

Committee for Examinations
Objective Structured Clinical Examination

Station 1
Gold Coast April 2019



CONTENT	PAGE
Bye Station 1 Notes	2
Overview <ul style="list-style-type: none">- Descriptive summary of station- Main assessment aims- 'MUSTs' to achieve the required standard- Station coverage- Station requirements	3-4
Instructions to Candidate	5
Station Operation Summary	6
Instructions to Examiner <ul style="list-style-type: none">- Your role- Background information for examiners- The Standard Required	7 7-11 12
Marking Domains	13-15

DO NOT REMOVE FROM ROOM

ACTIVE BYE STATION 1 NOTES

The following information is provided for you. These same 'Instructions to Candidate' will be available in Station 1.

You may make notations on your notepad, which you will take with you into Station 1.

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

Instructions to Candidate

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

Your tasks are to:

- Explain how you would have managed that situation if you were the doctor conducting the interview, after it was temporarily halted at 7.12 minutes, when the patient experienced difficulties.
- Present your mental state examination of the patient.
- Present your formulation of the patient's situation.
- Discuss the risks and benefits of the patient's current choice of treatment.
- Outline your management plan for this patient.

You will not receive any time prompts.

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 of a patient with panic disorder. During the course of the interview, the patient has a panic attack. The interview halts at this time and resumes at a time a few minutes later, when the patient has recovered from the panic attack. The candidates are expected to present a mental state examination, formulation and management plan for the patient.

The candidate is also expected to describe how they would have managed the panic attack, if they were the doctor conducting the interview. The patient asks the doctor to let them to keep using clonazepam, which they get from 'a friend'. The candidate is to present the issues pertaining to this request.

1.1 The main assessment aims are to:

- Identify and present important features of a mental state examination, formulate and provide a management plan.
- Describe the risks associated with long term benzodiazepine use, and acquiring medication from unlicensed sources.
- Outline how to manage a panic attack.

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

- Describe the use of controlled breathing, and at least one more technique to control the panic attack.
- Identify anticipatory anxiety and avoidance or ruminations as part of the patient's anxiety.
- Link the premorbid personality and childhood adversity to the development of panic disorder.
- Explain the risk of self-medicating with unprescribed medication from an unlicensed source.
- Address the patient's low self-esteem as part of the management.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders, Core clinical skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Collaborator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Mental State Examination, Formulation, Management – Treatment Contract, Management – Therapy), Collaborator (Patient Relationships), Professional (Ethics)

References:

- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder, Gavin Andrews, Caroline Bell, Philip Boyce, Christopher Gale, Lisa Lampe, Omar Marwat, Ronald Rape and Gregory Wilkins
- Textbook of Anxiety Disorders: Author: Dan J. Stein (ed.); Eric Hollander (ed.); Barbara O. Rothbaum (ed.)
- Ment Health Clin. 2016 Jun; 6(3): 120–126. Published online 2016 May 6. doi: 10.9740/mhc.2016.05.120 Benzodiazepine use, misuse, and abuse: A review Allison Schmitz, PharmD
- Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition. American Psychiatric Association. 2013
- World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (Vol. 1). World Health Organization.
- National Institute for Health and Care Excellence (2011a) Common Mental Health Disorders: Identification and Pathways to Care (Clinical Guideline [CG123]). Leicester; London: The British Psychological Society and the Royal College of Psychiatrists.

- National Institute for Health and Care Excellence (2011b) Generalised Anxiety Disorder and Panic Disorder in Adults: Management (Clinical Guideline [CG113]). Manchester: NICE
- National Institute for Health and Care Excellence (2012) Panic Disorder Overview. Available at: <http://pathways.nice.org.uk/pathways/panic-disorder>
- Broocks, A, Bandelow, B, Pekrun, G. (1998) Comparison of aerobic exercise, clomipramine, and placebo in the treatment of panic disorder. *The American Journal of Psychiatry* 155: 603–609.
- Milrod, B, Leon, AC, Busch, F. (2007) A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *The American Journal of Psychiatry* 164: 265–272.
- Feske, U, Goldstein, AJ (1997) Eye movement desensitization and reprocessing treatment for panic disorder: A controlled outcome and partial dismantling study. *Journal of Consulting and Clinical Psychology* 65: 1026–1035.
- Depping, AM, Komossa, K, Kissling, W. (2010) Second-generation antipsychotics for anxiety disorders. *The Cochrane Database of Systematic Reviews* 8: CD008120.
- CNCPs Second Phase Investigators (1992) Drug treatment of panic disorder: Comparative efficacy of alprazolam, imipramine, and placebo: Cross-national collaborative panic study, second phase investigators. *The British Journal of Psychiatry* 160: 191–202.
- Katzman, MA, Bleau, P, Blier, P. (2014) Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. *BMC Psychiatry* 14(Suppl. 1): S1.
- Stein, MB, Goin, MK, Pollack, MH. (2009) Practice Guideline for the Treatment of Patients With Panic Disorder, 2nd Edition. Arlington, VA: American Psychiatric Association
- Baldwin, DS, Anderson, IM, Nutt, DJ. (2014) Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology. *Journal of Psychopharmacology* 28: 403–439.

Acknowledgements:

- RANZCP Auckland Training Programme Mock Objective Structured Clinical Examination Station No. 2, April 2008.

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: doctor should be a professionally dressed male; role player for the patient is a male in his mid 30s, polite, well dressed, worried looking.
- 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.

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

You have viewed a DVD recording of an interview in the active bye station.

Your tasks are to:

- Explain how you would have managed that situation if you were the doctor conducting the interview, after it was temporarily halted at 7.12 minutes, when the patient experienced difficulties.
- Present your mental state examination of the patient.
- Present your formulation of the patient's situation.
- Discuss the risks and benefits of the patient's current choice of treatment.
- Outline your management plan for this patient.

You will not receive any time prompts.

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' and any other candidate material specific to the station.
 - Pens.
 - Water and tissues (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 that there are no cues / time 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 **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.

This is a VIVA station. There are no opening statements or prompts.

3.2 Background information for examiners

In this viva station, the candidate is to watch the DVD of an interview of a patient with a panic disorder. Candidates are expected to present a mental state examination, formulation and management plan for the patient.

During the course of the interview the patient has a panic attack. The interview halts at this time, and resumes at a time a few minutes later when the patient has recovered from the panic attack. The candidate is expected to describe how they would have managed the panic attack if they were the doctor conducting the interview. The patient requests the doctor to permit them to keep using clonazepam which they acquire from 'a friend', and the candidate is to present the issues pertaining to this request.

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

- Describe the use of controlled breathing, and at least one more technique to control the panic attack.
- Identify anticipatory anxiety and avoidance or ruminations as part of the patient's anxiety.
- Link the premorbid personality and childhood adversity to the development of panic disorder.
- Explain the risk of self-medicating with unprescribed medication from an unlicensed source.
- Address the patient's low self-esteem as part of the management.

A surpassing candidate may:

- present a sophisticated mental state examination and formulation
- consider legal and ethical aspects of self-medicating
- be aware of countertransference issues in regard to this
- present levels of evidence in their outline of the management plan.

DSM 5 defines a **panic attack** as a discrete period of intense fear or discomfort in which four or more of the following symptoms developed abruptly, and reached a peak within 10 minutes:

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensation of shortness of breath or smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, light-headed, or faint
9. Derealisation or depersonalisation
10. Fear of losing control or going crazy
11. Fear of dying
12. Paraesthesia (numbing or tingling)
13. Chills or hot flushes.

Panic disorder is a common distressing and often disabling condition in which patients experience recurrent unexpected panic attacks followed by at least one month of persistent concerns about having additional attacks (i.e., anticipatory anxiety), worry about implications of the attack, or a significant change in behaviour (e.g., avoidance) related to the attacks.

According to DSM 5, to diagnose panic disorder, one needs:

- One or more of the attacks followed by a month (or longer) of one or both of the following:
- Persistent worry about having more panic attacks and / or their consequences (e.g., having a heart attack).
- A significant abnormal change in behaviour in response to the attacks, such as avoiding unfamiliar situations.
- The disturbance cannot be attributed to the physiological effects of a substance, such as a drug or medication, or another medical condition.
- The disturbance cannot be better explained by another mental disorder, such as social anxiety disorder or specific phobia, which may involve panic attacks.

ICD 10 criteria

According to ICD-10, for a definite diagnosis of panic disorder, several severe attacks of autonomic anxiety should have occurred within a period of about one month:

- a. In circumstances where there is no objective danger;
- b. Without being confined to known or predictable situations; and
- c. With comparative freedom from anxiety symptoms between attacks.

ICD-10 further clarifies that panic disorder must be distinguished from panic attacks occurring as a part of established phobic disorders. When secondary to depressive disorders fulfilling the criteria, panic disorder should not be given as the main diagnosis.

Management of a panic attack

While there is plenty of information on how to manage panic disorder, scant literature is available about how to stop a panic attack. The management should include:

1. Clear reassurance about the nature of attack, and the fact that these attacks are not lethal and will resolve spontaneously.
2. Directing the patient to loosen the tight clothes.
3. Allow room and space for breathing, allow fresh air to come in.
4. Encourage to do controlled breathing: try to relax by taking slow, deep and complete breaths.
5. Encourage to use positive statements to oneself like: *'I know this is just an anxiety attack', 'I am not going to die', 'This is going to finish soon'*.
6. If the attack continues, a fast-acting benzodiazepine like clonazepam may be offered but is best avoided.
7. The therapist / clinician must remain calm and in control throughout the process.

Risks of Benzodiazepine misuse and using medication from an unlicensed source

Although the addiction potential of benzodiazepines (BZDs) became widely known decades ago, much remains unknown about identifying individuals at risk for developing addiction and how to treat individuals abusing BZDs. Prescription drug abuse has received more attention in recent years, but most of the research has focussed on prescription opioid abuse. Despite the risk of abuse and the introduction of safer alternatives, BZDs are one of the most prescribed classes of medications.

BZD misuse can be divided into two patterns:

- 1) deliberate or recreational abuse with the intention of getting high and
- 2) unintentional misuse that begins as legitimate use but later develops into inappropriate use.

Young adults ages 18 to 35 years comprise the largest portion of BZD abusers. BZD use and misuse have a strong association with comorbid psychiatric disorders, and personal or family history of substance use disorders. Comorbid psychiatric disorders are more common in BZD abusers than in other substance misuse populations. Approximately 40% of BZD abusers report a comorbid psychiatric disorder, highlighting the importance for clinicians to address both the underlying psychiatric disorder, as well as the BZD misuse. Nevertheless, alprazolam and clonazepam are the two BZDs associated with the most misuse-related ED visits; the rate of alprazolam involvement is more than double that of clonazepam.

Sources of prescription drug diversion are numerous, and can include both health care-related and non-health care-related sources. The most frequently reported health care source of BZD diversion was a regular prescriber, followed by a script doctor (i.e. a provider that sells prescriptions), doctor shopping (i.e. an individual receives care from multiple providers for multiple prescriptions), and pharmacy diversion (i.e. undercounting pills by pharmacy staff, employee theft). Recommendations for identifying high-risk individuals and reducing BZD abuse include obtaining a thorough personal and family substance use history, obtaining a urine drug screen, monitoring frequently for signs of abuse, reassessing the risks and benefits of ongoing therapy, prescribing a limited number of as-needed doses to reduce physiologic dependence, and differentiating carefully between physiologic dependence and addiction.

Some clinicians argue the medical community has overreacted to the risks of BZD misuse, stating it may result in under-prescribing of a safe and efficacious class of medications, and they argue for responsible but continued benzodiazepine prescribing. Although benzodiazepines possess abuse potential, particularly in substance misuse populations, it is crucial that risks be balanced with benefits. Prescribers must also weigh the risks of untreated illnesses. Poorly controlled or untreated anxiety or insomnia may increase the risk of alcohol relapse. Evidence-based pharmacotherapy and use of agents without abuse potential should be prescribed first-line and when appropriate, but BZDs may be indicated for some patients at elevated risk for misuse. When this occurs, provide thorough education on the risk of combining these drugs with alcohol or other substances, discuss diversion, prescribe a BZD with lower abuse potential, monitor for adverse effects, and monitor for inappropriate use.

Despite risks of misuse and diversion, BZDs are a safe and efficacious class of medications and continue to have a place in therapy. Lawmakers and health care professionals will be tasked with reducing misuse while maintaining accessibility for appropriate patients. Reductions in inappropriate prescribing rather than all prescribing should be emphasised and encouraged. Education is vital. Health care professionals must be knowledgeable about abuse patterns and diversion trends. It is imperative that prescribers and pharmacists educate patients not only on the risks to themselves, but also the risks to others, to reduce medication sharing. It is critical to identify BZD misuse risk factors prior to prescribing, use safer alternatives, and make appropriate interventions to combat ongoing abuse.

Outline of the evidence base for panic disorder that should be part of the management plan

A collaborative, pragmatic approach is recommended, beginning with psychoeducation and advice on life-style factors followed by specific treatment. In addition to efficacy, selection of initial treatment should take into account severity, patient preference, accessibility, cost, tolerability and safety.

A large body of level I evidence demonstrates the efficacy of CBT, antidepressant pharmacotherapy with SSRIs, SNRIs or TCAs and benzodiazepines for the treatment of panic disorder. There is limited or lower quality evidence for other psychological therapies, other antidepressant classes and other medication classes.

Initial treatment options are CBT, medication with an SSRI (or an SNRI if SSRIs are ineffective or are not tolerated) in combination with graded exposure to anxiety triggers, or a combination of CBT plus medication. Initial treatment should be selected in collaboration with the patient, based on the severity of the disorder, previous response to treatment, availability and the person's preference.

NICE guidelines recommend the use of CBT over first-line pharmacotherapy, and that pharmacological interventions should only be routinely offered to people who have not benefitted from psychological interventions (National Institute for Health and Care Excellence, 2011b, 2012).

Other guidelines, including Canadian clinical practice guidelines (Katzman et al., 2014), those by the American Psychiatric Association (Stein et al., 2009) and the British Association of Psychopharmacology (Baldwin et al., 2014), suggest that the choice of treatment (between CBT and pharmacotherapy) should be based on the person's preferences, previous response to treatment, comorbidity and availability of treatment options.

CBT for panic disorder

CBT has been shown to be efficacious in the treatment of panic disorder. It has been extensively studied in studies comparing CBT with a control, pharmacotherapy, and the combination of CBT and pharmacotherapy.

Typical CBT programs address the physical, cognitive and behavioural symptoms of panic disorder, and aim to prevent relapse in three stages.

The first stage includes psychoeducation (explaining about anxiety and the symptoms of panic disorder), formulation, treatment rationale, symptom monitoring and addressing factors that facilitate or hinder therapy. Motivational interviewing and education of the person's family or members of their social support network should also be considered, and written information or links to reliable online information should be provided.

The second stage includes identifying and reducing cognitive symptoms through challenging unhelpful thinking, particularly about catastrophic cognitions, using behavioural experiments and in vivo exposure to test hypotheses, with the aim of reducing safety behaviours and avoidance, and interoceptive exposure to feared physical sensations.

The final stage is relapse prevention that includes identifying potential precipitants for setbacks, identifying the patient's early warning signs and developing a plan to manage setbacks and prevent relapse.

The optimal duration of CBT for panic disorder is 7–14 hours, usually delivered in weekly sessions.

CBT can be delivered face-to-face (individual or group), accessed by computer, tablet or smartphone application (dCBT), or through self-help books. CBT delivered face to face (particularly individual) is the most traditional form of delivery and the most widely available, hence has been the most extensively studied.

dCBT has been an area of rapid development and study over recent years. There have been 12 RCTs of automated guided dCBT, which show a mean effect size of 1.31 (95% CI = [0.85, 1.76]) at a mean follow-up of 7.8 months post intervention, and an average adherence of 74%. Three of the studies included a comparison with face-to-face CBT and showed no difference in efficacy.

Other psychological therapies and interventions

There is currently much interest in other potentially useful therapies such as mindfulness, and Acceptance and Commitment Therapy (ACT). However, there is insufficient evidence from meta-analyses specific to panic disorder to make conclusions at this time.

Exercise as a form of treatment has been reported to be less effective than medication and no more effective than relaxation (Broocks et al., 1998; Wedekind et al., 2010). Exercise is, nevertheless, recommended by National Institute for Health and Care Excellence (NICE) as part of general health care for people with panic disorder (National Institute for Health and Care Excellence, 2011a). Often, patients with panic disorder have stopped exercising because they catastrophically misinterpret the bodily sensations produced such as increased heart rate, shortness of breath and sweating. This can be managed by careful explanation and encouraging gradual introduction of exercise.

Panic-focussed psychodynamic psychotherapy delivered twice a week in a 12-week manualised treatment program has been shown to be effective in one RCT (Milrod et al., 2007).

Emotion-Focussed Therapy (EFT) developed by Shear and Colleagues, specifically targets emotional regulation as it related to interpersonal control and to fears of being abandoned or trapped. However, in a randomised comparison, EFT was found no better than a pill-placebo and was less effective than both CBT and imipramine.

Two studies of Eye Movement Desensitisation and Reprocessing (EMDR) have reported equivocal or unsustained benefits, and do not support the use of EMDR for panic disorder (Feske and Goldstein, 1997; Goldstein et al., 2000).

Relaxation Therapies such as progressive muscle relaxation have been regarded as weak treatments for panic disorder.

Pharmacotherapy for panic disorder

Medication with SSRIs, SNRIs, TCAs and benzodiazepines has been shown to be efficacious in the treatment of panic disorder. These medications have been extensively studied in RCTs comparing medicines with pill placebo control, CBT, and the combination of CBT and pharmacotherapy.

On average, rates of response to medication are 50–70%. Meta-analyses report equivalent efficacy for SSRIs, TCAs and benzodiazepines. These studies also report no differences in attrition and dropout rates for the different medications (SSRIs 23.1%, TCAs 23.5% and benzodiazepines 17.7%). MAOIs are effective in managing the symptoms of panic disorder, but their use is limited by their safety and tolerability profile.

Medications with less supportive evidence include Mirtazapine, Duloxetine, Milnacipran, Moclobemide, Bupropion, Divalproex, levetiracetam and Gabapentin.

A Cochrane review of second-generation antipsychotic agents (Depping et al., 2010) reported no clear benefits for their use in panic disorder.

Although there is lack of clear evidence for what constitutes an adequate trial of medication, consensus expert recommendation is to wait for at least six weeks with at least two weeks at the full dose, however the recently updated British Association of Psychopharmacology guidelines recommend 12 weeks.

The optimal duration of treatment has not been well studied. Most guidelines refer to expert consensus recommendations and suggest continuation for at least six months (National Institute for Health and Care Excellence, 2011a) to a year.

When medication is discontinued, consensus advice is to taper medication down over weeks to months to reduce the risk of discontinuation symptoms.

Role of Benzodiazepines

Benzodiazepines (alprazolam, clonazepam, diazepam, lorazepam) have been shown to be efficacious for the treatment of panic disorder, approximately equal to that of SSRIs and TCAs. Benzodiazepines have a rapid onset of action. Alprazolam is the most extensively studied of the benzodiazepines, and was the benzodiazepine used in the Cross National Collaborative Panic Study (CNCPS Second Phase Investigators, 1992). It is effective in the treatment of panic disorder but is no longer recommended due to safety concerns, mainly a high risk of dependency, and difficulty discontinuing.

Despite their efficacy, benzodiazepines are not recommended as first-line treatment options, largely because of the risk of side effects (particularly sedation and cognitive impairment), tolerance and dependence (especially with alprazolam). Their use in combination with CBT also has potentially detrimental effects. Because of these concerns, recommendations are for benzodiazepines to be used short term, and to be dosed regularly rather than 'as required' (Katzman et al., 2014; Stein et al., 2009).

Occasionally, benzodiazepines may be useful in an emergency setting for short-term management of severe agitation or anxiety, and for the management of an acute panic attack. They should not be used as a treatment for panic disorder in people with a history of substance use disorder.

A possible formulation

Anthony is a 36-year-old male who was referred by his GP for psychiatric assessment due to the presence of panic symptoms.

These panic symptoms were closely correlated to Anthony commencing his own accounting business. One might hypothesise that Anthony's fear of failure, and somewhat dependent nature made it difficult for him to work in a more autonomous role.

From a cognitive perspective, Anthony is experiencing a vicious cycle of anxiety and avoidance. His physical symptoms of anxiety lead to the cognition that he is suffering from a medical illness (e.g. heart attack), which fuels his physical symptoms further resulting in avoidance of areas he deems unsafe. His anticipatory anxiety regarding the fear of further attacks reinforces his avoidance which ultimately leads to greater dysfunction.

Anthony is currently managing his anxiety symptoms with benzodiazepines which, in the short term, alleviates his anxiety. He is at risk of benzodiazepine dependence with tolerance to the effects of his clonazepam, as well as the risk associated with acquiring an ongoing supply of medications in an illicit manner which may lead to forensic related issues. This is of particular concern, given his past history of alcohol misuse, and a similar history in his father which may indicate a biological predisposition towards substance abuse or dependence.

It would seem that Anthony has adopted a physical explanatory model for his symptoms. He believes that he has a 'medical illness' which shifts the focus away from psychological strategies, and other ways of dealing with his anxiety. The possibility of a medical explanation for his symptoms (e.g. arrhythmia) merits consideration, and this is, potentially, a driving factor for his anxiety.

Anthony's developmental history may shed some light on his current difficulties. He has a childhood history of anxiety with fears of separation. As a small child he utilised periods of distress to obtain care from his mother which may have led to more entrenched dependence. His current panic symptoms may, from a psychodynamic perspective, be an unconscious expression of distress which has the aim of eliciting care from those around him. Anthony seems to have had an ingrained sense of poor self worth, perhaps dating back to the invalidation and violence he witnessed from his father, as well as the feeling of disappointing his mother. His feelings of being unable to manage his anxiety may be compounding his low sense of self-worth, and a feeling of helplessness.

Looking to the future, Anthony has a number of challenges. His ongoing stress at work may continue to fuel his anxiety, and his misuse of benzodiazepines may lead to dependence, as well as rejection of psychological therapies for his panic disorder. Despite these, Anthony seems to have a number of protective factors. He has engaged well with his psychiatrist, and his family seems to be a source of support for him.

3.3 The Standard Required

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

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

- i. they have competence as a **medical expert** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).
- ii. they can act as a **communicator** who effectively facilitates the doctor patient relationship.
- iii. they can **collaborate** effectively within a healthcare team to optimise patient care.
- iv. they can act as **managers** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.
- v. they can act as **health advocates** to advance the health and wellbeing of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

STATION 1 – MARKING DOMAINS

The main assessment aims are:

- Identify and present important features of a mental state examination, formulate and provide a management plan.
- Describe the risks associated with long term benzodiazepine use, and acquiring medication from unlicensed sources.
- Demonstrate the ability to manage a panic attack.

Level of Observed Competence:

3.0 COLLABORATOR

3.4 Did the candidate develop an appropriate therapeutic relationship with the patient? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

Recognises the complexity of the situation; prioritises use of specific additional resources to meet the specific needs of the patient; positively promotes safety for all involved.

Achieves the Standard by:

Demonstrating ability to develop therapeutic relationship in a stressful situation; responding quickly to concerns raised; maintaining open communication; appropriately informing patient of useful techniques; describing options like providing reassurance and plenty of space, loosening tight clothes, remaining calm, using positive statements and offering a fast acting benzodiazepine as a last resort.

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

- Describe the use of controlled breathing, and at least one more method to manage the panic attack.

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

Below the Standard (scores 2):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality.

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

3.4. Category: PATIENT RELATIONSHIPS	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
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

1.3 Did the candidate demonstrate adequate proficiency in presenting a mental state examination? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

demonstrating capacity to present a thorough, organised and accurate mental state examination; assessing key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; deciding on the importance of a cognitive assessment; providing a succinct presentation with accurate use of phenomenological terms; including appropriate positive and negative findings.

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

- Identify anticipatory anxiety and avoidance or ruminations as part of the patient's anxiety.

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):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality.

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

1.3. Category: ASSESSMENT – Mental State Examination	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
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 (scores 5) if:

provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and social 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; analysing vulnerability and resilience factors.

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

- a. Link the premorbid personality and childhood adversity to the development of panic disorder.

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):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality.

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

1.11. Category: FORMULATION	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
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 – 15%)

Surpasses the Standard (scores 5) if:

sensitively explains the risks of using benzodiazepines when not properly prescribed and monitored; seeks peer review in difficult countertransference situations; comprehensively considers 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; apply ethical principles to resolve conflicting priorities; demonstrate the ability to clearly communicate indications for treatment with clonazepam; work within patient treatment goals, and negotiate targeted outcomes; adequately inform regarding treatment risks / benefits and complications, including potential adverse outcomes; provide psychoeducational material; employ a psychologically informed approach, especially to risky behaviours.

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

- a. Explain the risk of self-medicating with unprescribed medication from an unlicensed source.

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):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality.

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

7.1. Category: ETHICS	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
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

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological and psychosocial therapies? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support treatment options.

Achieves the Standard by:

demonstrating awareness of the efficacy of CBT, antidepressant pharmacotherapy with SSRIs, SNRIs or TCAs and benzodiazepines for the treatment of panic disorder; demonstrating the understanding of these treatments; identifying specific treatment outcomes and prognosis; appropriate selection, benefits / risks, application, adherence, monitoring of specific interventions; medication(s) choice, dosing and monitoring; application of psychoeducation; sensitive consideration of barriers to implementation; identifying the role of other health professionals.

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

a. Address the patient’s low self-esteem as part of the management.

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

Below the Standard (scores 2):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality.

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

1.14. Category: MANAGEMENT - Therapy	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
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 level of a junior consultant psychiatrist?

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