell you about longer term treatment, you need to indicate that you are happy to discuss this at a later date, and that right now your only concern is Kate's safety in hospital.

4.5 Responses you MUST make:

'Why did Kate have to be moved?'

'I still can't believe this happened to Kate!'

'How can you be sure that Kate will be safe now?'

'What will happen to the patient who attacked her?'

'What's the hospital going to do about this?'

4.6 Responses you MIGHT make:

'Why wasn't Kate in this area earlier?'

'Well I hope he's not near her now.'

'What's wrong with the man who did this?'

'I'm not interested in the future – I want to hear about what you will do now.'

'At my school, we have procedures to follow if a student assaults anyone. What do you do?'

If told that the candidate does not have Kate's permission to talk to the mother

Scripted response: ***'When Kate came in she told the doctor that she was happy for anyone to discuss anything about her illness with me. I am sure he put it down in her notes. You can check this if you don't believe me.'***

4.7 Medication and dosage that you need to remember:

You do not know any specifics about medication; only that the GP started Kate on something for depression.

STATION 2 – MARKING DOMAINS

The main assessment aims are:

- To listen to the concerns of a parent of a patient who has been injured, and address these concerns appropriately.
- To gather history about a patient with a first episode of mania.
- To provide psychoeducation regarding mania and the associated risks.
- To discuss an immediate management plan that encompasses the ongoing risk.

Level of Observed Competence:

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

effectively de-escalates the situation; positively promotes safety for all involved; demonstrates sophisticated reflective listening skills; considers engaging a consumer / carer worker.

Achieves the Standard by:

recognising challenging communications; listening to differing views; demonstrating capacity to apply management strategies; effectively managing psychiatric emergencies with due regard for safety and risk; being aware of the responsibility to all patients and staff; being able to apologise without being defensive.

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

- Apologise to Jennifer that she was not informed of the incident.
- Respect the confidentiality of the other patient involved in the incident.

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:

any errors or omissions impair attainment of positive outcomes; inadequate ability to reduce conflict, unable to maintain rapport or does not reflect that the mother's concerns are valid.

2.3. Category: CONFLICT MANAGEMENT	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"/>	

2.1 Did the candidate illicit information relevant to a risk assessment? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the mother taking regard to gender, background etc.; communicating plans and discussing acceptability; containing conflict or behavioural abnormalities; recognising confidentiality and bias; gathering a history of the illness as well as the incident.

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

- Conduct a risk assessment specific to mania.

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 materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport, does not explore risks related to aggression or impulsivity.

2.1. Category: PATIENT COMMUNICATION - To Patient / Family / Carer	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"/>	

4.0 MANAGER

4.1 Did the candidate demonstrate a capacity to apply principles of clinical governance? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

able to tolerate and manage uncertainly; offers assistance from the consumer / complaint liaison officer or discusses the formal complaints process; respects the confidentiality of the co-patient involved and explaining this issue to the mother.

Achieves the Standard by:

identifying principles of clinical governance and standards, explaining quality assurance activities, applying governance within organisational structures; being aware that the situation involves both a critical incident and a complaint by a carer, and having an awareness of management of both these issues are separate, yet overlapping processes.

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

- a. Provide details of both the incident and complaint management 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:

lacks clarity about clinical governance and standards; poorly defines own scope of practice and responsibilities; dismisses or doesn't address concerns regarding co-patient.

4.1. Category: GOVERNANCE	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"/>

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills appropriate to providing psychoeducation to a concerned family member? (Proportionate value – 15%)

Surpasses the Standard (scores 5) if:

shows an understanding that the mother may be distrustful of the doctor / hospital, integrates information in a manner that can effectively be utilised by the audience; provides succinct and professional information.

Achieves the Standard by:

providing accurate and structured verbal report / feedback; prioritising and synthesising information; adapting communication style to the setting; demonstrating discernment in selection of content; uses examples of the patient's behaviour to clarify explanations

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

- a. Confirm the mother's understanding of the psychoeducation provided.

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:

any errors or omissions impact on the accuracy of information provided; does not explain the risks associated with mania.

2.5. Category: SYNTHESIS	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"/>

1.0 MEDICAL EXPERT

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value – 15%)

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; provides a comprehensive rationale for why least restrictive management was initially trialled (i.e. why not initially managed in ICU / HDU).

Achieves the Standard by:

demonstrating the ability to prioritise and implement evidence based acute care; explaining risk management; considering involuntary / inpatient modes; outlining medication and other specific treatments; engaging safely and skilfully appropriate treatment resources / support; having safe, realistic time frames / review of the plan; communicating to necessary others; identifying potential barriers; recognising the need for consultation.

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

- a. Explain the purpose of HDU / PICU.
- b. Justify the current use of practice that is not least restrictive.

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:

does not recognise or explain why less restrictive practices are not currently possible; 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"/>

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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1.0 Descriptive summary of station:

In this station the candidate will review a man with schizoaffective disorder who is on multiple medications, and is referred by his GP for assessment of symptoms and a medication review. The candidate needs to demonstrate the ability to identify cardiovascular risk of polypharmacy, appropriately interpret investigation results and undertake a focussed physical examination to exclude any cardiac abnormalities, and identify metabolic syndrome.

1.1 The main assessment aims are:

- To undertake a focussed physical examination to exclude cardiac abnormalities and identify metabolic syndrome.
- To accurately interpret investigation results (ECG and blood investigations).
- To identify cardiovascular risks related to psychotropic polypharmacy.
- To present the diagnosis and management plan to the examiner.

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

- Use accurate technique to assess blood pressure and BMI.
- Accurately explain at least two of hypercholesterolemia, hypertriglyceridemia, hyperlipidaemia, raised LDL or fasting glucose as part of a raised metabolic profile.
- Link presentation to polypharmacy.
- Explain QTc prolongation on the Electrocardiogram (ECG).
- Address the patient's concern of tiredness.
- Manage the metabolic syndrome through psychoeducation, dietary management and exercise.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Medical Disorders in Psychiatry; Psychotic Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Collaborator
- RANZCP 2012 Fellowship Program Learning Outcomes: Medical Expert (Assessment – Physical – Selection; Diagnosis – Investigation Analysis; Diagnosis; Management – Initial Plan)

References:

- The Maudsley Prescribing guidelines in Psychiatry, 12th Edition, D Taylor, C Paton, S Kapur
- Metabolic syndrome: Overview and current guidelines, Julian Halcox & Arshed A. Quyyumi, PP 1-12, Hospital physician 2006
- A comprehensive definition for Metabolic syndrome, Paul L Huang, Disease Model & Mechanics. 2009 May-Jun; 2(5-6): 231–237.
- Clinical examination – A systematic guide to physical diagnosis, 3rd Edition – Talley N.J., O'Connor S
- ECG Interpretation made incredibly easy, 5th edition, Lippincott Williams and Wilkins.
- Waist Circumference and Waist-Hip Ratio – Report of a WHO expert Consultation, Geneva, December 2008

1.4 Station requirements:

- Standard consulting room: physical examination requirements – cardiac, measuring tape, BMI calculating table
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: 40-year-old male, approximately 170cm tall and weighing about 100kg, wearing a buttoned shirt and casual pants
- Pen for candidate.
- Timer and batteries for examiners.

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 community mental health setting. Mr Ryan Butler has been referred by his General Practitioner Dr Thomas for an assessment and a review of his medication.

Ryan is a 45-year-old single unemployed man, diagnosed with schizoaffective disorder 8 years ago. He has had 3 hospital admissions and was case managed in the past. One year ago, he was discharged to his GP on olanzapine 25mg nocte and lithium 500mg BD as his condition was stable.

Ryan suffered a minor soft tissue injury a few months ago leading to ongoing pain. At that time, he noted worsening in his mood and sleep. His GP increased the olanzapine to 30mg nocte and lithium to 500mg mane and 750mg nocte. In the past few weeks the GP also prescribed quetiapine 100mg nocte and 50mg PRN, mirtazapine 30mg nocte, diazepam 10mg daily, and amitriptyline 25mg nocte.

Ryan smokes up to 10 cigarettes per day but denies current alcohol or illicit substance use. Ryan has no significant past medical history. He lives a sedentary lifestyle. His father died of heart failure 7 years ago.

Today Ryan shows no sign of relapse. He does complain of 'an occasional funny feeling' in his chest, which developed after his GP increased his medications. Ryan reports feeling tired a lot of the time. He is also worried about 17kg weight gain over the last year, and currently weighs 108kg. His height is 170cm.

There are three (3) tasks.

Your first two tasks are to:

- Conduct a focussed physical examination while providing an explanatory commentary **to the examiner**.
- In the context of your findings, interpret the blood results and ECG **to the examiner**.

(You are not required to take a history, you may make enquiries to assist with your assessment)

At **eleven (11) minutes** the examiner will present you with the third task.

Blood Results

07.09.2017 - Full Blood Examination:

Haemoglobin	120 g/L	(135-180)
Red Cell count	$3.9 \times 10^{12}/L$	(4.2 – 6.0)
Haematocrit	0.32	(0.38 -0.52)
Mean Cell Volume	98 fL	(80 – 98)
Mean Cell Haemoglobin	33 pg	(27 -35)
Platelet Count	$319 \times 10^9 /L$	(150 – 450)
White Cell Count	$6.9 \times 10^9 /L$	(4.0 – 11.0)

07.09.2017 – Biochemistry Serum

Na	139 mmol/L	(135-145)
K	4.0 mmol/L	(3.5 -5.5)
Cl	105 mmol/L	(95-110)
Bicarbonate	27 mmol/L	(19-32)
Urea	3.9 mmol/L	(2.8 – 8.0)
Creatinine	75 umol/L	(60-110)
eGFR	>75 mL/min/1.73m ²	
Cholesterol	6.8 mmol/L	(<5.5)
Triglycerides	3.9 mmol/L	(<2.2)
LDL	5.72 mmol/L	(0.0 – 4.0)
HDL	0.68 mmol/L	(0.90 – 1.50)
T. Bilirubin	10 umol/L	(<21)
Alk Phos	98 U/L	(30-110)
GGT	65 U/L	(0 – 50)
ALT	43 U/L	(0 – 40)
AST	20 U/L	(0 – 45)
LDH	223 U/L	(120 -250)
Fasting Glucose	8.0mmol/L	(3.6-6.0)
CRP	23mg/L	(<10)
Serum Troponin I	0.02 µg/L	(<0.03)
Lithium Level	0.6mmol/L	(0.5 – 1.0)

A copy of ECG is provided.

ID:

7-Sep-2017 11:43:27

Ryan Butler

Vent. rate 91 bpm

PR interval 152 ms

QRS duration 92 ms

QT/QTc 394/496 ms

P-R-T axes 40 42 36

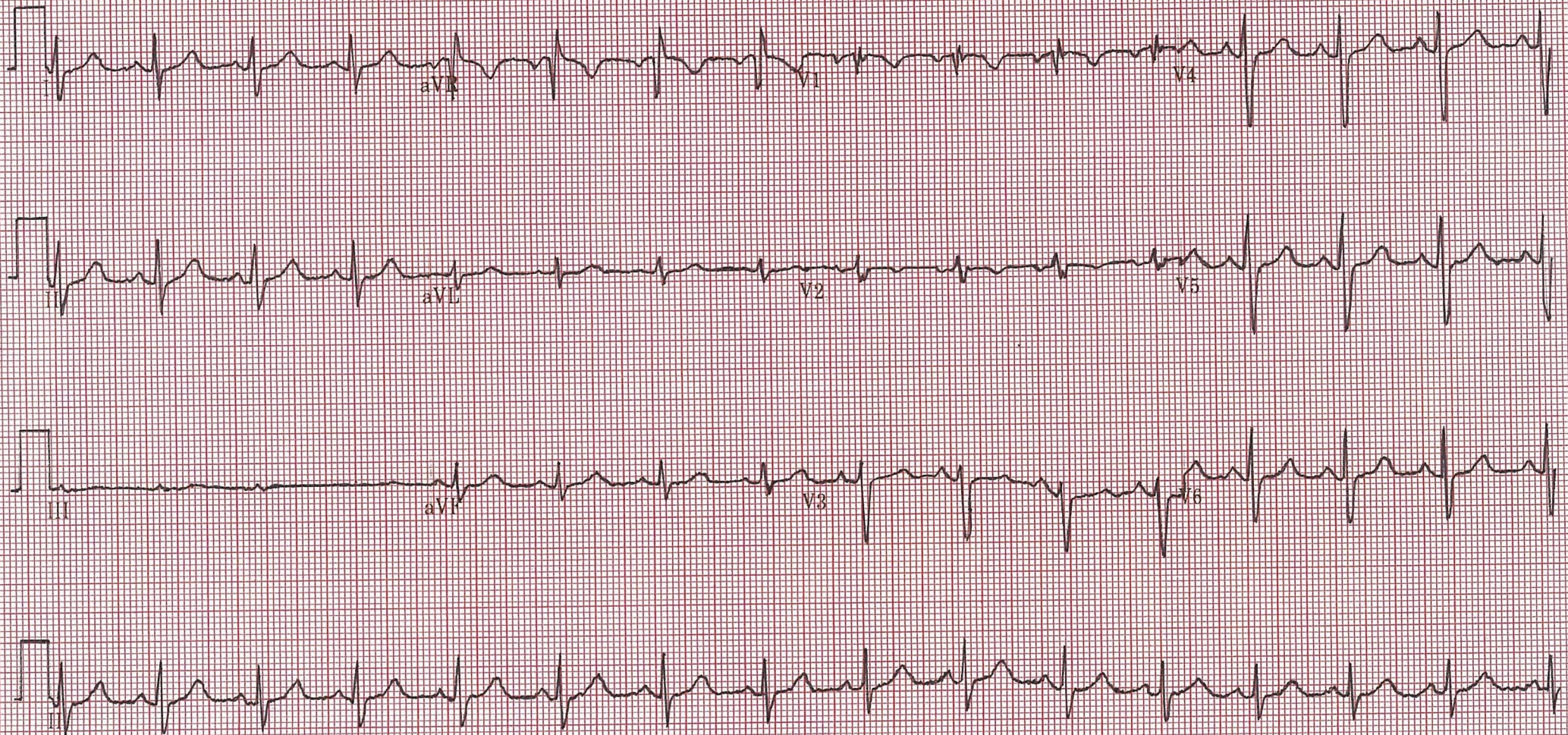
Borderline ECG

45 years old

Male

Technician: brooke

Unconfirmed



Station 3 - 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 the medical examination kit as required in the station.
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient and co-examiner

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 / time for the scripted prompt you are to give.
- At **eleven (11) minutes**, provide the candidate with the third task and say:
'Present your diagnosis and initial management plan to the examiner.'
- 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.'
Discuss your diagnosis and appropriate management plan.
- 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 the first two tasks early (i.e. before 11 minutes):

- You are to state the following:
'Do you want to proceed to the final task?'
- If yes, handover the third task to the candidate and say the following:
'Please proceed to the final task and you can return to the other tasks later.'

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.

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

“I am worried about how tired I feel, how much weight I am putting on and about this funny feeling in my chest”.

At **eleven (11) minutes** please hand the candidate the last task and say:

The ***THIRD TASK*** is:

‘Please present your diagnosis and management plan to the examiner.’

If the candidate attempts to exam the lower abdomen or groin area please say:

‘Examination of that area is not required.’

3.2 Background information for examiners

In this station candidates are expected to identify cardiovascular risks related to psychotropic polypharmacy and demonstrate this by undertaking a focussed physical examination to exclude cardiac abnormalities and features of metabolic syndrome.

The candidate should cover most of the essential aspects of the examination with correct technique. Ideally this should include blood pressure (including postural), pedal oedema, inspection (for cyanosis, clubbing, dyspnoea), palpation (pulse, apex beat, JVP, percussion) and auscultation (heart sounds, breath sounds, may examine for forced expiratory time), waist measurements to assess the waist:hip ratio (WHR), calculate BMI (height and weight measurements will be given).

They must then accurately interpret investigation results in keeping with metabolic syndrome, including diagnosis of QTc prolongation on the ECG and then present the key findings, diagnosis and appropriate initial management with the examiner.

Candidates are expected to develop a biopsychosocial plan and implement evidence based interventions where available. It is important to review medication potentially causing to QTc prolongation and metabolic signs and identify the need to address polypharmacy; balancing risks and benefits in reducing and changing psychotropic medications. There is a need to consider gradual reduction of medication with close monitoring for any relapse, and may even suggest the benefit of case management. They should recommend adequate psychoeducation and an ongoing insight oriented approach.

Incorporating a multi-disciplinary approach with referral to allied health, referral for an echocardiogram, regular GP follow-up arrangements, assessment and treatment for Type 2 diabetes and hyperlipidemia, and referral to a cardiologist for review of cardiac status.

Better candidates may be able to identify potential barriers in management (for example – limited social support, medication side effects).

In order to ‘Achieve’ this station the candidate **MUST**:

- Use accurate technique to assess blood pressure and BMI
- Accurately explain at least two of hypercholesterolemia, hypertriglyceridemia, hyperlipidaemia, raised LDL or fasting glucose as part of a raised metabolic profile.
- Explain QTc prolongation on the Electrocardiogram (ECG)
- Address the patient’s concern of tiredness.
- Link presentation to polypharmacy.
- Manage the metabolic syndrome through psychoeducation, dietary management and exercise.

Background Information:

The risk of cardiovascular-related morbidity and mortality is known to increase in patients with schizophrenia and related psychoses. Patients with schizophrenia have an increased risk of sudden death and are 2-4 times more likely to die prematurely compared to the general population. The second-generation antipsychotics (SGAs) are associated with cardiovascular side effects that can have serious consequences to patients.

The following list provides a description of the features of a cardiovascular examination. Candidates would be expected to demonstrate their competence in undertaking this examination.

Cardiovascular examination:

General appearance:	Evidence of malnourishment, evidence of laboured respiration
General:	Cyanosis, pallor, jaundice
Nails:	Clubbing, stage 1-5 seen in cyanotic heart disease, chronic lung disease, advanced liver disease and infective endocarditis, splinter haemorrhages – infective endocarditis
Hands:	Peripheral cyanosis, pallor of palmar creases (extreme pale colour of the palmar creases may indicate anaemia secondary to blood loss, malabsorption), tremor (thyrotoxicosis or hyperactive thyroid gland)
Pulse:	Rate, rhythm, character, radio femoral delay
Blood Pressure:	Lying, standing / sitting looking for postural hypotension within 2 minutes of change of posture
Face /Eyes:	Pallor, jaundice
Mouth:	Central cyanosis, anaemia
Neck:	Carotid pulsations, amplitude and upstroke may provide information on cardiac output or heart failure, aortic stenosis or regurgitation, auscultate for bruits - may be clue to carotid artery stenosis. Jugular venous pressure (JVP) may be elevated when there is right heart failure or fluid overload (with patient at 45 degree).
Chest inspection:	Scars, visible pulsations, apex beat
Palpation:	Apex beat, thrills, heaves
Percussion:	For heart size
Auscultation:	Heart sounds, murmurs and listen at lung bases
Abdomen:	Liver (which may be enlarged in right heart failure) and renal bruits suggesting blockage of the renal arteries
Legs:	Inspection of the legs may reveal swelling or oedema usually associated with congestive heart failure; brawny discolouration as seen with peripheral vascular disease or diabetic vascular disease.

ECG:

The electrocardiogram (ECG) measures the electrical activity of the heart and can serve as a diagnostic aid to determine possible heart complications.

The phases of ECG:

- P wave: Atrial depolarisation
- PR Interval: Time between the onset of depolarisation in the atria and the onset of depolarisation in the ventricles
- QRS complex: Ventricular depolarisation
- ST segment: Plateau phase of ventricular depolarisation
- T wave: Ventricular repolarisation
- QT interval: Ventricular depolarisation and repolarisation.

ECG monitoring is essential for all patients prescribed antipsychotics. Most psychotropic drugs are associated with ECG changes and some are causally linked to serious ventricular arrhythmia and sudden cardiac death. Some antipsychotics block cardiac potassium channels and are linked to prolongation of the cardiac QT interval, a risk factor for the ventricular arrhythmia torsade de pointes. The other cardiovascular side-effects of antipsychotics and antidepressants are: myocarditis, cardiomyopathy (clozapine, risperidone, chlorpromazine, haloperidol), pulmonary embolism and hypertension.

ECG abnormalities associated with antipsychotics, antidepressants and mood stabilisers:

Tachycardia – clozapine, TCA's, MAOI's

Bradycardia – SSRI's, lithium

Heart blocks – TCA's

Risk factors for cardiovascular adverse effects associated with the use of second-generation antipsychotic drugs include advanced age, autonomic dysfunction, pre-existing cardiovascular disease, female gender (for risk of QTc interval prolongation and torsades de pointes), electrolyte imbalances (particularly hypokalemia and hypomagnesemia), elevated serum antipsychotic drug concentrations, genetic characteristics and the psychiatric illness itself.

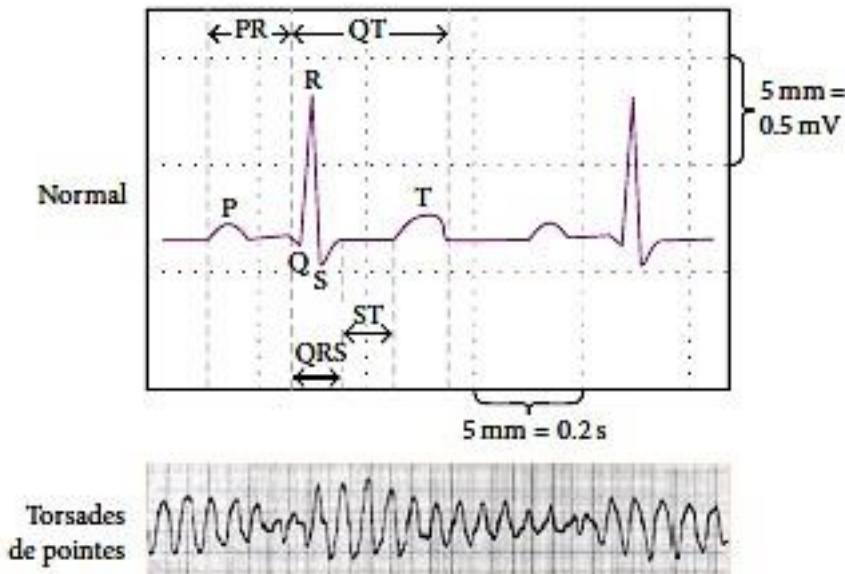
QTc Interval prolongation and Torsades de pointes (TdP):

The normal QTc intervals are less than 440msec for men and 470msec for women. The greater the duration is, the more likely that ventricular arrhythmias may occur, especially if the interval is greater than 500msec. QTc intervals of >650msec may be more likely than not to induce torsades. QTc determination remains an important measure in estimating risks of arrhythmia and sudden death.

TdP is a polymorphic ventricular tachycardia associated with a prolonged QTc interval. The ECG pattern is distinctive and is called twisting because the peaks are at their smallest in one lead, and largest in another lead. TdP is often self-limiting, but when sustained can cause ventricular fibrillation and sudden death. Risk factors for TdP are female sex, history of heart disease, presence of QT interval prolonging agent, hypokalemia, history of QT prolongation, family history of QT prolongation, QTc > 450ms at baseline and bradycardia. Potassium channels play an important role in ventricular arrhythmias (i.e., torsades de pointes).

Other reported antipsychotic-induced changes include atrial fibrillation, giant P waves, T-wave changes and heart block.

Normal versus Torsades de Pointes ECGs



Effects of antipsychotics on QTc

No Effect	– Aripiprazole, Lurasidone
Low Effect - severe QTc prolongation has been reported only following overdose or where only small average increase (<10msec) have been observed at clinical doses)	– Asenapine, Clozapine, Flupenthixol, Fluphenazine, Perphenazine, Prochlorperazine, Olanzapine, Paliperidone, Risperidone, Sulpiride
Moderate Effect - drugs which are observed to prolong QTc by >10msec on average when given at normal clinical doses	- Amisulpiride, Chlorpromazine, Haloperidol, Quetiapine, Ziprasidone
High effect - drugs for which extensive average QTc prolongation, usually >20msec at normal clinical doses)	– Any intravenous antipsychotic, Any drug or combination of drugs used in doses exceeding recommended maximum.
Unknown Effect	– Trifluoperazine, Zuclopenthixol

Patients with mental disorders have a higher prevalence of modifiable risk factors for cardiovascular disease that may include obesity, hypertension, diabetes mellitus and dyslipidemia. Obesity can be 1.5 – 2 times more prevalent in people with schizophrenia and affective disorder than in the general population. Most of the antipsychotics also contribute to weight gain. Added to other cardiovascular risks such as sedentary lifestyle, obesity, substance abuse and smoking that psychiatric patients are more prone to, there is clearly a higher rate of cardiovascular mortality.

Metabolic syndrome:

The cluster of risk factors for atherosclerosis that constitute the metabolic syndrome was first recognised in 1983. In 1988, Reaven introduced the term Syndrome X to highlight insulin resistance as a common denominator for the dyslipidemia, elevated blood pressure, and impaired glucose tolerance in the context of abdominal obesity that characterize this syndrome. Other notable features of the syndrome include a pro-inflammatory state (low-grade systemic inflammation, characterised clinically by elevated levels of c-reactive protein), microalbuminuria, and hypercoagulability. Metabolic syndrome is now the accepted term.

Cardiovascular disease is considered the principal clinical end point of the metabolic syndrome, while type 2 diabetes mellitus is considered another sequelae. The principal determinant of the syndrome is obesity, particularly visceral/abdominal obesity.

WHO criteria – Metabolic Syndrome (1988)

Insulin resistance is defined as:

- Type 2 DM (fasting plasma greater than or equal to 7mmol/L or 2-hour post glucose load (oral GTT) greater than or equal to 11.1 mmol/L (or)
- Impaired fasting glucose greater than or equal to 5.6 mmol/L (or)
- Impaired GTT (<11.1 mmol/L and > 7.8 mmol/L) after oral GTT (or)

Plus 2 of the following:

- Abdominal Obesity (waist-to-hip ratio - WHR >0.9 in men or >0.85 in women, or BMI >30kgs/m²)
- Triglycerides 1.7 mmol/L or greater, and /or HDL- Cholesterol < 1.04 mmol/L in men and <1.29 mmol/L in women
- BP 140/90mmHg or greater
- Increased urinary albumin excretion (urinary albumin secretion rate 20 micrograms/minute or greater, or albumin-to-creatinine ratio 20mg/g or greater)

Body mass Index (BMI) and waist circumference are commonly used to estimate central obesity and assessing risk of cardiovascular disease and diabetes.

$$\text{BMI} = \text{Weight (kg)} / \text{Height (m)}^2$$

<18.5 Underweight
18.5 – 24.9 Healthy weight range
25 – 29.9 Overweight
>30 Obesity

BMI is less accurate for assessing healthy weight in some groups of people, as it does not distinguish between the proportion of weight due to fat or muscle.

Waist circumference is a better estimate of visceral fat. It is therefore a more accurate predictor of cardiovascular risk, type 2 diabetes in women and metabolic syndrome.

Waist measurement:

Waist circumference is a simple check to tell if you are carrying excess body fat around your middle. Carrying excess body fat around your middle is more of a health risk than if weight is on your hips or thighs. This can be used along with measure your body mass index (BMI). Together, these tools given an indication of your risk linked with excess body fat.

Regardless of your height or build, for most adults a waist measurement of:

- >94 cm for men (about 37 inches)
- >80 cm for women (about 31.5 inches)

is an indicator of level of internal fat deposits which coat the heart, kidneys, liver, digestive organs and pancreas. This can increase the risk of heart disease and stroke.

Waist-Hip Ratio = W (cm) / H (cm) – Ratio of circumference of the waist to that of the hips.

Due to the relative ease of obtaining waist circumference, its use is favoured over waist-hip ratio.

How to measure:

- Measure the waist circumference at the end of several consecutive natural breaths, at a level parallel to the floor, midpoint between the top of the iliac crest and the lower margin of the first palpable rib in the mid axillary line.
- Measure the hip circumference at a level parallel to the floor, at the largest circumference of the buttocks.
- Make both measurements with a stretch-resistant tape that is wrapped snugly around the subject, but not the point that the tape is constricting, Keep the tape level parallel to the floor at the point of measurement.

Combined recommendations of body mass index and waist circumference cut-off points made for overweight or obesity, and association with disease risk.

	Body mass index	Obesity class	Disease risk (relative to normal weight and waist circumference)	
			Men < 102 cm Women < 88 cm	Men >102 cm Women >88 cm
Underweight	<18.5			
Normal	18.5–24.9			
Overweight	25.0–29.9		Increased	High
Obesity	30.0–34.9	I	High Very high	Very high Very high
	35.0–39.9	II		
Extreme obesity	>40.0	III	Extremely high	Extremely high

Source: NHLBI Obesity Education Initiative (2000)

International Diabetes Federation criteria for ethnic or country-specific values for waist circumference

Country or ethnic group	Sex	Waist circumference (cm)
Europid	Men Women	>94 >80
South Asian	Men Women	>90 >80
Chinese	Men Women	>90 >80
Japanese	Men Women	>90 >80

Source: Adapted from Zimmet & Alberti (2006)

There is an association between SGA's and hypertriglyceridemia. The age, sex, low levels of high-density lipoprotein (HDL) and high plasma triglycerides (TG) are independent risk factor for development of coronary atherosclerosis and coronary heart disease (CHD). The mechanism of hyperlipidemia due to SGA's is still unclear but the condition is more prevalent among those who are overweight or obese. Both hyperlipidemia and hypertriglyceridemia are thought to be associated with insulin resistance.

Orthostatic hypotension is defined as a decrease of 20mm Hg or more of systolic pressure or the decrease of 10mm Hg or more of diastolic pressure within 3 minutes of standing. Orthostatic hypotension is a common side effect of SGA's. It is caused by anticholinergic or alpha-1 adrenoreceptor blockage. Prolonged effect of orthostatic hypotension has been associated with adverse outcomes such as stroke or myocardial infarction in severe cases. The agents that most commonly cause hypotension include Clozapine, Quetiapine, and risperidone.

Hypertension: The SGA's that are associated with hypertension include Clozapine, Olanzapine and Ziprasidone. Quetiapine and Risperidone appear to have the lowest risk of hypertension.

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 Ryan Butler, a 45-year-old single man currently living alone. You have been unemployed for nearly 8 years. You have a diagnosis of schizoaffective disorder and receive a disability support pension.

You are at the clinic today because you have experienced tiredness and 'funny feelings in the chest' for 4-5 weeks. You went to see your GP, Dr Thomas, 2 weeks ago. He wanted you to increase one of your medications (diazepam), but you insisted on seeing the mental health team. He had organised for blood investigations and an ECG, which you had done 2 days ago, and arranged the referral.

History of your current concerns:

You feel strange in your chest and have had this for few weeks. It started after your GP started increasing your medicines when you started sleeping poorly. The GP told you that he thought the change in sleep may be due to anxiety, and that the drop in your mood was likely to be due to your mental illness relapsing.

The feeling in your chest is not pain. It is not worsened by activity and rest does not relieve it. It comes and goes and lasts for a few seconds, and this happens a few times every day. It feels as if your heart is beating a little faster for a few seconds.

The candidate may ask you some of the following symptoms to try to understand if you have angina or other symptoms of insufficient blood supply to your heart that could lead to a heart attack. You must be sure that you say NO to all of these symptoms. There is no pain in your left arm or shoulder or in your jaw. You do not have any symptoms that feel like indigestion. It is not associated with a difficulty in breathing.

You smoke around 10 cigarettes per day. You don't use any illicit substances, but do drink alcohol occasionally.

You do not like cooking and usually get frozen food from the supermarket or go for the lunch buffet at the local club, where there is a large spread. You love eating at McDonalds as well.

You have always been a big lad, but are now embarrassed by how overweight you have become. You feel hungry all the time and then eat whatever you can get, so it is often biscuits or cake that you have at home. You do not like exercising.

How did this start:

If you are asked, about 6 weeks ago you accidentally bumped your left forearm into a wall. There was bruising for a few days, but the pain did not subside for nearly 3 weeks. An X-ray was done and it was normal. The pain interfered with your sleep and even after it subsided 3 weeks ago, you have not returned to your previous restful sleep.

In the past you slept 7-8 hours every night without a problem, but now you take a long time to fall asleep and wake up 1 or 2 times every night for no real reason. You then take 10-20 minutes to fall asleep. You do not get out of bed at the time, unless you need to go to the toilet. You wake up in the morning feeling tired, a bit like a hangover and so sometimes have a nap in the afternoon. You now feel tired a lot of the time during the day as well.

Dr Thomas has been your GP for one year and you have been reviewed every 2 weeks for the past year. The accident affected your levels of energy and also your sleep. Due to pain, poor sleep and low mood, your GP increased the dose of the medications and also started you on new medications to manage your change in mood. You really like Dr Thomas, but you think he is not sure of what he is doing at present, as each time you see him you come back with more medication, and you think that is making matters worse.

If asked about your Mental Health History:

You were fine until the age of 28 years. You suffered psychotic illness (psychosis is a mental disorder where a person loses the capacity to tell what's real from what isn't. They may believe or sense things that aren't real). Later were diagnosed with a schizoaffective disorder which is a chronic mental illness that can present with psychosis and changes in mood.

Over the last 8 years you have had 3 long hospital admissions. You were followed up with the community mental health service and you had a case manager. Your last admission was 4 years ago, and your general practitioner now looks after your mental health and writes your prescriptions since the past 12 months.

When you were unwell, you believed that aliens were following you, and that you were their leader and were soon going to be vapourised into their spaceship. You communicated with them through the TV and spoke to them in a special language. You would get angry when people laughed at you, but you can now see that these were silly ideas and would rather not talk about them.

You feel that your mental illness is fine and you don't have any other symptoms, but are worried about medication side effects. You are not feeling suicidal and have never self-harmed in the past. Your mood is fine now; you do not feel sad or hopeless – you just feel tired.

Medications (see summary below):

When you were referred to the GP one year ago by the mental health service you were relatively well. For most of this time you were taking olanzapine 25 milligrams at night, and lithium 2 tablets in the morning and 2 at night.

Since these problems started your GP has been increasing your medication doses and added additional medications. Over the last six weeks you have also been taking mirtazapine, diazepam, amitriptyline and quetiapine.

Dr Thomas would provide you with an explanation each time he added a medicine or changed a dose, but there have been so many changes that you are unsure which medicine was started first and for what reason. You do not remember if you have been on any other medicines previously.

If asked about your Personal and Family History:

Your family lives in North Queensland. Your father suffered from schizophrenia and he died of heart attack 7 years ago.

You don't do much each day and with the side effects, you have very little motivation. You do not have many friends and prefer being alone. You enjoy watching TV.

4.2 How to play the role:

You will be wearing casual clothes (buttoned up shirt and shorts / trousers). The candidate might ask you to remove your shirt.

You will be cooperative with requests by the candidate.

4.3 Opening statement:

'I am worried about how tired I feel, how much weight I am putting on and about this funny feeling in my chest.'

4.4 What to expect from the candidate:

In this station, candidates are not expected to take a long history from you, even though information is provided for you. The main aim of this station is for the candidate to undertake a physical examination then talk to the examiner.

Candidates are expected to seek your permission for physical examination and to explain each step of the physical examination. They should briefly examine your eyes, mouth, neck, hands, legs, upper abdomen and chest. If you do not understand what is required of you with any particular examination, ask the candidate to explain again.

The candidate should explain what they are doing to the examiner as they proceed. You are not expected to respond.

If asked about your weight and / or height, you are to advise the candidate that you are 108 kg and 170 cm tall.

4.5 Responses you MUST make:

None

4.6 Responses you MIGHT make:

If asked about any current psychotic symptoms / mood symptoms / anxiety features:

Scripted Response: ***'No doctor.'***

If asked if you have any other concerns:

Scripted Response: ***'I feel drowsy.'***

If asked about your family history of medical conditions, especially heart conditions:

Scripted Response: ***'Yes, my father died of heart attack and my uncle had similar problems.'***

if asked about any past blood results:

Scripted Response: ***'My GP had concerns about my cholesterol level and he also thought I might be developing diabetes.'***

4.7 Medication and dosage that you need to remember:

In the last few months you have been taking:

(OL-ANZA-PEEN) Olanzapine 30 milligrams at night

Lithium 2 tablets in the morning and 3 tablets at night

(KWET-IA-PEEN) Quetiapine 100 milligrams at night

Diazepam 10mg at night

(MURT-AZA-PEEN) Mirtazapine 30 milligrams at night

(AMI-TRIPT-ALEEN) Amitriptyline 25 milligrams at night

STATION 3 – MARKING DOMAINS

The main assessment aims are:

- To undertake a focussed physical examination to exclude cardiac abnormalities and identify metabolic syndrome.
- To accurately interpret investigation results (ECG and blood investigations).
- To identify cardiovascular risks related to psychotropic polypharmacy.
- To present the diagnosis and initial management plan to the examiner.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.4 Did the candidate carry out an appropriately focussed and relevant physical examination? (Proportionate value - 35%)

Surpasses the standard if (scores 5) if:

examination is relevant to the patient's cardiac and metabolic problems; conducts a sophisticated physical examination involving general examination and systems examination.

Achieves the standard by:

covering most essential aspects with correct technique including: examining for pedal oedema, inspection (for cyanosis, clubbing, dyspnoea), palpation (pulse, apex beat, JVP), percussion) and auscultation (heart sounds, breath sounds); measure abdominal obesity (measuring waist and hip circumference, calculating waist: hip ratio or calculate BMI); attending to privacy for the physical exam; providing adequate commentary as instructed.

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

- Use accurate technique to assess blood pressure and BMI.

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 organisation of examination; inaccurate technique, omissions or errors adversely impact on examination outcome.

1.4. Category: ASSESSMENT - Physical - Selection	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"/>

1.10 Did the candidate interpret investigations correctly and communicate findings to the examiner? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

achieves the standard and demonstrates a superior performance in interpreting abnormal blood investigations and ECG and linking relevant investigations with diagnostic formulation; recognises linkage between raised CRP as a pro-inflammatory state and metabolic syndrome.

Achieves the Standard by:

accurately interpreting the normal and abnormal blood results including slightly raised liver functions and incorporating them into the relevant diagnostic profile; interpreting ECG and its relative significance; commenting on lithium level and related endocrine tests.

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

- Accurately explain at least two of hypercholesterolemia, hypertriglyceridemia, hyperlipidaemia, raised LDL or fasting glucose as part of a raised metabolic profile.
- Explain QTc prolongation on the Electrocardiogram (ECG).

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:

inaccurate or inadequate interpretation of investigations; errors or omissions are significant and significantly adversely affect conclusions.

1.10. Category: DIAGNOSIS - Investigation Analysis	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? (Proportionate value – 15%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of available information to guide diagnosis.

Achieves the Standard by:

identifying predisposing and precipitating factors; demonstrating capacity to integrate available information in order to formulate a diagnosis of metabolic syndrome, antipsychotic induced QTc prolongation; recognising the risk of untreated or undetected QTc prolongation; specifying key features of central obesity, impaired GTT and raised fasting glucose, hyperlipidaemia and hypercholesterolemia; describing long term risks of metabolic syndrome.

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

- a. Link presentation to polypharmacy.

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 partly meet (a) above, fails to consider psychotropic polypharmacy, fails to consider all the features for metabolic syndrome; 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 formulate and 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 (for example – limited social support, medication side effects).

Achieves the Standard by:

prioritising and implementing evidence based interventions; developing a biopsychosocial plan; reviewing medication potentially causing to QTc prolongation and metabolic signs; identifying the need to address polypharmacy; balancing risks and benefits in reducing and changing psychotropic medications; considering gradual reduction of medication with close monitoring for any relapse; suggesting potential benefit of case management; recommending an ongoing insight oriented approach; incorporating a multi-disciplinary approach; referral for an echocardiogram, regular GP follow-up arrangements; treating Type 2 diabetes and hyperlipidemia; referral to a cardiologist for review of cardiac status.

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

- a. Address the patient's concern of tiredness.
- b. Manage the metabolic syndrome through psychoeducation, dietary management and exercise.

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 inadequate management of polypharmacy, does not consider psychoeducation, does not provide rationale for medication changes (Quetiapine due to QTc prolongation, Olanzapine due to significant weight gain) and provides inadequate follow-up; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

errors or omissions will impact adversely on patient care; fails to manage polypharmacy or antipsychotic dosage; 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"/>

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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1.0 Descriptive summary of station:

This is a short VIVA station, where the candidate is asked to prepare to assess a woman, Jenny Jones, with schizophrenia who has mild symptoms of relapse in the context of relationship stress. Her new partner is using methamphetamine and most likely diverting family income to pay for it. He is becoming increasingly angry, threatening, and probably physically abusive. He is not the biological father of Jenny's two children, aged 4 and 2. The candidate is to present to the examiner what their concerns may be, and interventions that may be appropriate.

1.1 The main assessment aims are:

- To consider the potential causes of the presentation, and identify the important features of domestic violence (DV) that need to be addressed further with Jenny.
- To describe an appropriate range of interventions to support Jenny.

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

- Clarify with Jenny the causes of her injuries in the context of the available history.
- Identify domestic violence (intimate partner violence) as the most likely trigger for relapse of symptoms.
- Specifically address safety and welfare of Jenny and children as a priority.
- Consider whether reporting to child safety services is required.
- Assist Jenny to organise ongoing support in relation to domestic violence.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy)
- **Area of Practice:** Child & Adolescent Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Formulation, Management – Initial Plan, Management – Long-term, Preventative)

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Committee for Examinations
Objective Structured Clinical Examination
Station 4
Adelaide September 2017



1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- 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.

This is a **VIVA** station, there is no role player.

You are working as a junior consultant psychiatrist in a community psychiatry setting. The case manager has asked you to urgently review Ms Jenny Jones, and has provided the following information:

Jenny has chronic schizophrenia, and is usually somewhat disorganised. She now reports difficulties with concentration, loss of motivation, and feeling sad. She also has derogatory auditory hallucinations telling her she is worthless and a bad mother, and feels that people are aware of and talking about her badness.

Jenny is a loving but disorganised mother of two children - Joey aged 4, and Gemma aged 2. For example, she has difficulty getting them to childcare and kindergarten on time. Her sister, Melissa, lives close by and is very involved.

Yesterday Melissa informed the case manager that Jenny said that she had tripped to explain bruising on her arm and face. Melissa thought it would be best to have the children stay the night with her.

The case manager is concerned that twelve months ago Jenny started a relationship with a co-patient, Phil. He has a drug induced psychosis, forensic history and regularly uses methamphetamine. He moved into Jenny's house two months ago.

Jenny always receives her monthly depot paliperidone 100mg on time, and has been stable on this dose for 6 months.

Your tasks are to:

- Describe to the Examiner the issues of concern that you need to address at Jenny's next appointment.
- Describe to the Examiner the interventions you would consider.

You will not receive any time prompts.

Station 4 - 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'.
 - 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 place.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there are no cues / scripted prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:
***'Are you satisfied you have completed the 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.

When the candidate enters the room briefly check ID number.

This is a VIVA station.

3.2 Background information for examiners

In this VIVA station the candidate is asked to consider the potential causes of the change in presentation of a woman, Jenny, mother of two children aged 4 and 2. She has schizophrenia, and has mild symptoms of relapse in the context of relationship stress. Her partner of a few months is using methamphetamine, and the history provided indicates that he is becoming increasingly angry, threatening and physically abusive. He may also be diverting family income to pay for drugs. The candidate is to identify the important features of domestic violence that need to be addressed further with Jenny, and then describe an appropriate range of interventions to support Jenny.

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

- Clarify with Jenny the causes of her injuries in the context of the available history.
- Identify domestic violence (intimate partner violence) as the most likely trigger for relapse of symptoms.
- Specifically address safety and welfare of Jenny and children as a priority.
- Consider whether reporting to child safety services is required.
- Assist Jenny to organise ongoing support in relation to domestic violence.

The candidate is expected to see the changes in presentation within the 'bigger picture' using a biopsychosocial model. The candidate must specifically address the role of domestic violence (Intimate Partner Violence - IPV), and be able to comment about the impact on mental health of the individual and her family. The candidate should clarify:

- The possible reasons for this relapse, with a high index of suspicion that domestic violence is a significant contributing factor.
- Alternative causes for the change in presentation (e.g. Jenny using substances).
- The welfare of the patient: what is the extent of the domestic violence; her relationship with Phil; how she is coping, and to what extent is her family involved as support?
- The welfare of the children and what interventions should be considered.
- Discussions with the case manager, the appropriate use of a community team approach and the capacity to act as leader in this situation.
- Whether a notification to child protection services should be considered.

Candidates should be able to allude to the issues related to under recognition and under reporting of domestic violence, and that clinicians often do not enquire about it or fail to appropriately put strategies in place. Consideration of shame and the consequences of DV on individuals and children are also relevant.

Better candidates may outline the relevant factors which include that Phil is not the biological father and the implications of this; the nature of Jenny's symptoms - some reality basis and perhaps the need to follow Jenny's cues, which may help her to clarify the issues that are troubling her.

Any intervention recommended must address issues of safety (including the children's safety and welfare), and consideration of options such as referral to a women's refuge; assisting Jenny with evicting Phil, and the taking out of a legal order with the police. They should also consider the role of the extended family for further information / collateral, and as a resource for initial support and their ability to look after the children in the short and medium term.

The role of the consultant is to ensure that the team is involved and delegation of tasks occurs, e.g. case manager, social worker, registrar for mental state review.

A better candidate will be able to describe in depth the issues of IPV and the treatment - short, medium, and long-term consequences of IPV and any interventions.

Domestic Violence

According to the Australian Federal Department of Health, '*domestic violence (also referred to as intimate partner violence or family violence) occurs when one person attempts to control and dominate another in an intimate or familial relationship. Numerous studies have demonstrated that domestic violence is primarily perpetrated against women and children. Domestic violence manifests in a variety of forms, including physical, psychological, economic, social and sexual abuse. Domestic violence is relatively common during pregnancy. The frequency and severity of violence initiated by male partners against women may be higher during pregnancy (Burch & Gallup 2004; Martin et al 2004) but the evidence is not consistent (Campbell et al 2004; Walsh 2008)*'.

Intimate partner violence (IPV) is a global public health and human rights problem that causes physical, sexual and psychological harms to men and women. IPV includes physical aggression, sexual coercion, psychological abuse and / or controlling behaviours perpetrated by a current or previous intimate partner in a heterosexual or same-sex relationship. IPV affects both men and women, but women are disproportionately affected with nearly one third reporting IPV during their lifetime. Physical and sexual harms from IPV include injury, increased risk for sexually transmitted diseases, pregnancy complications and sometimes death. Psychological consequences include depression, anxiety, posttraumatic stress disorder, substance abuse, impulsivity and suicidality, and non-specific physical complaints thought to be related to the traumatic nature and chronic stress of IPV. Children who witness IPV are also negatively impacted in the short and long term.

Robinson & Moloney conclude that there are several core propositions which are supported in the literature: family violence is a significant problem, which is associated with a broad range of poor outcomes for children and for other family members; consensus supports that definitions of family violence must encompass the ways in which violence is expressed, and the range of ways in which one individual seeks to control the life of another. Violence is not just physical, and significant fear can be engendered by attitudes and behaviours that are not necessarily obvious to the untrained observer. While it is acknowledged that not all violence is gender specific, there are a variety of reasons why gender plays an important role in the institutionalisation and maintenance of violence, and this cannot be ignored.

Violence against women (VAW) or gender-based violence (GBV) are endemic and may present in many forms in war and peace. Intimate partner violence (IPV) and sexual violence (SV) in women are common abuses with serious physical and mental health consequences. Women are more likely than men to experience more severe forms of violence and abuse, and sustain more serious physical and mental health sequelae.

Health professionals are increasingly being expected to be alert and assess for signs and symptoms of violence, and most of the research in this area has focussed on the perinatal period. Research indicates that very few women who experienced abuse / violence ever told a doctor, and very few doctors reported ever asking about victimisation. This is also true in mental health settings.

The NICE guidelines note that health professionals should give women the opportunity to disclose in an environment in which they feel secure. Research has shown that most women find it acceptable for health professionals to ask them about experiences of domestic violence (Keeling & Birch 2004). Some women may not disclose to health professionals (Bacchus et al 2003) unless asked directly. Screening or assessment tools may increase the identification of domestic violence (Webster & Holt 2004) as they provide a series of structured questions asked of all women.

The major barriers offered by psychiatrists towards discussing two common forms of abuse, intimate partner or sexual violence, include: lack of adequate training about how to ask or respond; lack of knowledge regarding prevalence; scepticism about treatment effectiveness; uncertainty about appropriate referrals; patient resistance; physician discomfort with the issues; time constraints; fear of losing patients; and fear of safety of the person or oneself.

It is important to be alert and consider when to ask, who can / should ask and what to do next. If a clinician has any suspicions of domestic violence, then that is the time to ask. More recent recommendations suggest asking about the risk of any form of domestic violence as part of a routine assessment.

- Clinicians can explain that enquiring about domestic violence is a routine part of assessment and that it aims to identify individuals who would like / may need assistance. It is important to reinforce confidentiality and provide opportunities for people to discuss domestic violence in privacy (e.g. without their partner present).
- A clinician may need to seek support, depending on their skills and experience, when discussing domestic violence and assisting individuals. Most jurisdictions are developing training programs and support resources for clinicians. There are also the options of clinical supervision, mentoring and / or helplines.
- Taking a holistic approach if a person affirms that they are experiencing domestic violence; considerations include counselling and ongoing support. The safety of the person and any children should be assessed, and referral to other services (e.g. police, emergency housing, community services) made as required.
- As available support services vary by location it is important for mental health clinicians to know their local area.
- Documenting the discussion in the medical record, especially any evidence of injuries, treatment provided because of injuries, referrals made and any information the person provides.
- Be aware of relevant legislation as each State and Territory (Australia), and New Zealand has requirements about reporting violence as set out in its legislation.

Once identified, when providing first-line support to a person who has been subjected to violence, four kinds of needs deserve attention:

- Immediate emotional / psychological health needs
- Immediate physical health needs
- Ongoing safety needs
- Ongoing support and mental health needs.

It is critically important to recognise the effects of family violence on children, not only in terms of violence directed at children, but also the effects of 'inter-parental' violence and abuse on a range of physical and psychological factors that impact on a parent's capacity to remain attuned to the needs of their children. Clinicians may be able to make a difference by clearly communicating information to parents that summarises what is known about the impact of family violence on children; including those likely to exist and continue even if there are no signs of physical harm. A range of child-focussed resources exist to support clinicians, including the mechanisms by which family violence leads to a range of poor outcomes for children (e.g. In the Name of the Child by Johnston, Roseby, & Kuehnle, 2009 which explores 'the prism and the prison' of the child caught up in these circumstances).

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 4 – MARKING DOMAINS

The main assessment aims are:

- To consider the potential causes of the presentation, and identify the important features of domestic violence that need to be addressed further with Jenny.
- To describe an appropriate range of interventions to support Jenny.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate consider an appropriately detailed history and collateral history? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; carefully considers alternatives to domestic violence that need to be ruled out.

Achieves the Standard by:

identifying a detailed but targeted assessment; content of history taking is hypothesis-driven; integrating key psychosocial issues relevant to the assessment; demonstrating ability to prioritise; focussing on the key issues; considering important positive and negative features; considering their role in assisting Jenny to acknowledge relationship triggers; checking on symptoms and stability of her mental illness.

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

- Clarify with Jenny the causes of her injuries in the context of the available history.

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) if:

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 will adversely impact on the obtained content; does not consider following up on collateral history.

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

1.11 Did the candidate generate an adequate formulation of the information to make sense of the presentation? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

identifies potential barriers to disclosure of domestic violence by Jenny; provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated biopsychosocial formulation.

Achieves the Standard by:

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

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

- Identify domestic violence (intimate partner violence) as the most likely trigger for relapse of symptoms.

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) if:

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 including inability to synthesise information obtained; failure to consider domestic violence; provide inadequate formulation.

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"/>	

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value – 25%)

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 acute interventions, plan for risk management; selecting treatment environment; engaging safely and skilfully the appropriate treatment resources / support; providing safe, realistic time frames / risk assessment / review plan; keeping record and communicating to necessary others; recognising of their role in effective treatment; identifying potential barriers; recognising the need for consultation / referral / supervision.

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

- Specifically address safety and welfare of Jenny and children as a priority.
- Consider whether reporting to child safety services is required.

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) if:

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; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances; plan does not consider children's welfare.

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

1.16 Did the candidate formulate an appropriate longer term management plan, including preventative interventions and referral to specialists / resources? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

acknowledges the broader issues related to children's performance at school / preschool; overall plan is sophisticated, tailored yet comprehensive; incorporates a sophisticated psychosocial approach into plan; plan separates out the specific needs of both patients involved.

Achieves the Standard by:

giving priority to continuity of care; demonstrating awareness of episode reducing / ameliorating effects of specific interventions; seeking out community support for domestic violence victims available longer term; putting in place monitoring systems to reduce recurrence; acknowledging appropriately realistic possibility of treatment failure of treatment alliance, resources, or psychological therapies; recognising the needs of the partner who is also a patient.

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

- Assist Jenny to organise ongoing support in relation to domestic violence.

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) if:

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 adversely affect outcomes; candidate has difficulty with most of the skills above.

1.16. Category: MANAGEMENT – Long-term, Preventative	Surpasses Standard		Achieves Standard		Below the Standard		Standard Not Achieved
	5	4	3	2	1	0	
ENTER GRADE (X) IN ONE BOX ONLY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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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1.0 Descriptive summary of station:

Jordan, a 36-year-old male patient with history of schizophrenia and polysubstance dependence, is being treated with olanzapine long-acting injectable (LAI), and is also on pegylated interferon-alpha and ribavirin for Hepatitis C. The case manager has booked him in for review as he is concerned about his mood.

1.1 The main assessment aims are:

- To demonstrate knowledge of neuropsychological side-effects of Hepatitis C and its treatments.
- To demonstrate ability to assess for relapse of substance use.
- To competently generate a robust management plan and explain the plan to the patient.
- To accurately assess a range of potential aetiologies of a mood disorder.

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

- Evaluate the role of Hepatitis C and its treatment in the development of current mood symptoms.
- Explore for relapse of substance use.
- Explain their understanding of the problems to the patient.
- Develop the management plan in collaboration with the patient.
- Include liaison with the physician treating Hepatitis C in the management plan.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Addictions
- **CanMEDS Domains:** Medical Expert, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Formulation, Management – Initial Plan); Collaborator (External Relationships)

References:

- Asnis G, De La Garza R. Interferon Induced Depression, Strategies in Treatment, Progress in Neuropsychopharmacology and Biological Psychiatry. 2005 Jun;29(5):808-18.
- Bonaccorso S1, Marino V, J Depression induced by treatment with interferon-alpha in patients affected by Hepatitis C virus. J Affect Disord. 2002 Dec;72(3):237-41.
- Lieb K1, Engelbrecht MA, Cognitive impairment in patients with chronic hepatitis treated with interferon alpha (IFNalpha): results from a prospective study. Eur Psychiatry. 2006 Apr;21(3):204-10.
- Palumbo E. Pegylated Interferon and Ribavirin Treatment for Hepatitis C Virus Infection. Ther Adv Chronic Dis. 2011 Jan; 2(1): 39–45. doi: 10.1177/2040622310384308.
- Foster G, Goldin R Thomas H Hepatitis C virus causes a significant reduction in Quality of Life in the Absence of Cirrhosis Hepatology 1998 Jan, Vol27, p209-217.
- Adair D et al Differential display analysis from brains of Hepatitis C infected patients. AIDS 2005 Vol 19 pS145-S150.

1.4 Station requirements:

- Standard consulting room
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male in mid 30s, slim build, unshaven, wearing T-shirt and jeans, appearing a bit bedraggled.
- Pen for candidate.
- Timer and batteries for examine.

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 a community outpatient clinic. A case manager has arranged an appointment for a patient as she is concerned about his mood.

Jordan is a 36-year-old man with history of schizophrenia, and polysubstance dependence who is being treated with olanzapine long-acting injectable (LAI). He is also being treated with pegylated interferon-alpha and ribavirin for Hepatitis C as he is currently unable to access interferon-free direct acting antiviral agents.

Your tasks are to:

- Take a focussed history in order to understand his presentation.
- Explain your understanding, of what is going on, to Jordan.
- Devise a suitable management plan with Jordan, with reference to your hypothesised diagnosis.

You will not receive any time prompts.

Station 5 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - 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 that there is no cue for any scripted prompt.
- DO NOT redirect or prompt the candidate – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can'.
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:
***'Are you satisfied you have completed the 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.

When the candidate enters the room briefly check ID number.

You have no opening statement or scripted prompt.

The role player opens with:

'I feel awful since starting this treatment: it's getting worse and worse – I feel like giving up.'

3.2 Background information for examiners

In this station the candidate is expected to take a history from Jordan, a 36-year-old male community patient with history of schizophrenia, and polysubstance dependence treated with olanzapine long-acting injectable (LAI). He is currently also being treated with pegylated interferon-alpha and ribavirin for Hepatitis C, and the case manager has booked him in for review as he is concerned about changes in his mood.

The candidate is expected to demonstrate their knowledge of the neuropsychological side-effects of the treatments, pegylated interferon-alpha and ribavirin. They are asked to assess and manage the symptoms that the patient presents with.

The candidate will need to consider the information presented, and differentiate whether the history aligns with a relapse of the underlying Schizophrenia; a Depressive Disorder due to another Medical Condition (Hepatitis C); or Substance / Medication Induced Depressive Disorder.

In this station the latter is the preferred diagnosis, and will require the candidate to enquire about the relationship of the timing of symptoms to onset of Hepatitis C and of its treatment, and hence will inform the management plan.

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

- Evaluate the role of Hepatitis C and its treatment in the development of current mood symptoms.
- Explore for relapse of substance use.
- Explain their understanding of the problems to the patient.
- Develop the management plan in collaboration with the patient.
- Include liaison with the physician treating Hepatitis C in the management plan.

In order to meet the standard in this station the candidate should be able to evaluate mood symptoms including core symptoms of a depressive episode as in DSM-5 including mood, anhedonia, sleep, appetite / weight change, agitation / retardation, hopelessness, fatigue, concentration / thinking ability and thoughts of death / suicide.

They should delineate the time course of symptoms related to the time course of Hepatitis C and its treatment, and also consider whether the symptoms expressed are likely to be caused by the Hepatitis C, treatment of Hepatitis C or a mood episode secondary to the interferon. Suicidality must be explored, and also checking for a relapse of psychotic symptoms or presence of manic / mixed symptoms is also expected (as another possible less common side effect of interferon). Candidates should be able to identify that some of the symptoms (e.g. more physically based symptoms experienced at the treatment initiation such as fatigue, insomnia, aches and pains) are physical side effects of the interferon.

Candidates are also expected to assess whether or not the patient has relapsed into intravenous drug use; or has had cravings; or has felt close to relapsing.

The candidate is asked to outline to the patient in layman's terms the differential diagnosis and preferred diagnosis, ie that symptoms could be simply a part of their schizophrenia, caused by the underlying illness of Hepatitis C, or most likely, given the time course, are caused by the interferon treatment. A better candidate should be able to provide, in more detail, the causes of depression from interferon via inflammatory chemicals and reduction in certain brain chemicals, and identify that interferon rather than ribavirin is the cause - but that ribavirin alone will not treat Hepatitis C.

Candidates should demonstrate a biopsychosocial approach, and be able to identify that there are no symptoms to support a relapse of symptoms of schizophrenia, and would not be expected to make any changes to the antipsychotic medication. Neither is any specific substance use intervention required in this scenario.

The candidate should discuss that antidepressant medication is usually helpful, incorporating the evidence for the good (80%) response rate to antidepressants in this diagnosis (i.e. depression secondary to interferon). They should ask the patient their views on this topic, and discuss options while making suggestions for antidepressant treatment, e.g. SSRI and psychological therapy including time frames to expect improvement. Candidates would be expected to seek patient feedback, and also develop a safety plan for worsening symptoms, e.g. more frequent meetings with case worker, use of respite options, and family involvement.

Given the seriousness of the symptoms (with suicidality and thoughts of returning to IV drug use to escape), candidates are expected to identify the importance of discussing with the Hepatitis C treatment provider about possible risks to treatment success of slowing down treatment or having a pause whilst the antidepressant takes time to work. A candidate should also identify in what circumstances treatment might need to be stopped. This would be a last resort and is unlikely to be necessary. Finally, candidates should be able to clearly address any questions and concerns raised by the patient about these issues, e.g. efficacy or need to stop treatment.

Hepatitis C and its impact on mental wellbeing

1. Psychological Impact of HCV – This theory suggests that depression related to HCV infection is due to the psychological burden and distress associated with this chronic disease. Foster and colleagues demonstrated that in a sample of HCV-infected patients without cirrhosis, quality of life scores were reduced, particularly regarding mental health and physical function, when compared with a control group. Many health experts are recognising that chronic Hepatitis C virus infection alone leads to physical symptoms capable of reducing a person's quality of life, the springboard for depression.

2. Biological Result of HCV – This theory describes the potential for the Hepatitis C virus to negatively affect the central nervous system bringing about depression. Although not directly proven, this hypothesis is supported by studies demonstrating that HCV directly causes fatigue and other neuro-cognitive symptoms. Adair and colleagues used gene expression analysis to evaluate gene expression in HCV-infected patients and a control group. The researchers found a difference in the expression of 29 genes, including those involved in brain oxidative and energy metabolism. These findings support a biological basis for the link between HCV infection and depression. Additionally, Hepatitis C viral particles noted to cause chemical changes that could initiate depressive symptoms have been found in the central nervous system.

Traditional medications used in the treatment of Hepatitis C

Interferon (IFN) is a pro-inflammatory cytokine that is widely used for the treatment of a number of disorders including viral infections, hematological proliferative disorders, and skin malignancies. Unfortunately, IFN frequently induces depression, and has led to compromised tolerability with lowering of the dose of IFN, and even discontinuation of treatment. Thus, it is imperative to diagnose IFN-induced depression early, evaluate whether this depression is associated with IFN-induced anemia or thyroid dysfunction, which can be corrected, and if necessary treat with antidepressants. IFN-induced depression is highly responsive to antidepressants with benefits occurring frequently at relatively low doses, and after only a few weeks.

Although SSRIs have mainly been studied, non-SSRIs appear to be effective also. Antidepressants have a number of risks and side effects that must be considered, and may enter into the decision as to which antidepressant to choose. If IFN induces a depression in a patient with a bipolar disorder history, antidepressant treatment must include a mood stabiliser. In the case of vulnerable patients (e.g. those who have significant depressive symptoms prior to IFN or who have had an IFN-induced depression in the past) prophylactic antidepressant treatment appears to decrease the likelihood of having an IFN-induced depression. On the basis of known and effective treatment strategies, IFN-induced depression should not be an obstacle for continued treatment in most patient populations. (Asnis G, De La Garza R. *Interferon Induced Depression, Strategies in Treatment, Progress in Neuropsychopharmacology and Biological Psychiatry*. 2005 Jun;29(5):808-18)

Mechanisms for producing this side effect of pegylated interferon-alpha are unclear but several have been postulated including that IFN- α suppresses hippocampal neurogenesis and induces depression via its receptor in the brain, IFN- α is suggested to modulate mood, behaviour, and the sleep-wake cycle by the activation of the proinflammatory cytokine network and IFN- α treatment-mediated induction of c-jun N-terminal kinases (JNK), and p38 promote the expression of the beta isoform of the glucocorticoid receptor, which is an inactive form of the receptor to which glucocorticoid binding does not result in the inhibition of proinflammatory cytokine release and inhibition of CRH release. These changes magnify the stress response and hence the risk of treatment-emergent depression, μ opioid receptor activation by IFN- α and IFN- β increases brain prostaglandin E2 levels, resulting in excitotoxicity due to an imbalance between the NMDA receptor agonists and antagonist (kynurenic acid). This neurotoxic challenge causes a reduction in the density of serotonergic and adrenergic neuron, and loss of neurons in the hippocampus. Additionally, proinflammatory cytokines such as IFN- α inhibit neurogenesis by inhibiting neural stem cell differentiation. These neurochemical and neurohistological changes predispose to depression.

Pegylated interferon-alpha is an immunomodulatory medication which reduces viral load. It is used in combination with other anti-virals of a different class of drugs. It is injected either subcutaneously or intramuscularly in cycles of treatment. The most common side effects are flu-like symptoms such as headache, sweating, muscle aches, and tiredness after the injection.

Ribavirin is in a class of antiviral medications called nucleoside analogues. It works by stopping the virus that causes Hepatitis C from spreading. It is taken in oral form-usually twice daily. It is not effective alone and is prescribed as an adjunct to interferon. The most serious side-effect is anaemia.

Diagnostic Formulation

DSM-5 Diagnostic Criteria for Substance / Medication Induced Depressive Disorder

- A: A prominent and persistent disturbance in mood that predominates in the clinical picture, and is characterised by depressed mood or markedly diminished interest or pleasure in all or almost all activities.
- B: There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 - 1. The symptoms in criterion A developed during or soon after substance intoxication or withdrawal or exposure to a medication.
 - 2. The involved substance / medication is capable of producing the symptoms in criterion A.
- C: The disturbance is not better explained by a depressive disorder that is not substance / medication induced. Such evidence of an independent depressive disorder could include the following:
 - The symptoms preceded the onset of the substance / medication use; or there is other evidence suggesting existence of an independent non substance / medication induced depressive disorder (e.g. a history of recurrent non substance / medication related episodes).
- D: The disturbance does not occur exclusively during the course of a delirium.
- E: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In this station Criterion B2 is met by Interferon, and it is well accepted that depression can be a serious and common side effect of interferon with literature to support this.

There is a diagnostic code in the International Classification of Disease that refers to mood disorders caused by substances: ICD-10 F19.94 - *Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder*.

As an alternative diagnosis, some candidates could identify Depressive Disorder Secondary to Hepatitis C as the key issue, and develop a management plan to address this diagnosis. Whilst acceptable, this is not the preferred diagnostic conclusion in this station.

In this station it is also important that the candidate screens for the relapse of substance use (though it is not present at this stage). The low mood is a significant stressor increasing the risk of substance relapse or if relapse had already occurred then this could be a further possible differential diagnosis (as cause of the low mood), and if relapse is present then this would increase the risk of suicidal thinking or behaviour as well as endangering the success of Hepatitis C treatment if the use was intravenous.

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 Jordan, a 36-year-old man with a diagnosis of schizophrenia. Your illness is stable, and you are receiving a regular monthly injection of an antipsychotic medication called OLANZAPINE. You also have a history of taking a range of drugs in the past, and you contracted Hepatitis C because you used to share needles when injecting a drug called Ritalin with friends. You have been through a residential rehab programme, and have not used any drugs for three years.

After you were diagnosed with Hepatitis C your doctor referred you to a 'liver clinic' where you are currently receiving treatment for your Hepatitis C. This involves a weekly injection of a medication called INTERFERON plus you take RIBAVIRIN tablets every day. You have been on this treatment for about 4 months under the care of the local Hepatitis C clinic, but you don't know the name of the doctors who work there.

You have this appointment today because you have not been feeling well, and your mental health case manager has been worried about you.

The candidate should ask you about the following symptoms, you do not need to offer them unless asked: Since you started your Hepatitis C medication you noticed that you have been more tired, experiencing aches and pains all over, and your appetite is reduced. At present you are sleeping poorly with trouble getting to sleep and then waking during the night, but in the daytime you feel exhausted and slowed up.

You thought you could deal with all of this but lately (over the past month), you have been experiencing very low mood and anxiety, and feeling agitated. You have been thinking dark thoughts about your future and the world in general, and a feeling of 'brain fog' which makes it hard to concentrate on anything. You have also lost interest in your usual activities, even online gaming which you had been doing quite a bit near the start of treatment, as you don't have energy for anything more active. You feel like you aren't really enjoying anything, even catching up with mates. You have started to feel worthless as you can't do anything.

You are frightened by how low you are feeling, and have been having suicidal thoughts, which has led you to want to give up on treatment. You have thoughts about hanging yourself, but have made no preparations. You have never harmed yourself or had suicidal thoughts in the past, but you don't know if you can carry on like this. However, the thought of having to keep living with Hepatitis C if you give up the treatment also makes you feel like there is no point in living, as you are aware that it has damaged your liver, and you think it will get worse over time.

If asked about your schizophrenia: you don't think you are experiencing any relapse of psychosis which in the past had made you feel paranoid, and hold very strong beliefs that your family wanted to kill you. In the past you have also heard voices (but this has not recurred). You have never experienced any episodes of mania (where you would have had extreme energy, lots of ideas, and a sense of being driven accompanied by little sleep).

If asked about your substance use: you used to drink, and smoke cannabis as a teenager then started using other tablets like amphetamines. You then started injecting intravenous (IV) RITALIN, and this is how you got Hepatitis C. Lately, feeling so exhausted and low, you have been reminded of when you were hanging out, and you have been wondering if some Ritalin could make you feel better even though you know this is a bad idea. However, these thoughts have been getting stronger lately.

Your social and living arrangements: you live in a flatting situation having split up with a long term partner, Jilly, a year ago. You do drink alcohol although you know this is a harmful to your liver, and try to keep this to a 24 pack of beer a week. You have had to stop working as a part-time gardener because you are so tired, and are now on the sickness benefit.

Your upbringing was unremarkable but you had trouble at school, and fell in with the 'wrong crowd' in adolescence and got into drug use. You have a rather strained relationship with your parents who live in Melbourne. However they are pleased with your recent progress in treatment. You have a brother whom you don't see. You don't have any children.

You have no other medical problems apart from Hepatitis C, but your teeth are in bad shape, and you want to be able to work, and be able to pay for dental treatment.

The plan: the candidate is expected to tell you they think you have depression caused by your medication, and they may ask whether you are willing to take an antidepressant, and talk to you about which one and its possible side effects. You are willing to give it a go but you are sceptical of it helping, as you can't see how it will help if the depression is caused by the treatment. You wonder if this means you will have to stop the treatment for Hepatitis C.

4.2 How to play the role:

You are casually dressed in a t-shirt and jeans, unshaven, a bit bedraggled.
You are feeling ill and tired, listless and flat.

4.3 Opening statement:

'I feel awful since starting this treatment: it's getting worse and worse – I feel like giving up.'

4.4 What to expect from the candidate:

The candidate should ask about your physical symptoms (pain, tiredness, and poor sleep) as well as mood (low and fed up), feelings (hopeless), and thoughts (negative and at times suicidal), and the timecourse of your physical symptoms (since the start of the Hepatitis C treatment 4 months ago), and mood, motivation and enjoyment symptoms (just over the past 3-4 weeks).

Candidates should also check for recurrence of psychotic symptoms such as hearing voices or paranoid ideas or strange things happening. They should ask about any recent drug use (no, but thoughts of it), and suicidal thoughts (yes, but no plan).

They should then explain what they think is happening for you (depression caused by the interferon treatment), and what could help to make you feel better (antidepressants, support, and maybe psychological therapy). They should involve you, and ask your opinion of possible strategies. They may ask you about the liver clinic, and the name of the doctor who is treating your Hepatitis C.

4.5 Responses you MUST make:

'Should I stop the interferon?'

If told that 'This could be a side effect of your interferon.' you **MUST** respond:

'What do you mean, my symptoms could all be related to the interferon?'

4.6 Responses you MIGHT make:

If asked about whether you would start an antidepressant

Scripted Response: ***'I don't see how that would help if it's the interferon that has caused it.'***

If asked whether you would consider seeing a drug counsellor again for some relapse prevention work (to help with the thoughts you have been having about drugs)

Scripted Response: ***'Yes, if you think it will help although I kind of know what I should do.'***

4.7 Medication and dosage that you need to remember:

- PEGYLATED INTERFERON-ALPHA injections twice a week – for Hepatitis C
- RIBAVIRIN 2 tablets twice daily – for Hepatitis C
- OLANZAPINE antipsychotic injection once a month – for schizophrenia.

You do not know any of the doses.

STATION 5 – MARKING DOMAINS

The main assessment aims are:

- To demonstrate knowledge of neuropsychological side-effects of Hepatitis C and its treatments.
- To demonstrate ability to assess for relapse of intravenous drug use.
- To competently generate a robust management plan and explain the plan to the patient.
- To accurately assess for presence of mood disorder.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

meets the requirements to achieve the standard, and is able to elicit the important cognitive / emotional symptom groups when assessing depression in the context of physical illness; demonstrates knowledge of less common side effects of interferon such as psychosis / mania through their interview questions.

Achieves the Standard by:

asking about physical side effects of Hepatitis C treatment; clarifying details of physical / neurovegetative, and emotional / cognitive symptoms of depression; including timeframes of symptoms; obtaining sufficient detail to make a diagnosis of depressive episode; checking for relapse of positive symptoms of psychosis or presence of mania; assessing for relapse of drug use thoughts / craving; undertaking a risk assessment, including suicidal ideation and plans.

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

- Evaluate role of Hepatitis C and its treatment in development of current mood symptoms.
- Explore for relapse of substance 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) 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:

multiple omissions in history taking adversely impact on the obtained content; significant deficiencies such as substantial omissions about suicidal ideation and planning, or relapse into drug use.

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

1.11 Did the candidate provide the patient an appropriate explanation in order to make sense of his presentation? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

demonstrates prioritisation and sophistication in formulation; justifies pathological mechanisms for interferon induced depression as the primary agent; clearly explains onset of specific physical symptoms with treatment; separates out psychological symptoms as part of treatment induced depression; cites relevant literature.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating physical, developmental, cognitive, psychological, and sociological information as it relates to illness and side effects; developing diagnostic hypotheses to make sense of the patient's predicament; accurately linking formulated elements to any diagnostic statement; analysing vulnerability and resilience factors particularly to relapse of drug use; considering differential diagnoses of mood symptoms secondary to the interferon, or Hepatitis C, or the symptoms being part of their schizophrenia, or an adjustment disorder.

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

- Explain their understanding of the problems to the patient.

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:

unable to synthesise information in a cohesive manner; does not make link between interferon and symptoms of depression.

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"/>

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

Surpasses the Standard (scores 5) if:

meets the requirements to achieve the standard, and provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan; incorporates evidence in explanations; demonstrates comprehensive knowledge of medication effects and side effects.

Achieves the Standard by:

recommending evidence-based treatment of the depression with antidepressants including brief discussion of side effects, likely response and timeframe; suggesting possible psychological treatment for mood e.g. CBT; outlining increased social / practical supports while unwell; planning risk management of suicidal ideation, and working with patient to temporarily increase monitoring; considering inpatient care or respite; mitigating against substance use relapse; appropriately responding to questions around ceasing medication; identifying stopping treatment as a last resort.

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

- a. Develop the management plan in collaboration with the patient.

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; fails to discuss management; takes an autocratic approach and does not take patient's views into account.

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"/>

3.0 COLLABORATOR

3.3 Did the candidate demonstrate an appropriately skilled approach with other health professionals? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

meets the requirements to achieve the standard; proactively consults with the patient as to the form and content of the communication with the physician.

Achieves the Standard by:

investigating where Hepatitis C treatment is received; identifying medical staff involved in care; acknowledging and understanding stakeholder roles; intending to develop effective working alliances.

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

- a. Include liaison with the physician treating Hepatitis C in the management plan.

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 consider informing Hepatitis C physician of symptoms and treatment plan.

3.3. Category: EXTERNAL RELATIONSHIPS	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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1.0 Descriptive summary of station:

Bradley, a 29-year-old man, is attending a follow-up appointment after an admission for an episode of mania. He continues to have mild symptoms and has recently been inconsistently adherent to medication. He has brought paperwork for extending his driver's licence which includes driving heavy vehicles. The registrar who reviewed Bradley is not confident in dealing with this situation, and has asked that the consultant see Bradley. The candidate is to devise and negotiate a management plan with Bradley, and diffuse any conflict that arises. The candidate is then to address the ethical issues raised in a patient driving a heavy goods vehicle despite advice that he is medically unfit to do so.

1.1 The main assessment aims are:

- To assess fitness to drive with the clinical information provided.
- To negotiate a plan related to driving with a patient.
- To evaluate understanding of ethical issues pertinent to 'fitness to drive'.

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

- Assess for compliance with medication
- Advise Bradley not to drive a heavy vehicle
- Provide Bradley with information about the possible consequences of his actions if he were to drive against medical advice
- Identify the protection of public as an ethical component of 'fitness to drive'.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (e.g. ethics, capacity, advocacy)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Initial Plan); Communicator (Conflict Management); Professional (Ethics)

References:

- Assessing Fitness to Drive for Commercial and Private Vehicle Drivers: 2016 Medical Standards for Licensing and Clinical Management Guidelines. Austroads Ltd 2016.
- Medical Aspects of Fitness to Drive: A Guide for Medical Practitioners: NZ Transport Agency 2009.
- Code of Ethics: RANZCP 2010.

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: fit young man aged 25-35, casually 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 a community clinic. The registrar asked you to see Bradley, a 29-year-old man who brought in paperwork to extend his driver's licence which includes driving heavy vehicles.

The registrar assessed Bradley today:

Bradley was discharged 2 months ago, following a 4-week admission for mania. Admitted under the Mental Health Act but discharged voluntary. Bradley feels back to normal for about 3 weeks. He described his mood as really good, not excessive, with 'enough energy'. Sleeping well when he takes his olanzapine 10mg nocte. Bradley plans to find further employment, and to renovate his unit. He denies over-spending, and is working towards paying off debts. Bradley does not misuse substances.

Bradley appears mildly elevated, confident and distracted at times. He has reduced attention and concentration on cognitive testing.

Bradley admits to 2 speeding fines in the past plus a minor car accident 10 years ago. He mentioned having a 'near miss' a few days ago but feels that the other driver was at fault.

You will have two (2) tasks:

- Your first task is to devise and negotiate with Bradley a management plan relevant to 'fitness to drive'.
- At **five (5) minutes** the examiner will give you a VIVA task to address.

Station 6 - 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.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- TAKE NOTE of the time for the second task you are to give at **five (5) minutes**.
- ***'Please proceed to address the second task.'***

THE SECOND TASK:

Bradley had previously been advised NOT to drive a heavy goods vehicle.

One month later, Bradley's partner contacted the clinic to cancel his appointment because he is making a truck delivery run.

Address the ethical issues relating to 'fitness to drive' raised by this situation to the examiner.

- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can'.
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the first task (i.e. before five (5) minutes):

- You are to state the following:
***'Are you satisfied you have completed the first task?
If so, do you want to proceed to the second task?'***
- If yes, handover the second task to the candidate and say the following:
'Please proceed to the second task and you can return to the first task at a later time.'

If a candidate elects to finish early after the final task:

- 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.

When the candidate enters the room briefly check ID number.

You have no opening statement.

The role player opens with the following statement:

'Hi Doc, the registrar said you could sign these forms for me.'

This is your specific prompt:

At **five (5) minutes** the examiner hands the question to the candidate and say:

'Please proceed to address the second task.'

THE SECOND TASK:

Bradley had previously been advised NOT to drive a heavy goods vehicle.

One month later, Bradley's partner contacted the clinic to cancel his appointment because he is making a truck delivery run.

Address the ethical issues relating to 'fitness to drive' raised by this situation to the examiner.

3.2 Background information for examiners

In this station the candidate is expected to undertake a brief assessment related to fitness to drive in a young man who still presents with residual symptoms following a manic episode 2 months ago. The candidate is required to negotiate a plan with a patient who is reluctant to accept advice given about not driving.

In the second task, which is a VIVA, the candidate is advised that the patient is driving against medical advice. They must address the ethical issues pertinent to 'fitness to drive'.

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

- Assess for compliance with medication
- Advise Bradley not to drive a heavy vehicle
- Provide Bradley with information about the possible consequences of his actions if he were to drive against medical advice.
- Identify the protection of public as an ethical component of 'fitness to drive'.

Driving a motor vehicle is a complex task involving perception, appropriate judgement, adequate response time and appropriate physical capability. A range of medical conditions, disabilities and treatments may influence these driving prerequisites. Such impairment may adversely affect driving ability, possibly resulting in a crash causing death or injury.

Medical practitioners must develop skills to assess their patients' fitness to drive, promote the responsible behaviour of their patients (having regard to their medical fitness), conduct medical examinations for the licensing of drivers as required by licensing authorities, and recognise the extent and limits of their professional and legal obligations with respect to reporting fitness to drive.

The aim of determining fitness to drive is to achieve a balance between minimising any driving-related road safety risks for the individual and the community posed by the driver's permanent or long-term injury or illness, and maintaining the driver's lifestyle and employment-related mobility and independence.

Consideration of the physical and mental requirements to perform the **driving task** is fundamental to assessing a person's medical fitness to drive. Important aspects of cognitive function that influence the ability to drive include attention and concentration, comprehension, memory, insight, judgement, decision making and reaction time.

Medical practitioners will frequently treat patients who have conditions that only temporarily affect the ability to drive safely. These conditions are self-limiting and hence **do not impact on licence status**; therefore, the licensing authority need not be informed. However, the treating health professional should provide suitable advice to such patients regarding driving safely, particularly for commercial vehicle drivers. Such advice should be based on consideration of the likely impact of the patient's condition, and their specific circumstances on the driving task as well as their specific driving requirements.

Clinical Assessment of 'fitness to drive':

This involves a history and mental state examination, including cognitive function. Pertinent aspects of the history for patients with a psychiatric disorder include: whether the person has ever been found unfit to drive a motor vehicle in the past; problems arising from alcohol and / or drugs; whether the person has a history of motor vehicle incidents (crashes, near misses, driving offences); whether the person is taking medications that might affect their driving ability, the existence of other medical conditions that, when combined, might exacerbate any road safety risks; the degree of insight the patient has into their ability to drive safely; and the nature of their current driving patterns and needs, for example, how frequently they drive, for what purposes, over what distances and whether they travel at night.

In regards to psychiatric conditions, a person is not fit to hold an unconditional private (car) licence if their condition is of such severity that it is likely to impair insight, behaviour, cognitive ability or perception required for safe driving. Although the threshold for a commercial licence is higher due to the increased risks present, the conditions are the same.

A conditional licence may be considered if:

- the condition is well controlled and the person is compliant with treatment over a substantial period; and
- the person has insight into the potential effects of their condition on safe driving; and
- there are no adverse medication effects that may impair their capacity for safe driving; and
- the impact of co-morbidities has been considered (e.g. substance misuse).

While many medications have effects on the central nervous system, most, with the exception of benzodiazepines and some tricyclic antidepressants, tend not to pose a significantly increased crash risk when the medications are used as prescribed, and once the patient is stabilised on the treatment. There are a number of factors that a medical practitioner should consider when prescribing medication:

- the balance between potential impairment due to the medication and the patient's improvement in health on safe driving ability;
- the individual response of the patient to the medication – some individuals are more affected than others;
- the type of licence held and the nature of the driving task (i.e. commercial vehicle driver assessments should be more stringent);
- the added risks of combining two or more medications capable of causing impairment, including alcohol;
- the added risks of sleep deprivation on fatigue while driving, which is particularly relevant to commercial vehicle drivers;
- the potential impact of changing medications or changing dosage;
- the cumulative effects of medications;
- the presence of other medical conditions that may combine to adversely affect driving ability; and
- other factors that may exacerbate risks such as known history of alcohol or drug misuse.

Health professionals have both an ethical and legal duty to maintain patient confidentiality. The patient–professional relationship is built on a foundation of trust. Patients disclose highly personal and sensitive information to health professionals because they trust that the information will remain confidential. If such trust is broken, many patients could either forgo examination / treatment and / or modify the information they give to their health professional, thus placing their health at risk.

Although confidentiality is an essential component of the patient–professional relationship, there are, on rare occasions, ethically and / or legally justifiable reasons for breaching confidentiality. With respect to assessing and reporting fitness to drive, the duty to maintain confidentiality is legally qualified in certain circumstances in order to protect public safety. The health professional should consider reporting directly to the driver licensing authority in situations where the patient is either:

- unable to appreciate the impact of their condition;
- unable to take notice of the health professional's recommendations due to cognitive impairment, or continuing to drive despite appropriate advice and thus likely to endanger the public.

It is preferable that any action taken in the interests of public safety should be taken with the consent of the patient wherever possible, and should certainly be undertaken with the patient's knowledge of the intended action.

The patient should be fully informed as to why the information needs to be disclosed to the driver licensing authority, and be given the opportunity to consider this information. The patient should be encouraged to report their condition voluntarily to the driver licensing authority, and should be reminded of their legal obligation to do so. In cases where the health professional becomes aware that a patient is continuing to drive and is likely to endanger the public, despite the health professional's advice, reasonable measures to minimise that danger will include notification of the driver licensing authority. The patient should be informed of the health professional's intent to report.

In making a decision to report directly to the driver licensing authority, it may be useful for the health professional to consider:

- the seriousness of the situation (i.e. the immediate risks to public safety);
- the risks associated with disclosure without the individual's consent or knowledge, balanced against the implications of non-disclosure the health professional's ethical and professional obligations;
- whether the circumstances indicate a serious and imminent threat to the health, life or safety of any person.

Sometimes patients feel affronted by the possibility of restrictions to their driving or withdrawal of their licence and may be hostile towards their treating health professional. In such circumstances the health professional may elect to refer the driver to another practitioner or may refer them directly to the driver licensing authority without a recommendation regarding fitness to drive. Driver licensing authorities recognise that it is their role to enforce the laws on driver licensing and road safety, and will not place pressure on health professionals that might needlessly expose them to risk of harassment or intimidation.

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 Bradley, a 29-year-old man, living with your partner Kylie, and you have been working as a (cash in hand) labourer for a few weeks. You were recently discharged from hospital for your 'bipolar disorder'.

You are seeing this doctor so that you can get your driver's licence paperwork signed. Earlier today you saw a psychiatrist trainee doctor (called a registrar) for a scheduled follow-up appointment in the clinic. You asked him to sign the forms but he said he wasn't sure he could, and he would ask this psychiatrist to see you.

About driving and the driver's licence

You have received notification in the mail for renewing your driving licence (including heavy vehicle use). In the past you have had to make a special appointment to see a psychiatrist to get written approval so you are quite pleased that you are lucky to be seeing a psychiatrist at the same time that the licence renewal is required.

You have been driving since you were 18. You gained a commercial heavy duty licence when you were 23, and had been working for a friend of the family in a delivery business. You have tried some other jobs following the previous episode of mania but returned to driving trucks as you preferred it. You have never had any driving problems at work.

You did have a minor crash 10 years ago when you hit the car in front of you when it stopped suddenly. You have had 2 speeding fines from 2 years ago.

On Monday you were pulling out from a T-junction when you had to brake and swerve to miss a vehicle on the main highway. You are adamant that they were '*speeding*', and so you must have just misjudged the safe distance for pulling out into the road. You do not believe that you have any problems with driving at the moment.

How you feel now:

You had a 4-week admission to hospital in the mental health ward 2 months ago. At the moment, you feel good in your spirits. You feel sharp and clear in your thoughts. Your energy is '*enough for work, gym and living*'. You sleep well if you take the medication.

Since discharge from hospital you have been working as a labourer, and you are making sure that your debts (following '*extravagant*' purchases of a car and motor bike 2 years ago) are being reduced. Your plans for the future are focussed on finding better employment, and more long term renovation plans for your unit. You are looking for work that requires your Heavy Vehicle licence.

If asked about your medication, you can forget your pills sometimes. This was especially the case about 10 days ago when you had a camping trip (for 3 nights) with some friends, and left your medication at home. You don't really think it made a difference to miss those doses; because you feel well again, so you might not need the medication anyway.

Your recent past psychiatric history

Before this recent admission, you had an episode of mania that began gradually about a month beforehand. You became unwell following the stress of losing your job as a delivery driver as the firm had gone bankrupt. The first symptoms included disturbed sleep and restlessness precipitated by worry about debts. You became more irritable and easily frustrated. The mental health acute Crisis team were seeing you a day or two before the admission.

By the time of admission your thoughts were racing and you could not concentrate, you had come up with many schemes to generate money, you could not sleep, you had increased sex drive, and you were '*rushing around not managing to achieve anything*'. You had been more prone to outbursts of anger. Kylie had hidden your car keys as she was worried what may happen, and had called the Crisis mental health team for help. You were admitted involuntarily under the Mental Health Act but this was changed after about 2 weeks when your symptoms began to settle.

When you were first discharged you still didn't feel your normal self, but the clinical team felt you were well enough to be at home. You felt sedated in the mornings because of the night time medication – OLANZAPINE 10milligrams a day – that you have been told it is '*a mood stabiliser*'. Your thoughts could still race at times, and ideas could '*run away with themselves*'. Your sleep could still be broken through the night, and you could not concentrate as well as before. But as time has progressed you felt back to your '*normal self*'.

Other mental health history:

You had a previous episode of mania about 5 years ago when you spent a similar time in hospital. You have also had an episode of depression over a few months in the past that did not require admission. You did not take medication prior to this recent episode.

You do not use any illicit substances, and very rarely drink. You are physically healthy.

4.2 How to play the role:

You are casually dressed but clean and tidy. You come across as confident, and a bit overly friendly. You can be distractible. You will become angry and frustrated if told that you cannot drive either a car or heavy vehicle. You will need to express concern about your future job prospects if your heavy vehicle licence is withdrawn. You can be persuaded to settle, and accept a plan that involves you not driving for only a short period.

4.3 Opening statement:

'Hi Doc, the registrar said you could sign these forms for me.'

4.4 What to expect from the candidate:

The candidate should briefly check your psychiatric history, and will want to discuss a plan in relation to your 'fitness to drive'. They may wish to address treatment, and ways to improve how to take your medication regularly. They will want to discuss your current driving, and plan for a period where you do not drive before having a future review. The candidate should use conflict resolution skills to diffuse your anger at not being able to drive a truck.

4.5 Responses you MUST make:

'You better not say you can't sign, Doc!'

4.6 Responses you MIGHT make:

'That's ridiculous! How am I supposed make a living?'

4.7 Medication and dosage that you need to remember

You are taking OL-ANZ-A-PEEN 10 milligrams at night.

STATION 6 – MARKING DOMAINS

The main assessment aims are:

- To assess fitness to drive with the clinical information provided.
- To negotiate a plan related to driving with a patient.
- To evaluate understanding of ethical issues pertinent to 'fitness to drive'.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 20%)

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

Achieves the Standard by:

obtaining a history relevant to the patient's circumstances with appropriate depth and breadth; history taking is hypothesis-driven; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to driving; demonstrating phenomenology; clarifying important positive and negative features; assessing for typical and atypical features.

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

- a. Assess for compliance with medication.

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) if:

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 if: omissions adversely impact on the obtained content; significant deficiencies in key parts of the history.

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

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value – 25%)

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 capacity to prioritise plans; address risk management; review medication and other specific treatments; engage appropriate treatment resources / support safely and skilfully; incorporate safe, realistic time frames / review plan; recognise their role in effective treatment; identify potential barriers; consider the need for consultation.

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

- a. Advise Bradley not to drive a heavy vehicle.

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) if:

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"/>

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

constructively de-escalates the situation; positively promotes safety for all involved; demonstrates sophisticated reflective listening skills.

Achieves the Standard by:

recognising challenging communications; listening to differing views; demonstrating capacity to apply management strategies; aiming to reach a positive outcome; effectively managing the situation with due regard for safety and risk.

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

- a. Provide Bradley with information about the possible consequences of his actions if he were to drive against medical advice.

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:

any errors or omissions impair attainment of positive outcomes; inadequate ability to reduce conflict.

2.3. Category: CONFLICT MANAGEMENT	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"/>

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

comprehensively considered all major aspects of ethical conduct and practice.

Achieves the Standard 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; identify influence of industry / available resources in the local setting; apply ethical principles to resolve conflicting priorities; 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.

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

- a. Identify the protection of public as an ethical component of 'fitness to drive'.

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 appear aware of or adhere to accepted medical ethical principles.

7.1. Category: ETHICS	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

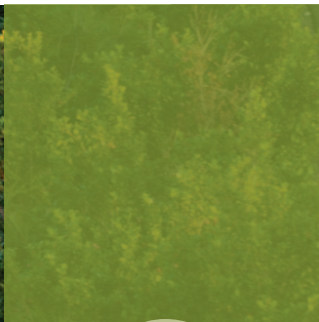
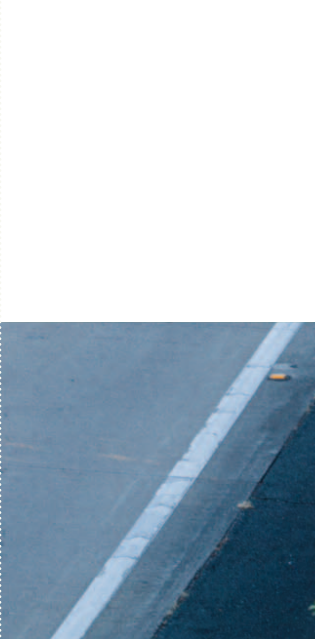
Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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Assessing Fitness to Drive

for commercial and private vehicle drivers



2016

Medical standards for
licensing and clinical
management guidelines



Medical condition notification form

To: [Insert the address of your local driver licensing authority – refer to [Appendix 9: Driver licensing authority contacts](#)]

Patient details [please print]:

Mr/Mrs/Ms: _____ Surname: _____

Given names: _____

Full address: _____

Date of birth: / / Licence no.: _____

Assessment of Fitness to Drive – Report

I have examined the patient (whose name, address and date of birth are set out above) in accordance with the relevant National Medical Standards (private or commercial) as set out in *Assessing Fitness to Drive, 2016*.

Private vehicle standards Commercial vehicle standards

I have known/treated the patient for _____ years.

According to this assessment, please select **ONE** of the **THREE** options below and provide supporting information:

Option 1

In my opinion, the person who is the subject of this report **does not meet** the medical criteria to hold an unconditional licence (as outlined in *Assessing Fitness to Drive*) but may meet the medical criteria to hold a **conditional licence**.

Please describe the nature of the condition and the medical criteria that are not met.

Please provide information to support the consideration of a **conditional licence** including evidence of the medical criteria met and consideration of the nature of the driving task.

Please describe any recommended **licence conditions** or **restrictions** relating to the driver’s medical condition including requirements for periodic review (e.g. annual review), vehicle modifications, corrective lenses or restricted daytime driving, etc.

Further comments on medical condition(s) affecting safe driving appear attached

OR

Option 2

In my opinion, the person who is the subject of this report **does not meet** the medical criteria to hold an **unconditional** or **conditional licence** as outlined in *Assessing Fitness to Drive*.

Please describe the nature of the condition and the medical criteria not met, including a consideration of the driving task.

Further comments on medical condition(s) affecting safe driving are attached

OR

Option 3

Reinstatement of licence:

In my opinion the medical condition of the person who is the subject of this report has improved so as to meet the criteria for a **conditional** or **unconditional licence**.

Please provide details of: the criteria previously not met; the response to treatment and prognosis; duration of improvement; and other relevant information including consideration of the driving task.

Further comments on medical condition(s) affecting safe driving are attached.

Health professional's details: Reporting professional's name [please print]:

Professional's address:

Telephone: ()

Fax: ()

Date of examination: / /

Signature:

1.0 Descriptive summary of station:

The candidate has been asked to urgently see a patient Dianne, whom they have been treating for bipolar disorder for the past 2 years. Her illness is well controlled and her mental state has been stable. Dianne has requested the appointment, as she is concerned about her son Jack. Jack started preschool about 1 month ago. The teacher from the kindergarten approached Dianne last week and suggested she get Jack assessed for a possible Autism Spectrum Disorder (ASD) without much explanation as to why. Dianne would like to know what ASD is, how it is diagnosed and how it is managed.

1.1 The main assessment aims are:

- To explain what ASD is, how it is diagnosed and some of the management strategies that can be used to manage it.
- To manage the distressed patient whose son may have a diagnosis of ASD while still providing accurate information about the condition.

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

- Explain that the information may not apply to Jack, as he has not yet had a formal assessment.
- Explain that there is no scientific evidence linking vaccines to autism.
- Mention deficits in social interactions, behaviour and communication as key components of ASD.
- Mention at least one of each of the biological, psychological and environmental interventions useful in the management of ASD.
- Mention the importance of early intervention.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders (e.g. sex, neuropsychiatric, sleep, somatoform, eating, etc.)
- **Area of Practice:** Child & Adolescent Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Diagnosis, Management - Therapy), Communicator (Synthesis), Scholar (Application of Knowledge)

References:

- <https://www.autismcra.com.au/national-guideline-autism-diagnosis-australia>
- Behavioural and Developmental Interventions for Autism Spectrum Disorder: A Clinical Systematic Review Maria B. Ospina, Jennifer Krebs Seida, Brenda Clark, Mohammad Karkhaneh, Lisa Hartling, Lisa Tjosvold, Ben Vandermeer, Veronica Smith
- PLOS, Published: November 18, 2008, <https://doi.org/10.1371/journal.pone.0003755>
- Paediatrics November 2012, VOLUME 130 / ISSUE Supplement 2, http://pediatrics.aappublications.org/content/130/Supplement_2 Nonmedical Interventions for Children With ASD: Recommended Guidelines and Further Research Needs Margaret A. Maglione, Daphna Gans, Lopamudra Das, Justin Timbie, Connie Kasari, For the Technical Expert Panel,, HRSA Autism Intervention Research – Behavioural (AIR-B) Network
- www.betterhealth.vic.gov.au/health/conditionsandtreatments/autism-spectrum-disorder-asd
- www.autismspectrum.org.au
- www.autismtreatmentcenter.org
- Autism spectrum disorders Tonge, Bruce; Brereton, Avril. Australian Family Physician; Melbourne 40.9 (Sep 2011): 672-7.
- Roberts, J. M. A., & Prior, M. (2006). A review of the research to identify the most effective models of practice in early intervention of children with autism spectrum disorders. Australian Government Department of Health and Ageing, Australia.

Committee for Examinations
Objective Structured Clinical Examination
Station 7
Adelaide September 2017



1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Young woman, late 20s, neatly dressed, easy to talk to.
- 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 a community mental health centre. Dianne has bipolar disorder that you have been treating for the last two years. Her mental state has been stable for the past 18 months and there are no reports of recent concerns.

Dianne requested this appointment as she is concerned about her 3-year-old son Jack. His teacher at preschool suggested Dianne get him assessed for a possible diagnosis of an Autism Spectrum Disorder (ASD) with no explanation as to what the condition is and why she feels Jack should be assessed. Dianne understands that her son has not actually been diagnosed with Autism Spectrum Disorder (ASD) but would like to know about the condition as the possibility has been raised.

Your tasks are to:

- Provide accurate information on the current understanding of ASD and its causes.
- Explain how a diagnosis of ASD is made.
- Outline the management options available for ASD.

You are **NOT** expected to gather any history about Jack's development or behaviour.

You will not receive any time prompts.

Station 7 - 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'.
 - 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 that there are no cues / scripted prompts for you to give.
- 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 **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:
***'Are you satisfied you have completed the 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.

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'Hello doctor, thanks for seeing me at short notice.'

3.2 Background information for examiners

The aims of this station are to assess the candidates ability to describe current knowledge about the causes of Autism Spectrum Disorder (ASD), how the condition is diagnosed and what management options are available. They are required to do this while managing the distress evident in a mother who happens to be a patient with bipolar disorder.

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

- Explain that the information may not apply to Jack, as he has not yet had a formal assessment.
- Explain that there is no scientific evidence linking vaccines to autism.
- Mention deficits in social interactions, behaviour and communication as key components of the ASD.
- Mention at least one of each of the biological, psychological and environmental interventions useful in the management of ASD.
- Mention the importance of early intervention.

A surpassing candidate may acknowledge the limitations of the information provided in that they are giving general information and that this may not apply to her child, but can assist in her understanding ASD and whether any of these issues and suggestions are relevant to her child and family. The better candidate will comprehensively cover a range of biological, psychological and environmental domains for diagnosis and interventions for autism spectrum disorder. The better candidate will be able to not only describe current knowledge about the causes of ASD but also the limitations of this knowledge.

About Autism Spectrum Disorders

ASDs are lifelong, pervasive developmental disabilities characterised by markedly impaired development and difficulties in social interaction and social communication; and restricted and repetitive, stereotyped interests and behaviours. It is a disorder that is usually diagnosed in early childhood with developmental delays in social interaction and language surfacing prior to age 3 years. A type of autism characterized by very early detection (< 30 months) may present with social coldness, grossly impaired communication, and bizarre motor responses.

It is a condition that affects a person's ability to interact with the world around them. ASD varies greatly in if presentation and has wide-ranging levels of severity and varying characteristics. Children with autism might have problems talking with others, or they might not look people in the eye when they talk to them. They may spend a lot of time putting things in order before they can pay attention, or they may say the same sentence again and again to calm themselves down.

The word 'spectrum' is used because the range and severity of the difficulties people with an ASD experience can vary widely. Currently all children on the autism spectrum are diagnosed with ASD. Previously, a number of different terms were used including autistic disorder, Asperger's disorder (milder version) and pervasive developmental disorder.

Research shows that about 1 in 100 children, (e.g. almost 230 000 Australians), have an ASD and that it is more prevalent in boys than girls. Because of the range of presentations, it is important to present an optimistic outlook in this scenario. Many famous people are considered to suffer from ASD: e.g. Daryl Hannah, Dan Aykroyd, Andy Warhol, Mozart, Thomas Jefferson, James Joyce and Stanley Kubrick.

Currently, there is no single known cause for ASD, however recent research has identified strong genetic links. ASD is not caused by an individual's upbringing or their social circumstances (see below).

There are a range of behaviours commonly linked with ASD. These may include:

- language – absent, delayed or abnormal developmental patterns
- play – isolated, repetitive, a preference for predictable play, difficulty with imaginative play; stereotypical behaviour, such as flapping and toe walking, and other behaviours that may cause self-injury.
- restricted or obsessive behaviour – with favourite topics, objects, places, people or activities
- rituals and routines – these bring some order to chaos and confusion. A change to routine can result in the person displaying high levels of stress, anxiety or acting out
- tantrums 'meltdowns' – can be a way to express extreme confusion, stress, anxiety, anger and frustration.
- sensory processing differences – difficulties processing certain sounds, colours, tastes, smells and textures. People may seek or avoid particular sensations. Some people will have difficulty with discriminating sensory information too, for example hot versus cold.

There is no medical test for diagnosing ASD. ASD is diagnosed through observation and assessment by health professionals, which may include a paediatrician; psychologist or psychiatrist; speech pathologist or occupational therapist. Usually two separate professionals will assess a child for ASD to confirm a diagnosis.

The tools used for assessment often include questionnaires for teachers, carers and family. These can be formalized by using the:

- Child Autism Rating scale CARS II
- Autism Diagnostic Observation Schedule ADOS II
- Modified checklist for autism in toddlers M-CHAT
- Ages and stages questionnaire
- Autism Diagnostic Interview (Revised)
- Autism Screening Questionnaire (ASQ)

Some children will show signs of ASD by the age of two and will be diagnosed then. Others may be diagnosed when they are older. The earlier ASD can be diagnosed the sooner therapy can begin. Early intervention has been shown to improve outcomes for children on the autism spectrum.

Causes of ASD

To date, there is no accepted single cause of Autism although there are numerous theories. It is becoming apparent that, 1) ASD is most probably caused by multiple factors interacting in complex ways (i.e. multiple genes, environment and brain) and, 2) that ASD is not etiologically homogeneous. That is, there are probably numerous sub-types of ASD each with differing aetiologies. For example, there is evidence of a sub-group of children diagnosed with ASD (20-30%) who show skill regression between 18 - 24 months after apparently normal initial development (Lainhart et al, 2002) while other children with ASD show consistently delayed development.

Genetics have been shown to play a role but do not explain the full picture or the recent increase in reported cases. Studies have shown that if one identical twin has the diagnosis, then there is a 30-40% chance that the other twin will develop ASD. This concordance is hardly ever seen with non-identical twins. (Bailey et al, 1995). When a wider definition of ASD is used, the probability rates rise to 90% for identical twins and 10% for non-identical (Bailey et al, 1995). The probability of receiving an ASD diagnosis when another sibling has already been diagnosed is estimated between 2 and 14%, a 10- to 20 -fold increase over the general population incidence (see Hertz-Picciotto et al, 2006. Research into genetics suggests that at least 40% of ASD cases may have an environmental cause (Hertz-Picciotto et al, 2006).

A few studies have begun to find some cases of ASD linked to maternal exposure to certain viruses (measles, mumps, rubella, herpes, syphilis, cytomegalovirus and toxoplasmosis) and chemicals (thalidomide and valproic acid). However, these account for a very small proportion of all cases (Hertz-Picciotto et al, 2006). More and more researchers are turning to environmental causes (e.g. heavy metals, PCBs pesticides and PDBEs) as a central hypothesis. Large-scale studies have been set up to begin to understand the contribution of environmental factors to the aetiology of ASD, for instance the CHARGE (Childhood Autism Risk from Genetics and Environment) study at University California-Davis.

A 2003 article in The Journal of Autism and Developmental Disorders reported a 10-fold increase in incidence of ASD diagnosis in the United States from 4-5 per 10,000 children (1980s) to 30-60 per 10,000 (1990s). A portion of this increase is undoubtedly due to greater clinician awareness and wider inclusion criteria, but this cannot explain such a rapid and dramatic increase.

It is widely accepted that atypical brain development underlies the development of the observable symptoms of ASD. These differences in brain development can be traced to either before birth or very soon after birth even though the behavioural and social signs of Autism tend not be observable until after 18 months following birth.

Studies have shown differential development in many brain areas including the frontal and temporal lobes, the cerebellum, and the sub-cortical amygdala and hippocampus. Scarcity of evidence, methodological challenges and conflicting findings have not yet allowed precise conclusions to be drawn about either the specific brain regions affected or the mechanism of development that lead to observed brain differences.

Other health conditions

Below are some other conditions known to be associated with ASD:

- muscular dystrophy – a group of inherited genetic conditions that gradually cause muscles weakness.
- Down's syndrome – a genetic condition typically causing learning disability and a range of physical features.
- cerebral palsy – brain and nervous system conditions causing problems with movement and coordination.
- neurofibromatosis – a number of genetic conditions causing tumours to grow along the nerves (the main types are neurofibromatosis type 1 and neurofibromatosis type 2).
- rare genetic conditions fragile X syndrome, tuberous sclerosis and Rett syndrome.
- foetal alcohol syndrome.
- intellectual impairment.
- attachment disorder.

Misconceptions about the causes of ASD

In the past, a number of things were linked to ASD, but extensive research has found no evidence to suggest that any of these contribute to the condition, including:

- the MMR vaccine.
- thiomersal – a compound that contains mercury, which is used as a preservative in some vaccines.
- the way a person has been brought up.
- diet, such as eating gluten or dairy products.

Any link between immunisation and ASD has been completely discredited. The key study that questioned this was the Wakefield Study in 1998.

Extensive research conducted globally for a decade did not establish any link between vaccines and ASD. Despite this finding, as a precaution, thiomersal in particular has been withdrawn from the standard childhood vaccines in Australia and many other countries.

DSM-5™ 299.0 (F84.0)

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions or affect, to failure to initiate or respond to social interactions.
 2. Deficits in nonverbal communicative behaviours used for social interaction; ranging for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behaviour to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behaviour [Level 3 – “Requiring very substantial support,” Level 2 – “Requiring substantial support,” Level 1 – “Requiring support.”]

- B. Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g. simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour (e.g. extreme distress at small changes, difficulties with transitions, rigid thinking pattern, greeting rituals, need to take same route or eat same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g. strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behaviour [Level 3 – “Requiring very substantial support,” Level 2 – “Requiring substantial support,” Level 1 – “Requiring support.”]

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

ASD may be comorbid with intellectual impairment and may have accompanying language impairment. It can be associated with a medical or genetic condition or environmental factor, or with another neurodevelopmental, mental, or behavioural disorder, or with catatonia.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. Autistic Disorder in ICD-10-CM diagnostic code.

Diagnosis of ASD in adults

It is not unusual for people on the autism spectrum to have reached adulthood without a diagnosis. Sometimes people will discover some information about ASD that makes them consider if that diagnosis fits their difficulties or symptoms. Some may then choose to talk to a health professional for a diagnosis if:

- they have been diagnosed with a mental health condition and/or intellectual disability during childhood
- they have struggled with feeling socially isolated, had lifelong social challenges or felt different from their peers throughout life.
- they have not benefitted from a range of interventions to assist with social challenges and wonder if these are lifelong problems.
- members of their family have suggested they may have ASD.
- a child or another family member has been diagnosed with ASD and some of the characteristics of autism sound familiar.

Summary of Treatments for Children with Autism Spectrum Disorders

There is no cure, but treatment can help. Treatments include behaviour and communication therapies and medicines to control symptoms. Starting treatment as early as possible is important (National Institute of Child Health and Human Development). A large number of treatments are currently used with children with autism.

For most of interventions, further research is required to: (a) examine which children are most likely to benefit, (b) identify the most effective strategies for supporting their introduction and use, and (c) ascertain the extent to which a child's experience of a treatment fosters his or her general adaptive functioning. The following is a summary of the research evidence for treatments identified in this review.

1. Biologically Based Interventions Medication

There is currently no medical treatment for the core features of autism, although attempts have been made to use medications to treat symptoms and co-morbid disorders of autism such as anxiety and ADHD, as well as to increase the likelihood that children will benefit from concurrent interventions. The following medications have been demonstrated to have some effect, although careful monitoring is required to measure effects and side effects: risperidone, SSRIs, stimulants, anticonvulsants. The following medications have been shown to be ineffective and/or harmful for children and adolescents with autism: naltrexone, secretin, adrenocorticotrophin Hormone (ACTH).

2. Complementary and alternative interventions

These include exclusion diets (casein and gluten-free diet), anti-yeast therapies, chelation, secretin, withholding the MMR vaccine and vitamin/dietary supplements including vitamin B6. There is minimal evidence demonstrating the effectiveness of these interventions and considerable evidence demonstrating no effect for some such as secretin and withholding the MMR vaccine.

3. Psychodynamic Interventions

Psychodynamic therapies are based on the assumption that autism is the result of emotional damage to the child, are seldom used today, as there is strong evidence to support the perspective that autism is a developmental and cognitive disorder.

4. Educational Interventions

Autism Intervention Programs and specific schools offer:

- smaller class sizes to improve teacher and student relationships
- the availability of school support officers to assist children to manage anxiety in class and in particular in group situations
- the use of alternate communication pathways such as PECS (picture exchange communication systems); Makaton; Auslan and text to speech software.

5. Behavioural Interventions

Behavioural interventions are those in which operant learning techniques based on learning theory constitute the predominant feature of the intervention approach (Francis, 2005). Applied behaviour analysis (ABA) is an approach in which operant learning techniques are applied in a systematic and measurable manner to increase, reduce, maintain, and/or generalise target behaviours.

Discrete Trial Training (DTT) is one of the instructional methodologies frequently used in ABA-based programs, and involves breaking down specific skills into small discrete components. The Lovaas program, also known as the Young Autism Project, is a widely imitated example of the intensive behavioural programs.

6. Contemporary Applied Behaviour Analysis

There are several contemporary ABA programs including Pivotal Response Training (PRT), Natural Language Paradigm (NLP), and Incidental Teaching.

There is universal agreement that behavioural interventions have produced positive outcomes for children with autism that are well supported by research. Few other treatment programs have been subjected to the level of research scrutiny that has been applied to behavioural interventions. However, there continues to be controversy about particular behavioural interventions and programs, concerns about methodological issues, and differences in the interpretation of research findings.

7. Developmental (normalised) Interventions

Developmental or relationship based interventions focus on the child's ability to form positive, meaningful relationships with other people. Generally, the aims of these programs are to promote attention, relating to and interacting with others, experience of a range of feelings, and organised logical thought. To date, there is little research evidence to support the effectiveness of developmental interventions for children with autism.

Further research is required to determine the effectiveness of these interventions. The Developmental Social-Pragmatic Model emphasises the importance of initiation and spontaneity in communication, following the child's focus of attention and motivations, building on the child's current communicative repertoire, even if this is unconventional, and using natural activities and events as contexts to support the development of the child's communicative abilities.

8. Floor Time (DIR)

Floor Time, or the Developmental Individual-Difference Relationship-Based Model (DIR), is a developmental approach for early intervention with infants and children with a disability, including autism. The program includes interactive experiences, which are child directed, in a low stimulus environment. Proponents contend that interactive play, in which the adult follows the child's lead, will encourage the child to 'want' to relate to the outside world.

9. Relationship Development Intervention (RDI)

RDI is a series of techniques and strategies built upon the typical developmental processes of social competence. The goal of RDI is to increase motivation and interest in social relating in individuals with autism and provide activities and coaching to assist them to enjoy and become competent in social relationships.

10. Responsive Teaching (RT)

Responsive Teaching (RT) is a parent-mediated program, grounded in contemporary child development theory, which aims to help parents to interact more responsively with their children Relationship Development Intervention (RDI).

Therapy Based Interventions

1. Communication Focused Interventions

A number of communication focused interventions are commonly used with children with autism. These may be used in isolation or integrated into a more comprehensive program. Some research has examined the effectiveness of communication focused interventions with mixed results but there is a lack of large, comprehensive, and well controlled studies

2. Visual Strategies and Visually Cued Instruction

Visual strategies and visually cued instruction are commonly used to facilitate children's expressive and receptive communication and to support their learning, information processing, and ability to navigate both the physical and social environment.

3. Manual Signing

Manual signing has long been used to support the comprehension and expression of children with autism. However, further research is required to evaluate the functional outcomes for children.

4. The Picture Exchange Communication System (PECS)

The Picture exchange Communication System (PECS) is a program that teaches children to interact with others by exchanging pictures, symbols, photographs or real objects for desired items. The goals of PECS include the identification of objects and the learning of responses to simple questions with multi-picture systems. It is a highly structured program.

5. Social Stories

Social stories were originally developed by Carol Gray (Gray & Garand, 1993) in order to explain social situations to children with autism and to help them to actively learn appropriate responses to social cues.

6. Speech Generating Devices

Speech generating devices (SGDs) have been used to support both the expressive and receptive communication of children with autism in particular to support comprehension, promote symbol learning, increase interactions with adults and peers, and support the expression of wants and needs.

7. Auditory Integration Training (AIT)

Auditory integration training aims to address the hypothesised hearing distortions, hyper-acute hearing, and sensory processing anomalies, which may cause discomfort and confusion in people with autism.

8. Sensory Integration Therapy

Sensory Integration Therapy aims to improve the sensory processing capabilities of the brain through the provision of vestibular, tactile, and / or proprioceptive stimulation. Current research does not support SI as an effective treatment for children with autism.

Combined Interventions

1. The SCERTS Model

The SCERTS model focuses on Social Communication, Emotional Regulation, and Transactional Support as the principal dimensions for intervention planning. The goal of the program is to directly address the core deficits observed in children with autism, based on a highly individualised approach.

2. Treatment and Education of Autistic and related Communication Handicapped Children (TEACCH)

TEACCH is a 'whole life' approach aimed at supporting children, adolescents, and adults with autism through the provision of visual information, structure, and predictability. The results of a small number of studies have indicated positive outcomes for children who access the TEACCH program.

3. Learning Experiences-An Alternative Program for Pre-schoolers and Parents (LEAP)

LEAP is a comprehensive preschool service, designed for both children with autism and typically developing children. LEAP has the components of an integrated preschool program and a behaviour skills training program for parents.

4. Family Based Interventions

A number of programs have been developed to provide support to the families of children with autism. Support may include helping parents to understand the nature of autism and their child's learning style, providing parents with teaching and strategies to help support their child's learning, helping family members to establish their own support networks, and providing information about other services and support programs that are available. In family support programs, therapists and professionals work with the parents, siblings, and significant others, rather than directly with the child with autism.

5. Family-Centred Positive Behaviour Support (PBS)

Programs Family-centred PBS programs involve parents and professionals working together, in a systematic and collaborative fashion, to address a child's challenging behaviour. Family centred PBS plans include

- (a) strategies for teaching and increasing skills that are intended to replace the problem behaviours,
- (b) strategies for preventing the problems before they occur,
- (c) strategies for dealing with the problems if or when they do occur, and
- (d) strategies for monitoring progress.

6. The Hanen Program (More than Words)

'*More than Words*' is an intensive training program for parents of pre-school children with autism. The program derives its theoretical framework from a social-pragmatic developmental perspective and emphasises the blending of aspects of both behavioural and naturalistic child-centred programs; the breaking down of activities into structured, small steps found in an ABA program, and the provision of opportunities to use language for functional purposes built into more naturalistic approaches. A preliminary evaluation of treatment outcomes has indicated that the program has some positive outcomes for children and families. Further research is required in order to evaluate this program more comprehensively." *Taken from Roberts, J. M. A., & Prior, M. (2006). A review of the research to identify the most effective models of practice in early intervention of children with autism spectrum disorders. Australian Government Department of Health and Ageing, Australia.*

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 Dianne the 27-year-old mother of Jack aged 3 years - you are a single mother. You and Jack live with your dog, Jemma.

Jack started preschool 1 month ago and you thought things were going well. However, when you went to pick Jack up from preschool his teacher approached you on Tuesday this week and said she was concerned about Jack. The teacher suggested you take him to the GP to start the process of getting him assessed for a possible diagnosis of something called an Autism spectrum disorder. Unfortunately, the teacher was rushing to a meeting and did not have time to explain why she was concerned.

You have never heard of Autism spectrum disorder before but have assumed it is some sort of mental illness. Over the past few days you have become increasingly distressed by the thought he may have a mental illness. You requested an urgent appointment with your psychiatrist (the candidate) to get information on the condition and what it may mean.

You are aware that your son has not actually been diagnosed with Autism spectrum disorder and that this might only occur after a doctor has seen him. You would like information about the condition as the possibility has been raised and you are getting increasingly worried about it.

About Jack

You fell pregnant with Jack after a brief relationship 4 years ago when you were having a hypomanic episode. You were not aware you were pregnant when the relationship ended with Peter and you have had no contact with Jack's father since. With regard to Jack's biological father, you cannot recollect much from this hypomanic period and have no idea how to find him.

You have been single since that time and have raised Jack on your own. Up until now, you have not had any concerns about your son's development. You always thought he was a normal little boy but Jack is your only child and you are not sure how he compares to other children. Your sister and husband live nearby and they have five children who regularly play with Jack. There have never been any concerns raised by the maternal child health nurse or your GP about Jack's development.

About your mental illness

You have a history of bipolar disorder – this means that you have a chronic mental illness that has times when you are very elevated and others when your mood is very low. You first became unwell with depression 5 years ago. You have had 2 manic episodes and one further depressive episode but you have been completely stable for the past 18 months.

If the candidate asks; while you have been distressed since seeing Jack's teacher you do not think you are unwell or becoming unwell. You deny feeling depressed or elevated in your mood. If asked, your sleep, appetite and concentration are normal. Your thoughts are not racing or slowed down. You are able to enjoy things that you usually do, and have hope for the future. Your energy levels are normal. You deny feelings of guilt or hopelessness. You deny suicidal thoughts. There is no anxiety or unusual symptoms (e.g. no voices, feeling unsafe, paranoid etc.) You take your medications regularly every day - which is called olanzapine (10 milligrams tablet at night). You have kept all your recent appointments because you are very committed to keeping well.

4.2 How to play the role:

Casually but neatly dressed female in her late twenties. Easy to engage, and listen attentively to what the doctor has to say. You can be somewhat anxious about Jack.

4.3 Opening statement:

'Hello doctor, thanks for seeing me at short notice.'

4.4 What to expect from the candidate:

The candidate may enquire if you have had any concerns about Jack's development and if your mental state is OK. The answer to both is no. The candidate should then go onto an explanation of the condition and how it can be managed.

4.5 Responses you MUST make:

'I think he is fine.'

'So what sort of difficulties could Jack have?'

'What causes autism; is it something I have done?'

'Can autism spectrum disorder be caused by vaccinations?'

4.6 Responses you MIGHT make:

If you are asked whether you think any of the presenting symptoms fit Jack:

Scripted Response: ***'No, he seems like a normal little boy to me but he is my only child and I am not sure what normal is.'***

If you are asked whether you were on any medications when you were pregnant:

Scripted Response: ***'No, I was off my medicines when I fell pregnant and the hypomanic episode settled without treatment.'***

4.7 Medication and dosage that you need to remember:

You are on olanzapine (OL-ANZA-PEEN) 10 milligrams daily.

STATION 7 – MARKING DOMAINS

The main assessment aims are:

- To explain what ASD is, how it is diagnosed and some of the management strategies that can be used to manage it.
- To manage the distressed patient whose son may have a diagnosis of ASD while still providing accurate information about the condition.

Level of Observed Competence:

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills appropriate to the context of speaking with a worried parent of a young child? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

integrates and provides information in a manner that can effectively be utilised by a carer requesting information about ASD; communication is accurate, empathetic and clear. Clear use of reflective listening techniques.

Achieves the Standard by:

providing an accurate and structured explanation about ASD to the mother; delivering information in a sensitive way that would be understood by most lay people; recognising that the information may be distressing to the carer and demonstrating discernment in selection of content; taking into account that no formal diagnosis has been made.

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

- Explain that the information may not apply to Jack, as he has not yet had a formal assessment.

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. This would include a failure to be empathetic or accurate.

Does Not Achieve the Standard (scores 0) if:

any errors or omissions impact on the accuracy of information provided; fails to be both empathetic and accurate in information provided.

2.5. Category: SYNTHESIS	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

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature, research and clinical experience on the possible causes of ASD? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

acknowledges that scientific information is not in a state of known versus unknown but is the subject of debate; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:

identifying key aspects of the available literature; commenting on the veracity of the available evidence; discussing major strengths and limitations of available evidence; describing the relevant applicability of theory to ASD; including information on genetic, environmental and neurodevelopmental aetiologies.

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

- Explain that there is no scientific evidence linking vaccines to autism.

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. There is also an acknowledgement about the limitations of current knowledge.

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. This would include providing inaccurate information regarding current knowledge.

Does Not Achieve the Standard (scores 0) if:

unable to demonstrate adequate knowledge of ASD; inaccurately identifies or applies literature / evidence.

6.4. Category: APPLICATION OF KNOWLEDGE	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"/>

1.0 MEDICAL EXPERT

1.9 Did the candidate describe how a diagnosis of ASD is reached? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; clearly describes diagnostic criteria in detail along with commenting on severity; appropriately identifies the limitations of diagnostic classification systems.

Achieves the Standard by:

demonstrating an understanding of diagnostic systems to provide an explanation of how ASD is diagnosed; explaining about exclusion criteria; elaborating that there is no diagnostic test but that the diagnosis is made by history and observations, often by a multidisciplinary team; describing that mild forms may remain undiagnosed for years and do not prevent the individual from leading a normal life.

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

- a. Mention deficits in social interactions, behaviour and communication as key components of the ASD.

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. The candidate would be able to acknowledge some of the limitations of diagnostic criteria.

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. A failure to describe diagnostic criteria or the information is significantly inaccurate.

Does Not Achieve the Standard (scores 0) if:

provides inaccurate or inadequate diagnostic criteria; errors or omissions are significant and do materially adversely affect diagnostic explanation.

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"/>

1.14. Did the candidate demonstrate an adequate knowledge and application of relevant biological, psychological and social therapies can be used in the management of ASD? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support intervention options in ASD; takes a systematic approach that covers the full range of specific biological, psychological and environmental interventions; promotes optimism in outlook; cites examples of famous people with the diagnosis. e.g. Daryl Hannah, Dan Aykroyd, Andy Warhol, Mozart, Thomas Jefferson, James Joyce and Stanley Kubrick.

Achieves the Standard by:

demonstrating an understanding of interventions that can be used in the early intervention and management of ASD; identifying specific outcomes and possible prognosis; outlines choices and rationales for biological, psychological and environmental interventions; outlining the role of family in management; sensitively considering barriers to care; identifying different professional roles involved in care.

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

- a. Mention at least one of each of the biological, psychological and environmental interventions useful in the management of ASD.
- b. Mention the importance of early intervention.

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), or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1. A failure to describe biological, psychological and environmental interventions.

Does Not Achieve the Standard (scores 0) if:

errors or omissions would impact adversely on patient care; recommended plan lacks structure and/or is inaccurate; fails to describe biological, psychological and environmental interventions; demonstrates excessive therapeutic nihilism.

1.14. Category: MANAGEMENT - Therapy	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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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)

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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 final task:

- 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.

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:**

- 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 <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 take an appropriately detailed and focussed history related to panic disorder? (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:**

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

1.2 Did the candidate take an appropriately 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 <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 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 <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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1.0 Descriptive summary of station:

In this station the candidate must assess the suicide risk and offer management recommendations for a 20-year-old woman with an established diagnosis of Borderline Personality Disorder presenting in crisis, who is initially refusing any assistance following an overdose of a small quantity of Paracetamol. The candidate is expected to de-escalate the patient's distress triggered by an unhelpful comment by an emergency department nurse and then proceed to the assessment.

1.1 The main assessment aims are:

- To sensitively manage the interaction with an irritable and challenging patient in crisis.
- To gather information about the patient's intent to self-harm.
- To demonstrate familiarity with current guidelines on management of Borderline Personality Disorder.

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

- Empathically validate that the statement made by the nurse in Emergency Department exacerbated matters.
- Identify the significance of this crisis presentation in the context of two years stability.
- Elicit that the patient is happy to see an alternative therapist.
- Address the issue of the patient refusing medical assessment.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Personality Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Process, Management – Initial Plan); Communicator (Patient Communication – To Patient); Collaborator (Patient Relationships).

References:

- NHMRC CPG on Management of Borderline Personality Disorders.
- RANZCP CPG on Management of Deliberate Self Harm.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: 20-year-old woman, casually attired.
- 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 the local general hospital. You have been called to the Emergency Department in the middle of the working week. There you meet Amanda, a 20-year-old woman, who is well known to the mental health service but not known to you.

Amanda has a diagnosis of Borderline Personality Disorder. She had self-presented stating that she had overdosed on ten tablets of Paracetamol some hours earlier.

After presenting to the Emergency Department, she has become angry and irritable. She is now refusing to have any tests done. Amanda wants to leave the hospital but is willing to talk to you.

Your tasks are to:

- Take a focussed history including a risk assessment from Amanda.
- Address Amanda's concerns.
- Provide your management recommendations to Amanda.

You will not receive any time prompts.

Station 9 - 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'
 - 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 that there are no cues / scripted prompts for you to give.
- 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 **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:
***'Are you satisfied you have completed the 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.

When the candidate enters the room briefly check ID number.

There are no prompts.

The role player opens with the following statement:

'Look doctor, I don't like that stupid nurse – she has really upset me.'

3.2 Background information for examiners

In this station the candidate is expected to engage a distressed young woman who has presented to the Emergency Department after a paracetamol overdose following a crisis. The woman's distress has escalated in response to a negative comment made by a nurse.

The main assessment aims are to evaluate the candidate's ability to sensitively manage the patient's irritability and challenging behaviour. The candidate is required to gather information about the intent to self-harm and complete a risk assessment. The candidate's approach should demonstrate their familiarity with current guidelines on management of Borderline Personality Disorder.

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

- Empathically validate that the statement made by the nurse in Emergency Department exacerbated matters.
- Identify the significance of this crisis presentation in the context of two years stability.
- Elicit that the patient is happy to see an alternative therapist.
- Address the issue of the patient refusing medical assessment.

Candidates are expected to interact and engage the patient in a positive manner and contain the distress by being empathic. They may offer medication to help settle her distress, acknowledging she has found Quetiapine effective in the past.

A surpassing candidate may:

- Recognise that the patient is in an acute crisis due to unforeseen circumstances beyond her control.
- Focus on assisting the patient to manage her distress by being available to manage stressful times until the therapist returns or making alternative arrangements with a willing / helpful stance, and offering to facilitate arranging help.

Borderline Personality Disorder (BPD) is a condition that can make it difficult for people to feel safe in their relationships with other people, to have healthy thoughts and beliefs about themselves, and to control their emotions and impulses. People with BPD may experience distress in their work, family and social life, and may harm themselves as a maladaptive coping strategy.

For many people with BPD, their goals for treatment involve managing their emotions, finding purpose in life, and building better relationships. Many people with BPD have experienced significant trauma, either in the past or in their daily lives, so they need health care that makes them feel safe while they recover.

General principles of BPD care for all health professionals

Health professionals working with people who have BPD should be respectful, caring, compassionate, consistent, and reliable. They should listen and pay attention when the person is talking about their experiences, take the person's feelings seriously, and communicate clearly. If a person with BPD is upset or letting their feelings take over, health professionals should stay calm, and keep showing a non-judgemental attitude.

Health professionals should understand that people with BPD may be very sensitive to feeling rejected or abandoned, and so may be upset when their treatment comes to an end or if they can no longer see the same staff. Health professionals should plan these changes in advance, and explain them to the person.

If people with BPD repeatedly self-harm or attempt suicide, their usual health professional should assess their risk regularly. Health professionals need to gain an understanding of the person over time to be able to tell when the person is at high risk of suicide, and to know whether the person needs to keep working on their long-term BPD treatment or whether they need immediate special care to keep them safe. People who live with thoughts of suicide over time tend to recover when their quality of life improves.

When a person with BPD is experiencing a crisis, health professionals should focus on the 'here and now' matters. Issues that need more in-depth discussion (e.g. past experiences or relationship problems) can be dealt with more effectively in longer-term treatment by the health professional who treats them for BPD (e.g. the person's usual psychiatrist).

Health professionals should try to make sure the person stays involved in finding solutions to their own problems, even during a crisis.

Psychological treatment

People with BPD can stabilise and improve with structured psychological therapies such as Dialectical Behaviour Therapy (DBT). The therapies are conducted by one or more health professionals who are adequately trained and supervised. There is evidence that structured psychological therapies for BPD are more effective than the care that would otherwise be available.

Medicines

Doctors should not choose medicines as a person's main treatment for BPD, because medicines can only make small improvements in some of the symptoms of BPD, but do not improve BPD itself.

Hospitals and specialised BPD services

Admissions to hospitals or other inpatient facilities should not be used as a standard treatment for BPD, and should generally only be used as short-term stays to deal with a crisis when someone with BPD is at risk of suicide or serious self-harm. Hospital stays should be short, and aim to achieve specific goals that the person and their doctors have agreed on. Health professionals should generally not arrange long-term hospital stays for people with BPD.

If a person with BPD needs to visit an emergency department because they have harmed themselves or cannot cope with their feelings, staff should arrange mental health treatment to begin while the person's medical needs are being dealt with. Emergency department staff should attend to self-inflicted injuries professionally and compassionately.

Making health system work better for people with BPD

Health professionals at all levels of the healthcare system and within each type of health service, including general practices and emergency departments, should recognise that BPD treatment is a legitimate use of healthcare services.

Having BPD should never be used as a reason to refuse health care to a person.

If more than one health service is involved in an individual's care, all the health professionals and services should choose one health professional to be the person's main contact person, who will be responsible for coordinating the person's care across all health services that they use.

For all people with BPD, a tailored management plan should be developed in collaboration with them. The person's family, partner or carer should be involved in developing the management plan, if this is in the person's interests and they have given consent for others to be involved. The management plan (including a clear, short crisis plan) should be shared with all health professionals involved in their care, and should be updated from time to time.

If a person with BPD repeatedly visits the emergency department or their GP for immediate help during a crisis, the crisis plan should be made available to these health professionals too.

People who are responsible for planning or managing health services that provide care for people with BPD should make sure the health professionals who work there get proper training in how to care for people with BPD, adequate supervision according to their level of experience, and the type of work they are doing. Health system planners and managers should also make sure health professionals are given enough support, and have access to help from experts who are experienced in caring for people with BPD.

DSM-5 Criteria:

The essential features of DSM 5 Diagnostic Criteria for a Personality Disorder are impairments in personality (self and interpersonal) functioning, and the presence of pathological personality traits. To diagnose a personality disorder, the following criteria must be met:

1. Significant impairments in self (self-identity or self-direction) and interpersonal (empathy or intimacy) functioning.
2. One or more pathological personality trait domains or trait facets.
3. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
4. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio- cultural environment.
5. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

The Criteria for Borderline Personality Disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose borderline personality disorder, the following criteria must be met:

- A. Significant impairments in personality functioning manifest by:
1. Impairments in self functioning (a) or (b):
 - (a) **Identity:** Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
 - (b) **Self-direction:** Instability in goals, aspirations, values, or career plans.AND
 2. Impairments in interpersonal functioning (a) or (b):
 - (a) **Empathy:** Compromised ability to recognise the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
 - (b) **Intimacy:** Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealisation and devaluation, and alternating between over involvement and withdrawal.
- B. Pathological personality traits in the following domains:
1. Negative Affectivity, characterised by:
 - (a) **Emotional liability:** Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and / or out of proportion to events and circumstances.
 - (b) **Anxiousness:** Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
 - (c) **Separation insecurity:** Fears of rejection by, and / or separation from, significant others, associated with fears of excessive dependency and complete loss of autonomy.
 - (d) **Depressivity:** Frequent feelings of being down, miserable, and / or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feeling of inferior self-worth; thoughts of suicide and suicidal behaviour.
 2. Disinhibition, characterised by:
 - (a) **Impulsivity:** Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behaviour under emotional distress.
 - (b) **Risk taking:** Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.
 - (c) **Antagonism:** Characterised by hostility - persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.
- C. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.

- (a) The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.
- (b) The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

ICD-10:

F60 SPECIFIC PERSONALITY DISORDERS

G1. Evidence that the individual's characteristic and enduring patterns of inner experience and behaviour deviate markedly as a whole from the culturally expected and accepted range (or 'norm'). Such deviation must be manifest in more than one of the following areas:

- (1) cognition (i.e. ways of perceiving and interpreting things, people and events; forming attitudes and images of self and others);
- (2) affectivity (range, intensity and appropriateness of emotional arousal and response);
- (3) control over impulses and need gratification;
- (4) relating to others and manner of handling interpersonal situations.

G2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations (i.e. not being limited to one specific 'triggering' stimulus or situation).

G3. There is personal distress, or adverse impact on the social environment, or both, clearly attributable to the behaviour referred to under G2.

G4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence.

G5. The deviation cannot be explained as a manifestation or consequence of other adult mental disorders, although episodic or chronic conditions from sections F0 to F7 of this classification may co-exist, or be superimposed on it.

G6. Organic brain disease, injury, or dysfunction must be excluded as possible cause of the deviation (if such organic causation is demonstrable, use category F07).

F60.3 Emotionally unstable personality disorder: F60.31 Borderline type

A. The general criteria of personality disorder (F60) must be met.

B. At least three of the symptoms mentioned above in criterion B (F60.30) must be present, and in addition at least two of the following:

- Disturbances in and uncertainty about self-image, aims and internal preferences (including sexual).
- Liability to become involved in intense and unstable relationships, often leading to emotional crises.
- Excessive efforts to avoid abandonment.
- Recurrent threats or acts of self-harm.
- Chronic feelings of emptiness.

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 can 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 a 20-year-old woman called Amanda. You live locally on your own, and you are a student at the local university. You are aware that you have what is called a Borderline Personality Disorder (see description of behaviours below).

Current Crisis

You have been seeing a mental health clinician called Penny weekly for your therapy sessions. Unfortunately, Penny had to go overseas due to a sudden family emergency, it is uncertain when she will return, and this has suddenly left you without your usual support. You got the message from a phone answering service two days ago. You cannot recall discussing alternative arrangements with Penny if she was going to be away or be unavailable for your scheduled appointments.

Additionally, you feel you have done poorly in an important university graphic design course assessment that you submitted yesterday. You feel you've let yourself down. You have felt yourself becoming progressively more stressed.

Becoming stressed and overwhelmed in an unexpected manner, and in the absence of your support (Penny), you find yourself reverting to old less helpful habits that you thought you had overcome. As a result of this, you impulsively overdosed on 10 Paracetamol tablets you had in your possession. Straight afterwards you regretted your action, it added to your feelings of being stressed, and you were regretting that you may have inadvertently harmed your physical health.

You decided to go to the hospital to obtain help and support from professionals for your current state. However, soon after arriving in Emergency Department, you see a nurse called Gloria, with whom you had 'run ins' three or four years ago, who said, 'Oh no, you're up to your old tricks again; what have you done now?'. You had felt that Gloria had been particularly unfair and hurtful years ago, when you had a pattern of presenting after multiple self-harm episodes like overdoses or cutting yourself on the inside of your arms or upper thighs.

However, since then, you have worked hard in therapy and made significant gains in your growth and overall stability. You are upset that all this hard work has been undermined by the off-hand comment by Gloria, which has added to your stress and burden. You found yourself becoming angry, and experiencing a desire to return to your old patterns of behaviour that you know are ultimately damaging and unhelpful to you. In the Emergency Department, after hearing Gloria's comment, you were initially angry and dismissive, insisting you be allowed to leave. When the doctor ordered blood tests you refused to have them done.

However, you have agreed to wait to see the Psychiatrist (candidate). You are aware that ultimately the Psychiatrist could help you through your difficult time. You are amenable to being convinced by the candidate to have blood tests done. Also, if offered, you are willing to accept medication that has been effective for you in the past (detailed below). You are also willing to consider seeing an alternative therapist until such time that you can return to seeing Penny again. **You have to be clear that you do not want to be admitted to hospital.**

Risk – although you impulsively took the 10 paracetamol tablets, you are not feeling suicidal at present and you did not take the pills with the intent to die. In the past you have self-harmed in relation to stress, but you have actually never been suicidal.

You do not have access to large amounts of medication, and you have not stock-piled your tablets. You do not 'doctor shop' for additional medication. You do have access to normal kitchen knives at home, and you feel safe and confident using them without thinking you will use them on yourself. You have no access to or interest in accessing firearms or other objects that could be used to harm yourself.

Personal circumstances

You are in the second year of a Graphic Design degree. Your family are not nearby, and your relationship with them is estranged. You do not wish to talk about your family or share any more details than the ones below. You do have a couple of acquaintances at university, but you do not mix with them outside of the university.

Past History

You have been known to the local mental health services over the past four years or so. You have an established diagnosis of Borderline Personality Disorder, and are engaged in treatment with a local therapist (Penny). Due to this, you have been doing well over the last two years. Your treatment is called Dialectical Behaviour Therapy (DBT).

Consequently, you have not needed any other specific help, and you had not presented in crisis to any mental health service in the last two years. You have been getting on with your life. You have been making good progress recovering from very difficult experiences in your early childhood, which comprised:

- being abandoned by your mother at birth;
- growing up in multiple foster homes;
- being sexually abused in your childhood – if asked for details, please say you do not wish to discuss this with a stranger.

Ultimately you know you have made gains in psychotherapy, and you have hope for the future - like completing your studies.

Explanations of previous behaviours

If you are asked, before engaging in therapy with Penny, your aggressive and irritable behaviour related to your personality led you to be a challenge for others to deal with. You also had difficulties managing your emotions and behaviours like:

- finding it difficult to be soothed/calmed by a person who appeared to understand you whenever you became angry;
- being impulsive with episodes of spending large amounts of money, using alcohol in excess and making poor decisions about random sexual interactions;
- self-harming by cutting yourself on your arms and upper legs. The pain of the self-harm has brought you relief for brief moments and seemed to relieve your internal suffering;
- impulsively overdosing on medications available to you in response to stressors;
- tending to interpret comments from people as being negative or derogatory even though they were not meant that way;
- tending to amplify difficulties in your relationships, to make them harsher than they truly are.

If asked about the following symptoms:

You do not feel depressed. Your mood is not low all the time, you have no difficulty sleeping, and your appetite is normal. You have not gained or lost weight. You have adequate energy and concentration. You continue to enjoy the things you previously did – reading and cooking. You do not feel hopeless or worthless.

You have no anxiety issues nor do you worry constantly. You do not have episodes of experiencing shortness of breath, a pounding heart or sweaty palms. You do not have any repeated intrusive thoughts or engage in any rituals like washing your hands repeatedly or needing to check things.

You do not hear voices, and never have. You do not think anyone is trying to harm you or follow you. You do not get messages from the TV.

You are physically well.

You drink wine minimally, on social situations only and never on your own.

You have been abstinent of any illegal drugs for the past two years. You had previously smoked marijuana occasionally with friends and tried cocaine once, but did not like it. You stopped the marijuana once you were in therapy. You do not smoke cigarettes and do not gamble.

Medications:

You are only on a single antidepressant, called Fluoxetine (pronounced *floo-ox-ah-teen*), one tablet (20 milligrams) in the morning. You have been on this for the past three years, and it is prescribed by your GP.

In the past, at times of stress, you have been prescribed another mental health medication called Quetiapine (pronounced *kwe-tie-a-peen*) 25 milligrams (one pink tablet) at a time that has helped you calm down, and it also helped your sleep at night. You do not have any supply of this medication at the moment.

4.2 How to play the role:

Casual attire, covering your arms and legs e.g., long sleeve top and long pants or dress – the presumption is that this covers past self-harm scars. Mildly dishevelled like as if you've not slept well in a day or two. Clothes are crumpled, hair in disarray if possible.

At the commencement of the station, you should be standing and if there is space in the room, pace to reflect your irritability, as well as your wish to leave the facility. This should go on for about the first two minutes. Keep answering the questions the candidate asks, but reluctantly initially. Please don't exit the room.

Although you are irritable and angry, you are amenable to being calmed if the candidate is polite and encourages you to feel calmer. Ultimately, your overall manner is to be made to feel less hostile, and follow the calming endeavours by the candidate.

If however, a candidate does not manage to talk with you in a supportive way that makes you feel less angry, or helps you reach a calmer state, you are to remain angry and hostile.

You will then convey your impulsive intension to:

- get pissed (referring to getting intoxicated) when you can find a pub;
- find any guy to form an intimate relationship with;
- to harm yourself but not with a view to killing yourself – you will not tell the doctor how you intend to do this.

4.3 Opening statement:

'Look doctor, I don't like that stupid nurse – she has really upset me.'

4.4 What to expect from the candidate:

The candidate should introduce themselves and be polite to you. Not uncommonly, the candidate may ask your permission to talk to you for some time, ask you to sit, and elaborate about matters that has led to you being in hospital.

If you have been calmed, and the candidate sets the tone for easy communication, do inform on your past and present experiences as noted above.

4.5 Responses you MUST make:

'Penny had to go away unexpectedly and I'm doing poorly in my course.'

'I do not want to go into hospital.'

'I will have the blood test if you think it has to happen.'

'I do not want things to be the way they were three years ago.'

4.6 Responses you MIGHT make:

If asked whether you want to hurt yourself / kill yourself?

Scripted Response: ***'I don't want to hurt myself or kill myself, but I think I'm hurting.'***

If asked whether you would like to see another therapist?

Scripted Response: ***'I would like that, until Penny gets back.'***

If asked whether any medication helped you at times of crisis?

Scripted Response: ***'Yes, Quetiapine (pronounced kwe-tie-a-peen) has helped in the past.'***

If you feel that the candidates is not adequately listening to you:

Scripted Response: ***'This is all a waste of time. I should never have come here today. Can I leave?'***

4.7 Medication and dosage that you need to remember:

- Fluoxetine (pronounced *floo-ox-ah-teen*) one tablet (20 milligrams) in the morning
- Quetiapine (pronounced *kwe-tie-a-peen*) 25 milligrams (one pink tablet) – take one at a time that has helped you calm down, and it also helps your sleep at night.

STATION 9 – MARKING DOMAINS

The main assessment aims are:

- To sensitively manage the interaction with an irritable and challenging patient in crisis.
- To gather information about the patient's intent to self-harm.
- To demonstrate familiarity with current guidelines on management of Borderline Personality Disorder.

Level of Observed Competence:

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from the patient and manage challenging communications? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

able to generate a sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment; constructively de-escalates the situation; demonstrates sophisticated reflective listening skills; calmly presents an empathic approach; easily interacts and engages the patient.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the patient, effectively managing challenging communications; accommodating inappropriateness; containing conflict or behavioural abnormalities; recognising confidentiality and bias.

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

- Empathically validate that the statement made by the nurse in Emergency Department exacerbated matters.

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 materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

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

3.0 COLLABORATOR

3.4 Did the candidate develop an appropriate therapeutic relationship with the patient by addressing her concerns? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

prioritises use of additional resources to meet specific patient needs; gives priority to continuity of care; with a willing / helpful stance focuses on being available to manage stressful times until the therapist returns.

Achieves the Standard by:

demonstrating ability to develop a therapeutic relationship; gathering information; responding to concerns raised, respecting confidentiality; acknowledging she has found Quetiapine effective in the past; offering to facilitate arranging help; maintaining open communication; appropriately providing opinions.

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

- Elicit that the patient is happy to see an alternative therapist.

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:

lack of consideration of individual goals, capabilities or preference; any errors or omissions adversely impact on alliance.

3.4. Category: PATIENT RELATIONSHIPS	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"/>		

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct a focussed assessment and risk assessment of the patient? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

clearly achieves the standard overall with a superior performance in a number of areas; overall, manages the interview with competence; eliciting information with superior technical competence.

Achieves the Standard by:

demonstrating flexibility to adapt the interview style to the patient, problem or special needs; prioritising information to be gathered; asking 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, enquiring about current and historical risk factors; determining that the patient has been stable in the two years leading up to this presentation; identifying an acute crisis due to unforeseen circumstances beyond her control.

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

- a. Identify the significance of this crisis presentation in the context of two years stability.

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 such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

1.1. Category: ASSESSMENT – Data Gathering Process	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 formulate and describe a relevant management plan? (Proportionate value - 25%)

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; considers working with the Emergency Department staff to improve their understanding of Borderline Personality Disorder.

Achieves the Standard by:

demonstrating ability to prioritise and implement evidence based acute interventions; planning for risk management; selecting treatment environment; recommending medication and other specific treatments; skilful engagement of appropriate resources / support; having safe, realistic time frames / risk assessment / review plan; communicating to necessary others; recognition of the limitations of their role in effective treatment; identifying potential barriers.

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

- a. Address the issue of the patient refusing medical assessment.

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 mention (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"/>

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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1.0 Descriptive summary of station:

The candidate is treating James, a 34-year-old married accountant, who suffers from obsessive compulsive disorder, with exposure and response prevention therapy (ERP). The candidate has been working with him for two (2) months in an outpatient clinic. Mary, James' wife, has come to an arranged appointment to discuss her husband's progress.

1.1 The main assessment aims are:

- To demonstrate an ability to communicate the principles of psychological therapy for treatment of OCD.
- To demonstrate knowledge of how to monitor symptoms of OCD using rating scales.
- To outline the importance of family when intervening in anxiety disorders.

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

- Explain the core concept of Exposure Response Prevention and / or Cognitive Behaviour Therapy.
- Provide at least one example of a rating scale for OCD.
- Explain that recovery/remission is possible.
- Explain how accommodating OCD related behaviours is unhelpful.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorder
- **Area of Practice:** Psychotherapies
- **CanMEDS Domains:** Medical Expert, Communicator.
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Therapy); Communicator (Patient Communication – To Family / Carer, Patient Communication – Disclosure)

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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 aged 35 – 45.
- 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 an outpatient clinic.

You have been treating James, a 34-year-old accountant for two (2) months. He suffers from Obsessive Compulsive Disorder (OCD) characterised by fear of contamination, and infection for himself and his family. He has developed rituals that he wants his family to follow as well, and when they refuse he gets very distressed. James is not on any medication – he has refused this when it has been suggested.

You have an arranged appointment with his wife Mary, with James' consent. You met Mary previously at the time of your initial assessment of James.

Mary is happily married to James, and they have two children. She is a lawyer.

There is no history of family trauma or intra-familial problems.

Your tasks are to:

- Explain which type of psychological therapy you are using to help James with his OCD, and how it works.
- Explain how you will monitor James' response to treatment, and the likelihood of success.
- Educate Mary on how she can help James.

You will not receive any time prompts.

Station 10 - 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.
- 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 that there are no cues / scripted prompts for you to give.
- 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 **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:
***'Are you satisfied you have completed the 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.

When the candidate enters the room briefly check ID number.

There are no prompts.

The role player opens with the following statement:

'Hello Doctor thanks for meeting me. Can you tell me about the treatment that James is receiving from you?'

3.2 Background information for examiners

In this station, Mary, the wife of a man with OCD has come to see the psychiatrist providing therapeutic interventions for him. He is showing some improvement and Mary is keen to get a better understanding of what the therapy entails and how it is monitored. She also wants to know how she can help, as there are ongoing difficulties at home in relation to James symptoms.

The aims of this station are:

- To demonstrate an ability to communicate the principles of psychological therapy for treatment of OCD.
- To demonstrate knowledge of how to monitor symptoms of OCD using rating scales.
- To outline the importance of family when intervening in anxiety disorder.

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

- Explain the core concept of Exposure Response Prevention and / or Cognitive Behaviour Therapy.
- Provide at least one example of a rating scale for OCD.
- Explain that recovery/remission is possible.
- Explain how accommodating OCD related behaviours is unhelpful.

A surpassing candidate may:

- Choose to use diagrams and examples to explain the concept of ERP.
- Describe the role of metacognitions (e.g. thought action fusion).
- Demonstrate greater knowledge of cognitive aspects of OCD, e.g. central role of intolerance of uncertainty.
- Have an in depth knowledge of rating scales.

As one of the most life interfering of the anxiety disorders, Obsessive Compulsive Disorder (OCD) is characterised by frequent thoughts, images or impulses that cause anxiety or distress (obsessions) about the possibility of usually intensely adverse outcomes (e.g. illness, injury, death). A key feature is that the obsessions are experienced as ego dystonic, usually persistent, irrational and recurrent. They are also usually experienced as intrusive. The anxiety or distress triggers the urge to undertake behaviours that are designed to prevent or reduce the severity of the feared outcome (compulsions). Compulsive behaviours may be overt (e.g. handwashing, checking) or covert (e.g. mentally repeating a phrase or saying a prayer). Generally, compulsions are performed in response to obsessions and are often experienced as senseless or repugnant. An individual generally recognises the compulsions as senseless and from which they do not derive pleasure although they may provide a release from tension. A person with an OCD diagnosis has significant daily impairment from these thoughts and behaviours, which has a daily impact on quality of life in several domains and serves as a significant source of distress.

By relieving anxiety, the compulsive behaviours act both to reinforce the obsessional fears and the continued use of compulsions as a response, hence resulting in maintenance cycles.

OCD tends to run in families. The symptoms often begin in children or teens. Treatments that combine medicines and therapy are often effective.

The candidates are expected explain that the core concept to be addressed in therapy is the link in the brain between the obsessional thoughts – the intense feelings of anxiety – the overwhelming urge to perform a compulsive behaviour – the subsequent immediate relief – then the anxiety starts to build again, completing the cycle.

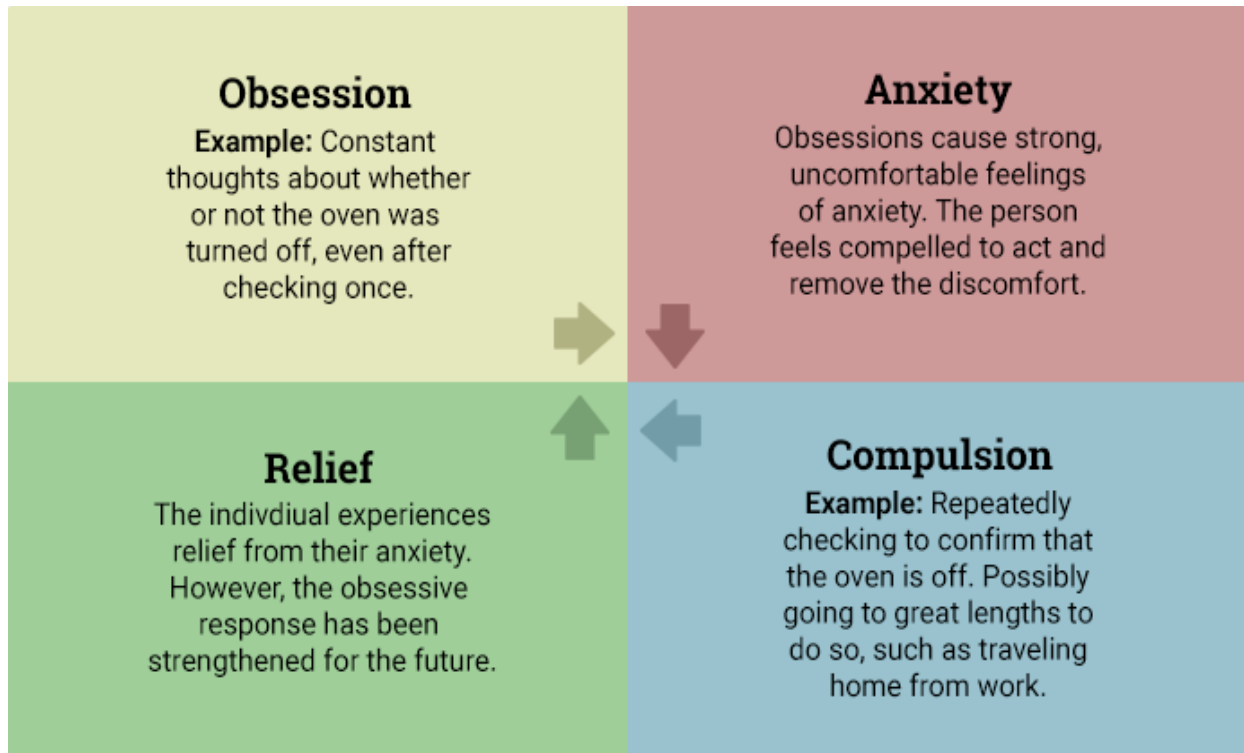


Image from - <https://twitter.com/javedaloo/status/839193421264928769>

Use of drawings to explain the cycle often will distinguish the better candidates, as it illustrates a collaborative approach and shows that they understand that: Thoughts → Feelings / Mood → Behaviours → Physical Reactions In this scenario an example would be to explain James' thinking around contamination.

Choice of effective therapeutic psychological interventions:

The gold standard for treatment of OCD is thought to be a treatment first described by Meyer (1966) "exposure and response prevention" or ERP. The treatment is to repeatedly expose the person to their obsessive thoughts while preventing them from carrying out the compulsions (or rituals).

The goal is to break the conditioning that maintains the disorder i.e. compulsions relieve anxiety (= negative reinforcement) and hence are more likely to continue to be used in response to obsessions, rather than the person having the chance to learn that the feared outcomes would not in fact occur. ERP has been extensively studied in the intervening 50 years, and continues to provide an average of 70% full remission of symptoms.

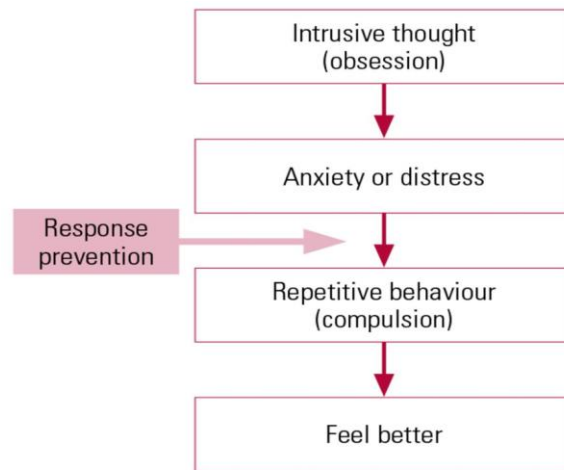


FIG 2 Behavioural treatment of obsessive–compulsive disorder: response prevention aims to break the link between the emotional changes and the compulsions.

Image from - Williams TJ, Shafran R, *Obsessive–compulsive disorder in young people*, *BJPsych Advances* May 2015, 21 (3) 196-205; DOI: 10.1192/apt.bp.113.011759

The key elements of ERP are:

- Identification of stimuli that trigger obsessions.
- Deliberate exposure to relevant stimuli.
- Resisting the urge to engage in compulsions to relieve the resulting anxiety / distress.
- Remain in the situation (or confronting the trigger) until anxiety / distress has reduced by at least 50%.

The goal of ERP is to break the reinforcement cycles that are maintaining the disorder. The repeated exposure to the obsessive thoughts, situations, events or other triggers of the obsessive thoughts without engaging in the compulsive behaviour will result in:

1. Reduced anxiety in response to the trigger(s).
2. Insight that the thoughts can be tolerated without the need for the compulsive behaviour.
3. Insight that the thoughts are not dangerous.
4. Learning that it is possible to have anxious thoughts but remain safe.

A graded approach to tolerating the anxiety associated with relevant stimuli and obsessional thoughts is generally best tolerated by patients. This is achieved by creating a “hierarchy” in terms of fear level (usually measured subjectively by the Subjective Units of Distress Scale (SUDS) and given a score out of 10 or 100). In general, patients should confront triggers that cause SUDS of about 40-60/100 as these are most tolerable but still result in treatment gains.

For example, an approach to reducing handwashing in response to fears about germs.

The patient identifies that after touching a doorknob at their work their anxiety level would be 50/100 if they resisted the urge to wash their hands; after catching the bus to work their anxiety would be 70/100; after shaking hands with someone they didn’t know their anxiety would be 60/100. They would therefore start with the doorknob. The therapist would ask them to resist washing their hands after touching doorknobs at their work. However, they may wash their hands normally before eating or after toileting.

Variations of ERP are also seen where the number of repetitions or duration of a behaviour may be negotiated, e.g. reducing showers from 15 minutes to 12 minutes to 10 minutes etc.

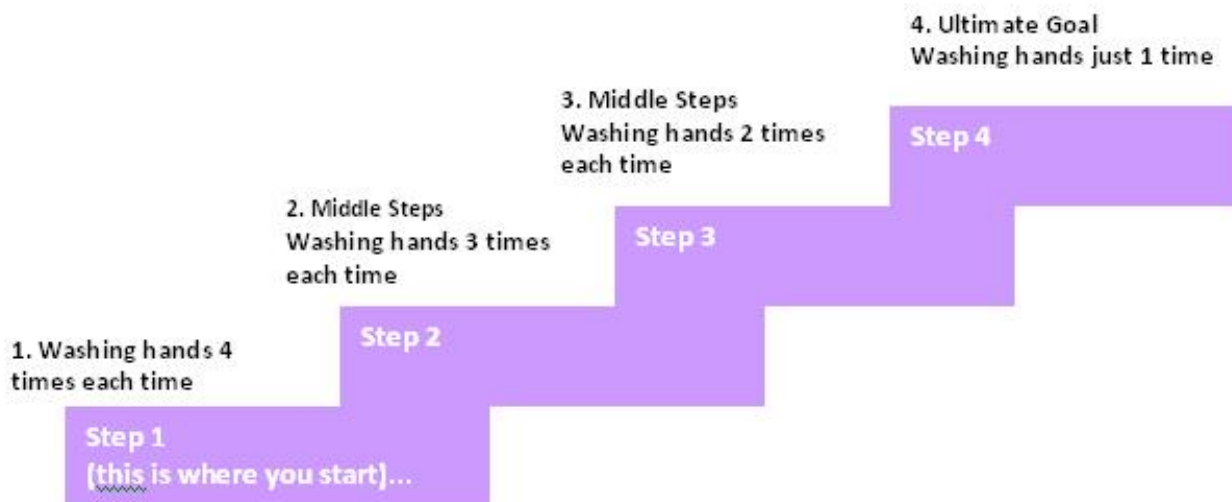


Image from - <http://www.cheo.on.ca/en/obsessive-compulsive-disorder>

Cognitive Behaviour Therapy (CBT) for OCD is also used but is less effective than ERP. It has proven effective for OCD based on fears of contamination, and would be an acceptable explanation if the candidate used similar explanatory model of the condition, and how increased tolerance of uncertainty and elimination of maladaptive responses that reinforce anxiety are the goal of treatment by any number of techniques including thought challenging, delaying behaviour until anxiety is reduced, alternative behaviours or thoughts. This Danger Ideation Reduction therapy has only been shown to be effective for contamination fears. The risks of thought challenging in OCD is that it can end up acting as reassurance, and reinforce obsessions.

Generally, CBT targets the negative automatic thought behind the OCD (could be pictorially illustrated). For example, a person with OCD related to contamination might have a thought:

“this object is dirty” – then “if I don’t wash my hands I’ll contaminate the whole family” – “my children will die from a disease I gave them”.

These thoughts are associated with rapidly increasing anxiety, fear and an overwhelming sense of responsibility. The following is often used to help explain how thoughts, feeling behaviours can interact and thus any part can be the primary target of psychological treatment.

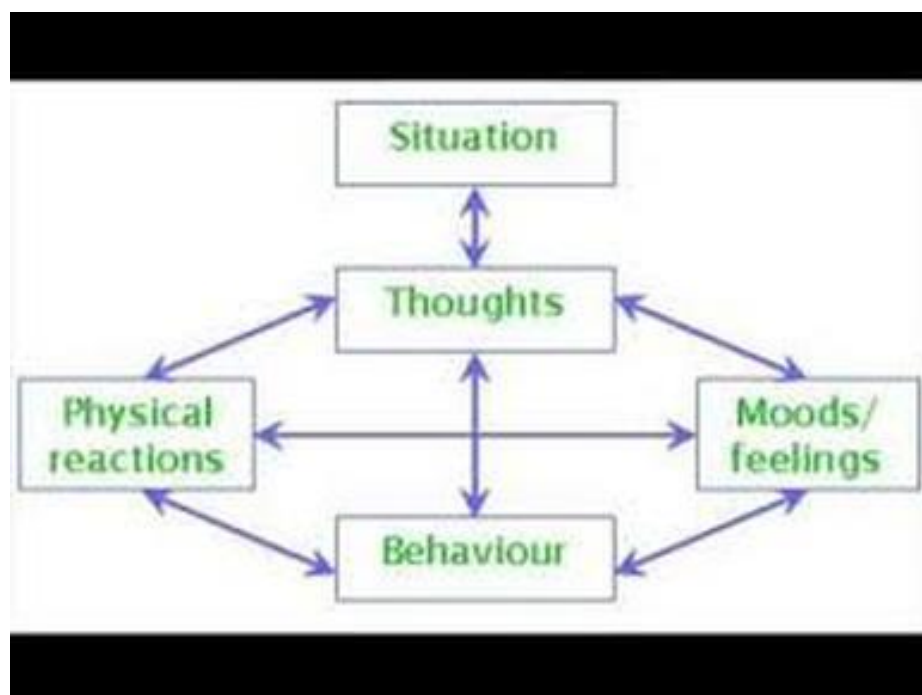


Image from - <https://noelbellblog.wordpress.com/2011/04/27/cognitive-behavioural-therapy-cbt>

To monitor response to structured psychotherapies like CBT, ERP or behavioural therapy, use of scales are the standard. These scales can be developed between the patient and the therapist, for example a Likert scale of 0 to 10 where 10 is most anxious ever, and 0 is almost asleep. The same type of scale may be used for all the symptoms troubling the patient, in this case it may be the level of worry about germs, where 10/10 is being so worried that the person cannot think about anything else. However, it is also important to monitor the level of functional recovery, and resistance to compulsions.

Alternately or in conjunction with a Likert scale, a Yale-Brown Obsessive Compulsive Scale can be used (Y-BOCS). This is considered the gold standard measure of OCD symptom severity. This is a semi-structured interview with the scale that covers many common symptoms of OCD. It should be done at the beginning, middle, and end of treatment or as often as desired in collaboration with the patient. Measurement of treatment response is an integral aspect of CBT (including ERP).

Goodman, W.K; Price, L.H; Rasmussen, S.A; et al. (1989). "The Yale–Brown Obsessive–Compulsive Scale. I. Development, use, and reliability". Arch Gen Psychiatry. 46 (11): 1006–1011. doi:10.1001/archpsyc.1989.01810110048007. PMID 2684084.

Storch, E. A.; Larson, M. J.; Goodman, W. K.; Rasmussen, S. A.; Price, L. H.; Murphy, T. K. (2010). "Development and Psychometric Evaluation of the Yale-Brown Obsessive-Compulsive Scale—Second Edition". Psychological Assessment. 22 (2): 223–232. doi:10.1037/a0018492. PMID 20528050.

Esfahani, S.; Motaghipour, Y.; Kamkari, K.; Zahireadin, A.; Janbozorgi, M. (2012). "Reliability and Validity of the Persian Version of the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). (English)". Iranian Journal Of Psychiatry & Clinical Psychology. 17 (4): 297–303.

DSM-5 Diagnostic Criteria for OCD

A. Presence of obsessions, compulsions, or both:

(a) Obsessions are defined by (1) and (2):

- (1) Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
- (2) The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralise them with some other thought or action (i.e., by performing a compulsion).

(b) Compulsions are defined by (1) and (2):

- (1) Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- (2) The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviours or mental acts.

- B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalised anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualised eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum, and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

Specify if:

- **With good or fair insight:** The individual recognises that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
- **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true.
- **With absent insight / delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

- **Tic-related:** The individual has a current or past history of a tic disorder.

Diagnostic Criteria for OCD

- A. Either obsessions or compulsions (or both), present on most days for a period of at least two weeks.
- B. Obsessions (thoughts, ideas or images) and compulsions (acts) share the following features, all of which must be present:
- (1) They are acknowledged as originating in the mind of the patient, and are not imposed by outside persons or influences.
 - (2) They are repetitive and unpleasant, and at least one obsession or compulsion must be present that is acknowledged as excessive or unreasonable.
 - (3) The subject tries to resist them (but if very long-standing, resistance to some obsessions or compulsions may be minimal). At least one obsession or compulsion must be present which is unsuccessfully resisted. (
 - (4) Carrying out the obsessive thought or compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tension or anxiety).
- C. The obsessions or compulsions cause distress or interfere with the subject's social or individual functioning, usually by wasting time.
- D. Most commonly used exclusion criteria: not due to other mental disorders, such as schizophrenia and related disorders (F2), or mood [affective] disorders (F3). The diagnosis may be specified by the following four character codes:
- F42.0 Predominantly obsessional thoughts and ruminations
 - F42.1 Predominantly compulsive acts
 - F42.2 Mixed obsessional thoughts and acts
 - F42.8 Other obsessive-compulsive disorders
 - F42.9 Obsessive-compulsive disorder, unspecified

Role of the family in treatment of OCD

Research investigating obsessive-compulsive disorder (OCD) in the context of the family has consistently found a bidirectional influence, insofar as families affect and are affected by the disorder. OCD has an adverse effect on the quality of family life and family interaction because of relatives' involvement in the sufferer's avoidance behaviours and compulsions, in an effort to relieve the fear and anxiety that the patient is feeling; the engagement in illness-related behaviours can dominate family life, and provoke intense disagreements among family members about how to respond to the patient's symptoms. On the other hand, several studies have also highlighted the negative effects of marital discord, and the climate of the familial environment in maintaining or worsening OCD symptoms.

Recognition that the family may play an important role in the maintenance of OCD has directed attention to strategies involving family members in therapy. Benefits have been described in case studies of family involvement in behavioural treatment of children and adolescents or adults with OCD, where the parent, spouse or other family member acted as a coach or supervisor during exposure homework. However, family participation in behavioural treatments (family-assisted behavioural treatments or the 'Multifamily Behavioural Treatment') has produced somewhat mixed results in larger controlled trials, with greater benefits reported in some studies but not in others.

Several researchers have also reported on the benefits of combined patient and family or family only time-limited psychoeducational and support groups, which included sessions on diagnosis, assessment, theories of OCD, behavioural and medication treatment, and relapse prevention. Psychoeducational interventions were aimed at reducing the direct involvement of families in the rituals, and of improving the perceived burden due to the disorder.

Relatives fall on a continuum of behavioural interaction patterns; the family may respond in various ways depending on the symptoms severity and functional impairment of the patient, as well as its own level of anger and frustration. This spectrum of responses can be visualised as having two polar opposites: on one hand are families that directly participate and / or assist in the rituals (enmeshed or accommodating families - in this case accommodation is used restrictively to indicate all kinds of participation in rituals); reasons for supporting the rituals (accommodating behaviours) were different, ranging from the wish to save the patient from conflicts to worry that burdens resulting from the obsessions could lead the patient into a state of crisis.

On the other pole of the continuum, according to this model, are families who completely resist and oppose OCD behaviours - these antagonistic behaviours included ignoring the rituals, attempting to stop the patient from performing compulsions, rejecting the patient's wishes for reassurance and, finally, forced, traumatic exposure to the feared stimuli. A third type of familial response lies in the middle of the continuum, and involves a divided stance of two or more family members (split family) that give equivocal responses; in this situation one family member is accommodating the symptoms while another is antagonistic, so that a certain amount of family disharmony can be expected.

Both type of responses can be counterproductive; relatives who take over roles and participate in or assist with compulsions tend to become emotionally over-involved, neglecting their own needs and at the same time perpetuating the cycle of obsessions and compulsions. Despite the fact that family accommodation is often well-intentioned, this form of involvement typically provides short-term relief from anxiety for the patient and for the family, thereby possibly reinforcing the continuation of these behaviours and the patient's symptoms over the long-term. Likewise, family members who are involved in the patient's symptomatology in a hostile or critical way may also inadvertently be increasing the frequency and the severity of the rituals, by augmenting the degree of anxiety experienced by patients, who tend to react performing rituals.

Consequently, some clinicians consider family members' responses to OCD during and after treatment to be critical to recovery, although relatively few investigations have studied this issue; preliminary data suggest that patients with relatives who express attitudes consistent with either an accommodating response or an antagonistic one appear to benefit less from otherwise successful treatments, and to be more likely to relapse after such treatments. Therefore, both type of responses, as family variables, may be viewed as negative predictors of outcome.

This would suggest that the approach to family members would be likely to be most helpful if it:

- Demonstrates an empathic understanding of the mixed emotions attendant on having a close relative or partner with OCD (frustration, distress, anxiety etc.)
- Demonstrates an understanding of the drivers of accommodation (e.g. relieve distress, avoid conflict, save time).
- Includes effective psychoeducation.
- Takes a collaborative approach that includes all involved family members in decision-making.
- Results in clear guidelines for action for all parties e.g., most usually that the patient agrees to resist the urge to ask for accommodation, and all parties have agreed on what the response will be if asked.
- Schedules follow up sessions.

The candidate is therefore expected to explain more than just the fact that family accommodating responses are unhelpful. They need to demonstrate an understanding of how the responses of the family to accommodate James' behaviour is impacting on maintenance of the symptoms.

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 well-being 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 a 36-year-old married lawyer called Mrs Mary Goodwin.

You have come to see the psychiatrist treating your husband James, aged 34, for OCD (obsessive compulsive disorder) which is related to his fear of contamination by germs. James worries that the germs might kill him or his family. This problem emerged about three (3) years ago after his mother died from an infectious illness – if asked, you think the doctors said she had septicaemia.

Your main goal for this meeting is better understand the details of treatment the psychiatrist is providing and how they check that it is working.

To do this, you want to know more about the treatment, how it may be expected to lead to recovery, what you can do to help your family at home.

He has never exhibited any other odd behaviours, never been aggressive or suicidal, and has never appeared to hear voices that other people do not. He does not appear depressed to you.

Background

Over the last three years James has developed multiple behaviours to try to reduce the risk of infectious illnesses to himself and your family. These behaviours have impacted on his ability to function effectively as an accountant, father and husband. The negative effect on the family was what finally lead him to seek treatment.

James had always been a clean, neat man but in the past three years he has become more and more driven to perform cleaning and to decontaminate the house, his work space and himself. He has also been putting pressure on you and your children to use antiseptic hand cleaner multiple times a day.

You think he has been responding to current treatment, and can now fulfil the requirements of his work without being distracted by rituals of decontamination however there is still a significant impact at home which is causing a lot of friction between James and the children. This has led to you being caught in the middle trying to keep the peace but you are worried that you may be contributing to the problem.

James seems to worry excessively about dirt, he nags the kids to wash frequently, and goes to their rooms to use cleaning products on their furniture almost daily. In order to ease the situation, you often find yourself encouraging them to listen to his requests, and clean their rooms as per his specific instructions. You just want to keep the peace.

About your family:

You met your husband James at university, while you were studying law, where he trained as an economist. You married while completing your study for the bar exam, and have specialised in business law. You have two children, Penny (11) and Robert (14), who are happy at a local private school. There are no problems within the marriage or the family apart from the reactions and effects of James' OCD.

James is the first person you have known personally who has a mental health problem. You have never experienced a mental illness before.

4.2 How to play the role:

You are a professional well-dressed woman who has left work today to attend this arranged appointment. James knows you are coming and is supportive. As a lawyer, you consider yourself to be well educated but have no understanding about biology, details of mental illness and how psychological therapies work.

You want to understand the treatment that James is receiving, and how the psychiatrist can know that it is working. You have not been exposed to someone with an anxiety disorder before, and don't know if they can recover.

You have tried to educate yourself by the Internet but keep being more scared by the sites that pop-up.

4.3 Opening statement:

'Hello Doctor thanks for meeting me. Can you tell me about the treatment that James is receiving from you?'

4.4 What to expect from the candidate:

Candidate should ask you about what you wanted to know and talk about, and should proceed to answer your questions.

That they should explain in layman's language what OCD is, how the main therapies, called ERP (exposure and response prevention) and / or CBT (cognitive behaviour therapy) or even just behaviour therapy, are thought to work and they can measure treatment response with James. Candidates are expected to instil hope for you that James can and should get better with treatment.

The candidate should also explain to you how your response to James' symptoms and the treatment is impacting on his recovery. A better candidate may explain details of how responses by family are so very important.

4.5 Responses you MUST make:

With the initial description of the therapy / or when asked if you understand ERP / CBT:

'If you could explain that to me in more detail?'

'What can we do to help him?'

'I find it really confusing.'

'I just don't know how I will talk to the kids about when it is best to listen to him and when it is best to ignore him. Which do you think is better?'

'How do you know this is working?'

'So do you think he will get better?'

4.6 Responses you MIGHT make:

If asked what you understand the problem to be:

Scripted Response: ***'He is troubled by thoughts of dying from germs he might catch in public, and of killing the family by germs he brings into the home.'***

'It has settled at work.'

If asked if you are worried whether James will recover:

Scripted Response: ***'Yes.'***

If asked if James is on any medicines:

Scripted Response: ***'No, you know he refused to take any tablets when you offered them previously.'***

If the candidate explains that James has a right to confidentiality:

Scripted Response: ***'Oh yes, I am not asking for private details I want to understand his problem so I can help him.'***

If given advice you need to assist James:

Scripted Response: ***'How will we do that?'***

STATION 10 – MARKING DOMAINS

The main assessment aims are:

- To demonstrate an ability to communicate the principles of psychological therapy for treatment of OCD.
- To demonstrate knowledge of how to monitor symptoms of OCD using rating scales.
- To outline the importance of family when intervening in anxiety disorders.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant CBT / ERP for treatment of OCD? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:

demonstrates a sophisticated understanding of CBT / ERP including a clear understanding of levels of evidence to support this treatment; uses a reinforcement cycle diagram (obsession-anxiety-compulsion-relief) to demonstrate the process.

Achieves the Standard by:

demonstrating a general understanding of CBT / ERP; using psychoeducation to help the wife understand expected treatment responses; explaining application of therapy; using symptoms and behaviour illustrations in the explanation; sensitively considering barriers to implementation; instilling hope in relation to outcomes.

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

- Explain the core concept of Exposure Response Prevention and / or Cognitive Behaviour Therapy.

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 explain link between thoughts-feelings-behaviours).

Does Not Achieve the Standard (scores 0) if:

Errors in information would lead to poor care; there is no structure and / or answer is inaccurate; does not answer that specific question; not tailored to the patient in the scenario.

1.14. Category: MANAGEMENT – Therapy	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"/>

2.0 COMMUNICATOR

2.1 Did the candidate explain the process of monitoring response to treatment and the likelihood of the treatment being successful? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

able to explain the role of review of symptoms and functioning in monitoring response to treatment, the role of medication in treatment if psychological treatment is unsuccessful; possesses an in-depth knowledge of rating scales; able to demonstrate awareness of various targets for monitoring including triggers and potency in triggering anxiety / distress, avoidance behaviours, and / or compulsive behaviours.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; explaining that improvement is gradual and setbacks are not uncommon; using non-technical language to instil better understanding; showing optimism with caution; recognising confidentiality; mentioning any means of monitoring improvement.

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

- Provide at least one example of a rating scale for OCD.
- Explain that recovery / remission is possible.

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:

Unable to maintain rapport; does not answer the question or is unaware that treatment outcomes are usually good.

2.1. Category: PATIENT COMMUNICATION – To Family / Carer	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"/>

2.2 Did the candidate appropriately and adequately explain the role of the family in the management of the patient's illness? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

comprehensively explains the principles of working closely with families / carers; demonstrates the importance of ensuring respectful and open communication; is aware of the range of responses of the family to the individual's compulsions; recognises the consequences these may have on the family and the illness.

Achieves the Standard by:

providing a clear and appropriate explanation; recognising the importance of explanations outside the usual doctor-patient / treatment relationship with a concerned and involved family member; addressing the concerns of the wife and the possible impact on the children, elaborating on how accommodation can act to maintain OCD but is not the sole responsibility of the family, i.e. the individual needs to work with the family to resist the urge to ask for it; empathic demonstration of awareness of the drivers to accommodate OCD suggesting the involvement of the entire family in the treatment + / - a support group.

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

- a. Explain how accommodating OCD related behaviours is unhelpful.

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 is disrespectful; does not offer any strategies to help the family cope with the illness and the behaviours.

2.2. Category: PATIENT COMMUNICATION – Disclosure	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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1.0 Descriptive summary of station:

The candidate is to assess a man with bipolar disorder which is usually well controlled. He has occasionally become acutely unwell leading to involuntary admissions, and requiring Clopixol-Acuphase® injection to control his agitation. He would like to make an advance health directive to decline the use of intramuscular Clopixol-Acuphase® in the future.

1.1 The main assessment aims are:

- To obtain adequate information about previous treatments for a patient with bipolar disorder.
- To weigh up ethical considerations regarding an advance health directive for this patient.

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

- Establish the high level of risk and need for urgent treatment when he is unwell.
- Identify that Clopixol-Acuphase® is the only treatment that works.
- Acknowledge that advance health directives can be overridden by the use of the Mental Health Act.
- Outline at least one ethical dilemma of applying advance health directives in psychiatry.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Process), Communicator (Synthesis), Professional (Ethics).

References:

Elbogen, E. et al (2007) Competence to Complete Psychiatric Advance Directives: Effects of Facilitated Decision Making. *Law and Human Behaviour*.

J Swanson and others 'Superseding Psychiatric Advance Directives: Ethical and Legal Considerations' (2006) 34(3) *Journal of the American Academy of Psychiatry and the Law* 385 at 394.

http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php

Papageorgiou and others 'Advance directives for patients compulsorily admitted to hospital with serious mental illness' (2002) 181 *British Journal of Psychiatry* 513 at 513.

<http://mhrm.mhcc.org.au/chapter-5/5f.aspx>

Atkinson, J. M., Garner, H. C. & Gilmour, W. H. (2004). Models of advance directives in mental health care: Stakeholder views. *Social Psychiatry and Psychiatric Epidemiology*, 39 (8), 673–680.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required
- Four chairs (examiner1 x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: a man in his 30s, well-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 a local Mental Health Services Community Health Service. Mr Billy Bob is a 37-year old man, recently discharged from hospital after an urgent admission for mania that required intramuscular Clopixol-Acuphase® during the early part of the admission.

Mr Bob has read on the Internet about Advance Directives, and has come to you to talk about making an Advance Directive to decline Clopixol-Acuphase® in the future.

Your tasks are to:

- Obtain a focussed history pertaining to Mr Bob's illness and its treatment.
- Explain to the patient what an Advance Directive is, and its limitations.
- Outline the ethical implications of Advance Directives in Psychiatry **to the examiner**.

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

Station 11 - 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 scripted time prompt you are to give at **six (6) minutes** if the candidate has not commenced the final task. You are to say:
'Please proceed to the final task'.
- 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 **eight (8) minutes**, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:
***'Are you satisfied you have completed the 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.

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'I have found some stuff on the Internet about Advance Directives. I want to talk to you about getting one that forbids doctors from giving me Clopixol-Acuphase® injection again.'

If the candidate has not commenced the final task by **six (6) minutes** - this is your specific prompt:

'Please proceed to the final task'.

3.2 Background information for examiners

The aim of this station is to assess the candidate's knowledge regarding the application of advance health directives in psychiatry and in particular the ethical issues they present clinicians with.

In order to achieve in this station, the candidate must demonstrate the ability to obtain a focussed history from a patient, particularly in relation to acute risk and the efficacy of previous treatments to manage mania. They must then sensitively explain to the patient what an advance directive including its limitations.

Finally the candidate must identify the ethical implications of advance health directives to the examiner - the candidate is required to outline at least one ethical dilemma.

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

- Establish the high level of risk and need for urgent treatment when he is unwell.
- Identify that Clopixol-Acuphase® is the only treatment that works.
- Acknowledge that advance health directives can be overridden by the use of the Mental Health Act.
- Outline at least one ethical dilemma of applying advance health directives in psychiatry.

A surpassing candidate may demonstrate the ability to identify a range of ethical implications in this case.

Advance Directives

Central to the debate in mental health policy, law, and bioethics lies a tension between the principle of respect for patient autonomy in healthcare decisions, and clinical responsibility to provide appropriate services to people with severe mental illness, many of whom experience intermittent impairment of decisional capacity and fluctuating attitudes towards accepting treatment.

Advance health directives have become more widely used in many areas of medicine. Advance health directives were originally developed to allow people to make decisions in relation to their end-of-life care, such as decisions to withdraw life support treatment ('do not resuscitate' orders), but they have subsequently been applied to mental health care.

A psychiatric advance directive (PAD) or mental health advance directive, is a written document that describes what a person wants to happen if at some time in the future they are judged to be suffering from a mental disorder in such a way that they are deemed unable to decide for themselves or to communicate their wishes effectively.

Generally, PADs enable individuals with mental illness to declare treatment preferences in the event they lose decision-making capacity in relation to those decisions in the future. An advance directive can inform others about what treatment patients want or do not want from psychiatrists or other mental health professionals, and it can identify a person to whom they have given the authority to make decisions on their behalf.

Advance directives can be viewed as legal instruments that allow patients to oppose a historical tradition of paternalism in mental health. Individuals with mental illness are very aware of the unequal bargaining power that can exist relative to their doctors in making decisions especially while under the Mental Health Act.

There are two major kinds of advance directives: proxy and instructional directives. A Proxy directive is a form of advance directive that specifies the person or persons who have power of attorney to make health care decisions for the patient if he or she is no longer competent to make choices. An Instructional directive is a type of advance directive that specifies particular health care interventions that a patient anticipates they will accept or reject during treatment for critical or life-threatening illness. A 'living will' is an example of such a directive.

General Advance Directives vs PADs

PADs can be distinguished from general advance directives in physical health care in three major aspects. First, people filling out general health care directives are often making decisions about end-of-life treatments they have never actually experienced. In contrast, psychiatric patients are generally dealing with chronic illness, and are therefore likely to have experienced the treatments they are describing. For example, a patient with schizophrenia may have an opinion about which antipsychotic drug is most effective, and which ones have not worked in the past.

Secondly, the goal of some general advance directives may be to increase the chance that life ends in comfort and dignity, whereas the goal of a psychiatric directive is often to maximise the chance of recovery while minimising unwanted interventions. More recent jurisprudence has recognised the power of PADs to give effect to patient participation, and the human rights approach to recovery in mental health.

Thirdly, the consequences of enforcing a general advance directive may also be different to enforcing PADs. Refusing treatment in end-of-life situations will usually hasten death. This can be seen as positive for the person (this is what they wanted), and arguably for their family, since not only have they respected the person's wishes but also do not have to watch a family member suffer. Refusing treatment for a mental illness is different to terminal physical illness in that it is unlikely to lead to death. However, a possible result of following a refusal of treatment in a PAD is that the patient could become severely ill, remain ill in hospital for longer than if treated, and possibly not recover to the previous level of function.

Purpose for making PADs (Grace Liang, 2013)

1. Therapeutic effect

A strong argument for increasing awareness of PADs is that they provide a mechanism to include the patient's 'voice' during a mental health crisis, when patients are often unable to participate meaningfully in treatment decisions. People react very differently to the same treatment, and nobody understands an individual's needs, experiences and preference as much as the individuals themselves. So unlike proxy directives, instructional PADs can accurately reflect the wants and needs of the patient at the time they made the advance directive, using the individual's own words. Through increased consumer participation, it has been argued that every execution of a PAD is therapeutic as it 'provokes people who suspect that their problems might escalate to prepare treatment early, before the condition gets out of hand'. (Winick, 1996). Therefore, PADs can also support planned, effective crisis treatment by identifying and mobilising resources to de-escalate crises, and serve as viable alternatives to hospitalisation. An often-overlooked advantage of PADs is that the process of completing such documents allows individuals to gain insight, and learn how to self-manage their mental illness.

2. Avoiding re-traumatisation

In particular circumstances, a PAD may be created directly in response to a negative experience with treatment. The PAD could refer to refusals of treatment or care which are catalysts for a previous traumatic experience. If adhered to, the PAD can prevent re-traumatisation where an individual relives the same negative experiences from a previous treatment or life event. For example, a patient who has suffered from sexual abuse or rape may be reminded of this traumatic time if pinned down (or put in other forms of restraint) during compulsory treatment. Without a PAD, and being unable to communicate, a common example of re-trauma can occur in a future similar situation.

3. Patient autonomy and empowerment

Making an advance directive is about the exercise of autonomy – the autonomy of the competent person to make decisions about their treatment in accordance with the principle of consent. This may be done in different ways. Opting out of the treatment may be motivated by the desire of the well person to preserve more of the autonomy by avoiding the side-effects of some treatments. Equally, the motivation to opt out may be linked with preserving the ‘autonomy’ of the person when ill, or indeed, the existence of the ill person. However, opting into treatment may be associated with preserving the autonomy of the well person. For most people this would be assumed to be the logical choice. Often individuals are choosing the timing of the treatment as well as the type of treatment.

4. Avoiding the stigma of coercive treatment

PADs can avoid the stigma of compulsory treatment, and provide an alternative to legal coercion. Formal commitment proceedings, or placing people under involuntary treatment, could be limited if patients included provisions in a PAD instrument to the effect that certain treatment or hospitalisation be provided to them on a voluntary basis notwithstanding an incompetent refusal by the patient. Such ‘voluntary commitment contracts’ would benefit those patients in particular who have previously had positive hospital experiences, but found the involuntary process to be demeaning, and can foresee future periods of commitment due to the relapsing nature of their mental illness.

5. Information sharing

For clinicians and practitioners, PADs can serve as a repository for patient histories on treatment preferences. In particular, for clinicians treating a patient with whom they have had no previous history, a PAD might provide insightful information on treatments that have proven effective on the patient. A PAD that specifies treatment that has previously been successful or very unsuccessful may help a clinician not make the same mistake again. On a wider scale, there may also be improved communication between patients, family members, and providers in the sense that a consensus about appropriate forms of treatment can be met and set in place before crisis. For instance, the New Zealand Medical Association recognises the advantages of advance statements in terms of encouraging openness, dialogue, and forward planning between all parties involved in making PADs.

6. PADs protecting bodily integrity

PADs give people who suffer from mental illness, and who are more likely to be subject to coercive treatment, a voice to reject medication that puts their general health at risk. Even when administered correctly, psychotropic drugs have been known to have particularly severe side effects, and in extreme cases could cause fatality. Although the newer antipsychotic drugs may be safer, they have still been known to cause weight gain, sexual dysfunction, and significantly increase the chance of developing diabetes. PADs give people a platform to expressly refuse these treatments on grounds of bodily integrity.

Will advance directives always be followed?

It is critical that patients identify that there may be circumstances where an advance directive is not followed. When deciding whether or not to follow an advance directive, the clinician will consider particular questions, for instance:

- Was the person competent to make the decision when they made the advance directive?
- Did the person make the decision of their own free will?
- Was the person sufficiently informed to make the decision?
- Did the person intend their directive to apply to the present circumstances, which may be different from those anticipated?
- Is the advance directive out of date?

An advance directive will not override the ability of a clinician to authorise compulsory treatment if the patient is subject to a compulsory treatment order under a Mental Health Act. Patients are advised this it may still be worth having an advance directive even if they are subject to a compulsory treatment because it will give clinicians an indication of their wishes.

Making a PAD

There is no set way to make an advance directive. However, the following are some guidelines:

- Make sure it is clear and easy to understand (an Advance Care Directive will not be enforced if it is vague and non-specific about what the patient actually wants to happen if they become unwell).
- A PAD must be witnessed by someone, preferably by someone independent who is not referred to in the document.
- PADs should be kept in a safe place and with a copy given to relatives, friends or carers, and to any person who has been involved in the treatment.

Advance directives are most effective if they are made in consultation with treating health care professionals (that is for example, GP, case manager and / or psychiatrist).

If the patient can afford to get private legal advice about preparing the advance directive, then this should be the next step.

An advance directive will not be valid, and can be ignored later, if the patient does not have capacity when signing it. To protect against an advance directive being challenged on this basis, the patient should ask their GP or psychiatrist to certify that they have capacity at the time they sign the advance directive.

A patient can include in their advance directive that they want to be treated with particular drugs and not with other drugs if they become unwell, and can include that they do not want to be treated (or do want to be treated) with particular procedures such as electro-convulsive therapy (ECT).

For instance, the Queensland Mental Health Act 2016 - Guide form for completing an Advance Health Directive, consent to receiving electroconvulsive therapy states:

You can consent to receiving electroconvulsive therapy under your advance health directive. If you consent to this, you may place limits on the consent, such as the number of treatments to which you consent. It is very important you discuss this type of treatment with a doctor who is likely to be responsible for your treatment and care if you do not have capacity to make decisions for yourself about your healthcare at a future time.

You may also state in your advance health directive that you do not wish to receive electroconvulsive therapy.

Under the Mental Health Act 2016, a doctor may perform electroconvulsive therapy on an adult only if the person gives informed consent or, if they are unable to give informed consent, the Mental Health Review Tribunal approves the treatment. In deciding whether or not to approve the treatment, the Tribunal must consider any views, wishes and preferences stated in an advance health directive. A doctor may also perform electroconvulsive therapy for specified involuntary patients under the Mental Health Act 2016 in emergency circumstances, which is then referred to the Tribunal for consideration.

Patients can also put in their advance directive their wishes about life management arrangements if admitted to hospital with a mental illness in an acute phase. This could include details about what they want to happen about the care of their children, the care of pets, and who in their work place can be told.

Limitations of PADs

1. Patients believe that an advance statement is putting in place something that will be there for them in the event of an emergency but in reality, these wishes may be disregarded, e.g. if they are admitted as an involuntary patient under the Mental Health Act.
2. One of the factors related to completing a PAD, which can make them a difficult document for courts to uphold, is possible advances in medical technology, not evident at the time of making the statement. In other words, somebody may say that they want this and don't want that based on the knowledge of the time, but in fact the treatment may be much less intrusive than it was at that time, by the time that the PAD is called on to be used.
3. A Guardian appointed to act for the patient can also overturn PADs. Guardianship Acts provide for an appointed decision maker to consent to various treatments including medical and dental treatment where a patient is unable to do so. This means that a PAD made in common law would have to be respected while the patient was 'competent', but once the patient lost 'capacity', the person responsible for their care could make a decision that goes against the advance statement if they did not consider the advance statement to be in the best interests of the patient.

When the patient nominates someone to act on their behalf it should be someone who has good advocacy and negotiation skills, is assertive, and whom the patient trusts with their life. It also needs to be someone who is physically, geographically available, and at short notice. This nominated person needs to be someone who can cope with strong feelings, from all sides, if it becomes a situation, for example, where an aspect of the PAD is not being adhered to. It would work best if the nominated agent shared the values, and understood the health and treatment preferences of the patient. Unfortunately, not everyone has access to such a person.

4. If the individual becomes an involuntary patient under a Mental Health Act it will be up to the treating team to decide if they will follow the advance directive. They should take the information in the PAD into account, but they do not have to. It is unlikely that the courts would allow a PAD to overturn the choices of treatment made by a hospital to treat an involuntary patient.
5. There may be fears of potential litigation amongst medical professionals especially where doctors need to override advance directives that contained treatment refusals.
6. Lack of information has been identified as a major barrier to the successful implementation of PADs.

Other Ethical Aspects of PADs

Key issues related to advance directives are related to issues of autonomy and consent for the patient. A person might develop a PAD with full intentions of honouring it when they become unwell. However, they might change their minds. If patients change their minds, the issue is whether the new instructions must be heard, and new facts and circumstances considered.

Concern has been expressed about the potential for patients to have unrealistic expectations regarding the power of their advance directive. There is the requirement of a certain level of knowledge about the illness, and the likely chances of recovery that may not generally be known or considered when the PAD is made.

Moreover, potential conflicts can arise between family members if they did not agree with treatment discussed in the PAD.

The clinician needs to consider how the PAD enables non-maleficence and can promote beneficence. The level of risk associated with acute presentations may be too significant to allow the clinician to safely follow the PAD. The therapeutic alliance could potentially be damaged if the advance directive was overridden during a psychiatric crisis without the patient being prepared for this possibility. In such cases, to do justice to its development, clinicians should try as far as possible to follow aspects of the advance statement and take into account information provided in the PAD.

Overriding a PAD by clinicians may be linked to their failure to be aware of its existence, either because it is genuinely not available or because clinicians do not take time to look / ask for the existence of one. Ensuring access to PADs by health practitioners is an important organisational challenge to be addressed.

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 Billy Bob, a 37-year-old man who was discharged from hospital three weeks ago after an admission for an acute manic episode. You have suffered from bipolar disorder for the last 20 years. You have come to see the psychiatrist today as you want to write a specific document about your future expectations for treatment called an Advance Directive.

Reason for your request:

At this last admission, you had to be given a specific injection called **CLOPIXOL-ACUPHASE®** three times, on alternate days. You do not ever want to have this injection again if you get unwell.

You have no symptoms of depression or mania, you feel that you are back to your usual self, you are somewhat optimistic about the future, and your family is pleased with how you are doing.

You are sure there must be another way for things to be managed when you are in hospital, and you have been reading on the internet about Advance Directives. A psychiatric advance directive (PAD) or mental health advance directive, is a written document that describes what a person wants to happen if at some time in the future they are judged to be suffering from a mental disorder in such a way that they are unable to decide for themselves or to communicate their wishes effectively.

You wish to forbid treatment with this injection ever again, despite the fact that you have had this discussion with doctors many times, and have been repeatedly told that the injection is the safest way to make you well again quickly. Your wife agrees with the doctors. You do not remember your manic episodes, and wonder if they are exaggerating the risk. You are not convinced: it makes you feel dreadful, you sometimes need to be held down when you are receiving it, and so you never want to take it again. You think this is a bad product, and it should never be used for you again. In fact, you would prefer it if they never had to use any injectable medicine for you again.

Your psychiatric history:

You have a 20-year history of having bipolar disorder, which is a disorder presenting with depressed and elevated/irritable (manic) symptoms. You have had four hospital admissions in total. All your admissions have been due to manic episodes. You tend to be irritable and agitated when unwell, and tend to get into arguments and threaten people.

This is unlike your usual easy-going temperament, and family members say you are scary to be around at these times as you shout at people, and say you are going to hit them. Consequently, you are taken to hospital – against your will - and have ended up needing this injection Clopixol-Acuphase® at each of these admissions. On this last admission, your wife has told you this is the most unwell she has ever seen you.

You have been treated under the Mental Health Act every time, but since discharge from hospital you have been doing well. You are taking medications called mood stabilisers, even though you have been feeling tired. You do not intend to stop your medicines, as you know they keep you well. You have never stopped your medications in the past, and always obey the doctor's orders.

Why you became unwell:

The company you were employed at as an accountant closed down just prior to this admission, and the stress of losing a job you loved and are good at, precipitated a manic episode. You have been told that you were highly irritable, and physically aggressive towards nursing staff. You have no memory of this, feel that this is not like you, and wonder whether the injection actually made you aggressive.

Treatment:

In the past you have discussed the treatment that you received in hospital with the psychiatrist whom you saw in the community clinic after discharge. He had explained that the risk you pose to other patients, the staff, your family, and yourself when you are unwell is very high. They are concerned that you will assault someone, and need to control your symptoms as soon as they can. The medicines that they use when you relapse (in addition to the lithium that you are usually on) do not seem to be effective. The doctors have prescribed tablets of different antipsychotic medicines (olanzapine, quetiapine and risperidone), but apparently these do not calm you down. They have even tried diazepam tablets. They have tried injections of olanzapine, haloperidol, and lorazepam as well, but you were told that these did not work either.

Consequently, the doctors state that they need to give you an injection, and since the Clopixol-Acuphase® worked really well the first time they used it (when you were admitted at age 18), they continue to use it when things get really bad. You, however, wonder if it is the injections that make the illness worse, and they leave you feeling drained, tired and very slow in the head for 2-3 weeks after you receive them.

If you are asked about details of your current medications:

You always take your LITHIUM – 250 milligrams every morning, 500 milligrams every night. The side effects are manageable – you feel thirsty, have a dry mouth, and occasional diarrhoea. Your blood levels are usually 0.7 to 0.8 and your kidney and thyroid blood tests have been fine. You do not wish to stop lithium as you know it is the best medicine for your condition, and you do not want to risk relapses.

You do not wish to have electro convulsive therapy (ECT).

When you start becoming unwell:

You seem to lose awareness of this, but your family recognise the signs. You sleep poorly, feel energetic, talk loudly, begin challenging people, and believing that your ideas are right. You overestimate your abilities and achievements, drive rashly, and have an increased sexual drive. Your family has always managed to keep you safe from actually doing reckless things by getting you into treatment early. So far you have not endangered yourself or anybody at home, but are aware that '*something really bad could happen*' at these times.

Things go downhill rapidly over a few days, and you have been described as '*hard to control*' at home and in hospital. Your family and doctors have repeatedly told you that the quickest, and most efficient way to control your symptoms is the injection. The episodes usually resolve in 3-4 weeks, and you go home and return to work about 2 weeks after that. Your ex-boss has been very understanding about your illness, and you are worried you will never find such a good job again.

You describe yourself as a regular ordinary sort of person with an inconvenient illness. You have never had longer than a brief period of feeling sad or low, having no energy or appetite, and losing interest in life. To the best of your knowledge you have never had a depressive episode. You have never been suicidal or intentionally harmed yourself.

Specific history and symptoms:

You do not use drugs and have never done so. You rarely drink alcohol (5-6 times a year), and have never got drunk. You are not a gambler.

You have never had any problems with the law.

Your personal history:

You had an uneventful childhood and were not exposed to any traumatic events. You studied accounting in university. Your parents are alive and you have a good relationship with them. You have two older sisters, they are both well.

You are presently worried about your lack of job, but your wife works in a bank, and you are financially okay. You have no children – you are aware that bipolar runs in families, and did not want to risk passing your genes on to them. Your mother's brother had bipolar disorder but he died young, and you do not know anything about him.

4.2 How to play the role:

You are unhappy with the fact that you keep being given Clopixol-Acuphase® when you are unwell. You are very keen to put in place a plan that the medical staff will need to follow in the event that you get admitted again. You have been investigating these advance directives and the candidate will need to clearly demonstrate in a non-judgemental manner that this is not a good idea based on your psychiatric history.

Today you present as well groomed, with no signs or symptoms of depression or mania.

4.3 Opening statement:

'I have found some stuff on the Internet about Advance Directives, I want to talk to you about getting one that forbids doctors from giving me Clopixol-Acuphase® injection again.'

4.4 What to expect from the candidate:

A good candidate will be confident, and put you at ease whilst they gather information. They may repeat statements back to you, and empathise how difficult things are for you.

They will ask you about medications, admissions to hospital, and questions about risk. They should then explain what an Advance Directive is to you, and what its limitations are.

4.5 Responses you MUST make:

'I hate Clopixol-Acuphase®!'

'They tell me I'm really bad; I think they are exaggerating.'

About Clopixol-Acuphase®: ***'It makes your head fuzzy for weeks.'***

'I think it makes you worse; makes you more aggressive.'

About treatment options: ***'That's why I came to you; I thought you should know.'***

4.6 Responses you MIGHT make:

'It's hard to believe that there is no tablet which can be used instead.'

If asked if you have ever been admitted as a voluntary patient:

Scripted Response: ***'No, I have always been admitted under the Mental Health Act.'***

If asked about your thoughts on electroconvulsive therapy (ECT):

Scripted Response: ***'Is that the same as shock treatment? No, never, and I do not want to have it.'***

4.7 Medication and dosage that you need to remember:

- Lithium carbonate 250 mg every morning (1 tablet), 500 mg every night (2 tablets)
- Clopixol-Acuphase® injection.

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- To obtain adequate information about previous treatments for a patient with bipolar disorder.
- To weigh up ethical considerations regarding an advance health directive for this patient.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct an assessment of the patient's illness and treatment? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:

clearly achieves the standard overall with a superior performance in a number of areas; competent overall management of the interview; superior technical competence in eliciting information.

Achieves the Standard by:

managing the interview environment; 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; 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; establishing the high level of risk and need for urgent treatment when patient is acutely unwell; enquiring about the use of ECT.

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

- Establish the high level of risk and need for urgent treatment when he is unwell.
- Identify that Clopixol-Acuphase® is the only treatment that works.

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:

significant deficiencies such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

1.1. Category: ASSESSMENT – Data Gathering Process	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"/>

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills in addressing the patient's request for an advance directive, including its limitations? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

integrates information in a manner that can effectively be utilised by the patient; provides succinct and professional information; presents a balance of the advantages and limitations of an advance directive.

Achieves the Standard by:

providing accurate and structured information; prioritising and synthesising information; adapting communication style to the setting; tailoring appropriate use of language to the patients level of sophistication; demonstrating discernment in selection of content; having an awareness of the process of setting up a PAD, and its advantages and limitations without being overly pessimistic.

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

- Acknowledge that advance health directives can be overridden by the use of the Mental Health Act.

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 the information presented to the patient is too one sided, either for or against PADs with some minor inaccuracies; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

no information provided or information provided is grossly inaccurate.

2.5. Category: SYNTHESIS	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"/>

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

comprehensively considers all major aspects of ethical conduct and use of PADs.

Achieves the Standard by:

demonstrating the capacity to: identify and adhere to professional standards of practice in accordance with College Code of Conduct / Code of Ethics and legal guidelines; integrating ethical practice into the clinical setting; apply ethical principles to resolve conflicting priorities; utilising ethical decision-making strategies to manage the impact on patient care; presenting ethical principles in the framework of beneficence, non-maleficence, autonomy and justice; identifying that patients may have unrealistic expectations of future treatment through the advance directives.

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

a. Outline at least one ethical dilemma of applying advance health directives in psychiatry.

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:

did not appear aware of ethical issues raised by advance directives.

7.1. Category: ETHICS	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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