Committee for Examinations
Objective Structured Clinical Examination

Station 9
Brisbane September 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate has a meeting with the sister of a patient who has been admitted to a medical ward with complications related to anorexia nervosa. The candidate's tasks are to convey information about anorexia nervosa, provide information about the medical complications of this disorder and answer any questions.

1.1 The main assessment aims are:

- To demonstrate how to empathically interact with an anxious relative of a patient who is seriously ill.
- To convey DSM-5/ICD-10 diagnostic criteria of anorexia nervosa to a lay person.
- To demonstrate knowledge of the physical complications of anorexia nervosa and convey medical information to a lay person.
- To support the family member by providing relevant information and advocate for the least intrusive treatment.

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

- Describe disturbance in the way which one's body weight or shape is experienced.
- Refer to intense fear of gaining weight or of becoming fat.
- Accurately discuss the significance of the low potassium.
- Sensitively respond to the concern that Olivia may die.
- Carefully balance the concept of least restrictive practice with risk of poor medical outcomes.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders – Eating Disorders
- **Area of Practice:** Consultation Liaison
- **CanMEDS domains:** Medical Expert, Communicator, Health Advocate
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Diagnosis; Diagnosis - Investigation Analysis), Communicator (Synthesis), Health Advocate (Addressing Stigma)

References:

- Hay P, Chinn D et al: Royal Australian New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. ANZJP 2014, Vol. 48(11) 1-62
- Mehler SM and Brown C: Anorexia nervosa – medical complications. Journal of Eating Disorders 2015, 3:11. DOI 10.1186/s40337-015-0040-8
- Sanders B: Notes on Eating Disorders. www.askdoctorclarke.com. Pg. 1-5
- APA Practice Guidelines for eating disorders. www.psychiatrionline.org
- A guide to admission and inpatient treatment for people with eating disorders in Queensland. Mental Health. Eating Disorders Outreach Service (EDOS), Metro North Mental Health, QLD

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 - woman in her 20's who is mildly anxious/apprehensive about her younger sister, who is ill in hospital.
- 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 in the consultation liaison team at a local tertiary hospital. Olivia is a 19-year-old patient with anorexia nervosa, binge-eating/purging type. She is engaged in treatment with the local Eating Disorders Unit and your consultation with Olivia has been limited to when she has required hospital treatment for complications related to anorexia nervosa.

Olivia has been re-admitted to the medical ward the previous evening after she collapsed at home. Olivia has a BMI of 14 at this time and you have not yet seen her since she was admitted last night. She apparently had a series of blood tests and now has gone to another part of the hospital for an echocardiogram.

You are seeing Jane, Olivia's older sister. Jane has asked to see a doctor involved in her sister's treatment. Jane is anxious and worried about Olivia, who has given her consent to disclose all information to Jane.

Your tasks are to:

- Briefly explain the key features of anorexia nervosa to Jane.
- Describe the common medical complications of this condition.
- Answer any questions Jane may have about treatment options.

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' and any other candidate material specific to the station e.g. investigation results.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated family member.

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 are no cues or time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated family member 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 <u>final task</u>:

- You are to state the following:

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the activity undertaken in the station and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

You have no opening statement or prompts.

The role player opens with the following statement:

'Thank you for seeing me doctor. I am keen to know what is happening with my sister.'

3.2 Background information for examiners

In this station the candidate is in a Consultation Liaison (CL) setting. They are expected to demonstrate skills to empathically engage a close relative of a patient who is anxious about her sister. They are to briefly explain the key features of the diagnosis of anorexia nervosa and outline the expected common medical sequelae to a lay person using non-complex terminology.

The candidate will be expected to answer a question posed by the sister related to the role of compulsory treatment and forced feeding (nasogastric feeding). The candidate must convey the aim of least intrusive multidisciplinary treatment but, at the same time, outline the rationale for admitting patients to hospital to treat life-threatening states.

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

- Describe disturbance in the way which one's body weight or shape is experienced.
- Refer to intense fear of gaining weight or of becoming fat.
- Accurately discuss the significance of the low potassium.
- Sensitively respond to the concern that Olivia may die.
- Carefully balance the concept of least restrictive practice with risk of poor medical outcomes.

A surpassing candidate will be able to clearly delineate their role in the patient's care, be able to easily engage the sister and contain her anxiety. They will advocate that they would be available to answer questions at a later date and refer to a family support agency as well as provide written information.

Diagnosis of anorexia nervosa

According to the DSM-5 criteria, to be diagnosed as having anorexia nervosa a person must display:

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

There are two main subtypes identified in DSM-5: Restricting type, and binge-eating/purging type.

The ICD-10 defines anorexia nervosa as a disorder characterised by deliberate weight loss, induced and sustained by the patient, which occurs most commonly in adolescent girls and young women, but adolescent boys and young men may also be affected, as may children approaching puberty and older women up to the menopause. It is associated with a specific dread of fatness and flabbiness of body contour which persists as an intrusive overvalued idea. Patients impose a low weight threshold on themselves and there is usually undernutrition of varying severity with secondary endocrine and metabolic changes and disturbances of bodily function. Symptoms include restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics.

For a definite diagnosis of anorexia nervosa the following are required:

- Body weight maintained at least 15% below that expected (either lost or never achieved), or Body Mass Index (BMI) of 17.5 or less. Pre-pubertal patients may show failure to make the expected weight gain during the period of growth.
- Weight loss is self-induced by avoidance of 'fattening foods' and one or more of the following: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and/or diuretics.
- Body-image distortion in the form of a specific dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on themselves.
- Endocrine complications manifesting as amenorrhoea or loss of sexual interest and potency in men.
- If onset is pre-pubertal, the sequence of pubertal events is delayed or even arrested (in girls there is no breasts development and the menarche is delayed; in boys, genitals remain juvenile). With recovery, puberty is often completed normally, but the menarche is late.

Usually the key information explored in history would include:

- pattern of dietary restriction, details of main meals and if any snacks consumed and feelings of early satiety
- disturbed eating behaviours - eating alone
- ritual patterns - like long meals, food division into small pieces
- weight loss/inability to restore weight
- body image disturbance and fears about weight gain
- binging and purging behaviours
- excessive exercising
- constipation
- use of laxatives, diuretics, medications to decrease weight
- any history of fainting, light headedness, palpitations, chest pain, SOB, ankle swelling, weakness, tiredness and amenorrhoea.
- cognitive changes such as slowed thought processing, impaired short-term memory, reduced cognitive flexibility, and attention and concentration difficulties.
- suicidal ideation or active self-harm

Physical complications of anorexia nervosa

The candidate should provide a systematic explanation of physical complications of anorexia nervosa. Indications for admission to hospital for adults are usually:

- BMI <12 (psychiatric admission may be indicated at BMI <14 - better candidates identify this point).
- 1kg weight loss per week or grossly inadequate nutritional intake – rapid weight loss or grossly inadequate intake
- Hypotension especially systolic <80mmHg, and postural hypotension noted by >20mmHg drop with standing
- Blood Sugar Level <2.5-3mmol/l
- Hypothermia - temperature <35°C with or without cold/blue extremities; or hyperthermia >38°C
- Metabolic alkalosis or acidosis
- Hyponatraemia - <125mmol/l
- Hypokalaemia - <3.0mmo/l
- Lowered Magnesium/lowered Phosphate
- Lowering renal function as noted by decreasing eGFR
- Hypoalbuminaemia - <30g/L
- Elevated liver enzymes - elevated aspartate aminotransferase (AST) and alanine aminotransferase (ALT) - >500
- Albumin <30g/L
- Any arrhythmia including QTc prolongation, or non-specific ST or T-wave changes including inversion or biphasic waves
- Starvation induced bone marrow suppression causing neutropenia (<0.7 x 10^9/L)

Medical treatment
Inpatient treatment should focus on medical stabilisation as the first priority followed by prevention and treatment of re-feeding syndrome, weight restoration and reversal of cognitive effects of starvation prior to outpatient psychotherapy. Continued treatment in specialist Eating Disorder Unit (EDU) if available, either inpatient or outpatient after liaison with usual clinical team.

- It is important for the candidate to convey the need for gradual medical stabilisation and to specify which part of treatment takes place where.
- The candidate should convey the role of the CL Services – involvement in clinical care while the patient is in hospital until they are medically stable. At this stage the patient's care is then transferred to another psychiatric unit/team or an EDU for ongoing nutritional rehabilitation and psychiatric treatment. The CL service can ensure two-way communication, and influence management decisions as to whether to proceed as a psychiatric inpatient or out patient.
- Medical treatment prioritises management of:
  - Electrolytes
  - Bone marrow suppression
  - Glucose
  - BP
  - Weight
- The candidate should convey the need to aim for oral food and fluids instead of nasogastric or IV as a preference: done gradually with no glucose-based food/fluids initially to prevent 'refeeding syndrome.' A candidate may briefly explain this as a potentially fatal complication of aggressive re-feeding especially in someone who has been starving over a long period – with a better candidate presenting this information in a sensitive manner so as not to increase levels of anxiety, particularly as this is not the issue with this patient who does not need forceful refeeding.

Refeeding Syndrome – is understood to be a clinical state reached due to switch from fasting state glucose production to carbohydrate induced insulin release, leading to rapid intracellular intake of potassium, phosphate and magnesium to metabolise the carbohydrate. This then aggravates the already existing low electrolyte state. The first two weeks of refeeding pose the greatest risk with potential biochemical abnormalities including hypokalaemia, hypophosphataemia, hypomagnesaemia and hypocalcaemia. The risk of heart failure in refeeding syndrome is reduced by gradual refeeding.

The cascade is further complicated by already existing low glucose that is aggravated by a background of poor glycogen stores. It is mitigated by controlling weight gain to 500 to 1400g/week in an in-patient setting. With dietician input, patients gain weight faster.

- Since medical complications are the consequence of starvation, effective treatment means that regular food intake with supervision is supported when the patient returns to the community. In this case Olivia's sister may be willing to play a part to assist with this.
- Candidates should convey clearly that nutritional counselling is not the sole treatment. Family therapy is crucial part of treatment in an adolescent. In this scenario, given that the patient is living in her parents' home with older sister recently returned, it will be critical to look at family therapy as an option: a better candidate may recommend this.

Nasogastric feeding and compulsory treatment
If the patient is unable or unwilling to maintain oral intake the question should be asked, 'Is it ethical to watch someone die from a reversible disorder?' based on starvation of the brain.

The ethical issues of treatment that need to be considered are the autonomy of the patient who has been offered choices, beneficence in taking the best action for patient, within the context of patient capacity – starvation and low body weight lead to impaired capacity to make decisions about nutrition, which is reversible through nutrition to the brain. The Minnesota Semi-starvation Study conducted (Ancel Keys - http://en.wikipedia.org/wiki/Minnesota_Starvation_Experiment) demonstrated that loss of 25% of body weight led to profound cognitive changes in all subjects. Such starvation-induced changes include obsessive preoccupation with food and eating, and loss of perspective and insight. These changes were found to only be reversed when weight was restored.

24hr continuous nasogastric (NG) feeding using a low fibre, energy dense enteral feed should not be delayed. This can be commenced whilst awaiting dietitian consultation. The decision to move to more invasive treatment should be based on medical risk as well as BMI. If a patient is unwell enough to need to be admitted to a medical ward the illness needs to be treated; for instance, if bradycardia, postural hypotension and an inability to eat are present.

It could actually be that it is safer to use NG feeding on a medical ward as it can prevent rebound hypoglycaemia because of slow continuous feeding, and there may be better management because of difficulty of monitoring eating regularly on a busy medical ward.

Anorexia nervosa is a mental illness that can be life-threatening – it has the highest mortality rate (20%) of any psychiatric illness: deaths are due to malnutrition and suicide. It is associated with impaired capacity due to the mental illness itself as well as the effects of starvation on the brain. The use of compulsory treatment can be appropriate in a situation where the patient's impaired capacity is putting them at risk. Either guardianship or mental health legislation can be considered, although in many jurisdictions mental health acts provide the patient and staff a clearer legal framework with closer oversight. The decision can depend on the team.

Decisions for compulsory treatment should be based on the fact that the patient has a mental illness and requires immediate treatment (that is available through an authorised service). Because of the patient's illness there is an imminent risk that the person may cause harm to themselves (or someone else) and they are likely to suffer serious mental or physical deterioration. The patient lacks the capacity to consent to be treated for the illness, or they have unreasonably refused proposed treatment for the illness.

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:

Your name is Jane, and you are 21 years old and single. You are the older sister of Olivia, who is 19 years old. You have just moved home with your parents and Olivia as it is situated close to the University of Queensland where you plan to be a Master's student from next year. You have just returned one week ago from a year-long overseas trip. You and a friend travelled around UK, Europe and USA after completing your Bachelor's degree. The last week has been hectic with you catching up with old friends, looking into your university registration and generally settling back into home. You have not spent too much time with the family, but had been looking forward to seeing them all this weekend.

Jane was fine when you went away – she had been plump in her late teens but had lost some weight before you went away and you were glad that she was doing so because she was worried about being fat. In the year that you have been away she has lost a lot of weight and you were surprised to see her when you returned a week ago. She has refused to tell you how much she weighs.

You are both university students – Olivia is a first year Fine Arts student and you are to start your Master's in English Literature. You are the only children to your parents – Roger and Mary. Your parents are very busy. Your father is a General Surgeon and has a busy private practice while your mother has a fashion boutique in a local mall. Mom had mentioned Jane's weight loss to you a couple of times when you spoke in the past year, but you did not pay much attention to it. You had no idea she was under treatment for anything. You suppose your family did not want to worry you.

Roger and Mary are both at work at the moment and they have conveyed their concerns but are unable to be present at this time given the unscheduled admission of Olivia the preceding evening. They plan to come to see Olivia this evening. You are at the hospital and you would appreciate a chance to talk to the doctor.

You are keen to know exactly what is wrong with Olivia and what her diagnosis actually is. You are anxious and worried as you were the one who witnessed her collapse and called the ambulance.

Events of the preceding day – you had noticed your sister going for a run: she runs for over one hour most days. She fainted just after coming home from her run. Fortunately, you were home, witnessed her collapsing and called the ambulance. You are sure Olivia had passed out for a few seconds. Olivia soon woke up but was very dizzy when trying to stand up. You kept her on the ground until the paramedics came.

The paramedics took her blood pressure which they said was low, her pulse was slow even though she had just returned from a run. They said her heart was not right after they attached electrical leads to her chest and did an ECG. They then brought her into hospital and she was admitted overnight.

It was a very anxious time for you. You had never experienced anything like this before and you were very scared. You rang your mother at work who thanked you for your quick action – she was relieved that Olivia was getting care at the hospital. Your parents eventually came home from work later last night; Fridays are usually a busy day for both of them.

Today you have been informed that Olivia has been getting a drip since coming in last evening. She has gone to have a special ultrasound to examine her heart. You did manage to talk with her briefly and you are surprised that she is completely unconcerned by what happened and her thin appearance - she seems to want to lose weight even though she is so thin. You get the feeling that she is scared of gaining weight despite being so thin.

Last night your parents told you that over the last six months she has stopped going out with friends and is focussing on her body. This is what they have heard from Olivia's friends. Come to think of it, you think you have heard her vomiting but Olivia completely denies this.

She has no known allergies, and this is her first ever hospitalisation. You do not believe Olivia has any alcohol or drug issues and you know she does not smoke.

The rest of your family are healthy. If expressly asked about inherited or other conditions in your wider family, you can disclose that your father's first cousin died unexpectedly at age 20. He just dropped dead. He was a university student. He was said to have had a '*dilated heart, something like that*'.

The nurse advised you that Olivia has been diagnosed with anorexia nervosa. You are shocked, you knew about girls in high school and at university with eating disorders, but didn't ever think someone in your family would get this. You are distressed by her physical ill health – especially when all she seemed to do was exercise! You don't have first-hand knowledge of severe cases and never paid much attention as only Hollywood actresses and super models get really bad.

It was that same nurse you overheard talking to the other staff about force feeding Olivia (see section 4.5 below).

You have never met anyone with anorexia before and you are unsure of details of Olivia's eating patterns, other daily routines and beliefs as you have been away while she has been unwell.

4.2 How to play the role:

You are neatly dressed in casual attire, much like any other more senior university student. You come across as generally anxious but trying to be friendly and co-operative. Your speech is initially quite fast because of your anxiety, but dependent on how the candidate speaks to you this can settle.

4.3 Opening statement:

'Thank you for seeing me doctor. I am keen to know what is happening with my sister.'

4.4 What to expect from the candidate:

The candidate should try to reassure you and give you a chance to ask all the questions you want to ask. They should briefly explain what anorexia nervosa is and offer any additional information you need. They should then talk about some of the physical complications that can arise in patients with anorexia nervosa without causing you to feel highly anxious. The candidate should also carefully explain when people are 'force fed.'

If the candidate keeps asking you questions about Olivia's illness, inform them that you are unaware of any details as you have just returned home. You wish to learn about the illness today.

The candidate may offer you some written information, to see you again to make sure the family understands. They may also explain their role in the facilitation of referral to correct services before Olivia is discharged from hospital.

4.5 Responses you MUST make:

'A nurse said that because Olivia's "K is 1.9" she is critically ill – what does this mean?

'Is she going to die?'

'The nurses are saying that they are going to force feed Olivia – could they do that?'

4.6 Responses you MIGHT make:

Anticipated Question: *How much does Olivia eat?*
Scripted Response: *She has been eating less in last six months. Dinner might be just a banana while in the past she would have had steak and chips.*

Anticipated Question: *Is she afraid of weight gain?*
Scripted Response: *Yes, she seems to be. Perplexing when she is eating so little and is thin.*

Anticipated Question: *What does she think about her body shape?*
Scripted Response: *I do not know.*

Anticipated Question: *Does she ever say she feels fat/big/overweight/too big for her size?*
Scripted Response: *She has never said this to me.*

Anticipated Question: *Does Olivia seem unconcerned by her low weight?*
Scripted Response: *Yes – she will not believe me that she should be worried!*

Anticipated Question: *Do you know anything about Eating Disorders? In particular anorexia?*
Scripted Response: *There were girls at school who had eating disorders, but none of them were as bad as Olivia.*

Anticipated Question: *Do you have good supports?*
Scripted Response: *Yes, my classmates and friends.*

Anticipated Question: *Have I answered all your questions?*
Scripted Response*: Yes, I think so. (as long as they have adequately responded to the MUST say questions (section 4.5))*

Anticipated Question: *Would you like to be referred to a support service?*
Scripted Response*: What does that involve?*

4.7 Medication and dosage that you need to remember:

None.

STATION 9 – MARKING DOMAINS

The Main Assessment Aims are:

- To demonstrate how to empathically interact with an anxious relative of a patient who is seriously ill.
- To convey DSM-5/ICD-10 diagnostic criteria of anorexia nervosa to a lay person.
- To demonstrate knowledge of the physical complications of anorexia nervosa and convey medical information to a lay person.
- To support the family member by providing relevant information and advocate for the least intrusive treatment.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.9 Did candidate formulate and describe the relevant diagnosis of anorexia nervosa? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard and demonstrates a superior performance that prioritises information without overloading the sister with excessive detail; appropriately identifies any limitations of diagnostic classification systems to guide treatment.

Achieves the Standard by:
integrating available information in order to describe the diagnosis; utilising a biopsychosocial approach; adequately prioritising information relevant to the situation and findings; clearly explaining the core features of anorexia nervosa, including communicating in appropriate language and detail and according to good judgment.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Describe disturbance in the way which one's body weight or shape is experienced.
b. Refer to intense fear of gaining weight or of becoming fat.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; 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:
provides 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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.10 Did the candidate interpret history/tests/investigations correctly when describing the complications of anorexia nervosa? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard and demonstrates a superior performance linking relevant history, investigations with other diagnostic procedures to explain medical complications.

Achieves the Standard by:
accurately interpreting the history and results and incorporating them into the explanation of complications; any errors are minor and do not materially adversely affect outcomes; utilising information to prioritise significance and interpretation for the sister; referring to the most likely cardiac complications; describing importance of acute treatment and follow up based on available information.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Accurately discuss the significance of the low potassium.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; 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:
provides inaccurate or inadequate interpretation of history and investigations; errors or omissions are significant and do materially 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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills appropriate to the audience and context? (Proportionate value – 20 %)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard and 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 and feedback to questions; prioritising and synthesising information; adapting communication style to the situation; demonstrating discernment in selection of content; considering the impact of information provided and adapting style; demonstrating capacity to listen to and respond sensitively to those areas of specific concern raised by her sister.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Sensitively respond to the concern that Olivia may die.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; 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; inadequately adapts to responses; unable to maintain rapport.

2.5. Category: SYNTHESIS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

5.0 HEALTH ADVOCATE

5.2 Did the candidate appropriately seek to address possible discriminatory practice from the nursing staff? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard and recognises the important role of psychiatrists in addressing stigma; balances the impact of stigma and the need for treatment; considers interventions with staff and family to reframe compulsory or forced feeding.

Achieves the Standard by:
identifying the impact of alternative beliefs and stigma of mental illness on patients and families; recognising the role of staff in the generation and maintenance of stigma; applying principles of prevention, promotion, early intervention and recovery to clinical practice; taking into account the ethical principles that underlie application of appropriate clinical interventions; constructively address competing attitudes towards mental health; promoting positive aspects of non-intrusive, non-invasive interventions where possible; giving a brief context of any potential role for or boundaries of legal options i.e. mental health legislation, doctrine of necessity.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Carefully balance the concept of least restrictive practice with risk of poor medical outcomes.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; 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:
limited capacity to identify impact of possible stigma on decision making for people with mental illness; does not consider addressing perceived stigma.

5.2. Category: ADDRESSING STIGMA	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

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

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