

BYE STATION 1 NOTES

The following information is provided for you to read during the bye station. You may make notations on this document and on your notepad. You may take this document and your notes into the station. Please leave this document with the examiner when you exit Station 1.

- You have **twenty (20) minutes** in this Active Bye Station to review the provided information including a complaint and the associated incident report and background documentation regarding restraint, and to start working on your responses to the tasks outlined below based on this information.
- After you leave the bye station you have **five (5) minutes outside the examination room** to read and continue working on the responses you will present to the examiners.

Instructions to Candidate

This is a **VIVA** station.

You are working as a junior consultant psychiatrist in an adult general inpatient ward in the Western Health Service.

The service has received a complaint about a recent episode of restraint involving a young man whose care has been transferred to you since the incident. The previous psychiatrist involved in his care has since retired and so no longer works for the mental health service.

The director of the service has asked to meet with you to discuss your recommendations as to how the complaint should be dealt with, and discuss whether you see any issues that the service needs to follow up. You have been given copies of the complaint, the associated incident report, the Western Health Service policy on restraint and an excerpt from the RANZCP position statement on restraint (2016).

Using the information that you have reviewed in the active bye your tasks are to:

- Outline your assessment of the facts of the complaint in relation to the Incident Report, the service policy and the RANZCP Position Statement (2016).
- Describe your approach to responding to the complaint.
- Propose a brief outline of an action plan for service improvement and your role in its implementation.

You will not be given any time prompts.

In this bye station, you have been given:

- **Attachment 1** - Letter of complaint from Sean and Sally Wright, dated 4th April 2018;
- **Attachment 2** - Incident Report 1087, dated 9th March 2018;
- **Attachment 3** - Western Health Ward Policy on Personal Restraint;
- **Attachment 4** - An excerpt from the RANZCP Position Statement 61, minimising the use of seclusion and restraint in people with mental illness (2016).

ATTACHMENT 1

Nurse in Charge
Acute Adult Inpatient Services
Mental Health Services

Dear Nurse in Charge,

We are writing to express concern about the experience that our son, Robert (Robbie) Wright, had during his recent stay in hospital.

Robbie was admitted to the more open part of the psychiatric ward on the 8th March 2018. On his second day in hospital he was forcibly taken to the intensive mental health care ward where staff held him down, and gave medication into his muscles and veins. Robbie was very frightened at the time as he believed that his life was in danger from the staff and this made him struggle quite desperately against being held down. He has a history of asthma and he has told us that he felt as though he was going to suffocate, plus he had bruises on his arms from the way he was manhandled.

Overall Robbie spent just over three weeks in hospital and is now much better, although not yet back to his normal self. He looks back on his first few days in hospital with terror, and would be fearful to set foot into the hospital again.

Although we are grateful for the help Robbie received once back on the open ward, we have concerns about several aspects of what happened and would like to talk with you about them. We believe that:

- It was unnecessary to use force in order to transfer him. If either of us had been asked to come into the hospital we could have talked Robbie into accepting the move without force;
- The force used was excessive. Robbie has never been a violent person and, although he was very unwell, he did not threaten himself or anyone else;
- We should have been contacted about the medication that was going to be given and its side effects.

We look forward to meeting with you to talk about our concerns.

Yours truly,
Sean and Sally Wright
4th April 2018

ATTACHMENT 2

Incident Report 1087 Name: Robert Wright **DOB:** 26 July 1999

Date of incident: 8th March 2018

Time of incident: 14:40

Staff member reporting: XXXXXXXXXXXX, Registered Nurse

Other staff involved: XXXXXXXX, XXXXXXXX, XXXXXXXX

Background:

Mr Wright is an 18-year-old Year 12 student admitted voluntarily to the hospital with first episode psychosis on 8th March 2018. This was his first presentation to Mental Health Services. He had no past history of self-harm, harm to others or active substance abuse. The episode was thought to be secondary to genetic vulnerability and psychosocial stress (exams and relationship breakdown).

Brief Description of Incident:

On the first day of admission Mr Wright had been withdrawn and difficult to engage. On the second day at 11h30, he became agitated and required prn olanzapine after review in the morning ward round. He settled a little but at lunch he refused to leave his room to eat. He became increasingly insistent that he did not want food or any contact from the staff, and his level of physical agitation was such that he was escorted to the High Dependency Area at 14h40.

Interventions:

- 1) Patient put under the Mental Health Act and transferred to the High Dependency area of the ward.
- 2) Administration of olanzapine 10mg IMI at 14h43 by XXXXXXX.
- 3) Patient physically restrained in prone position by team until situation controlled at 14h55.
- 4) Patient secluded until sleeping comfortably in supine position at 15h10, at which point door opened.
- 5) Physical observations made every 15 minutes and all within normal limits.
- 6) Patient reviewed by registrar at 16h45.

Outcome of interventions:

- 1) Patient received bruising to upper limbs and upper back as a result of struggle.
- 2) Patient sedated and slept after medications.
- 3) Staff member XXXXXXX received kick to right lower leg as patient was transferred to the bed for medication.

Documentation completed:

As per protocol. An account written into patient's notes.

Communications:

Patient's parents unavailable by telephone.

Recommendations for prevention of further incidents:

Review of patient's treatment plan as patient was insufficiently medicated prior to transfer.

ATTACHMENT 3

FROM Western Health Policy

RESTRAINT MINIMISATION & SAFE PRACTICE

Approved Restraint

CATEGORY OF RESTRAINT	Personal Restraint
APPROVED FOR	Planned and Unplanned restraint events
INDICATIONS FOR USE	<ol style="list-style-type: none"> 1. When a person is making a serious and determined attempt(s) or act(s) of self-harm and is unable to stop of their own volition. 2. When a person makes a serious or sustained attack on another person. 3. When a person damages the environment in such a way that a real danger is created to her / himself or others and the situation cannot be defused by other interventions. 4. When all other interventions fail and it is necessary to give an essential treatment to a patient who is resistive and who is under compulsory assessment / treatment. This may also apply to emergency situations where a person is an informal / voluntary patient. 5. When it is necessary to prevent a person at high risk going absent without leave. 6. When a patient under a compulsory assessment / treatment order, attempts to leave and cannot be persuaded to stay. 7. When using restraint is necessary to detain a person under provisions of the Mental Health Act. 8. When a person is behaving in a physically intimidating and / or verbally threatening manner which staff believe may result in injury (physical / psychological). 9. When Personal Restraint is part of an agreed treatment regime e.g. providing personal security for a patient.
HOW IS THIS EPISODE REPORTED & RECORDED	<ul style="list-style-type: none"> • Record time restraint applied and removed, initiating clinician, any adverse outcomes and if evaluation was completed. • Document the restraint event. • Comment on: <ul style="list-style-type: none"> ○ Precipitating behaviours prior to using restraint. ○ Alternative strategies tried prior to restraint usage. ○ All interventions during restraint episode including monitoring requirements. ○ Any communication with family / carers. ○ Criteria used for removing restraint. ○ Document clinicians involved in initiating restraint and ongoing monitoring / termination of restraint. ○ Any adverse outcomes for either staff or patient.

<p>POTENTIAL RISKS ASSOCIATED WITH USE i.e. what injury / harm (physical, cultural, psychological) to patient or staff may result from its use.</p>	<ul style="list-style-type: none"> • Distress, agitation or confusion • Misinterpretation of use • Risks associated with reduced mobility • Isolation • Increased patient dependence • Loss of dignity • Injury • Fracture <p>Note: The prone position should be avoided if at all possible and the period that someone is restrained in the prone position needs to be minimised.</p> <p>Whenever a patient is held face down in the prone position the maximum period of continuous restraint should not exceed three (3) minutes.</p>
<p>SUGGESTED ALTERNATIVES TO USING THIS INTERVENTION</p>	<p>Calming and de-escalation techniques.</p> <p>Refer to Restraint Alternatives.</p>
<p>MONITORING REQUIREMENTS</p>	<p>Monitoring requirements are based on Comprehensive Assessment however the minimum observation requirement is every 15 minutes.</p> <ul style="list-style-type: none"> • Observation based on comprehensive assessment including risk assessment tools and subsequent treatment plan. • Position checks and alterations as per need. • Hygiene, nutrition, fluid & toileting as identified from assessment. • Call bell if available or alternative means of calling for assistance. • Psychological / emotional support as per individual need. • Regular medical reviews. <p>Note where the patient is to be located e.g. not in isolation.</p>
<p>EVALUATION OF RESTRAINT INCIDENT</p>	<p>Each episode of restraint must be evaluated as soon as possible following the episode ending and will involve the multi-disciplinary team (if not possible, then on the first working day).</p> <p>Wherever possible, participation of the consumer, family, carer, advocate and cultural advisor (if appropriate) will be sought for the evaluation. If not involved, the reason should be noted.</p> <p>The evaluation should consider and address:</p> <ul style="list-style-type: none"> • Adherence to the consumer's treatment plan • Alternative strategies attempted and those that could have been considered • Appropriateness of the decision to use restraint • Safety, efficacy and effectiveness of interventions • Impact on and the support needs of all participants including the consumer and other consumers on the unit • Adherence to policy • Team practices and training issues. <p>The evaluation informs the review and update of the consumer's treatment plan by the clinical team with participation from the consumer and their family or care.</p> <p>Document the evaluation of the restraint event in the body of the clinical note.</p>
<p>DEBRIEFING</p>	<p>Ensure the consumer's support and debriefing needs are appropriately met.</p> <p>Ensure the staff are appropriately debriefed by initial post-event debriefing, and formal debriefing at a later stage.</p>
<p>STAFF TRAINING</p>	<ul style="list-style-type: none"> • Communication, De-escalation & Interpersonal Skills Training • Personal Restraint Training / Occupational Violence Training

Excerpt from Position Statement 61 Minimising the use of seclusion and restraint in people with mental illness February 2016



Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is committed to the delivery of quality mental health services that seek to improve safe practice and promote optimal outcomes to those receiving care. Therefore, the RANZCP is committed to achieving the aim of reducing, and where possible eliminating, the use of seclusion and restraint in a way that supports good clinical practice and provides safe and improved care for consumers. Reducing the use of seclusion and restraint requires commitment and leadership to changing practices and continued investment in delivering high quality care.

Definition

Both seclusion and restraint have long been used as an emergency measure to manage violent behaviour or agitation in mental health settings. The primary aim is to reduce risk of traumatic experience and / or injury for both consumers and staff involved.

- **Seclusion** is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.
- **Restraint** is the restriction of an individual's freedom of movement by physical, chemical or mechanical means. Here, 'physical' means bodily force that controls a person's freedom of movement, 'chemical' means medication given primarily to restrict a person's movement not to treat a mental illness or physical condition and 'mechanical' means a device that controls a person's freedom of movement.

While this position statement applies to the use of seclusion and restraint in mental health settings, it should also be used to inform policy in all other health, welfare or disability settings. This includes the use of seclusion and restraint on individuals with intellectual disability and in aged care settings and those presenting in emergency departments.

Evidence

Seclusion and restraint are generally used in the hope of preventing injury and reducing agitation, but studies have reported substantial deleterious physical and more often psychological effects on both patients and staff (Fisher, 1994).

It is acknowledged that there are situations where it is appropriate to use restraint and / or seclusion but only as a safety measure of last resort where all other interventions have been tried or considered and excluded. Under these circumstances, seclusion and restraint should be used within approved protocols by properly trained professional staff in an appropriate environment for safe management of the consumer. Seclusion and restraint are not a substitute for inadequate resources (such as lack of trained nursing staff). They should *never* be used as a method of punishment.

There is considerable variation in the clinical standards governing the use of seclusion and restraint in mental health services and guiding the appropriate use of the interventions or the use of alternative strategies. The aim is to reduce the use of these interventions and the adverse events that accompany them. Reduction of seclusion and restraint is possible, as demonstrated in studies such as those in the United States which have reduced use considerably without additional resources (Huckshorn, 2005). Evidence also shows that de-escalation and debriefing strategies can help minimise the use of seclusion and restraint. It requires leadership, commitment and motivation, and a change culture underpinned by recovery with a focus on workforce and training, prevention and early intervention, good clinical care, and supporting practice change.

The main barriers to reducing seclusion and restraint are:

- lack of identified good practice / agreed clinical standards for the use of seclusion and restraint
- lack of quality improvement activity and clinical review – i.e. poor governance
- inappropriate use of interventions and variation in practice – e.g. using threat of restraint or seclusion to coerce particular behaviour
- lack of staff knowledge or skills to prevent, identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations
- lack of staff knowledge or skills regarding appropriate triaging of mental health presentations
- lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint
- lack of staff education and training, particularly in non-mental health care settings
- lack of resources and poor facilities.

Many of the barriers above are being addressed through the MHSC initiatives in Australia and the recent updates by Te Pou and Standards New Zealand. Common themes developed in all strategies for the reduction of seclusion and restraint include:

- national direction and appropriate funding
- leadership towards organisational, clinical and cultural change
- use of data to inform practice
- improved governance and review
- workforce development, including de-escalation and debriefing strategies
- use of practical and evidence-based seclusion and restraint prevention tools
- service user development and participation
- better care planning
- consumer roles in inpatient settings
- debriefing techniques
- review of relevant mental health legislation.

The RANZCP supports the development of these strategies and believes that an increased focus on developing good clinical care, governance, research and education will help reduce the use of seclusion and restraint in practice.

The RANZCP also supports measures to improve the environment and physical layout of mental health services to help consumers to feel as safe and secure as possible. These measures can, in turn, help services to reduce the need to utilise seclusion and / or restraint practices. Potential examples include having natural light and spaces specifically designed to provide comfort to people who are in crisis or distressed and enabling doors to the main wards to be unlocked (National Mental Health Commission, 2015).

Recommendations

- The RANZCP is committed to achieving the aim of reducing, and *where possible* eliminating, the use of seclusion and restraint in a way which supports good clinical practice and provides safe and improved care for consumers.
- Seclusion and restraint are interventions and not therapies. The RANZCP acknowledges that there are situations where it is appropriate to use restraint and / or seclusion but only as a safety measure of last resort where all other interventions have been tried, or considered and excluded. Seclusion and restraint should never be used as a method of punishment but rather should aim to restore a collaborative patient–clinician relationship.
- If seclusion and / or restraint are to be used, they should only be used in line with formal policies in a safe, dignified and respectful manner as possible by appropriately trained staff.
- Prone (face down) physical restraint should only be used if it is the safest way to protect the patient or any other person. If face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately two to three minutes, the minimum amount of time necessary to administer medication and / or remove the person to a safer environment (NSW Ministry of Health, 2012).
- In the interests of consumer and staff safety, and the delivery of quality mental health services, the RANZCP fully supports systems-oriented activities such as Trauma-Informed Care that seek to minimise harm and promote improved outcomes for individuals receiving care.
- The RANZCP endorses the principles underpinning the entry on seclusion and restraint presented in *National safety priorities in mental health: a national plan for reducing harm* (National Mental Health Working Group, 2005) and in the Te Pou report (O’Hagan et al., 2008), and is encouraged to see progress in terms of the identified strategies.
- The RANZCP considers that the skills and attitudes of staff involved are the most critical aspect in reducing the use of seclusion and restraint and supports the principles of training and education for health staff in effective de-escalation and debriefing techniques.
- The RANZCP also supports environmental measures to help improve the design and physical layout of mental health services, which in turn may help reduce the need for those services to utilise seclusion and / or restraint.
- The RANZCP will work to promote quality and safe practice within its training and continuing medical education programs to contribute to the reduction of seclusion and restraint.
- The RANZCP supports a review of the term ‘chemical restraint’.

Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

CONTENT	PAGE
Overview <ul style="list-style-type: none">- Descriptive summary of station- Main assessment aims- 'MUSTs' to achieve the required standard- Station coverage- Station requirements	2-3
Instructions to Candidate	4
Station Operation Summary	5
Instructions to Examiner <ul style="list-style-type: none">- Your role- Background information for examiners- The Standard Required	6 6 7
Marking Domains	8-9

1.0 Descriptive summary of station:

This is a viva station following an active bye in which the candidate will review information about a complaint and background documentation regarding use of restraint in mental health settings. Following an episode of restraint, the parents of a young person with first episode psychosis have made a complaint to the service about the care their son received while in hospital.

In this station the candidate will assess the situation leading to the complaint, plan a meeting with the persons making the complaint, and apply their understanding of current recommended practice in the use of restraint to plan changes to their service.

1.1 The main assessment aims are to:

- Assess the facts in relation to the complaint, and the associated incident report in the context of the service policy and the RANZCP position statement that they have been given.
- Evaluate the candidate's ability to synthesise the key elements of a clinical complaint and respond to the complaint.
- Develop an action plan for how the service can respond to the issues identified in the analysis of the complaint, and explain their role in its implementation.

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

- Accurately identify at least three suboptimal aspects of management: e.g. lack of use of alternative strategies; extended prone restraint position; failure to inform parents in timely manner; delay in accessing a medical review; leaving the patient lying sedated in the supine position;
- Prioritise the importance of acknowledging errors to the parents and the patient OR
- Prioritise the importance of apologizing to the parents OR
- Mitigate the potential impact of the incident on future treatment seeking by the patient;
- Identify the need for changing the culture within their organisation as an important part of the action plan OR
- Involve consumers and carers as part of the planning process;
- Identify the key role of the psychiatrist in ensuring adequate treatment plans OR
- Identify the key role of the psychiatrist in setting expectations for practice that lead to culture change.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Governance Skills, Other Skills (advocacy, complaints management, collaboration.)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domain:** Manager, Communicator, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Manager (Workload & Resource & Change Management; Organisational Structures – Governance), Communicator (Conflict Management), Scholar (Application of Knowledge)

References:

- RANZCP Position Statement 61, Minimising the use of seclusion and restraint in people with mental illness (2016)
- National MH Commission. A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services (2015)
- Sailas EES, Fenton M. Seclusion and restraint for people with serious mental illnesses. Cochrane Database of Systematic Reviews 2000
- Steinart T et al Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends. Soc Psychiat Epidemiol (2010) 45:889-897
- National Mental Health Seclusion and Restraint Project - National Document Outputs 2009 – Documents 1, 3, 5, 11
- Restraint Minimization and Safe Practice, New Zealand Standard 8134.2:2008, Ministry of Health

Committee for Examinations
Objective Structured Clinical Examination
Station 1
Sydney April 2018



1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Copy of Bye Station materials:
 - Attachment 1 - Complaint letter from Sean and Sally Wright, dated 4th April 2018
 - Attachment 2 - Incident Report 1087, dated 9th March 2018
 - Attachment 3 - Western Health Ward Policy on Personal Restraint
 - Attachment 4 – An excerpt from the RANZCP Position Statement 61, minimising the use of seclusion and restraint in people with mental illness (2016).
- 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 and preparation time.

This is a **VIVA** station.

You are working as a junior consultant psychiatrist in an adult general inpatient ward in the Western Health Service.

The service has received a complaint about a recent episode of restraint involving a young man whose care has been transferred to you since the incident. The previous psychiatrist involved in his care has since retired and so no longer works for the mental health service.

The director of the service has asked to meet with you to discuss your recommendations as to how the complaint should be dealt with, and discuss whether you see any issues that the service needs to follow up. You have been given copies of the complaint, the associated incident report, the Western Health Service policy on restraint and an excerpt from the RANZCP position statement on restraint (2016).

Using the information that you have reviewed in the active by your tasks are to:

- Outline your assessment of the facts of the complaint in relation to the Incident Report, the service policy and the RANZCP Position Statement (2016).
- Describe your approach to responding to the complaint.
- Propose a brief outline of an action plan for service improvement and your role in its implementation.

You will not be given 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'.
 - 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: there are no scripted prompts for you to give.
- DO NOT redirect or prompt the candidate.
- 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 bye station material from the candidate and place into the bag provided. Candidate **MUST NOT** take bye station material with them.
- 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 is no opening statement and no prompts.

3.2 Background information for examiners

This is a viva station that aims to assess the candidate's capacity to review an inpatient incident and assess the facts in relation to the complaint. They are expected to interpret the associated incident report in the context of the service policy and the position statement that they have been given. The candidate must then synthesise the key elements of a clinical complaint so as to respond to the complaint.

Finally the candidate is expected to outline a local action plan for how their service can respond to the issues identified in their analysis of the complaint, and to specifically explain their role as a junior consultant psychiatrist in the implementation of the plan.

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

- Accurately identify at least three suboptimal aspects of management: e.g. lack of use of alternative strategies; extended prone restraint position; failure to inform parents in timely manner; delay in accessing a medical review; leaving the patient lying sedated in the supine position;
- Prioritise the importance of acknowledging errors to the parents and the patient OR
- Prioritise the importance of apologising to the parents OR
- Mitigate the potential impact of the incident on future treatment seeking by the patient;
- Identify the need for changing the culture within their organisation as an important part of the action plan OR
- Involve consumers and carers as part of the planning process;
- Identify the key role of the psychiatrist in ensuring adequate treatment plans OR
- Identify the key role of the psychiatrist in setting expectations for practice that lead to culture change.

A surpassing candidate may provide additional detail, and a comprehensive coverage of the issues demonstrating their extensive knowledge of the challenges involved in the sustainable minimisation of restraint and other restrictive practices, and their understanding of their role in leadership in service development, change management and clinical governance.

The candidate is expected to recognise that a number of aspects of care have been lacking, and identify that principles of clinical governance and standards were not closely followed, in particular a failure of staff to follow organisational protocols.

The candidate is expected to recognise the importance of arranging a meeting with the patient and parents to discuss the complaint, and to mitigate the potential impact of the incident on future treatment seeking by the patient.

To assist in preparation for examining this station, it is recommended that examiners review the RANZCP Position Statement No. 61. This document has been provided in your pack.

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:

- Assess the facts in relation to the complaint, and the associated incident report in the context of the service policy and the RANZCP position statement that they have been given.
- Evaluate the candidate's ability to synthesise the key elements of a clinical complaint and respond to the complaint.
- Develop an action plan for how the service can respond to the issues identified in the analysis of the complaint, and explain their role in its implementation.

Level of Observed Competence:

6.0 SCHOLAR

6.4 While assessing the complaint, did the candidate prioritise and apply appropriate and accurate knowledge based on available literature and clinical experience? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

recognises the impact of environment, people and new knowledge on current understanding; considers impact on institutional attitudes in current situation; acknowledges their own gaps in knowledge.

Achieves the Standard by:

identifying key aspects of the available information and literature; commenting on the voracity of the available information; discussing major positives and limitations of the information provided; describing the relevant applicability of theory to the scenario; correctly analysing the suboptimal aspects of the management of the episode of restraint; aligning errors in care and governance with literature base; considering the ramifications for patient care; recognising how literature can lead to a greater understanding of how to develop core clinical skills.

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

- Accurately identify at least three suboptimal aspects of management: e.g. lack of use of alternative strategies; extended prone restraint position; failure to inform parents in timely manner; delay in accessing a medical review; leaving the patient lying sedated in the supine position.

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 demonstrate adequate appraisal of the literature / evidence relevant to the scenario; 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"/>	

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

constructively describes an approach to de-escalation of the situation; positively promotes safety for all involved; demonstrates sophisticated understanding of the need for transparency in communication and reflective listening skills; is aware of the need to progress with this without delay, considers involving the nurse in charge in this process and in the family meeting.

Achieves the Standard by:

recognising the importance of arranging a meeting with the patient and parents to discuss the complaint; acknowledging that interaction with staff and parents may be challenging; consulting with involved parties and listening to differing views; demonstrating capacity to apply management strategies; utilising supervision to effectively promote positive outcomes; managing the complaint in accordance with accepted strategies.

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

- Prioritise the importance of acknowledging errors to the parents and the patient OR
- Prioritise the importance of apologising to the parents OR
- Mitigate the potential impact of the incident on future treatment seeking by 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) or (b) or (c) 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"/>	

4.0 MANAGER

4.4 Did the candidate demonstrate effective allocation of tasks and resources for the plan to improve their service? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

effectively consults around complex implementation issues; chooses to lead change management to reduce restraint; sophisticated approach to financial and human resource allocation; robust approach to cost / risk / benefit analysis.

Achieves the Standard by:

demonstrating the ability to make decisions based on patient needs; taking responsibility for the allocation and management of tasks and resources; participating in inpatient redesign; organising and delegating tasks within a clinical setting; including education of all staff about the restraint policy; considering cost implications; including a process of review of changes made in their planning.

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

- a. Identify the need for changing the culture within their organisation as an important part of the action plan OR
- b. Involve consumers and carers as part of the planning 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) 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 underpin decisions on a clinical evidence base; the candidate does not prioritise decisions on efficient allocation of resources.

4.4. Category: WORKLOAD & RESOURCE & CHANGE 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"/>	

4.3 Did the candidate demonstrate capacity to contribute to clinical leadership within a service? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

effectively uses local clinical governance structures for quality improvement; communicates / escalates gaps at a systems level; takes a leadership role in service planning and review; manages conflicts of interest in the organisation and sponsorship.

Achieves the Standard by:

working in operational structures within services; participating in activities concerning inpatient service improvement, identifying the impact of staff attitudes on patient care; engaging widely with peers and managers about the process; consulting with multiple stakeholders on systems issues / quality improvement.

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

- a. Identify the key role of the psychiatrist in ensuring adequate treatment plans OR
- b. Identify the key role of the psychiatrist in setting expectations for practice that lead to culture change.

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:

demonstrates disorganised approach to clinical leadership; does not use clinical leadership role to improve health care systems.

4.3. Category: ORGANISATIONAL STRUCTURES - 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"/>	

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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-8</p> <p>8</p>
Instructions to Role Player	9-10
Marking Domains	11-13

1.0 Descriptive summary of station:

The candidate is a consultant on a general adult psychiatry ward. Dr Frank Thomas, a final year registrar, has turned up late for work, slightly dishevelled and malodourous. The nurse in charge of the unit has just told the candidate that she overheard the registrar saying to an inpatient 'I'm so sick of moaning patients' which immediately upset the inpatient. The candidate is meeting with Dr Thomas in their office to discuss this as soon as possible after he arrived at work.

1.1 The main assessment aims are to:

- Identify an impaired doctor and demonstrate understanding of mandatory reporting of a colleague with an addiction disorder.
- Cover the ethical dilemma presented by supporting the registrar you are supervising and mandatory reporting.
- Address the issue of having to stand him down from work to protect patients.
- Demonstrate an approach to the registrar that is professional, collaborative, empathetic and leads to an immediate action plan.

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

- Demonstrate interview skills that elicit criteria for alcohol use disorder.
- Identify that there is a risk to patients if this doctor continues working.
- Explain the requirement to escalate within the health service.
- Demonstrate awareness of process for reporting to the registration authorities.
- Address the dilemma of the dual role of support for the trainee and mandatory reporting.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Governance Skills, Other Skills (e.g. ethics, capacity, collaboration, advocacy.)
- **Area of Practice:** Addiction Psychiatry
- **CanMEDS Domain:** Medical Expert, Manager, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - data gathering process, Management – initial plan); Manager (Organisational structures – clinical responsibilities), Professional (Ethics, Compliance & Integrity)

References:

- Australian Health Practitioner Regulation Agency. <http://ahpra.gov.au>
- Medical Board of Australia. <http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx>
- Medical Council of New Zealand. <https://www.mcnz.org.nz/fitness-to-practise/health-concerns/>
- Royal Australian and New Zealand College of Psychiatrists. Code of Ethics Principle 9 & Guideline 6.

1.4 Station requirements:

- Standard consulting room.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: 30-year-old male, wearing a shirt with a collar which is very crinkled, hair looks greasy.
- 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 on a general adult psychiatry ward in a public hospital.

Dr Frank Thomas is the final year registrar working with you. You have a good working relationship and have known him since he was an intern.

Over the past two months Dr Thomas has been more distracted and irritable at work, and not followed through with tasks in his usual timely manner. There have been a couple of incidents where he has snapped at colleagues. You have also noticed that he has become a little untidy in his personal presentation. You have become concerned by this continuing deterioration in presentation and behaviour, but when discussed several times in supervision Dr Thomas has said that he has been doing a little extra overtime, repeating that he was 'okay' and would be fine.

It is a normal day on the ward, but Dr Thomas missed the morning handover. The ward nurse in charge has come to your office to tell you that Dr Thomas has just rushed into the ward looking for you, and that he appeared harassed and dishevelled. As he was leaving the ward a patient told him she didn't like the food to which he replied, '*I'm so sick of moaning people*'. The nurse reports that the patient was visibly distressed, but Dr Thomas ignored her and left the ward.

You have just found Dr Thomas alone in his office, and are going to talk to him about today's events.

Your tasks are to:

- Discuss with Dr Thomas what has happened this morning to develop a clear understanding of the problem.
- Advise Dr Thomas of your assessment of the situation and the implications for today.
- Identify immediate interventions and negotiate a plan with Dr Thomas.
- Outline key ethical issues **to the examiner**.

If you have not commenced the final task, you will be given a prompt at thirteen (13) minutes.

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'.
 - Pens.
 - Water and tissues (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 scripted prompt at **thirteen (13) minutes** to commence 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 **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.

You have no opening statement or prompts.

The role player opens with the following statement:

'Hello, sorry I was late this morning.'

If the candidate has NOT commenced the final task, at **thirteen (13) minutes** you are to give a time prompt. This is your specific prompt:

'Please proceed to the final task.'

3.2 Background information for examiners

In this station the candidate is expected to talk with their final year registrar, Dr Thomas, about his worsening presentation and behaviour which led to an altercation with a patient this morning. The aims of this station are to assess the candidate's ability to identify an impaired doctor, and demonstrate an understanding of mandatory reporting requirements of a colleague with an addiction disorder that is impacting on their ability to undertake their duties at work.

The candidate must include in their plan:

- That Dr Thomas must not continue with work for the day;
- Information to Dr Thomas about mandatory reporting and that they (the candidate) will have to report Dr Thomas to the relevant authority as an impaired doctor.
- Some discussion about how to access help.

The candidate is then expected to demonstrate their ability to apply ethical principles of behaviour of a psychiatrist / doctor in their discussion with the registrar. Their approach to the registrar should be collaborative, empathetic, and enable the candidate to negotiate an immediate action plan.

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

- Demonstrate interview skills that elicit criteria for alcohol use disorder.
- Identify that there is a risk to patients if this doctor continues working.
- Explain the requirement to escalate within the health service.
- Demonstrate awareness of process for reporting to the registration authorities.
- Address the dilemma of the dual role of support for the trainee and mandatory reporting.

A surpassing candidate may decide to help the registrar call the medical board and self-report their alcohol addiction; find a support organisation or GP, and make an appointment for the Registrar as soon as possible.

Regulatory requirements:

Professional conduct

The RANZCP Code of Ethics states that *'Psychiatrists have a duty to attend to the health and well-being of their colleagues, including trainees and students.'* (Section 9.1 Code of Ethics RANZCP)

Mandatory Reporting

- a. **In Australia** at the Australian Health Practitioner Regulation Agency (AHPRA) website:
 - i. Page 7 of mandatory notification guidelines for registered health practitioners.
<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx>
- b. **In New Zealand** at the Medical Council of New Zealand (MCNZ) website:
 - i. Health Concerns section of website: <https://www.mcnz.org.nz/fitness-to-practise/health-concerns/>

Levels of Governance

The Health Practitioners Competence Assurance Act 2003 notes that a *'mental or physical condition means any mental or physical condition or impairment, and includes, without limitation a condition or impairment caused by alcohol or drug abuse'*. This supports a lower threshold for referral than that of alcohol or drug dependence. According to MCNZ a practising doctor needs to be able to:

- make safe judgments
- demonstrate the level of skill and knowledge required for safe practice
- behave appropriately
- not risk infecting patients
- not act in ways that adversely impact on patient safety.

If anyone believes a doctor is unwell and may be unable to practise safely, they are required by law to let AHPRA / MCNZ know if they are one of the following:

- a doctor - self notification
- the doctor's employer
- any registered health practitioner
- anyone in charge of an organisation that provides health services
- a person in charge of an educational programme or course who believes a student may be unable to practise medicine safely.

Under section 140 of the National Law, one of the four identified areas of notifiable conduct for AHPRA includes *'practice while intoxicated by alcohol or drugs'*. Under the National Law, AHPRA works with health complaints organisations in each state or territory to decide which organisation takes responsibility for and manages complaints or concerns raised about a registered health practitioner. State-based arrangements for reporting concerns; for instance in Queensland reports are made to the Office of the Health Ombudsman; on New South Wales concerns are made via NSW Health Professional Councils Authority of the NSW Health Care Complaints Commission.

Every doctor has a responsibility to tell us about a colleague / doctor who is unable to practise safely. In New Zealand the reporting threshold is that of 'reasonable belief', that a doctor may be unable to perform the functions required for the practice of medicine, the obligation of a doctor to notify takes effect, otherwise meet a breach of professional obligation giving rise to disciplinary proceedings.

Delaying assessment, treatment, and assistance for the doctor can negatively impact on patient care, and may also affect the doctor professionally and personally. Without help and support, an unfit colleague or doctor puts the community, the profession, and their reputation at risk so early intervention can often enable a doctor to continue practising while receiving treatment.

The RANZCP Code of Ethics (July 2010) serves to guide ethical conduct and may be applied by other bodies as a benchmark of satisfactory ethical behaviour in the practice of psychiatry as this is interpreted in Australia and New Zealand. The Code applies to all Fellows and trainees of the College, and those seeking to qualify for election to Fellowship and Associates of the College. In this scenario the following three principles apply:

3. Psychiatrists shall provide the best attainable psychiatric care for their patients.
9. Psychiatrists have a duty to attend to the health and well-being of their colleagues, including trainees and students.
10. Psychiatrists shall uphold the integrity of the medical profession.

Diagnosis of Alcohol related disorder

ALCOHOL USE DISORDER DSM-5 (F10.20)

The key criteria are:

- Craving alcohol.
- Evidence of physical dependence – without alcohol person exhibits increased anxiety; tremors or shakes; increased sweating; nausea.
- Increasing tolerance to alcohol – requiring more alcohol for the same effect.
- Loss of control – can no longer curb or restrain drinking alcohol.

DSM-5 criteria:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
 - a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
 - b) A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
 - a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal).
 - b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

The severity of an AUD is graded *mild, moderate, or severe*.

The ICD-10 makes the following observations:

Identification of a substance use disorder may be made on the basis of self-reported data, reports from informed third parties, presence of drug paraphernalia, or objective analysis of specimens of urine, blood, etc. In cases where the consequence of use is significant it is highly advisable to seek corroboration from more than one source of evidence relating to substance use. History taking should elicit whether there has been harmful use or a dependence syndrome. In ICD-10 supplementary codes indicate the level of alcohol involvement (evidence of alcohol involvement determined by blood alcohol content; and, evidence of alcohol involvement determined by level of intoxication).

Additionally, many people with substance misuse take more than one type of substance, but the diagnosis of the disorder should be classified, whenever possible, according to the most important single substance (or class of substances) used, i.e. that causing the presenting problem. Misuse of other than psychoactive substances, such as laxatives or aspirin, should also be considered, as should other possible causes of erratic behaviour.

Candidates should aim to briefly identify harmful use versus dependence. According to ICD-10, harmful use is '*a pattern of psychoactive substance use that is causing damage to health*'. The damage may be physical (e.g. liver damage) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol). In this scenario harmful patterns of use are suggested, in that Dr Thomas's behaviour have been criticised by others and have been associated with adverse interactions in the ward. There may also be social consequences of various kinds, but this is not, in itself, evidence of harmful use. Just experiencing acute intoxication or 'hangovers' is not sufficient evidence of harmful use.

In ICD-10, dependence is diagnosed when '*a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value*'. Central to the dependence syndrome is the strong desire to continue use. Periods of abstinence may be followed by return to substance use associated with a more rapid reappearance of other features of the syndrome than would occur in nondependent individuals. ICD-10 recommends that harmful use should not be diagnosed if a dependence syndrome, a psychotic disorder or another specific form of drug- or alcohol-related disorder is present.

There are a number of key questions that the candidate could pursue in order to assess whether Dr Thomas may have an alcohol use disorder. In the past year, has Dr Thomas:

- had times when drinking more, or longer than intended?
- more than once wanted to cut down or stop drinking, or tried to, but could not?
- spent time drinking? Spent time being sick or getting over the aftereffects?
- experienced cravings - a strong need, or urge, to drink?
- found that drinking, or being sick from drinking, has often interfered with taking care of home or family, causing job troubles?
- continued drinking even though it was causing trouble with family or friends?
- given up or cut back on activities that were important or interesting, or given pleasure, in order to drink?
- more than once found himself in situations while or after drinking that increased chances of him getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
- continued to drink even though it was making him feel depressed or anxious or adding to another health problem, or after having had a memory blackout?
- developed evidence of tolerance, drinking much more than once needed to get the desired effect?
- found that when the effects of alcohol were wearing off, he experiences withdrawal symptoms, such as trouble sleeping, shakiness, irritability, anxiety, depression, restlessness, nausea, or sweating?
- experienced perceptual abnormalities.

If these symptoms are present, his drinking may already be a cause for concern. The more symptoms the candidate exists, the more urgent the need for change and the individual should seek formal assessment by a health professional.

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 Frank Thomas, and you are doing your psychiatric training in a general hospital. You are currently working in an acute inpatient psychiatric ward, and the candidate is your consultant that you report to (i.e. your boss).

Today you slept in and missed the morning handover. The nurse in charge of the ward has just told your consultant (the candidate) that you rushed into the ward to find the consultant. You were feeling harassed and as you were leaving the ward a patient told you she didn't like the food to which you replied, *'I'm so sick of moaning people'*. The nurse has reported that the patient was visibly distressed, you apparently ignored her and left the ward.

The consultant has come to find you are alone in your office, and is going to talk to you about today's events.

You are normally a thoughtful and conscientious doctor, but in the past few months you have become very reliant (dependent) on alcohol to help you manage your workload and medical training pressures. It started as drinking after work with friends, and then having a *'few extra'* at home to help you sleep. In the past two months you have started going straight home, and having at least one glass of wine before doing anything else. You are now drinking two bottles of red wine a night and having no alcohol-free days.

The candidate may ask you about any of the following and these are your responses:

- You have had times when you are drinking more, or longer than you had intended to. Most weeknights you intend to not drink, then with your meal you decide to have one glass of wine. After the bottle is opened you find it very hard to limit yourself to one glass and then end up opening another bottle – so you are drinking more than you intended which makes you very angry with yourself.
- Experiences of craving — you have noticed that you have a strong need, or urge, to drink often during the day and can't wait to get home for that glass of wine after work. You really look forward to your first glass of wine, and feel like it's the only way to relax after work.
- You now have increased the time you spend drinking, plus the time spent being sick or getting over the after-effects (hangovers). You have found that drinking, or being sick from drinking, has often interfered with taking care of home and meeting family commitments, and has now started causing job troubles.
- More than once you have wanted to cut down or stop drinking, and even tried to a few weeks ago, but could not. You have continued drinking even though it was causing trouble with family and friends – who have started commenting negatively about how much you are drinking.
- Part of this, is that you have given up or cut back on activities that were important or given you pleasure before (like playing soccer with friends and going surfing with your brother), in order to drink with friends or alone.
- More than once, recently, you have found yourself in situations while or after drinking that increased chances of getting hurt (such as driving, swimming, or having unsafe sex).
- Your mood has become more irritable and low, mainly related to the effects of alcohol itself or how it is impacting on you. Despite this you have continued to drink even though it was making you feel depressed or anxious, or after having had a memory blackout.
- Of concern you have noticed that you are able / need to drink much more than before to get the desired effect - evidence of the development of alcohol tolerance.
- You have also found that when the effects of alcohol were wearing off, you are experiencing withdrawal symptoms, such as trouble sleeping, shakiness, irritability, low mood, restlessness, nausea, or sweating.
- If asked, you are not aware of any unusual experiences like seeing, feeling or hearing unusual things that you cannot readily explain (called perceptual abnormalities).
- You delay drinking on weekends until after the normal working hours, but think about that first drink most of the day. You have taken on doing extra overtime to help delay that first drink.
- You know deep down that you are now dependent on alcohol, and feel completely trapped. You really want someone to help you.

As these symptoms are present, your drinking is already a cause for concern. The more symptoms the candidate elicits, the more urgent the need for change, and the individual should seek formal assessment by a health professional.

It is likely the candidate will ask you some/all of the criteria above and it is important to answer the questions consistently with all candidates.

4.2 How to play the role:

Wearing trousers and a business shirt with a collar and with sleeves rolled up which is crinkled and appears that has been slept in. Your hair is messy and, if normally clean shaven, you have not shaved today. If bearded, the beard is scruffy.

You appear harassed and are worried and feeling trapped by what is happening. Present as contrite about being late. You will intermittently remind the consultant that you go back a long way, he knows you are a good registrar.

You, as a normally conscientious doctor, feel both guilty and ashamed about your behaviour. You are very anxious that your consultant might find out about how much you are drinking and will think you are an idiot. You have always wanted to be a psychiatrist and you are scared you may lose your job and career if you are found out. However, you desperately want help. You have been nagging yourself to *'do what you are always telling your patients to do – see your GP'* but then you feel so embarrassed and think you can get 'over it' yourself.

You feel out of control and even today have been thinking *'This is it, no more alcohol'* but you know this has become almost impossible.

4.3 Opening statement:

'Hello, sorry I was late this morning.'

4.4 What to expect from the candidate:

The candidate is expected to inquire about your wellbeing and ask what happened today with the patients and any interaction with the staff. They should ask you about this sensitively, in a respectful manner, and try to understand what is happening for you.

4.5 Responses you MUST make:

'I know I snapped at a patient. I don't know what is happening to me.'

'Things are a little out of control; I'm not sure how I feel.'

'I go to sleep when I stop drinking; usually about 2.00am.'

4.6 Responses you MIGHT make:

If asked whether you think you are dependent on alcohol?

Scripted Response: **'Yes'**.

If asked whether you have done anything about your alcohol dependence.

Scripted Response: **'I just don't know what to do. Can you help me?'**

If asked whether you have seen a GP?

Scripted Response: **'Not yet.'**

If asked whether you have alcohol-free days?

Scripted Response: **'I am drinking too much alcohol and can't seem to have alcohol free days.'**

If asked how much you are drinking at night?

Scripted Response: **'I probably drink about two bottles of red wine a night.'**

If asked about being late for work?

Scripted Response: **'I know I have overslept for the third time in the last two weeks. I was really irritated with myself.'**

STATION 2 – MARKING DOMAINS

The main assessment aims are to:

- Identify an impaired doctor and demonstrate understanding of mandatory reporting of a colleague with an addiction disorder.
- Cover the ethical dilemma presented by supporting the registrar you are supervising and mandatory reporting.
- Address the issue of having to stand him down from work to protect patients.
- Demonstrate an approach to the registrar that is professional, collaborative, empathetic and leads to an immediate action plan.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct an assessment of the registrar? (Proportionate value - 20%)

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 that enables identification of immediacy of need for intervention.

Achieves the Standard by:

managing the interview environment; engaging the registrar as well as can be expected; demonstrating flexibility to adapt the interview style to the problem; prioritising information to be gathered; appropriately balancing open and closed questions; summarising; being attuned to specific disclosures, including non-verbal communication; recognising emotional significance of the registrar's situation and responding empathically; sensitively evaluating quality and accuracy of information; clarifying inconsistent information efficiently.

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

a. Demonstrate interview skills that elicit criteria for alcohol use 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 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 registrar; 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 initial management plan? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified, including the registrar, the hospital and the wider community needs; specifies that he cannot return to work until he has a clear, supportive management plan; clearly addresses difficulties in the application of the plan.

Achieves the Standard by:

demonstrating the ability to prioritise and implement a plan of action for both registrar and patients; planning for risk management; considering specific interventions; engaging appropriate treatment resources; considering rights for confidentiality of the registrar; outlining realistic time frames for action and review of the plan; ensuring appropriate record keeping and communication to necessary others; identifying potential barriers; recommending need for referral to a GP / specialist.

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

a. Identify that there is a risk to patients if this doctor continues working.

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 care of patients; plan lacks structure or is inaccurate; plan not tailored to registrar's immediate needs and 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"/>	

4.0 MANAGER

4.2 Did the candidate demonstrate capacity to understand their clinical role within an organisation? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

readily accepts the complex roles and responsibilities of psychiatrists in the system of care; acknowledges limitations of personal responsibility; considers the need to review care provided to patients while the registrar was impaired.

Achieves the Standard by:

competently explaining operational escalations within service; recognising the importance of undertaking expanded role within organisation; appropriately responding to this unfamiliar clinical situation; planning to meet potentially changed work demands; utilising broader clinical expertise.

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

- a. Explain the requirement to escalate within the health service

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:

has limited understanding of organisational leadership; not considering the organisational requirements for action; approach places patients at risk. Does not immediately stop the impaired doctor from working.

4.2. Category: ORGANISATIONAL STRUCTURES – Clinical Responsibilities	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

7.2 Did the candidate demonstrate an adequate knowledge of legislative and regulatory requirements? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

recognises the different approaches available to address non-compliance; analyses and incorporates other professional guidelines and codes of conduct into practice; balances aspects of individual rights / rights to natural justice with patient and organisation rights and reputation; addresses any role of media.

Achieves the Standard by:

applying relevant legislation / regulation particularly AHPRA / MCNZ; demonstrating integrity, honesty and compassion; distinguishing between professional and unprofessional behaviours; acting on unprofessional behaviour or misconduct of others; identifying how the registrar can independently self-report.

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

- a. Demonstrate awareness of process for reporting to the registration authorities.

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 seek advice or support; poor knowledge of regulation / legislation / College requirements; does not sufficiently address unprofessional behaviour / misconduct.

7.2. Category: COMPLIANCE & INTEGRITY	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"/>

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

comprehensively considered all major aspects of ethical conduct and practice.

Achieves the Standard by:

identifying professional standards of practice in accordance with College Code of Ethics and institutional guidelines; applying ethical principles to resolve conflicting priorities; utilising ethical decision-making strategies to manage the impact on professional practice / patient care; seeking peer review in difficult countertransference situations; recognising the importance and limitations of obtaining consent and keeping confidentiality. Maintaining professional boundaries between role of supervisor and clinician.

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

a. Address the dilemma of the dual role of support for the trainee and mandatory reporting.

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 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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
Instructions to Candidate	4
Station Operation Summary	5
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>6</p> <p>6-11</p> <p>11</p>
Instructions to Role Player	12-15
Marking Domains	16-17

1.0 Descriptive summary of station:

In this station the candidate is to assess Nicole, a 22-year-old woman referred to the consultation liaison psychiatry team due to concerns regarding paranoid thoughts and periods of confusion. The candidate is expected to identify a possible diagnosis of delirium. Better candidates will identify that the investigations provided inform that the patient has an ovarian teratoma, and that the teratoma can be linked to the current clinical presentation.

1.1 The main assessment aims are to:

- Take a history that is mindful of the changes to the patient's mental state and the likely link to recent physical symptoms / diagnoses.
- Accurately conduct an appropriate range of focussed bedside cognitive tests, particularly for orientation and sustained attention.
- Establish that a primary psychotic illness is unlikely and differentiate the preferred diagnosis based on the history gathered and results of investigations.

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

- Focus on exploring the symptom of suspiciousness.
- Accurately assess orientation and sustained attention in the cognitive screening.
- Identify delirium as a key differential diagnosis.
- Propose the link between teratomas and encephalitis.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Medical Disorders in Psychiatry, Clinical Assessment Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - data gathering content; Assessment - physical - technique; Diagnosis; Diagnosis – investigation analysis).

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Committee for Examinations
Objective Structured Clinical Examination
Station 3
Sydney April 2018



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: female in 20s
- 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 consultation liaison psychiatrist. You are about to see Nicole, a 22-year-old woman referred by the neurology team with concerns regarding irritability, suspicious thoughts, and periods of confusion.

The neurology team report that Nicole presented following a generalised seizure with no previous history of a seizure disorder. Nicole was reluctant to accept that she had a seizure and refused any medication. At times she won't eat the food provided. She has yelled at the nurses on several occasions but then denies doing this and accuses the staff of lying about her.

She has also been drowsy at times and is often asleep during the day. Occasionally Nicole has wandered into other patients' rooms and tried to get into the wrong bed.

Nicole's fiancé, Luke, has provided the following information:

Three weeks ago Nicole had some sort of 'flu or gastro' – she had a temperature, headache, vomiting and diarrhoea.

The headaches continued for two weeks and Luke noticed a change in Nicole. There were times when she appeared to get her days mixed up, sometimes she forgets plans that they'd made, and this was not like Nicole who is usually very organised. She was irritable and questioning where he'd been and what he had been doing. She seemed unaware that there was any problem and would get angry at him if he suggested there was. Luke managed to convince her to return to her GP.

A week later, Luke noticed that Nicole's face was twitching. Three days after this she collapsed and had a fit and he called the ambulance and Nicole was admitted to hospital.

Your tasks are to:

- Take a relevant and focussed history from Nicole.
- Conduct relevant specific bedside cognitive screening, while providing commentary on rationale, and interpretation of tests **to the examiners**.
- Review the relevant investigation results that will be **provided by the examiners** at twelve (12) minutes.
- Based on your assessment and the investigations provided, explain your preferred and differential diagnoses **to the examiners**.

You are not required to conduct a physical examination.

At **twelve (12) minutes** you will receive the investigations results.

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 any other candidate material specific to the station.
 - Pens.
 - Water and tissues (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.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- **At twelve (12) minutes**, take note of the cue for one examiner to provide the 'Investigation Results' to the candidate
- 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 – e.g. 'Investigation Results'.
- 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:

'There's no problem with my head.'

This is your specific prompt: At **twelve (12) minutes** you are to provide a copy of the investigations results below to the candidate.

INVESTIGATION RESULTS

CT and MRI brain

9 April 2018

Both unremarkable

EEG

10 April 2018

History - Generalised seizure. No history of epilepsy.

Patient status - The patient was drowsy during the recording

Factual Report

Background: diffuse generalised slowing present throughout the recording

Other: On two occasions there was a generalized spike lasting 4 seconds over the left posterior temporal region. There was no clinical change noted in the patient in these periods.

Pelvic Ultrasound

11 April 2018

Uterus – anteverted. Myometrium – homogenous. Endometrium – clearly visualised, thickness within expected limits. Right Ovary – clearly seen, normal morphology, outline smooth. Left Ovary – clearly seen, contains 6cm cystic mass with fluid levels and multiple thin echogenic bands. Findings consistent with dermoid cyst (mature teratoma) of the left ovary.

3.2 Background information for examiners

In this station the candidate is to interview a 22-year-old woman who presents, following a seizure with no history of epilepsy, with paranoia and periods of confusion. The candidate is expected to complete an assessment and focus on cognitive screening to elicit symptoms in keeping with a possible diagnosis of delirium and recognise that delirium is more likely than a primary psychotic illness. The candidate is provided with investigations that inform that the patient has an ovarian teratoma and should link the teratoma to the current clinical presentation.

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

- Focus on exploring the symptom of suspiciousness.
- Accurately assess orientation and sustained attention in the cognitive screening.
- Identify delirium as a key differential diagnosis.
- Propose the link between teratomas and encephalitis.

A surpassing candidate may correctly identify a likely diagnosis of anti-NMDAR encephalitis and its implications for the presentation.

DSM-5 Criteria for Delirium

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition diagnostic criteria for delirium is as follows:

- A. Disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment).
- B. The disturbance develops over a short period (usually hours to days) and tends to fluctuate during the course of the day.
- C. An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception).
- D. The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal such as coma.
- E. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a direct physiologic consequence of a general medical condition, an intoxicating substance, medication use, or more than one cause.

Bedside Cognitive Tests

The following is a summary of the common tests that may be undertaken by the candidate. Candidates are expected to prioritise testing of orientation, sustained attention, and memory. It is expected that the candidates should identify an acute confusional state and that assessment of domains other than orientation, attention and memory may not be currently appropriate. It would, however, be relevant for the candidates to conduct a screening test of global cognitive ability such as a test of constructional ability.

Attention & Sustained Attention / Vigilance / Alertness

Given the history of fluctuating presentation and concerns regarding confusion it is expected that the candidate would assess attention and alertness.

Ability to sustain attention and keep track of events is an important day-to-day function. A disturbance in attention or alertness can lead to vulnerability to interference and difficulty in inhibiting immediate, inappropriate responses. Disorientation to time and sometimes place may occur if attention is grossly impaired. Maintenance of attention requires integrated activity of the pre-frontal cortex, thalamus and brainstem linked via the reticular activating system.

Alertness is commonly considered to be normal when the patient is awake and fully cooperative. All other tests are impacted if the person is not alert. The patient's basic level of attention can be readily assessed by using the Digit Repetition Test or Serial Sevens Subtraction Test (or months of year / days of week backwards) and his / her orientation (to time and place).

Tests like serial subtraction of 7s or spelling a familiar word backwards (WORLD – DLROW) and days of the week of months of the year recited backwards examines sustained attention i.e. concentration.

Serial Sevens: The candidate should instruct the patient to '**subtract 7 from 100 and keep subtracting 7 from what is left**'. Once they have started, the patient should not be interrupted until they have completed five subtractions. If they stop before the five subtractions the instruction should be repeated.

In recitation of days of week / months of year many of these are familiar and so people have over-learned the sequence; therefore, capacity for fast and errorless reverse order recitation is a good measure of sustained attention.

Working Memory

Working memory is short-term memory and is critical for cognitive abilities such as planning, problem solving and reasoning. Working memory requires the information to be available and then the ability to manipulate it.

The amount of information that is readily accessible for individuals varies (working memory capacity / span) and so has a relationship to cognitive ability / general intelligence. Distraction, trying to hold too much information at one time, or engaging in demanding tasks can all affect working memory function.

Various components of working memory are responsible for immediate repetition of words, numbers and melodies as well as for spatial information. It works independent of and parallel to long-term memory and its central component is frontal lobe function (phonological memory in peri-sylvian language areas in dominant hemisphere: visuo-spatial in non-dominant hemisphere). Patients are asked to recall immediately after.

Verbal - orally administered test in which the respondent mentally re-orders strings of number and letters and repeats them to the examiner.

Digit span, especially reverse, depends on short-term (working) memory, which in turn depends on frontal executive and phonological processes. It is tested by asking the patient to repeat progressively longer strings of digits; usually starting with three. **The numbers should be read at a speed of one per second (like telling someone your phone number)**. Two trials are given at each level if required, and the digit span is the highest level the person passes on either trial. Normal forward digit span is 6 ± 1 depending on age and intellectual ability, and reverse is usually one less.

The bedside test is repetition and recall of a word list as described in the Folstein MMSE; or an address, after a short period of other cognitive activity. It is expected that repetition and recall would be assessed by the candidate.

Long-term Memory

Includes learning new information, retaining newly learned information over time and recognising previously presented material and recalling it when needed. Tests measure declarative (explicit) memory which are available to conscious access and reflection. This memory is responsible for the laying down and recall of personally experienced, and highly temporally specific events or episodes (episodic memory), and knowledge of facts and concepts (semantic memory). They both form components of long-term memory.

Constructional Ability

Constructional ability is a complex perceptual motor ability involving the integration of occipital, parietal, and frontal lobe functions. Both two- and three-dimensional drawings are used. The instructions can be: **'Please draw a picture of a clock with the numbers and hands on it'**; followed by asking the patient to **'Set the time as 11:10 or 10:20'**.

Other tests of constructional ability include asking the patient to draw a daisy in a flowerpot; or a house in perspective so that you can see two sides and the roof. A perfect clock drawing test strongly suggests that delirium is unlikely but no specific abnormalities on the test confirm a diagnosis of delirium.

Bedside Cognitive testing in Acute Confusional States

The approach to this task will vary but should include assessment of the patient's orientation, attention, registration and recall. Overall expectation is that the candidate will perform screening for orientation, registration, attention and concentration, and short-term memory.

O'Regan et al found simple attention tests may be useful in delirium screening. 'Months of the year' backwards used alone was the most accurate screening test in older people.

The Confusion Assessment Method (CAM) Criteria

The CAM is a validated delirium diagnostic tool which can be considered the 'gold standard' tool for detection of delirium.

1. **Acute onset and fluctuating course**

- a) Evidence of an acute change in mental status from the patient's baseline; OR
- b) The abnormal behaviour fluctuates during the day, tends to come and go or increase and decrease

2. **Inattention**

The patient has difficulty focusing attention, for example, easily distracted or having difficulty keeping track of what is said.

3. **Disorganised thinking**

Patient thinking is disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject.

4. **Altered level of consciousness**

Overall the patient's level of consciousness fits one of the below descriptors:

- a) Vigilant
- b) Lethargic
- c) Stupor
- d) Coma

A positive CAM result requires **both** 1 and 2 plus **either** 3 or 4.

Reference: Inouye SK, Van Dyck CH, Alessi CA, Balkin S, Siegel AP, Horwitz RI (1990) Clarifying confusion: the Confusion Assessment Method. Annals of Internal Medicine 113: 941-8

Potential causes of delirium

The mnemonic I-WATCH-DEATH is a useful tool that can be used to recall the common causes of delirium

- Infectious – in this case infective encephalitis or meningitis would be more likely than common causes of delirium such as pneumonia or urinary tract infection.
- Withdrawal state – in this case, given the recent seizure, alcohol or benzodiazepine withdrawal would be more likely than other withdrawal states.
- Acute metabolic disorder - electrolyte imbalance, hepatic or renal failure
- Trauma - head injury, postoperative
- CNS pathology - seizure disorder (including post-ictal state - in this case supported by recent seizure activity) stroke, haemorrhage, Parkinson's
- Hypoxia - anaemia, cardiac failure, pulmonary embolus
- Deficiencies - vitamin B12, folic acid, thiamine
- Endocrinopathies - thyroid, glucose, parathyroid, adrenal
- Acute vascular - shock, vasculitis, hypertensive encephalopathy
- Toxins, substance use, medication (anaesthetics, anticholinergics, narcotics)
- Heavy metals - arsenic, lead, mercury

Diagnosis and appropriate differential diagnosis

In the scenario it is expected that the candidate will provide the preferred diagnosis of delirium and a surpassing candidate will provide the correct diagnosis of anti-NMDAR encephalitis (see below).

An appropriate differential diagnosis would include:

- Encephalitis – either autoimmune or infective
- Meningitis
- Seizure Disorder – including post-ictal state or status epilepticus
- CNS tumour (given the ovarian mass, CNS metastasis would be more likely than CNS primary)
- Withdrawal state
- Autoimmune disorder such as SLE
- Psychotic disorder – however it is expected that the candidate will recognise that this is less likely than an organic course

Anti-NMDAR encephalitis

Braverman et al report that Anti-NMDA-receptor encephalitis was initially described in 1997, in two separate reports of young women presenting with an ovarian teratoma and symptoms that included psychiatric manifestations and altered level of consciousness. In 2005, a series of four women with ovarian teratoma, psychiatric symptoms, altered level of consciousness and central hypoventilation was described. It was hypothesised that the syndrome was a paraneoplastic process due to an antibody to an unknown antigen expressed in the hippocampus. The associated antibody was discovered to be anti-NMDA-receptor in 2007. In subsequent years, hundreds of cases have been reported in the neurology literature in both men and women, with approximately 80% of cases in females. The median age at onset of symptoms is 21 years old, although cases have been reported in patients ranging from 8 months to 85 years. Teratomas are found in large numbers of patients, most commonly in women between age 12 and 45 and in patients of Asian or African American descent.

Braverman et al also report that the syndrome often begins with viral-like symptoms including headache, nausea, vomiting, fever, and fatigue. The non-specific nature of these symptoms generally precludes diagnosis at this stage and is recognized as a prodrome only after the illness progresses with a spectrum of neuropsychiatric symptoms. These symptoms have been divided into early and late stage symptoms. Early stage symptoms generally present with two weeks of prodromal symptoms and include confusion, memory loss, paranoia, hallucinations, mood disturbances, anxiety, self-harming behaviours, seizures and movement disorders such as facial twitching and choreoathetosis. As the psychiatric symptoms are often the most prominent, 77% of patients are initially seen by psychiatrists and many patients are diagnosed with new-onset psychiatric disorders. However, these patients do not respond to anti-psychotics and progress to late stage symptoms, such as decreased responsiveness, hypoventilation, and autonomic instability including hypotension or hypertension, bradycardia or tachycardia, hyperthermia, and urinary incontinence.

According to Mark Oldham, prompt identification and management of autoimmunity are critical for optimal outcomes. The fact that undiagnosed and, therefore, untreated autoimmunity leads to debilitation demands vigilance for these conditions. Close attention to the unusual nature and course of neuropsychiatric symptoms, associated neurological features, and review of systems should guide the skilful clinician.

Autoimmune encephalopathy usually has a subacute onset, progressing over the course of 1–3 months. Computed tomography and magnetic resonance imaging are insufficiently sensitive to rule out autoimmune encephalopathy. In fact, reviews indicate that a single brain MRI may have less than 50% sensitivity for detecting several of these conditions. Viral prodromes are seen in more than half of patients with anti-NMDAR antibody encephalitis.

Oldman produced the following table of features suggestive of autoimmune encephalitis.

Clinical Features That Raise Suspicion for Autoimmune Cause	
Psychiatric symptoms	Personality change Multi-symptom presentations Non-auditory hallucinations
History	Viral prodrome Severe diarrhoea Fever Personal / family history of autoimmunity Personal / family history of neoplasm associated with paraneoplastic syndromes Current or significant history of tobacco use
Natural history	Abnormal age of symptom onset Abrupt or florid symptom onset Rapid symptom progression Changing neuropsychiatric symptoms Treatment resistance
Neuropsychiatric symptoms	Unexplained delirium Premature cognitive impairment Subacute anterograde amnesia Catatonic features REM sleep behaviour disorder
Neurological features	Seizures Unexplained stroke-like events, particularly multifocal Headache Localizing neurological signs including cranial nerve palsies Sensorimotor findings Movement disorder
Medical features	Hyponatremia Central sleep apnoea Dysphagia Dysautonomia

The group of Graus F, Titulaer MJ et al recommend the following diagnostic criteria for anti-NMDA receptor encephalitis (anti- NMDAR)

Probable anti-NMDAR

All three of the following:

1. Rapid onset (less 3 months) of at least four of the six following major groups of symptoms:
 - Abnormal (psychiatric) behaviour or cognitive dysfunction.
 - Speech dysfunction (pressured speed, verbal reduction, mutism).
 - Seizures.
 - Movement disorder, dyskinesias, or rigidity / abnormal postures.
 - Decreased level of consciousness.
 - Autonomic dysfunction or central hypoventilation.
2. At least one of the following lab study results:
 - Abnormal EEG (focal or diffuse slow, epileptic activity or extreme delta brush pattern).
 - CSF with pleocytosis or oligoclonal bands.
3. Reasonable exclusion of other disorders
 - Diagnosis can also be made in the presence of three of the above groups of symptoms accompanied by a systemic teratoma.

Definite anti-NMDAR

Diagnosis can be made in the presence of one or more of the six major groups of symptoms and IgG anti-GluN1 antibodies after reasonable exclusion of other disorders. Antibody testing should include CSF. If only serum is available, confirmatory test should be included (live neurons or tissue immunohistochemistry in addition to cell-based assay) (The NMDA receptor is a heterotetramer comprised of two GluN1 subunits and two GluN2/3 subunits. **Detection of IgG antibodies against the GluN1 subunit is a signature of anti-NMDAR encephalitis.**)

Dalmau, Joseph, Lancaster, Eric et al reported the following information about diagnostic tests:

- Brain MRI is unremarkable in 50% of patients (Although, Barry et al subsequently reported that MRI may be normal in up to 70% of cases), and in the other 50%, T2 or FLAIR signal hyperintensity might be seen in the hippocampi, cerebellar or cerebral cortex, frontobasal and insular regions, basal ganglia, brainstem, and, infrequently, the spinal cord. Follow-up MRIs either remain normal or show minimum change despite the severity and duration of symptoms.
- Electroencephalograms are abnormal in most patients, usually showing non-specific, slow, and disorganised activity sometimes with electrographic seizures. Slow, continuous, rhythmic activity in the delta-theta range predominates in the catatonic-like stage. This activity is not associated with abnormal movements and does not respond to antiepileptic drugs. Monitoring with video EEG is important to diagnose and treat seizures appropriately.
- The cerebrospinal fluid (CSF) is initially abnormal in 80% of patients and becomes abnormal later in the disease in most other patients. Findings include moderate lymphocytic pleocytosis, normal or mildly increased protein concentration, and, in 60% of patients, CSF-specific oligoclonal bands. Most patients have intrathecal synthesis of NMDAR antibodies.
- Brain biopsy does not provide a diagnosis of anti-NMDAR encephalitis.

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 Nicole Carter, a 22-year-old primary school teacher. You live in a unit with Luke, your fiancé of one year.

Recent Events

You think that it was about three weeks ago you had a virus infection of some sort, where you had headaches, vomiting and diarrhoea. The headaches continued for some time.

Luke says he has noticed you having difficulty remembering things and he tells you that you seem confused at times but you know this isn't true. You don't understand why Luke is telling these lies or why your GP seem to believe Luke. You are certain that Luke has made the doctors in the hospital get a psychiatrist to see you and that he wants you locked away.

In the last week some time – you are not sure of the exact day - you know you fainted at home but have been told that you actually had a fit (seizure) - you are not convinced that you had a fit and feel that the medical tests being performed on you are unnecessary.

You don't like being in hospital and you don't want to take the medication they are trying to give you. You distrust the hospital staff as they are listening to Luke.

You are aware a psychiatrist was coming to review you. You think this is happening because Luke and maybe the hospital staff want you locked away. You know that Luke and the hospital staff have been lying to you but you don't understand why.

You do not believe there is anything wrong with your mental health. You can admit that you might be anxious, but you think this is understandable given your partner has been telling lies about you, and the hospital staff are doing what Luke tells them.

If you are asked, you have no previous history of mental illness and have never seen a psychiatrist before.

If you are asked about unusual or bizarre experiences, you become annoyed and say you're not crazy but will answer the questions.

If you are asked about your childhood or early life

You are not aware of any problems during the pregnancy with you or at the time of your birth. No one has mentioned that there were any issues with your early growth and development. You feel you had a good childhood and that you were a happy child.

You fell off a swing and broke your arm when you were six but other than this you have had no significant accidents, injuries or illness.

You didn't have any problems at school. You got on with other students and teachers and still see some of your friends from school.

Some people have unusual behaviours that start when they are young, for instance counting things or needing to have things in a certain order, but you do not have any issues of this nature.

If you are asked about your family

You are close with your parents, who are both teachers, and with your older brother, Pete. Your family try to have dinner together at least once a week which Luke finds a little frustrating as he doesn't see his parents anywhere near as much.

There is no family history of major health problems, apart from your mother having rheumatoid arthritis. All your grandparents are still alive. No-one in your family has ever seen a psychiatrist or, to your knowledge, had any problems with their mental health.

Your family members are social drinkers and your brother smokes cigarettes, but you are not aware of anyone having any problems related to drugs or gambling.

If you are asked about your relationship with Luke

You met at university. You have been together for three years. You don't understand why he is saying that you are having memory problems and that you are confused. You are certain that he got the doctors to refer you to a psychiatrist and that he wants people to think you are crazy.

If you are asked about alcohol or drug use

You do not smoke. You drink one to two glasses of wine with dinner most nights. You tried cannabis a few times at parties in your first year of university but no other drugs and you do not smoke cannabis now.

You've never had any charges or been in trouble with the police.

If you are asked about unusual thoughts or experiences

You are adamant that you are not 'crazy'.

You have noticed a strange smell lately – like something is dead or rotting - and people keep telling you it isn't there but you know that they are lying to you.

You don't think you are safe in hospital.

You're been hearing people, including the staff, laugh at you and think Luke has made them do it.

You have seen people coming into your hospital room at night and you are frightened but everyone keeps lying to you and telling you no one was there.

You have noticed that the food tastes strange and believe that the nurses are trying to put the medication that you don't want to take into your meals.

4.2 How to play the role:

Dress in casual attire. Hair to be somewhat messy with rumpled or askew clothing as getting dressed has been difficult. You are to be suspicious and you fear that this doctor wants to lock you away.

The candidate is required to come to the conclusion that you are confused or 'delirious' to assist the candidate with this:

- You are to yawn frequently and tell the doctor that you're tired.
- You are to be vague on the timeline of events that have happened recently and you must not know the current date and time – see below for answers to be provided.
- You are to lose track of the conversation occasionally.
- You are to accuse the candidate of laughing about you when they have not been.
- You are to provide the responses below to the testing the candidate conducts.
- If you are asked about unusual or bizarre experiences, you become annoyed and say you're not crazy but will answer the questions.

Responses to Memory and Cognitive Testing – you will be trained in these tests

PLEASE PRACTICE THESE CAREFULLY

Tests for Orientation:

Your date of birth is **1 May 1995**. Your address is **1 King Street, Ashfield, Sydney**. You are to give a correct answer as to the hospital that you are at, and you must give the day as **Saturday**; but give the date as **30th January 2018** and **the time of day four hours ahead of what it is**.

Tests for Concentration:

The candidate should ask you to '**subtract 7 from 100 and keep subtracting 7 from what is left**' (serial 7's) you go wrong after 2nd number and then give up. You say: **93...88...70**'.

If the candidate does not give the full instruction (above) or asks for a different calculation start exactly as they tell you to but only get the first calculation correct and do not complete the sequence.

If asked to repeat 5 numbers forward you **can do 4 correctly but give the last wrong digit**.

If asked to repeat numbers backwards you **give only the first number correctly, the second and third numbers are wrong and then you stop**.

If asked to spell a word (like WORLD) backwards, you **give the first two letters correctly and then wrong letters after this**.

If asked to repeat the days of the week or the months of the year backwards, you **do this incorrectly – you give the days / months out of order and then stop (e.g. May, June, July)**.

Tests for Memory:

If asked to repeat a set of three separate words, you **will repeat two out of three immediately**. You should be asked what those words were again after a few minutes you are **only able to recall one, even if given clues**.

If asked to remember a name and address you **are only able to immediately repeat the name**. You **provide the street wrong number and you cannot recall the street name**. If asked again in the few minutes you **only recall the first name**.

Drawing:

You may be asked to draw interlocking pentagrams, a cube and / or a clock face. **Start to draw but have your hand shake and then stop** and say that you **can't do anymore**.

Writing:

If asked to write a sentence, **write one or two words and then stop**.

Fluency:

If asked to list as many words as possible in one minute starting with a particular letter – **say 2-3 words correctly and then give answers starting with the wrong letter**.

If asked to name animals, supermarket items, or something similar in one minute – **say 2-3 words correctly and then give incorrect answers**.

Similarities:

You may be asked to explain how X is similar to Y (e.g. how is an apple like an orange?) **Decline to do this**.

Proverb interpretation:

You may be asked to explain a proverb (e.g. 'A stitch in time saves nine' or 'Too many cooks spoil the broth') **Decline to do this**.

Physical tasks:

Decline to do any physical tasks or anything that has you copying the candidate's movements – say you are too tired for this.

Calculation:

You can only perform very simple calculations. Otherwise give a wrong number or say you don't know.

Language:

You cannot repeat a sentence back to the candidate correctly, you understand most questions and commands; you are able to solve simple problems but nothing complex or that has several steps.

General knowledge:

Answer as best you can but **do not know details of very recent news events** if asked about these.

If asked to do anything else decline to do them.

4.3 Opening statement:

'There's no problem with my head.'

4.4 What to expect from the candidate:

There are two parts to the station for you. The candidate is to:

1. take a history about what you think has been happening recently
2. ask you to do some tests

The candidates should politely and sensitively ask you about your recent illness. They are expected to conduct some tests of your orientation, attention and memory (the responses you are required to provide are listed above). If they ask you to do a test not listed, decline to do the test or say you are too tired and decline.

The candidate should explain what they want you to do but will provide an explanation **to the examiners** of their reasons and findings as they examine you. If you do not understand how to do the test, please ask them to explain again.

Towards the end of each session the candidate will address the examiner about their findings and recommendations.

4.5 Responses you MUST make:

'I shouldn't be here, there's nothing wrong with me.'

'Why are you laughing at me? I knew you were in on it.'

4.6 Responses you MIGHT make:

'No one is listening to me. You are all listening to Luke.'

'You're just here because you want to lock me away.'

4.7 Medication and dosage that you need to remember:

You are not currently taking any medication.

STATION 3 – MARKING DOMAINS

The main assessment aims are to:

- Take a history that is mindful of the changes to the patient’s mental state and the likely link to recent physical symptoms / diagnoses.
- Accurately conduct an appropriate range of focussed bedside cognitive tests, particularly for orientation and sustained attention.
- Establish that a primary psychotic illness is unlikely and differentiate the preferred diagnosis based on the history gathered and results of investigations.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

clearly elicits the recent physical symptoms / illness and associated mental state changes; achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; exploring the recent physical symptoms; obtaining a history relevant to the patient’s problems and circumstances with appropriate depth and breadth; demonstrating ability to prioritise; eliciting the key issues that the patient is paranoid (e.g. fears that medication is in her food, and doesn’t trust her fiancé or the staff); completing a risk assessment relevant to the individual case; demonstrating phenomenology including multimodal hallucinations; clarifying important positive and negative features; assessing for typical and atypical features.

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

- Focus on exploring the symptom of suspiciousness.

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 substantial omissions in 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"/>

1.5 Did the candidate demonstrate adequate and accurate technique in the selected bed side cognitive testing? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

overall examination technique is accurate and well organised; references the Confusion Assessment Method (CAM) and explains its relevance.

Achieves the Standard by:

competently explaining and applying selected tests; prioritising testing of attention and sustained concentration, and memory, and recognising that due to disorientation and inattention more detailed cognitive testing is not appropriate.

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

- Accurately assess orientation and sustained attention in the cognitive screening.

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:

demonstrates incorrect technique is for most tests selected; prioritises inappropriate tests; fails to assess orientation.

1.5. Category: ASSESSMENT – Physical - Technique	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 appropriate differential diagnoses? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; accurately identifies anti-NDMAR encephalitis as the most likely diagnosis; 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; adequate prioritising of conditions relevant to the obtained history and findings, utilising a biopsychosocial approach; identifying relevant predisposing, precipitating perpetuating and protective factors, recognising that an organic cause is more likely than a primary psychotic illness.

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

- a. Identify delirium as a key differential diagnosis.

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:

provides an 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"/>

1.10 Did the candidate interpret the cognitive tests, EEG and ultrasound results correctly in formulating a diagnosis and differential diagnosis? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance linking relevant investigations with other diagnostic procedures / formulations.

Achieves the Standard by:

analysing findings of cognitive screening and identifying the significance of disorientation and impaired attention, accurately interpreting the results and incorporating them into the relevant formulation of the presenting problem.

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

- a. Propose the link between teratomas and encephalitis.

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 link recent physical illness and abnormal EEG and ultrasound result with the patient's change in mental state.

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"/>

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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-9</p> <p>9</p>
Instructions to Role Player	10-13
Marking Domains	14-15

1.0 Descriptive summary of station:

The candidate is expected to identify the risks of stopping medication and suggest a comprehensive plan for future management for a 50-year-old married man (named John Brown) with a 15-year history of bipolar disorder. He has had 4 admissions to hospital under the mental health act (3 manic / 1 severely depressed). He has been told he cannot take lithium because of poor renal function, and has had unsuccessful trials of both carbamazepine and sodium valproate in the past. He has been taking olanzapine over the last 3 years, which he now wants to stop because he has developed hypercholesterolaemia and gained 20kg. He understands the significant risks his illness has caused in the past.

1.1 The main assessment aims are to:

- Conduct a thorough assessment including a risk assessment in order to formulate an individualised risk management plan.
- Make appropriate specific recommendations for Mr Brown's treatment based on at least one evidence-based guideline for the prophylaxis of bipolar disorder.

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

- Focus on assessing the high level of risk evident in previous episodes of illness.
- Explore the patient's views on medication options.
- Justify their preferred mood stabiliser and / or antipsychotic medication.
- Consider the benefit of re-introduction of lithium, despite the presence of Chronic Kidney Disease (CKD).

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Collaborator, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – data gathering content; Management – long-term, preventative); Collaborator (Patient relationships); Scholar (Application of knowledge)

References:

- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders (First published in Australian and New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1-185).
- NICE, Bipolar disorder: assessment and management. Clinical guideline [CG185] Published date: September 2014 Last updated: February 2016.
- The Maudsley Prescribing Guidelines, 12th edition (Taylor, David; Paton, Carol; Kapur, Shitij.).
- Gupta S, Khastgir U. Drug Information Update. Lithium and Chronic Kidney Disease: Debates and Dilemmas. *BJPsych Bull* 2017, 41:216-220.
- Lars Vedel Kessing et al. The Use of Lithium and Anticonvulsants and the Rate of Chronic Kidney Disease. A Nationwide Population-Based Study. *JAMA Psychiatry*. 2015;72(12): 1182-1191.
- Sharma P et al. Does Stage-3 Chronic Kidney Disease Matter? A Systemic Literature Review. *Br J Gen Pract* 2010; June: e266-e276.
- Werneke U et al. A decision analysis of long-term lithium treatment and the risk of renal failure. *Acta Psychiatr Scand* 2012: 126:186-197.

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 his late 40's or early 50's, who must be overweight.
- 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 a junior consultant psychiatrist working in private practice.

The GP has referred Mr John Brown, a 50-year-old married man with a 15-year history of bipolar disorder. He has had 4 admissions to a psychiatric hospital. The last was 3 years ago.

Mr Brown wants to stop the olanzapine he has been taking for 3 years as he has gained 20kg, and has high cholesterol.

His GP has told him that he cannot take lithium because of an abnormal kidney function (referral indicates eGFR between 50 and 55ml/min/1.73m²). He is otherwise physically well.

He had to stop taking carbamazepine because it caused thrombocytopenia, and sodium valproate failed to control a previous manic episode, despite good compliance.

His wife has urged him to attend today's appointment because she is worried that he will have another episode of illness if he stops medication.

Your tasks are to:

- Obtain a focussed psychiatric history (including a thorough risk assessment) from Mr Brown.
- Present a comprehensive, evidenced-based, individualised management plan **to the examiner**.

You will be given a time prompt to commence the second task at **five (5) minutes**.

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 (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 prompt you are to give at **five (5) minutes** to commence the second 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**, 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 is no opening statement.

The role player opens with the following statement:

'I want to stop my medication..... I'm just piling on the weight.'

If the candidate has NOT commenced the second task, at **five (5) minutes** you are to give a time prompt. This is your specific prompt:

'Please proceed to the second task.'

3.2 Background information for examiners

In this station the candidate is expected to take a history from a man with bipolar disorder, including carrying out a thorough risk assessment, and then formulate an appropriate individualised management plan. In developing the plan the candidate must demonstrate an appropriate level of knowledge of evidence-based treatments for the prophylaxis of bipolar disorder, and apply this knowledge to Mr Brown's illness and situation.

Mr Brown has had three admissions for mania and one for depression, with symptoms that increase risks to Mr Brown's safety, the safety of others, and the risks to his reputation and relationships (for instance, driving fast whilst having a delusional belief he was protected by angels, having multiple affairs, spending excessively, attempting to hang himself).

Mr Brown's experiences with mood stabilisers have been complicated by side effects or lack of effectiveness. He has developed signs of metabolic syndrome (primarily weight gain) that he attributes to olanzapine, his most recent medication.

The candidate is expected to make appropriate specific recommendations for Mr Brown's treatment, based on at least one evidence-based guideline for the prophylaxis of bipolar disorder.

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

- Focus on assessing the high level of risk evident in previous episodes of illness.
- Explore the patient's views on medication options.
- Justify their preferred mood stabiliser and / or antipsychotic medication.
- Consider the benefit of re-introduction of lithium, despite the presence of Chronic Kidney Disease (CKD).

A surpassing candidate is likely to rapidly grasp the high risks Mr Brown has posed in the past, and adapt their interview to investigate the high risks that would be involved if he stopped medication.

The surpassing candidate may identify the complexity of the decision whether or not to use lithium, and may cite recent research that suggests it could be used in Mr Brown's case if renal function is closely monitored and the lithium level well controlled. They may emphasise the importance of making a collaborative decision about the use of lithium, involving not only the patient but also his wife, the GP and a nephrologist. They may also emphasise the essential non-pharmacological components of the future management plan, including regular review, involvement of Mr Brown's wife, identifying early warning signs, and creating an emergency plan.

RANZCP clinical practice guidelines for mood disorders make the following suggestions:

Maintenance medication should be selected on the basis of both efficacy and tolerability profiles. The latter is critical for long-term treatment, and these factors need to be balanced alongside individual patient considerations (including preference), past response, and safety considerations (risk of suicide).

Medications

Lithium. The BALANCE study (Geddes et al., 2010) demonstrated that lithium alone and in combination with valproate is effective in prophylaxis. Lithium is more effective alone than valproate alone, and carries the extra significant benefit of reducing suicidal behaviour and death by suicide.

Anticonvulsant agents

Valproate is not formally approved for use as a maintenance agent and there are no RCTs that have demonstrated its efficacy in long-term prophylaxis. In comparison to lithium, it is less effective (Geddes et al., 2010) but does have modest efficacy in acute mania (Calabrese et al., 2005a; Macritchie et al., 2001; Tohen et al., 2003a). It is therefore often advocated in those patients that have a predominance of manic episodes.

Lamotrigine has greater efficacy in the prevention of depressive relapse but relatively modest impact on risk of manic relapse (Level I) (Bowden et al., 2003; Calabrese et al., 2003; Goodwin et al., 2004; Licht et al., 2010; Van der Loos et al., 2011). Its use is further complicated by the need for slow titration of its dose to limit the risk of severe skin reactions, such as Stevens-Johnson syndrome. Its advantages include its better overall tolerability and relatively low risk of weight gain or sedative side effects (Miura et al., 2014).

Carbamazepine is less effective than lithium in preventing mood episodes in bipolar disorder. It is probably better suited to patients with mixed features (Weisler et al., 2004) and may be useful in combination with lithium, especially where there is marked mood instability. In practice, carbamazepine should be regarded as third / fourth line treatment. Serum levels should be monitored with long-term use, mostly for monitoring adherence or to avoid toxicity and side effects such as skin reactions.

There is no evidence for the use of other anticonvulsants such as gabapentin and topiramate in the long-term maintenance treatment of bipolar disorder.

Second Generation Antipsychotics

There is evidence supporting quetiapine and olanzapine in the prevention of manic and depressive relapse as monotherapy or adjunctive therapy (both Level I), but care should be taken especially with olanzapine because of its propensity for metabolic syndrome and because its effect on depressive relapse may not be substantive (Miura et al., 2014).

Long-acting injectable risperidone and ziprasidone have some support in the prevention of both manic and depressive episodes (Level II) (Yatham et al., 2009), and

- *Paliperidone* has been trialled in the prevention of mania.
- *Aripiprazole* monotherapy has evidence for the prevention of manic relapse (Level II).

Despite a lack of RCT evidence, *clozapine* is widely regarded as an option for treating severe refractory bipolar disorder. However, its significant side effects and ongoing need for monitoring limit its use long-term.

Evidence on the use of *other atypical antipsychotic agents* is emerging, but most studies are of insufficient duration to properly study the maintenance stage of bipolar disorder (McIntyre et al., 2010a).

Many patients do not achieve remission with medication monotherapy. The combination of medications increases the risks of adverse interactions and the balance of risks and benefits must be considered. However bipolar disorders are highly disruptive to patients' lives and cause considerable distress to patients and others, even when substantially recovered but not in remission.

Research on antipsychotic long-term use for all second generation antipsychotics recommends doses within the established recommended dose range for other indications, but it is desirable to keep the maintenance dose to the minimum effective level so as to prevent side effects.

Non-pharmacological management

Monitoring sessions are important because they strengthen rapport and ensure the maintenance of an ongoing alliance, which provides an opportunity for additional psychoeducation, psychological interventions, life-style management, monitoring of blood levels and side effects, and continuing tailoring of treatment. In addition, patients will usually have more frequent follow-up appointments with other health professionals in their treating team, such as their general practitioner, psychologist, or case worker.

Regular visits may gradually become less frequent if the illness remains in remission, but access to help in a crisis situation must be available to both the patient and significant others, and the plan of action should be known to the patient and all members of the treating team.

Patient self-monitoring is also essential, and should be combined with psychoeducation and identification of early warning signs with an action plan to deal with them, particularly a plan to get rapid access to a psychiatrist (or other health professional).

In the care of an individual with bipolar disorder, it is central to acknowledge the impact of the illness upon the affected individual, their family, and other carers. Equally, the carers form an integral part of the management team with their capacity to provide often-crucial additional information, and to assist in the implementation of interventions. It is further essential to acknowledge the impact of serious mental illness like bipolar disorder on carers, the level of stress that carers may experience and their heightened risk for the development of their own mental health problems such as anxiety or depression.

Involving carers from assessment and throughout management should now be considered standard care.

Specific psychological interventions

Four specific psychological interventions can be considered evidence-based (i.e., have at least one positive RCT), and have associated published manuals to guide treatment.

Cognitive-Behavioural Therapy (CBT) (Lam et al., 2010)

Focusses on the reciprocal relationships between thinking, behaviour and emotions to decrease symptoms and relapse risk.

Psychoeducation (Colom and Vieta, 2006)

Aims to assist people to become experts on managing their bipolar disorder, emphasising adherence to medication and stabilising moods. Psychoeducation is a descriptive term referring to providing information about the condition, but has been developed into manualised high intensity treatments by two groups of researchers (Bauer et al., 1998; Colom et al., 2003) and these formal interventions are the focus of the majority of the evidence base.

Family-Focussed Therapy (FFT) (Miklowitz, 2008)

Based on evidence that family stress and interactions moderate relapse, FFT aims to improve communication and problem-solving skills in the family. Although only one family member may have a diagnosis of bipolar disorder, the entire family is considered 'the client'.

Interpersonal and Social Rhythm Therapy (IPSRT) (Frank, 2005)

An amalgamation of interpersonal therapy addressing losses, role conflicts and other interpersonal problems with behaviours aimed at stabilising circadian rhythms via stabilising social rhythms (e.g., fixing wake time across 7 days of the week).

NICE Guidelines - CG185

Long-term treatment

After each episode of mania or bipolar depression, discuss with the person, and their carers if appropriate, ways of managing their bipolar disorder in the longer term. Discussion should aim to help people understand that bipolar disorder is commonly a long-term relapsing and remitting condition that needs self-management, and engagement with primary and secondary care professionals and involvement of carers. The discussion should cover:

- the nature and variable course of bipolar disorder
- the role of psychological and pharmacological interventions to prevent relapse and reduce symptoms
- the risk of relapse after reducing or stopping medication for an acute episode
- the potential benefits and risks of long-term medication and psychological interventions, and the need to monitor mood and medication
- the potential benefits and risks of stopping medication, including for women who may wish to become pregnant
- the person's history of bipolar disorder, including:
 - the severity and frequency of episodes of mania or bipolar depression, with a focus on associated risks and adverse consequences
 - previous response to treatment
 - symptoms between episodes
 - potential triggers for relapse, early warning signs, and self-management strategies
- possible duration of treatment, and when and how often this should be reviewed.

Provide clear written information about bipolar disorder, including NICE's information for the public, and ensure there is enough time to discuss options and concerns.

Psychological interventions

Offer a family intervention to people with bipolar disorder who are living, or in close contact, with their family in line with recommendation 1.3.7.2 in the NICE clinical guideline on psychosis and schizophrenia in adults.

Offer a structured psychological intervention (individual, group or family), which has been designed for bipolar disorder and has a published evidence-based manual describing how it should be delivered, to prevent relapse or for people who have some persisting symptoms between episodes of mania or bipolar depression.

Individual and group psychological interventions for bipolar disorder to prevent relapse should:

- provide information about bipolar disorder.
- consider the impact of thoughts and behaviour on moods and relapse.
- include self-monitoring of mood, thoughts and behaviour.
- address relapse risk, distress and how to improve functioning.
- develop plans for relapse management and staying well.
- consider problem-solving to address communication patterns and managing functional difficulties.

In addition:

- individual programmes should be tailored to the person's needs based on an individualised assessment and psychological formulation.
- group programmes should include discussion of the information provided with a focus on its relevance for the participants.

Pharmacological interventions

When planning long-term pharmacological treatment to prevent relapse, take into account drugs that have been effective during episodes of mania or bipolar depression. Discuss with the person whether they prefer to continue this treatment or switch to lithium, and explain that lithium is the most effective long-term treatment for bipolar disorder.

Offer lithium as a first-line, long-term pharmacological treatment for bipolar disorder and:

- if lithium is ineffective, consider adding valproate.
- if lithium is poorly tolerated, or is not suitable (for example, because the person does not agree to routine blood monitoring), consider valproate or olanzapine instead or, if it has been effective during an episode of mania or bipolar depression, quetiapine.

Discuss with the person the possible benefits and risks of each drug for them.

If stopping long-term pharmacological treatment:

- discuss with the person how to recognise early signs of relapse and what to do if symptoms recur.
- stop treatment gradually and monitor the person for signs of relapse.

Continue monitoring symptoms, mood and mental state for 2 years after medication has stopped entirely. This may be undertaken in primary care.

The Maudsley Prescribing Guidelines

Suggest the following for the prophylaxis of bipolar disorder:

First line: lithium.

Second line: valproate (NOT in women of child-bearing age), olanzapine, or quetiapine.

Third line: an alternative antipsychotic that has been effective during an acute episode, carbamazepine, or lamotrigine.

Always maintain successful acute treatment regimens (e.g. mood stabiliser + antipsychotic) in prophylaxis.

Avoid long-term antidepressants.

Should lithium be used in the presence of Chronic Kidney Disease (CKD)?

Whether to continue or restart lithium in the presence of CKD remains controversial. Recent studies have shown somewhat contradictory outcomes of long-term lithium use on kidney function.

Kessing et al, suggests that although carefully monitored lithium usage is associated with an increased rate of CKD, so is the use of anticonvulsants. Lithium use does not increase the risk of end-stage CKD. Additionally, he suggests that bipolar disorder itself is associated with an increased risk of CKD (perhaps through lifestyle factors, increased somatic co-morbidity or common genetic factors affecting endothelial function).

Gupta and Khastgir point to the dangers of stopping lithium, increasing the risk of relapse in bipolar disorder, and to lithium's role in reducing the suicide risk. They also state that it is currently unknown whether stopping lithium in patients with CKD leads to any improvement in renal function. They suggest it may be an option to continue lithium, whilst keeping levels in the lower therapeutic range (i.e. around 0.6mmol/l) and closely monitoring renal function). They also suggest that acute lithium toxicity increases the risk of CKD and lithium levels should not be allowed to rise above 1.0mmol/l. Single daily dosing is thought to be safer than multiple daily dosing.

Pawana Sharma et al (2010) focussed on longer-term outcomes for patients with stage 3 CKD from any cause. This is subdivided into stage 3a (eGFR between 45-59) and stage 3b (eGFR between 30-44). End-stage CKD was a rare outcome (4%) and greater in stage 3b compared to 3a. Many patients showed no deterioration in renal function over 5 years. In patients with stage 3 CKD, monitoring of cardiovascular risks and diabetic risk improves life expectancy.

Werneke et al (2012) concluded that the case for lithium continuation exists despite CKD in view of its beneficial effects on overall life expectancy in bipolar disorder compared to other treatments.

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 John Brown, aged 50. You have had a diagnosis of a mood disorder called bipolar disorder for the last 15 years. You are currently well and in full-time self-employment as a sound engineer.

In the past you have been admitted to psychiatric hospital 4 times, always under the mental health act (i.e. for compulsory treatment). The last admission was 3 years ago, and you have been taking a medicine called olanzapine (an antipsychotic medication) since then. You are now taking 10 milligrams at night.

You have come to see the psychiatrist today because you want to stop the olanzapine medication as you believe (probably correctly) it has caused you to gain over 20kg in weight over the past 3 years. You are worried about your physical health, especially as your GP, Dr Singh, has recently told you the level of cholesterol in your blood is high.

Your wife, Lisa, wanted you to come to see the psychiatrist again to discuss what they would recommend. Lisa vividly remembers your hospital admissions and the damaging effect they had on your life together, so she desperately wants to avoid you becoming unwell again.

Your current wellbeing:

You are currently feeling well, with no major problems at work or at home. You are functioning well, and working full-time.

You are physically well apart from being overweight, and having recently been told your cholesterol is a bit high – the GP said you might even need to start medications.

You accept that your illness has caused significant damage to your life (finances, work and marriage), and when you have been unwell, has caused you to do very risky things in the past (suicide attempt, dangerous driving, taking sexual risks, possible loss of house).

You appreciate that you have caused problems for your wife over the years especially during the manic (abnormally elevated mood) episodes. Although you ideally would like to stop all medications, for the sake of your marriage you would be willing to discuss possible alternative medications - so long as you can stop olanzapine and lose some weight.

Your personal life:

You have been married for 20 years to Lisa, who is 45, and you have no children. Your relationship is good, but you accept your wife is '*long-suffering*', and has come close to leaving you at times because of the illness (especially the manic episodes). She works part-time as a nursing assistant at a local nursing home.

You and Lisa have your own home, but with a large mortgage and no savings.

You are a sound engineer. You started working for a large company, touring Australia with INXS (after the death of Michael Hutchence in 1997), but after your last manic episode the company made you redundant.

You have since built up your own company over the last 2 years, and now employ 5 people. The work includes arranging the sound for touring bands, local and State shows as well as for corporate events. The company is busy, and the work is demanding and stressful; always having to please customers, work to tight time frames, and having to be flexible and inventive if things go wrong. You are well respected in the industry. Since owning your own company, it is now easier for you to avoid going on long tours away from home as you can delegate this to others.

You drink alcohol in moderation (wine and beer – about 3 glasses at a sitting; maybe twice a week, mainly on weekends), and don't use any illicit drugs (you have seen the destructive effect of these in your work within the entertainment industry and deliberately avoid them).

You don't have any convictions, but you are close to losing your driver's licence for speeding offences which you got when you were unwell.

You are not aware of any family history of mental illness.

Information about your previous episodes of mental illness:

You have had 3 manic episodes (2003, 2008 and 2015), and one depressive episode (2009). You were admitted to hospital under the Mental Health Act (i.e. against your will) on all of these occasions, and each admission lasted between 2 and 3 months.

Manic episodes (2003, 2008, 2015):

Each episode of illness was characterised by having huge amounts of energy, little need for sleep, increased alcohol consumption, increased libido and several one-night stands. You spent money you didn't really have and got into debt, at one point risking the bank repossessing your home. On one occasion, you bought a hugely expensive sports car (\$150k). You got caught speeding several times, and you are close to losing your licence.

When acutely unwell, you also developed psychotic symptoms (having serious problems with thinking clearly, emotions, and knowing what is real and what is not). For you these included the beliefs that you:

- wrote many of the songs by INXS by 'thought transfer' to Michael Farriss (main composer of the group);
- were protected by angels when you were driving fast.

Depressive episode (2009):

You remained out of work for a year after the 2008 admission for mania. You then stopped taking lithium medication and within a month you became very depressed and ultimately tried to hang yourself at home when your wife went out shopping. She only discovered you by chance after she returned home to collect her purse that she had forgotten to put in her handbag. It was horrifying for both of you.

Treatments:

In the first manic episode (2003) you responded well to lithium (1gram at night), and an antipsychotic (you can't recall which one). The antipsychotic was stopped after a year, but you continued taking lithium for 4 years. After feeling well for so long, and finding it very hard to find time to see a doctor, and have blood tests regularly because of your work commitments, you stopped lithium without discussing it with your wife. Within a few months you were re-admitted (2008).

Because you told the hospital doctors you didn't want to take lithium anymore, they prescribed you big doses a medication called valproate, but this didn't control your manic symptoms and so they switched you to another 'mood stabiliser', carbamazepine twice a day. This helped, but unfortunately caused some kind of problem with your blood and so they had to stop it.

The doctors then persuaded you to take lithium again, and you continued this for about the next year into 2009. After that you again convinced yourself that it would be safe to stop medication, but within a month you became depressed and tried to commit suicide.

You were put back on lithium. An antidepressant was also added (you can't recall which one), and you took that for the next year. You remained well for several years, but then in 2015, your GP told you to stop the lithium because you couldn't get to see a doctor regularly enough for tests, and he was worried that your kidney function was deteriorating (you recall he mentioned that the 'GFR' was low).

Within 2 months you were manic and back in hospital, started on olanzapine. You needed 20 milligrams of olanzapine at night in hospital, but after you went home, this dose was gradually reduced, so that for the past 2 years you have only taken 10milligrams at night. It seems to have worked, but you are concerned about the side effects.

You are now unsure of what to do. You definitely don't want to continue olanzapine because you feel so unfit, but recognising that carbamazepine and lithium caused serious side effects and valproate didn't work, your GP couldn't think of any alternative medications which is why you are seeking specialist advice.

So in summary, the key issues are that without medication you rapidly become unwell and when you are unwell you make decisions and act in ways that really place you at high risk. So if asked about your thoughts on medication, you feel a bit stuck because even though you wish you would not have to take any medication, you realise you need to take something, but you are also worried about all the side effects you have experienced.

About bipolar disorder:

According to the Royal Australian and New Zealand College of Psychiatrists (RANZCP) community resource:

Bipolar disorder is a mental illness that affects a person's mood and energy levels.

Everyone has highs and lows, but people with bipolar have extreme ups and downs in mood. These mood changes can be distressing for them and other people. They can affect how they live their life, and even put them in risky situations. Between these mood swings, however, they feel and act normally.

People with bipolar disorder have times when their highs are extreme and they have too much energy. These highs are called 'mania' when severe, or 'hypomania' when less severe.

Most people with bipolar disorder also have times when they feel extremely down. They can feel hopeless, helpless or empty. This is called bipolar depression.

In the past, bipolar disorder was called 'manic depression'.

Bipolar disorder is a lifelong condition, but with the right treatment the symptoms can be well controlled.

4.2 How to play the role:

You should be casually dressed and present as friendly with an open style of interaction. You are happy to mention details of previous episodes of illness, accept that they have caused significant problems in your life, and acknowledge you have given your wife 'a hard time'. You are looking for a way to increase your chances of remaining well but without causing side-effects or problems with your physical health.

Lithium seems to have controlled the illness better than any other medication, but the GP has told you that you can't take it anymore because of its effect on your kidneys.

4.3 Opening statement:

'I want to stop my medication... I'm just piling on the weight.'

4.4 What to expect from the candidate:

The candidate should ask you questions about the previous episodes of illness, and what happened when you were ill. They should focus on uncharacteristic risky or potentially dangerous behaviour as well as behaviour that could have damaged your reputation (either in the family or in the wider world). They will also ask questions about medication you have taken over the years.

The candidate should also ask you about how things are going for you now, and how you are spending your time.

The candidate will then refer to the examiner to discuss treatment plans to address your concerns, that includes trying to ensure that you continue to take medication.

4.5 Responses you MUST make:

'Once, I tried to string myself up when my wife was out shopping.'

'I bought a really fancy sports car once. That set me back a bit!'

'I've had a few one-night stands. I'm not proud of that but who hasn't these days?'

4.6 Responses you MIGHT make:

If asked about why you want to stop treatment:

Scripted Response: *'I'm fed up with having to take tablets with all their side-effects.'*

If asked whether you mind if the doctor called your wife to find out her views:

Scripted Response: *'No problem at all, I think that would be a good idea.'*

If asked whether you would consider taking a different medication to olanzapine:

Scripted Response: *'Yes, I want to remain mentally well, but I don't want to risk my health.'*

4.7 Medications you need to remember:

Current Medication:

Olanzapine (pronounced oh-lanza-peen) - 20 milligrams a day;
an antipsychotic medication that can also be used to stabilise people's mood in bipolar disorder.

Previous Medication for your information:

Mood Stabilisers:

A group of medications that help to stabilise mood when a person with bipolar disorder experiences problems with extreme highs, extreme lows, or mood swings between extreme highs and lows.

Lithium - 1 gram a night

A well-established mood stabilising treatment for bipolar disorder. It requires regular blood tests to check its level as it is toxic if levels go too high. It can also cause thyroid gland and kidney problems with long-term use.

Carbamazepine

An anti-epileptic, also used as a mood stabiliser. It can cause blood problems where blood doesn't clot easily (increasing the risk of bleeding internally and strokes).

Sodium Valproate

An anti-epileptic, also used as a mood stabiliser; for both acute mood episodes and longer-term prevention.

Antidepressants and antipsychotics:

These medications are often used to treat symptoms of bipolar disorder. You cannot recall which ones you have previously taken, even if the candidate tries to prompt you with names.

Sedatives / tranquilisers:

These medications are used to calm patients, ease agitation and induce more peaceful sleep. When you were unwell and in hospital you have been prescribed these but cannot recall names.

STATION 4 – MARKING DOMAINS

The main assessment aims are to:

- Conduct a thorough assessment including a risk assessment in order to formulate an individualised risk management plan.
- Make appropriate specific recommendations for Mr Brown’s treatment based on at least one evidence-based guideline for the prophylaxis of bipolar disorder.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history, including information required to effectively assess and manage risk? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient’s problems and circumstances with appropriate depth and breadth; integrating key social issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues in the history and current presentation; demonstrating phenomenology.

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

- Focus on assessing the high level of risk evident in previous episodes of illness.

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 substantial omissions in history affecting risk assessment process.

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"/>	

3.0 COLLABORATOR

3.4 Did the candidate develop an appropriate therapeutic relationship with the patient? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

considers resources to meet specific patient needs; gives priority to continuity of care and meeting changing needs; clearly identifies support of the wife as important.

Achieves the Standard by:

developing a therapeutic rapport with the patient; gathering information in a professional manner; responding to concerns raised, maintaining open communication; providing opinion and information; working together to consider options.

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

- Explore the patient’s views on medication options.

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 consideration of individual goals or preference; 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"/>	0 <input type="checkbox"/>	

1.0 MEDICAL EXPERT

1.16 Did the candidate formulate an appropriate longer-term management plan, including preventative treatment? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

provides a sophisticated summary of the possible pros and cons of re-introducing lithium; demonstrates familiarity with more than one widely accepted clinical practice guideline; recognises variations in evidence; speaks confidently about at least one evidence-based psychosocial treatment.

Achieves the Standard by:

demonstrating the ability to incorporate evidence-based care; considering pros and cons of different approaches and providing one or more treatment option supported by CPGs, and relevant to the patient; prioritising continuity of care; clearly explaining the rationale of recommended option(s); identifying the risk of relapse with any change and referencing long-term outcomes; demonstrating awareness of episode, reducing / ameliorating effects of specific treatments; outlining psychiatric / somatic complications of illness or treatment, and available interventions / monitoring; identifying the role of other health professionals including GP and nephrologist.

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

- a. Justify their preferred mood stabiliser and / or antipsychotic 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):

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
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 / clinical experience? (Proportionate value - 20%)

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; references recent studies of the use of lithium in the presence of CKD, and recognised guidelines in the management and prophylaxis of bipolar disorder; acknowledges their own gaps in knowledge.

Achieves the Standard by:

identifying key aspects of the available literature; appropriately identifying medication choice, benefits / risks, application; commenting on the voracity of the available evidence; discussing major strengths and limitations of available evidence; describing the relevant applicability of theory to the scenario; identifying specific treatment outcomes and prognosis.

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

- a. Consider the benefit of re-introduction of lithium, despite the presence of CKD.

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 demonstrate adequate knowledge of the literature / evidence relevant to the scenario; 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"/>	

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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
Instructions to Candidate	4
Station Operation Summary	5
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>6</p> <p>6-11</p> <p>12</p>
Instructions to Role Player	13-15
Marking Domains	16-17

1.0 Descriptive summary of station:

This station is about assessing capacity in a 66-year-old woman who has chronic renal failure secondary to hypertension. She has been on haemodialysis for the past 5 years but now wants to stop this treatment. There is evidence of cognitive impairment on cross-sectional examination using the Mini-Mental State Examination. The candidate must synthesis the data obtained in the capacity assessment and present their conclusion to the examiner. In addition, the candidate is expected to discuss the initial management of an older person who requests euthanasia.

1.1 The main assessment aims are to:

- Obtain the key clinical information necessary for undertaking a capacity assessment in an older person with physical illness.
- Draw a conclusion from the capacity assessment specific to the request to stop dialysis.
- Discuss the initial management of an older person who has cognitive impairment and who requests euthanasia.

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

- Assess past and current self-harm / suicidal behaviours / depressive symptoms.
- Conclude Mrs Jones lacks capacity as she does not fully understand the consequences of stopping dialysis.
- Prioritise the need to explore whether Mrs Jones has an imminent plan to act on her euthanasia belief.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.)
- **Area of Practice:** Old Age Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:**
Medical Expert (Assessment – data gathering content, Diagnosis, Management – initial plan)

References:

- AMA Position Statement: Euthanasia and Physician Assisted Suicide 2016. Australian Medical Association Limited ABN 37 008 426 793.
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- Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. BMJ. 2003 Feb 1; 326(7383): 271–273.
- NZMA. Investigation into ending one's life in New Zealand: Submission to the Health Select Committee. New Zealand Medical Association. February 2016
- RANZCP Position Statement 67: Physician Assisted Suicide
- Snyder L, Sulmasy DP. Physician assisted suicide. Ann Intern Med. 2001; 135(3): 209-216.
- The National Kidney Foundation. Dialysis: Deciding to stop. Available from: <https://www.kidney.org/atoz/content/dialysisstop>

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Brief video on haemodialysis: <https://www.kidney.org/atoz/content/hemodialysis> (For Training Day only)
- Role player: Medium build woman aged 60-65, 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 a consultation-liaison service.

The renal team refers Mrs Jones for a capacity assessment. Mrs Jones is a 66-year-old widow with chronic kidney disease, from hypertension, who has been on haemodialysis 3 times per week for 5 years. She now tells the renal team that she wants to stop her dialysis.

Her current blood pressure control is good. She has no other concurrent medical illness.

The renal team wants you to assess whether Mrs Jones has capacity to make a decision to stop dialysis. They have explained to Mrs Jones on several occasions that she will die from renal failure within weeks of stopping dialysis.

Mrs Jones's Mini-Mental State Examination performed by the renal team was 23 out of 30: lost three points in orientation to time, three points in three-word recall at five minutes, and one point in spelling 'WORLD' backwards.

You have **three (3) tasks**:

- Conduct an assessment of Mrs Jones's capacity to make a decision to stop dialysis, including a focussed history relevant in this situation.
- Present and justify your capacity assessment to **the examiner**.
- At **six (6) minutes** the examiner will give you a VIVA task to address to **the examiner**.

NOTE: A cognitive assessment is **NOT** required in this station.

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 (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 third task you are to give at **six (6) minutes** while stating:
'Please proceed to address the third task.'
The **THIRD TASK** is:
The renal team has forgotten to tell you that Mrs Jones has also been requesting euthanasia. Describe your initial management of 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 and second task (i.e. before 6 minutes):

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

'I don't know why my doctor wants me to see a psychiatrist.'

At **six (6) minutes** the examiner hands the third task to the candidate and says:

'Please proceed to address the third task.'

The **THIRD TASK** is:

The renal team has forgotten to tell you that Mrs Jones has also been requesting euthanasia. Describe your initial management of this situation to the examiner.

3.2 Background information for examiners

In this station the candidate is expected to assess the capacity of an 66-year-old widow who has been on haemodialysis 3 times a week for the last 5 years. There is also evidence of cognitive impairment on the Mini-Mental State Examination (score = 23/30). As part of the assessment, the candidate is expected to obtain relevant history from the patient and demonstrate their expertise in eliciting the key clinical information necessary for undertaking a capacity assessment taking into consideration the impact of chronic physical illness, any evidence of cognitive disorder or potentially an undiagnosed depression.

Finally, the candidate is asked to discuss the initial management of an older person who has cognitive impairment and who requests euthanasia. A candidate should appreciate the specific expertise of psychiatrists in identifying psychiatric illnesses and assessing suicidal ideation in patients, even those who are medically ill, and being able to differentiate between suicide ideation in the context of depression and a physician assisted dying / euthanasia request. Candidates should also be able to describe the impact of cognitive impairment on capacity, and to demonstrate a high awareness of the current public, professional and political debate on these issues.

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

- Assess past and current self-harm / suicidal behaviours / depressive symptoms.
- Conclude Mrs Jones lacks capacity as she does not fully understand the consequences of stopping dialysis.
- Prioritise the need to explore whether Mrs Jones has an imminent plan to act on her euthanasia belief.

A surpassing candidate will focus specifically on conducting a sophisticated capacity assessment related to the request of stopping dialysis; skilfully use a range of well-formulated questions to test the various capacity domains; demonstrate an understanding of the limitation of cross-sectional capacity assessment; consider involving the family in the assessment process.

Dialysis: Deciding to stop

Dialysis patients are allowed to make decisions about stopping dialysis treatment. They are encouraged to discuss their reasons for wanting to stop treatment with their doctor, other members of their health care team and their loved ones before making a final decision. Health practitioners need to have a clear understanding of rationales for this decision (worsening health, worsening quality of life, specific treatment problems, depression) to determine if any improvements might be made that could affect their decision.

A psychiatrist assessment is beneficial if concerns are raised that a patient wants to stop dialysis for solely emotional reasons or because of depression, they may be asked to speak with a psychiatrist. A psychiatrist can play an important role in determining whether patients understand the full impact of stopping dialysis.

People who stop dialysis may live anywhere from one week to several weeks, depending on the residual level of kidney function and their overall medical condition.

Capacity Assessment:

The candidate should be able to demonstrate their ability to identify important information to assist them in the assessment of capacity. Taking a biopsychosocial approach, information about both physical and psychological wellbeing is critical, as will be the effects of illness and treatment of quality of life in a seriously ill patient. Clinical information that will be relevant in this case includes: past self-harm and / or suicidal behaviours, past and current depressive symptoms and current cognitive functioning.

Mental capacity is concerned with a person's decision-making ability. It focuses on whether the person retains that ability and, if not, who should decide on their behalf and on what basis. Capacity or incapacity is a legal decision informed by medical and other evidence. A capacity assessment is used to establish whether a person lacks capacity for decision-making in respect of specific decisions at a specific time.

People are presumed to have capacity until proven otherwise by a qualified health professional. In regard to capacity assessment, Darzins et al. (2000) has outlined the six steps involved in this process:

- Step 1: Perform capacity assessment only when there are valid triggers.
- Step 2: Find out from family members, health professionals, solicitors or financial advisors about the context in which decisions are to be taken.
- Step 3: Provide education to the person because ignorance can be mistaken for incapacity.
- Step 4: Involve the person, explaining the benefits of being able to document that they are competent, or to have opportunity for some protections to be put in place if their capacity is impaired.
- Step 5: Make conditions of examination as good as possible, for example exclude concurrent reversible illness and the person should be seen on his or her own to minimise coercion or undue influence.
- Step 6: Perform the assessment by determining whether the person can (i) understand the relevant information; (ii) reason about treatment / management options; (iii) appreciate the situation and its consequences; and (iv) communicate a choice.

Domains	Patient's Task	Physician's Assessment Approach	Questions for clinical assessment
1. Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor (or I) told you about <ul style="list-style-type: none"> ▫ The problem with your health now ▫ The recommended treatment ▫ The possible benefits and risks of the treatment ▫ The risks and benefits of no treatment
2. Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	<ul style="list-style-type: none"> ▫ How did you decide to accept or reject the recommended treatment? ▫ What makes (chosen option) better than (alternative option)?
3. Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	<ul style="list-style-type: none"> ▫ What do you believe is wrong with your health now? ▫ Do you believe that you need some kind of treatment? ▫ What makes you believe it will have that effect? ▫ What do you believe will happen if you are not treated? ▫ Why do you think your doctor has (or I have) recommended this treatment?
4. Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	<ul style="list-style-type: none"> ▫ Have you decided whether to follow your doctor's (or my) recommendation for treatment? ▫ Can you tell me what the decision is? (if no decision) What is making it hard for you to decide?

Key practice points:

- A person is presumed to have the capacity to make a decision unless there are good reasons to doubt this presumption.
- In general, capacity is assessed with respect to a specific decision at a specific time.
- Assessment is of a person's ability to make a decision, not the decision they make. A person is entitled in law to make unwise or imprudent decisions, provided they have the capacity to make the decision.
- It is important to explain to the person that the capacity assessment can result in confirming they are competent to make decisions independently; or if they are not competent, some protection can be put in place to support their decision-making ability.

Physician-assisted suicide and euthanasia:**RANZCP Position Statement 67****Background**

The RANZCP notes that there is considerable debate about the use of terminology in the euthanasia context. The terminology used by the RANZCP in this position statement is based on the psychiatric and medical literature.

The focus of this position statement is physician-assisted suicide (PAS), which is sometimes also called 'physician assisted dying', 'physician assisted death' or 'physician aided dying'. PAS refers to situations where doctors prescribe, but do not administer, lethal substances to informed patients who have a terminal illness or a grievous and irremediable medical condition and have the legal capacity to decide that they may end their own lives at a time of their own choosing. By contrast, 'euthanasia' refers to the act of deliberately ending another person's life at his or her request. If a doctor prescribes or supplies the drug at the patient's request, this constitutes 'PAS' whereas if a doctor administers a drug to bring about a patient's death at the patient's explicit request, this constitutes 'euthanasia'.

The issue of capacity is a critical consideration on the debate on PAS. Generally, in Australia and New Zealand, all adults are presumed to have decision making capacity but that can be rebutted if it can be shown, for instance, that the person is either unable to understand and retain the information relevant to the decision or to understand the consequences of the decision. The capacity test is not diagnosis-specific but rather focuses on a person's ability to make the decision at hand in the situation.

RANZCP members should note that legalising any activity does not make it ethically correct. The Australian Medical Association, New Zealand Medical Association and World Medical Association consider that doctors' involvement in euthanasia to be inappropriate and unethical. This position statement is not intended to bring any resolution to the ethical debate.

Although PAS is currently illegal in Australia and New Zealand, the RANZCP notes that some patients may request PAS of their doctors. There are also anecdotal reports of patients requesting assessment of their capacity by psychiatrists in Australia and New Zealand in order to facilitate PAS in another country.

Public opinion is divided over PAS and euthanasia in Australia and New Zealand. Recent surveys suggest that around 85% of Australians and 70% of New Zealanders support the legalisation of some kind of medically assisted dying.

PAS legislation

PAS (and euthanasia) was legalised in Australia's Northern Territory in 1995 by the *Rights of the Terminally Ill Act*. In 1997, the Northern Territory legislation was quashed by the Federal Parliament, using its power to overturn Territorial (as opposed to State) laws.

Currently, the provision of PAS is a criminal offence in all Australian jurisdictions and New Zealand. A 2015 New Zealand case – *Seales v Attorney-General* [2015] NZHC 1239 – confirmed that only Parliament could change the law to legalise PAS.

In recent years, both Australia and New Zealand have debated the issue of PAS. Recent examples of legislation that have been introduced into parliament include Medical Services (Dying with Dignity) Bill 2014 (Australia) and the End of Life Choice Bill 2015 (New Zealand).

The RANZCP notes that PAS or, in some cases, euthanasia has been legalised in some overseas jurisdictions. These include some European countries and some states of the United States of America.

PAS and role of psychiatrists

The RANZCP considers that the primary role of medical practitioners, including psychiatrists in end of life care is to facilitate the provision of good quality patient-centred care. Palliative care should strive to achieve the best quality of life during the final stages of patients' illnesses and allow patients to die with dignity. This should be adequately resourced and widely available.

Psychiatrists have specific skills and expertise to identify psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill. A person's capacity to make decisions may be affected by both mental and physical illness, including a treatable psychiatric condition.

Psychiatrists may have a role with patients who are considering or wish to discuss PAS through the identification and treatment of mental illness and, when appropriate, making recommendations for patients' mental health treatment and care.

To help inform the PAS debate, the RANZCP believes that the following issues should be considered in the Australian and New Zealand context:

- **The rights of people with mental illness** – The RANZCP does not believe that psychiatric illness should ever be the basis for PAS. The RANZCP also considers that unrelievable psychiatric suffering is rare and that ensuring that a person with mental illness has capacity in the PAS context may pose significant challenges.
- **The rights of older people, including people with dementia** – There is growing evidence to suggest that people who develop dementia under the age of 70 are at increased risk of suicide, especially if there are symptoms of depression and anxiety, meaning that they might, in some circumstances, consider PAS. The RANZCP strongly supports good quality assessment, care and support mechanisms for people with dementia.
- **Misconceptions about older people, PAS and suicide** – Figures show that Australia's oldest citizens, those aged 80 and above, are the age group most likely to die by suicide. This has led to a misconception that suicide in older people is largely driven by suffering associated with chronic, debilitating or terminal illness whereas the aetiology factors of suicide are complex and multifactorial. The RANZCP is concerned about the potential impact of the debate about euthanasia on older persons and considers that suicide prevention programs must be extended to, and target, older persons.
- **The right of medical practitioners to choose whether or not they wish to be involved in a PAS situation and the extent of their involvement, if any** – While psychiatrists see the psychiatric assessment and treatment of patients who are considering suicide as a core part of their role, psychiatrists may not wish to take on a 'gatekeeper role' in a potential PAS scenario.
- Research shows that while some 64% of British psychiatrists agree that psychiatric assessments are important in the PAS context, only 35% would be willing to carry out such assessments.

Recommendations

- The RANZCP considers that the primary role of medical practitioners in end of life care is to facilitate the provision of good quality, comprehensive and accessible patient-centred care.
- The need for psychiatric assessment and treatment should be considered for patients who request PAS of their doctors.
- RANZCP members should note that currently PAS is illegal in Australia and New Zealand.
- The RANZCP recommends that psychiatrists in Australia and New Zealand carefully consider their position if asked to undertake a capacity assessment of patients who are seeking to obtain PAS in another country.
- By virtue of their expertise about physical and mental illness, psychiatrists can play a crucial role in informing the debate about PAS.

Australian Medical Association: Euthanasia and Physician Assisted Suicide 2016

1. Good quality end of life care and the relief of pain and suffering

- 1.1 Doctors (medical practitioners) have an ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity.
- 1.2 Doctors should understand that they have a responsibility to initiate and provide good quality end of life care which:
 - strives to ensure that a dying patient is free from pain and suffering; and
 - endeavours to uphold the patient's values, preferences and goals of care.
- 1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life. There are some instances where it is difficult to achieve satisfactory relief of suffering.
- 1.4 All dying patients have the right to receive relief from pain and suffering, even where this may shorten their life. (1)
- 1.5 Access to timely, good quality end of life and palliative care can vary throughout Australia. As a society, we must ensure that no individual requests euthanasia or PAS simply because they are unable to access this care (2).
- 1.6 As a matter of the highest priority, governments should strive to improve end of life care for all Australians through:
 - the adequate resourcing of palliative care services and advance care planning;
 - the development of clear and nationally consistent legislation protecting doctors in providing good end of life care; (1) and,
 - increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia.

2. Patient requests for euthanasia and PAS

- 2.1 A patient's request to deliberately hasten their death by providing either euthanasia or PAS should be fully explored by their doctor. Such a request may be associated with conditions such as depression or other mental disorders, dementia, reduced decision-making capacity and / or poorly controlled clinical symptoms. Understanding and addressing the reasons for such a request will allow the doctor to adjust the patient's clinical management accordingly or seek specialist assistance.
- 2.2 If a doctor acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or PAS:
 - not initiating life-prolonging measures;
 - not continuing life-prolonging measures; or
 - the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

3. AMA position on euthanasia and PAS

- 3.1 The AMA believes that doctors should not be involved in interventions that have, as their primary intention, the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.
- 3.2 The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and PAS.
- 3.3 The AMA acknowledges that laws in relation to euthanasia and PAS are ultimately a matter for society and government.
- 3.4 If governments decide that laws should be changed to allow for the practice of euthanasia and / or PAS, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:
 - all doctors acting within the law;
 - vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
 - patients and doctors who do not want to participate; and
 - the functioning of the health system as a whole.

- 3.5 Any change to the laws in relation to euthanasia and / or PAS must never compromise the provision and resourcing of end of life care and palliative care services.
- 3.6 Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.
1. *The AMA supports nationally consistent legislation which holds that a doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under a medical practitioner's supervision, incurs no civil or criminal liability by administering or prescribing medical treatment with the intention of relieving pain or distress:*
 - a) *with the consent of the patient or the patient's representative; and*
 - b) *in good faith and without negligence; and*
 - c) *in accordance with the proper professional standards;*

even though an incidental effect of the treatment may be to hasten the death of the patient.

A doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under the doctor's supervision, is under no duty to use, or to continue to use, life sustaining measures which are of no medical benefit in treating the patient if the effect of doing so would be merely to prolong life.
 2. *Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and / or suffering. Physician assisted suicide is where the assistance of the doctor is intentionally directed at enabling an individual to end his or her own life.*

In their 2016 submission to the Health Select Committee the **New Zealand Medical Association** stated that:

'It is the NZMA's view that euthanasia and doctor-assisted suicide are contrary to the ethics of the profession:

The NZMA is opposed to both the concept and practice of euthanasia and doctor assisted suicide.

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical. Doctor-assisted suicide, like euthanasia, is unethical.

The NZMA, however, encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care.

In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical.

This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.'

Gastmans et al. (2004) described the initial management when a patient requests PAS or euthanasia. Such request can be the first place a signal that the patient gives to elucidate their views towards being ill, the physical pain, the possible deterioration that can come, and the hopeless nature of the situation. Each PAS / euthanasia request must therefore be open to discussion, even if medically speaking the actual dying is still far away. It is essential that the clinician shows their willingness to listen to the patient requesting PAS / euthanasia, while at the same time ensuring the decision of the patient is based on an autonomous, free, and informed choice. The following questions could be posed:

- What motivation lies at the ground of the request for PAS / euthanasia? Is this really a request to put actively an end to their life, or is the patient asking for caring guidance in the last days or weeks of their life?
- Does the patient have sufficient information (for example, diagnosis and prognosis) on the grounds on which they make their request?
- Is the patient mentally competent at the moment when making their request?
- Has the patient discussed their euthanasia request with other people?
- Does the patient make the request voluntarily? Is there no question of any form of coercion or pressure?

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 Mrs Jones, a 66-year-old woman, living alone in a city apartment. You are very independent and manage all your own affairs. Your husband died of a lung cancer about 20 years ago at the age of 49 years.

You have two daughters who both live in Melbourne: Elizabeth (45 years old) and Margaret (40 years old). They phone you every week. Your best friend and support person is Camila, a neighbour of 10 years.

You worked as a receptionist in a local medical centre for most of your working life. You retired about 5 years ago, around the time you started haemodialysis.

You have chronic kidney disease from high blood pressure. You have been on haemodialysis for the past 5 years. You are under the renal team (Doctor William, Nurse Kate). You come to the dialysis unit in this hospital 3 times a week. You do not drive and the long bus trip to the hospital takes an over an hour each way. You want to stop the dialysis because you are getting old and want to have more spare time to do the things you enjoy. You like reading and researching your family tree. You work at the local hospice shop as a volunteer in the weekends.

You have NO recent losses or significant life changes.

You will be shown a brief video on haemodialysis: <https://www.kidney.org/atoz/content/hemodialysis>

Dialysis: Deciding to stop

Like any treatment, dialysis patients are allowed to make decisions about stopping dialysis. People are encouraged to discuss their reasons for wanting to stop treatment with their doctor, other members of health care team and their loved ones before making a final decision.

In this scenario your clinicians will want to have a clear understanding of why you are making this decision (for instance, whether it is because of worsening health, specific treatment problems, or depression) in order to decide if any improvements might be made that could affect your decision. If they are concerned that you want to stop dialysis for solely emotional reasons or because you are suffering depression, they may ask for a psychiatrist opinion. The team may also want you to speak with a psychiatrist to make sure you understand the full impact of what stopping dialysis will mean.

How you feel and think

You are feeling good because you are convinced that stopping dialysis will free up your time from coming to the hospital 3 times a week plus it takes four hours each dialysis session. You get frustrated having to come to the hospital and find dialysis very time consuming. The bus trip takes an hour each way. Having dialysis makes you feel tired and bored and you hate the way it interferes with all the things you want to do.

You do not want to stop dialysis because you wish you were dead, in fact you also hold a clear belief that it will take a few years to die after stopping dialysis. You realise that this is a very sensitive and contentious topic, but you think you should be allowed to make this decision on your own. You feel fine in yourself and don't have any other concerns.

You have not really talked with your daughters about this decision; as you have no intention of worrying them with this: anyway, if you were not on dialysis three times a week you would be able to visit them inter-state more often. You don't know whether or not your daughters agree with your decision to stop dialysis.

Dr William has strongly advised you not to stop as he does not agree that you will have a better life with more time on your hands. You think he is probably just being overly conservative.

Your past psychiatric history

You have no past history of mental health or emotional problems. You have never suffered from depression, and do not feel low in mood now, nor have you ever attempted to commit suicide or even thought about it.

Other medical problems

You have high blood pressure, but it is controlled with taking a blood pressure tablet every day. You do not have any other medical problems.

You have good hearing and vision.

You do not drink alcohol or smoke.

The capacity assessment:

The candidate has been asked to assess whether you have capacity to make this decision to stop dialysis. The table below outlines the key questions that are often asked in order to assist a doctor to decide whether you have capacity:

Memory:	You deny anything wrong with your memory or thinking abilities and you think it is pretty good for your age.
Activities of daily living	You believe you take good care of yourself and don't need any help from anyone. You deny any problem with your activities of daily living such as cooking, shopping, cleaning, paying bills, transport, personal care. You have never driven a car.
Depression, anxiety:	'Apart from dialysis, I am fine.' You do not feel depressed or particularly anxious. There are things you very much enjoy and look forward to, e.g. spending time with your family. You sleep well. Your energy is on the low side given your chronic kidney disease, but this is not new. Your appetite is small, but this is not new, and you enjoy your food. Your concentration is good.
Suicidal thoughts:	You are not suicidal. You don't want to die, but you don't want to suffer the burden of dialysis.
Unusual strong beliefs or paranoia (delusions) or experiences such as voices, suspiciousness (hallucinations):	Nil
Your understanding of dialysis:	You have read all the pamphlets. After having it for 5 years, you think you should know everything about it.
Your understanding of stopping dialysis:	'It takes a few years to die after stopping dialysis, I guess, but in the meantime I would have a good life'
Should the candidate follow this up with an explanation that it will be 'weeks' rather than 'years' if you stopped the dialysis:	You are quite shocked and don't believe in them. You are sure you will not die in just a few weeks. You will NOT accept the fact that you will die in a few weeks.

4.2 How to play the role:

You are conservatively dressed and take good care of your appearance. You are stern but cooperative with the assessment. You are slightly puzzled why your doctor asked a psychiatrist to see you, but you are prepared to listen to their explanation. You speak in a normal tone and listen carefully to the psychiatrist. You tend to provide short answers to the psychiatrist's questions.

4.3 Opening statement:

'I don't know why my doctor wants me to see a psychiatrist.'

4.4 What to expect from the candidate:

The candidate needs to establish your reasons for wanting to stop dialysis and ask questions to support your decision. They may ask about a range of symptoms, and the details of what medications you have been taking. They should also ask you about your mental wellbeing like thoughts of suicide.

The candidate may also ask you about your personal life like your relationships and work history (answer as above).

4.5 Responses you MUST make:

'I really want to stop dialysis.'

'Apart from dialysis, I am fine.'

4.6 Responses you MIGHT make:

'It is my right to stop treatment, isn't it?'

If asked about how you know you will die in a few years and not weeks:

Scripted Response: ***'I just know, I know my body better than anyone else.'***

'Do you know how long it will take before I die? A few years right?'

If asked your understanding of what will happen if you stop dialysis:

Scripted Response: ***'It takes a few years to die after stopping dialysis, I guess, but in the meantime I would have a good life'***

4.7 Medication and dosage that you need to remember:

Quinapril (KWIN-A-PRIL) 40 milligrams every morning for your blood pressure. You have taken this medication for 10 years.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

- Obtain the key clinical information necessary for undertaking a capacity assessment in an older person with physical illness.
- Draw a conclusion from the capacity assessment specific to the request to stop dialysis.
- Discuss the initial management of an older person who has cognitive impairment and who requests euthanasia.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history relevant to the capacity assessment? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; expertly progresses through process of assessing capacity within the specific context.

Achieves the Standard by:

conducting a detailed but targeted assessment, using the framework of understanding, reasoning, appreciating and communicating a choice when assessing capacity; obtaining a history relevant to the patient's circumstances with appropriate depth and breadth; eliciting the reason for stopping dialysis; demonstrating ability to prioritise; eliciting the key issues; clarifying important positive and negative features; exploring cognitive functioning and activities of daily living; specifically exploring Mrs Jones's understanding of the consequences of stopping dialysis.

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

- Assess past and current self-harm / suicidal behaviours and depressive 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:

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in 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"/>	

1.9 Did candidate formulate and describe the findings of capacity assessment? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of a cross-sectional capacity assessment.

Achieves the Standard by:

demonstrating the ability to integrate available information in order to reach a conclusion on the capacity assessment; explaining the benefits of participating in a capacity assessment; adequately prioritising conditions relevant to the obtained history and linking the possibility of cognitive impairment to issue with capacity; communicating in appropriate language and detail and according to good judgment; outlining the framework of understanding, reasoning, appreciating and communicating a choice when assessing capacity; recommending protections if capacity is impaired.

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

- Conclude Mrs Jones lacks capacity as she does not fully understand the consequences of stopping dialysis.

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:

inaccurate or inadequate conclusion on the findings; 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 to the request for euthanasia? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

clearly addresses difficulties in planning an approach to the euthanasia request; provides a sophisticated link between the plan and key issues identified; prioritise and implement plans for risk management.

Achieves the Standard by:

identifying the need to further explore the euthanasia request with the person; evaluating prior personal beliefs and values in regards in to end of life issues; assessing for psychiatric illnesses and suicidal ideation in a person requesting euthanasia; considering the possibility of stopping dialysis as a passive way of ending one’s life; differentiating between suicide ideation in the context of depression and euthanasia request; describing the impact of cognitive impairment on capacity to make this euthanasia request; demonstrating a good awareness of the current public, professional and political debate on euthanasia; clarifying that physician-assisted suicide is not legal in Australia and New Zealand; recognising the need for consultation / supervision; involving the family to support the person in this situation.

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

- a. Prioritise the need to explore whether Mrs Jones has an imminent plan to act on her euthanasia belief.

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.

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"/>	<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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CONTENT	PAGE
Overview <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
Instructions to Examiner <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	5 5-8 9
Instructions to Role Player	10-12
Marking Domains	13-14

1.0 Descriptive summary of station:

In this station the candidate is working in an outpatient clinic. The patient is a mother recovering from a Major Depressive episode who now has concerns about her 6-year-old son. The candidate is to take a history from the mother regarding these concerns to determine what factors may be playing a role in his difficulties, and discuss potential ways to help her assist him. The station focusses on the theory of attachment in which the candidate is expected to consider specific disorders like oppositional defiant disorder (ODD), but to also assess the impact of parental mental illness on children.

1.1 The main assessment aims are to:

- Assess the possible effect of maternal psychiatric illness on the children.
- Formulate and communicate the possibilities to the mother.
- Make suggestions on how to assist the son with sleep, preferably based on attachment theory, recognising the importance of the child's recent maternal separation during illness.

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

- Establish that Joseph's problems emerged in the context of Annie's illness and hospitalisation, and did not precede it.
- Formulate the presentation in the context of attachment theory.
- Articulate the difference between Joseph's emotional distress and ODD.
- Suggest the mother help Joseph sleep by giving him opportunities to feel a secure connection with her.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Child & Adolescent Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Formulation, Diagnosis, Management – Initial Plan)

References:

- Bowlby, J. (1988). *A secure base: clinical applications of attachment theory*. London: Routledge.
- Cowling, V (1999) *Children of the Mentally Ill*. Camberwell: Acer press.
- Powell, B., Cooper, G. et al (2014) *The Circle of Security intervention*. Guildford.
- Schore, A. N. *Effects of a Secure Attachment Relationship on Right Brain Development, affect Regulation, and Infant Mental Health*. *Infant Mental Health Journal*, Vol. 22(1-2), 7-66(2001).
- Siegel, D. *No Drama Discipline*. Norton 2014.
- Winnicott, D. W. (1987; 1st ed.: 1964). *The child, the family and the outside world*. Pp. 239. Penguin Books.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: woman in her early 30's, tidy appearance.
- 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 outpatient clinic.

Your patient, Annie, is a 32-year-old married mother of two school age children (8-year-old Sofia, and 6-year-old Joseph). Annie has come to the psychiatric clinic for a routine follow up after discharge from hospital where she had been successfully treated for a Major Depressive episode. She is recovering well (you do not need to focus on Annie's mental state).

Today she raises concerns about Joseph being difficult to manage; obstinate, and argumentative. He has been unwilling to go to bed, and is having trouble getting to sleep. Annie wants advice on how to help him sleep.

His teacher says he has become uncooperative in class, and has refused to follow instructions and requests from school staff. The teacher raised the possibility of Oppositional Defiant Disorder after a playground incident when he pushed another boy.

Your tasks are to:

- Assess Annie's concerns about her son.
- Formulate causes of Joseph's difficulties, and communicate these to Annie.
- As part of the discussion with Annie, make at least one suggestion of how she can help Joseph with sleep, based on your understanding of his difficulty.

You will not be given any time prompts.

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'.
 - Pens.
 - Water and tissues (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 / time for any scripted prompt 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.

You have no opening statement or scripted prompt.

The role player opens with the following statement:

'I'm good, but my son is stressing me out because I can't get him to sleep.'

3.2 Background information for examiners

In this station the candidate is expected to assist a patient, Annie, about concerns related to the behaviour of her 6-year-old son, Joseph.

The candidate should enquire about the child's relationship with the mother prior to her illness. This may include exploration of how Joseph has responded to previous stresses, and apparent resilience in the setting of his father's absence, as well as how the mother responded to him, from an attachment perspective. The candidate should ask questions which reflect exploration of the child's experience of the mother's illness. They may ask about his capacity to use the mother as a secure base, and the child's capacity to ask for connection in a direct way, rather than miscues. Another additional factor could include Sofia's adjustment.

As the teacher has suggested Oppositional Defiant Disorder (ODD), the candidate should exclude this as diagnostic possibility. The candidate is expected to formulate the problem, demonstrating their understanding that maternal mental illness and absence can cause emotional distress in children, and that the child's behaviour at home can be understood through him seeking connection. A psychiatric diagnosis is not required.

The candidate should communicate the formulation to the mother in a way that helps her understand her child's experience. The candidate must recommend at least one strategy to help the child at bed time. Bedtime has been chosen because bedtime and sleep are a separation of the child from the mother, and so highlights the meaning of the child's behaviour. The candidate must suggest a strategy which reflects an understanding of the meaning of the child's behaviour i.e. that the child is having difficulty separating and needs support from the mother in order to feel secure, so that he is able to separate, and therefore sleep.

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

- Establish that Joseph's problems emerged in the context of Annie's illness and hospitalisation, and did not precede it.
- Formulate the presentation in the context of attachment theory.
- Articulate the difference between Joseph's emotional distress and ODD.
- Suggest the mother help Joseph sleep by giving him opportunities to feel a secure connection with her.

A surpassing candidate may use a model such as Circle of Security to explain the child's need for connection to feel secure. They may enquire about the wellbeing of the 8-year-old daughter, and help the mother think about how her children have each responded differently to her illness and her absence.

If the candidate diagnoses the child as having ODD this is a clear fail.

Theory of Attachment

This station focusses on the theory of attachment, its importance for child and parent relationships, and in maintaining good child mental health. Attachment theory was first described by Bowlby in *Attachment and Loss*, and later in further attachment research by Bowlby and his team. This strong initial relationship provides children with a secure connection with their primary carer, to develop and function optimally. It is within the primary attachment relationship that the infant learns to self-regulate, internal working models of relationships develop, and identity formation begins. This relationship is described with a range of attachment types including secure, insecure ambivalent, insecure avoidant (Ainsworth 1978) and insecure disorganised (Main and Solomon 1986). Those with a secure attachment relationship have a secure base for exploration and a safe haven to return to at times when the need for connection is triggered. Within this relationship the parent is able to help their child manage distress, trauma and negative events as well as engage in positive events and allow exploration. A secure attachment also protects children from the detrimental effects of stresses such as of low socioeconomic status, violence and some trauma, including war. The need for attachment is a primary need for human beings, for example demonstrated by studies on the Romanian orphans who failed to develop in environments where their physical needs were (barely) met, but their need for love and connection were not met. (Nelson, C.A, Fox,N.A., Zeanah,C. H.,(2014)) *Romania's abandoned Children: Deprivation, Brain Development and the struggle for recovery.* Harvard University Press).

Attachment relationships are mutually regulating (Schore, A. N., 2001). An infant or child being exposed to their parents' emotional regulation gives the child the opportunity to form their own understanding of the world and ways in which to evaluate the outside environment, and learn to make responses. A distressed child may be able to become regulated through the connection with the parent.

A child may need this safe haven experience when anxious or uncertain about an unfamiliar situation or person, or if the child has strong feelings which they need help to organise. Even in good relationships there will also be a process of rupture and repair when the parent may be miss-attuned to the child, and then repairs the rupture, for example by noticing the rupture, naming the feeling or describing the problem, accepting responsibility without blame, and providing what the child needs.

There can be a difficulty in the relationship precipitated by a situation or stress which does not meet the threshold for the diagnosis for an attachment disorder, as in this case. A child with secure attachment to their care-giver may express their distress with behaviour within the relationship which expresses their distress.

Parenting places demands on the adult and this can be especially significant at times of illness. Children are affected by psychiatric illness in a parent (Cowling, V. (1999) *Children of the Mentally Ill*, Camberwell: Acer Press (1975)) and this can be expressed in the attachment relationship. A general psychiatrist should be able to address the needs of the whole family at times of illness. Assisting a parent to understand their child's behaviour and meet the child's needs will also assist the parent's recovery. The overwhelming majority of parents wish to do the best job they can, and this can motivate and aid an unwell parent in recovery. Furthermore, being a parent can be a protective factor for an adult with mental illness, for example giving motivation to not act on suicidal thinking.

An understanding of attachment theory has broad applicability in psychiatric practise, not only in child psychiatry. Attachment relationships in childhood inform relationships throughout life. The relationship with a caring professional such as a psychiatrist, especially a psychotherapist, will be informed by attachment status. A number of psychiatric conditions in adulthood can be understood through the lens of attachment, particularly the personality disorders including Borderline Personality (Kernberg (1975), Fonagy and Bateman (2004)). Evidence supported treatment modalities such Mentalisation Based Therapy, Transference Focussed Therapy and other psychotherapies, are grounded in an understanding of attachment. Attachment theory informs much of contemporary psychoanalytic and psychodynamic psychotherapeutic formulation (Slade, A. 1999; Holmes, J. 2014).

As part of the formulation to the mother, the candidate is to offer a suggestion as to how to help Joseph with his difficulty going to bed. This should be informed by attachment theory, and based in an understanding that the child is expressing his feelings and his needs through the behaviour. Going to sleep requires separation from the parent. Therefore, separation difficulties often will present with problems at bedtime. Joseph experienced a significant and problematic separation from his mother through her illness and hospitalisation. The difficulties at bed time reflect his struggle to separate from her as a result.

Appropriate suggestions will help Joseph sleep by helping him feel a secure connection with her so as to help him feel safe to separate into sleep. The candidate may suggest that the mother try to stop and reflect what is going on for the child at the time i.e. what is the child's feeling? Why is he feeling this at this time?

What is his need and how can she meet his need? How can she help him express his need in a more direct way, for example, in words?

The parent could develop a bedtime routine in which the child is able to feel connected to the mother. Letting him know in advance that bedtime is coming up, spending quiet 'time in' with him, talking about the day, reading a book, for example. He may need reassurance that she will be there for him if he needs her. The mother may help the child to identify his feelings by asking are you sad or mad, or scared? She may name the feelings for him if he is unable to, e.g. I wonder if you felt mad when I asked you to go to bed and you didn't feel like it. She may help him express his feelings in words and understand why he feels that way at this time. Avoiding explanations which are blaming of either person, but rather develop explanations in which both people can take responsibility. The mother can model this in her reaction, by neither blaming him, nor herself, but explaining how the difficulty came about. For example, explaining that she was tired at the end of the day, and she forgot to warn him 1/2 hour before that bedtime was coming up, and she hoped that he wouldn't need a story tonight.

Better candidates will highlight the daughter's different way of expressing her distress and achieving connection with her mother, for example acting in, or being a somewhat parentified child, engaging in 'being an angel', which could perhaps express a denial of Sofia's own needs at the expense of her mother's needs. It is generally more gender typical for girls to 'act in' and boys to 'act out'.

Oppositional Defiant Disorder (ODD)

It can sometimes be difficult to recognise the difference between an emotional or strong-willed child, and a child with an oppositional defiant disorder. While it is normal to exhibit oppositional behaviour at certain stages of a child's development, signs of ODD usually begin during preschool years. Sometimes ODD may develop at a later age, but almost always before the early teen years.

Oppositional Defiant Disorder is not a sudden onset disorder. Distressed and angry children can present with similar behaviours to children with ODD. However, when the behaviour occurs in a context where it is acute, and clearly in response to a recent environmental of attachment stress, and where the symptoms are of recent duration then the symptoms are better understood as the child expressing their feelings and trying to engage with a care giver. It is important to identify and intervene as some children can go on to develop Conduct Disorder, especially those with more defiant, argumentative and vindictive symptoms. Depression and anxiety may also develop in children who have presented with angry, irritable mood symptoms.

A child may not see their behaviour as a problem, and may believe that unreasonable demands are being placed on them. However, if a child has features commonly found in ODD more frequently than is typical in their peers, then a professional assessment should be sought. These behaviours cause significant impairment with family, social activities, school and later with work.

ODD is described in both the DSM-5 and ICD 10.

In the **ICD 10: F91.3, Oppositional defiant disorder** is described under the group heading of Conduct Disorders (F91) and described as:

usually occurring in younger children, primarily characterised by markedly defiant, disobedient, disruptive behaviour that does not include delinquent acts or the more extreme forms of aggressive or dissocial behaviour. The disorder requires that the overall criteria for F91- be met; even severely mischievous or naughty behaviour is not in itself sufficient for diagnosis. Caution should be employed before using this category, especially with older children, because clinically significant conduct disorder will usually be accompanied by dissocial or aggressive behaviour that goes beyond mere defiance, disobedience, or disruptiveness.

DSM-5: Oppositional Defiant Disorder 313.81

A. A pattern of angry / irritable mood, argumentative / defiant behaviour, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry / Irritable Mood

- Often loses temper.
- Is often touchy or easily annoyed.
- Is often angry and resentful.

Argumentative / Defiant Behaviour

- Often argues with authority figures or, for children and adolescents, with adults.
- Often actively defies or refuses to comply with requests from authority figures or with rules.
- Often deliberately annoys others.
- Often blames others for his or her mistakes or misbehaviour.

Vindictiveness

- Has been spiteful or vindictive at least twice within the past 6 months.

Note: The persistence and frequency of these behaviours should be used to distinguish a behaviour that is within normal limits from a behaviour that is symptomatic. For children younger than 5 years, the behaviour should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behaviour should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviours are outside a range that is normative for the individual's developmental level, gender, and culture.

B. The disturbance in behaviour is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviours do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

Specify current severity:

Mild: Symptoms are connected to only one setting (e.g., at home, at school, at work, with peers).

Moderate: Some symptoms are present in at least two settings.

Severe: Some symptoms are present in three or more settings.

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 Annie, a 35-year-old married mother of two children. Joseph is 6 and in grade one at school. Sofia is 8 years old and is grade three. Today you would like to talk with your psychiatrist about your son.

About Joseph:

He has been difficult to manage for 2 months. He has been stubborn / obstinate and uncooperative, as well as being whingy. He doesn't want to go to bed in his own room. He wants to sleep in bed with you. He is making any excuse to delay bedtime. He gets out of bed and asks for a drink or a snack. He calls you back to his room after you finally get him to bed. You are getting exasperated and exhausted by this. He also doesn't want to go to school. He won't cooperate with getting dressed in the morning. He wants you to do up his shoes, which he was doing quite well a couple of months ago.

At times Joseph gets angry when you insist he does things like get dressed for school. Sometimes he hits you when he is angry. At times he gets tearful and upset about small frustrations. For example, the other day he couldn't find his favourite toy car and became really upset. Another example was last week when you had had a tiring day, you had been busy cleaning up after dinner and time had got away from you. You had forgotten to give him the usual reminder that it was bedtime, and had asked him to go to bed immediately. Because it was late, and you were tired, you said that you wouldn't read him a story and he just had to go straight to bed. Probably you sounded a bit more cranky and short with him than you intended. *'He just lost it'*, he got really upset, was crying and having a tantrum. You just didn't really know what to do. You thought you should be tougher with him but in the end, you tried to bribe him with more TV and ice-cream. It took a long time before he calmed down. You worry that he just exhausted himself with his tantrum, and went to sleep in the end because he was so spent. This is not like him.

The other day Joseph's teacher asked to meet with you after a playground incident when he pushed another boy, resulting in a complaint from the other child's parents. The teacher said he has been angry and uncooperative, and raised the possibility of something called Oppositional Defiant Disorder (or ODD). Joseph's behaviour has been worse over the last 6 weeks or so. It is now past the first few months of the year, and he had been quite settled last term and had seemed to enjoy school.

Before this behaviour change Joseph seemed to like school. He had settled into the new classroom at the beginning of the year. He liked school and had seemed to get on well enough with the other kids including a buddy who would come for play dates. He was achieving appropriately at school. He liked reading and maybe needed more help with maths, but he was going okay. He was pleased to be a big boy who could dress himself and tie his own shoes up.

You did see him struggle for a while when your husband Dave first went away. He was a bit of a baby at first. He wanted help tying his shoe laces for a while. You have been using Skype to stay in touch with Dave, but the 4-hour time difference made it tricky at times for the kids to have daily contact. But regular Skyping seemed to help, and Joseph appeared to get to cope okay with Dave away - until you got sick. But as you struggled more while getting unwell, Joseph had become increasingly needy.

Joseph has had no illnesses, nor operations, nor allergies.

About your personal life:

Your husband Dave, an engineer, has been working overseas for 8 months, having been posted to Indonesia for a year by the mining company he works for. You had talked a lot about the job offer before he went, and although you knew it would be tough, you thought that you could cope. Your marriage is stable and loving.

The kids get on pretty well with each other generally. Sofia takes her role of big sister quite seriously. She is a good helper and has really stepped up since Dave has been away. Sofia is a lot like you. She like things to be orderly and doesn't like to be late. She enjoys gymnastics. She enjoys school. She never gives you a moment's worry.

You are a police officer, working 4 shifts per week part time. Before you got depressed a few months ago (see notes on the following page), you liked work and are known as a bit of a perfectionist. You enjoy going to the gym and would go every day if you could. You like the house to be clean and tidy. You normally take care with your appearance, and like the kids to be smartly dressed. You are an independent person who doesn't like to ask for help. Before the depression that you are recovering from, you would have said that you were a strong person. People come to you for help, not the other way around.

You had felt embarrassed that you had got into this situation, with not being able to cope and getting depressed. Before the admission you had not told your parents or friends how much you are struggling with Dave away. Now you realise that you need to let people in to get support. You have a couple of friends, but you tend not to want to burden them with your difficulties because everyone is busy these days.

You love the kids to bits and it is important to you to be a good mum. Before you got ill the kids seemed to be doing okay.

Your mental wellbeing: *you do not have to provide this detail of information unless the candidate specifically asks about your mental health.*

You are recovering from a serious episode of depression, for which you were admitted to hospital for two weeks because you were so unwell. You were discharged four weeks ago. You are taking the medications prescribed. You are doing 'pretty well', and at the moment you are concerned about Joseph.

You started to become depressed 4 months or so ago, after Dave went to Indonesia. You were struggling to cope with work and family commitments. You were waking up at 3am and worrying about things. You lost your appetite and lost 10kg. You lost interest in things, you weren't looking after yourself. You stopped going to the gym, stopped paying the bills because it all seemed too hard. Even though you felt so lonely without Dave around, you were isolating yourself and stopped enjoying time with the kids.

You tried to keep everything normal for the kids, but it became such an effort. There were times you were irritable with them. You have never hit them or abused them, but you felt really bad when you yelled at Joseph one day and made him cry. Sometimes when it all seemed too hard you did tend to just let the kids do what they wanted. One day they had ice-cream for breakfast because you just couldn't argue about it. The kids had also started going to bed late.

For a short period of time you felt so awful that you believed that your family would be better off without you. The GP had given you some sleeping tablets because you had told him the problem was just difficulty sleeping. You had felt too ashamed to tell him you really weren't coping. One morning when your parents-in-law had the kids (so you could sleep), you drank a bottle of wine to help you feel better, but you felt worse. You wrote a letter to your children and one to your parents. You had connected the car exhaust to a hose and diverted it to the cabin of the car, closed the garage up, taken a few sleeping tablets and sat in the car. A colleague at work had become concerned when you had not shown up at work. She had arranged a welfare check. Subsequently the ambulance was called. After you were medically stable you had been admitted to the psychiatric ward, where you stayed for 2 weeks.

Dave came back for a couple of weeks but has gone back overseas as things seemed to be okay. When you were in hospital your family thought it best not to bring the kids in to see you, because the ward seemed to be a noisy somewhat scary place, and when they had come in Joseph got pretty upset when they went to leave.

In hospital, you were prescribed two medications - Desvenlafaxine (Des-ven-la-fax-een) (also known as venlafaxine in New Zealand) and Quetiapine (Kwet-i-apeen). You found the admission to be very helpful. The doctor had met with your family and helped arrange supports in the transition back home.

While you were in hospital your family rallied around, and the kids were cared for by both sets of grandparents and your sister. Your parents had come from the country for a week. The kids don't know your parents well and your dad is pretty strict, but you appreciated their help. Dave came home for a couple of weeks. Dave's parents had them for a couple of sleepovers, and the kids had a good time as Dave's Mum always spoils them.

Sofia has been an angel through this time. You have been pleased to see how mature she has been. You think she is strong, like you were before you got sick. Before you went to hospital she seemed to know you were struggling and would try to help. She would also help to get Joseph to cooperate.

Looking back, you think you probably had suffered from post-natal depression after Joseph was born. Joseph was difficult to settle as a baby, but by the time he was 15 months old it had seemed to work out. You didn't get any treatment; as at the time you put your low feelings down to being tired. You remember lying awake at night even when Joseph did sleep. You lost quite a bit of weight and didn't enjoy anything much.

4.2 How to play the role:

You are smartly dressed and are well groomed. You present with a generally fairly tough, no nonsense persona. You are well at the moment (not depressed). You are worried about Joseph but not too worried about Sofia.

4.3 Opening statement:

'I'm good, but my son is stressing me out because I can't get him to sleep.'

4.4 What to expect from the candidate:

Firstly, the candidate should ask about your son and the problems he is having. They should ask how he was before your illness and may ask you about what happened to Joseph while you were in hospital.

Secondly the candidate should explain to you what they think is causing the problems.

The third task for the candidate is to suggest some things that you could do that would help your son.

4.5 Responses you MUST make:

'He just seems to be so angry with me.'

'The teacher thinks it's Oppositional Defiant Disorder, what do you think?' (After about 3-4 minutes)

'How can I get him to sleep better?'

4.6 Responses you MIGHT make:

If the candidate asks what things were like before you became unwell:

Scripted Response: *'Joseph had really settled down after we moved to the new house. I think we all felt safe.'*

If the candidate asks whether you have been violent towards your children:

Scripted Response: *'I have never deliberately harmed the children.'*

If the candidate asks about Sofia:

Scripted Response: *'She has been an angel, she tried to help.'*

If the candidate asks about Joseph:

Scripted Response: *'He seemed to enjoy school.'*

'What can I do to help him, doctor?'

4.7 Medication and dosage that you need to remember:

Devenlafaxine (des-ven-la-fax-een) 150 milligrams in the morning.

Quetiapine (Kwet-I-apeen) XR 50milligrams at night.

STATION 6 – MARKING DOMAINS

The main assessment aims are to:

- Assess the possible effect of maternal psychiatric illness on the children.
- Formulate and communicate the possibilities to the mother.
- Make suggestions on how to assist the son with sleep, preferably based on attachment theory, recognising the importance of the child's recent maternal separation during illness.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take an appropriately detailed and focussed history from Annie? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; taking hypothesis-driven history; integrating key social issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features; enquiring about her relationship with the children over time.

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

- Establish that Joseph's problems emerged in the context of Annie's illness and hospitalisation, and did not precede it.

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 establish that the child's problems are related to the mother's illness. Omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in 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 to make sense of the presentation? (Proportionate value – 30%)

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; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient and child's predicament; accurately linking formulated elements to any diagnostic statement; including a sociocultural formulation; analysing vulnerability and resilience factors; explaining the child's behaviour as an expression of his emotional struggle in experiencing disruption of mother-child relationship.

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

- Formulate the presentation in the context of attachment theory.

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; provides 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 the candidate formulate and describe relevant diagnostic explanation? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

highlights the different expressions of distress between the children; uses concepts like Circle of Security; appropriately identifies the limitations of diagnostic classification systems to guide interventions.

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; adequate prioritising of conditions relevant to the obtained history and findings, utilising a biopsychosocial approach, identifying relevant predisposing, precipitating perpetuating and protective factors; including communication in appropriate language and detail, and according to good judgment.

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

a. Articulate the difference between Joseph’s emotional distress and ODD.

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; does not exclude oppositional defiant disorder; does not consider Joseph’s behaviour as an expression of his feelings to engage his mother; 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 - 10%)

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 care; recommending specific interventions; considering safe, skilful engagement of appropriate resources / supports; identifying realistic time frames for review; recognising their role in effective treatment; identifying potential barriers; recognising the need for consultation / referral.

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

a. Suggest the mother help Joseph sleep by giving him opportunities to feel a secure connection with her.

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:

plans are only based on learning theory; plan lacks structure; not tailored to the 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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Committee for Examinations
Objective Structured Clinical Examination
Station 7
Sydney April 2018



CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-8</p> <p>8</p>
Instructions to Role Player	9-10
Marking Domains	11-12

1.0 Descriptive summary of station:

This station involves an interaction between a junior consultation-liaison psychiatrist, and an inpatient nurse in charge about the management of a 25-year-old male patient with borderline personality disorder with self-inflicted burns whose recovery is not progressing along expected time lines. He is frequently non-compliant with requests and treatment plans. Staff are having difficulty treating him, and are responding variably to his many demands which is resulting in staff conflict and a deteriorating ward environment. The candidate is to meet with the nurse in charge who is asking the psychiatrist to see the patient and 'sort things out'. The patient has been seen earlier in the week by a psychiatric registrar who has ruled out acute mental illness as a current issue.

1.1 The main assessment aims are to:

- Evaluate knowledge of the psychodynamic mechanisms and factors which may be underlying the problems encountered on a surgical ward when treating a patient with a borderline personality disorder.
- Assess the appropriateness of strategies suggested by the candidate to help the team to work effectively in treating this patient.
- Assess ability to de-escalate and engage the nurse in charge, and achieve acceptance of a plan involving education of team members as a mainstay.
- Assess candidate's ability to address stigmatising attitudes when encountered in interactions with other health professionals.

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

- Describe at least three mechanisms, defences or other psychodynamic factors underlying the problems being experienced by staff and patient.
- Identify and clearly explain key strategies through which the problems can be addressed.
- Engage the nurse in charge in a manner which would be reasonably expected to de-escalate his level of arousal.
- Attempt to address stigma against mental health patients in a general hospital setting.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.)
- **Area of Practice:** Consultation Liaison
- **CanMEDS Domains:** Medical Expert, Collaborator, Health Advocate
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Formulation, Management-Therapy); Collaborator (Teamwork); Health Advocate (Addressing Stigma)

References:

- Groves James, Management of The Borderline Patient on a Medical or Surgical Ward: The Psychiatric Consultants Role International Journal of Psychiatry in Medicine, Vol6(3).1975.
- Stroudmire A, and Thompson T, The Borderline Personality in the Medical Setting, Annals of Internal Medicine 1982;96:76-79.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: middle aged male, tidy grooming.
- 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 consultation-liaison team.

You have been asked to come and 'sort out' a patient who is 'one of yours', and is 'disrupting' the surgical ward. The nurse in charge is angry about the behaviour of Danny, a 25-year-old male with self-inflicted burns, whom staff are having difficulty treating.

Problems include frequent complaints of severe pain and other discomfort; demands to be looked after only by certain nurses, and non-adherence to schedules, ward boundaries and rules. Staff responses to Danny's behaviours have resulted in staff conflict, and there is a deteriorating ward environment for staff and patients.

The patient was seen earlier in the week by your registrar who ruled out acute mental illness as a cause of these problems.

Your tasks are to:

- Obtain relevant history from the nurse in charge.
- Explain to the nurse in charge your understanding of at least 3 likely underlying factors and mechanisms which have resulted in this referral.
- Negotiate a management plan to address the issues raised, and explain your rationale for this plan to the nurse in charge.

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 (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 there are no cues / times for any scripted prompt.
- 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.

You have no opening statement or prompts for you to give.

The role player opens with the following statement:

'I'm glad you are here at last - we really need you to sort this man out.'

3.2 Background information for examiners

In this station, the candidate is expected to liaise with the nurse in charge of a surgical unit about the behaviour of a young man with borderline personality disorder who is being treated for self-inflicted burns. The aims of this station are to assess the candidate's ability to engage the nurse in charge, to address the issue of stigma, from staff towards patients on a general ward with a mental illness diagnosis, and to achieve acceptance of management strategies and a plan involving education of team members.

The candidate is expected to demonstrate knowledge of the psychodynamic mechanisms underlying the problems encountered when treating a patient with borderline personality disorder in medical / surgical wards.

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

- Describe at least three mechanisms, defences or other psychodynamic factors underlying the problems being experienced by staff and patient.
- Identify and clearly explain key strategies through which the problems can be addressed.
- Engage the nurse in charge in a manner which would be reasonably expected to de-escalate his level of arousal.
- Attempt to address stigma against mental health patients in a general hospital setting.

A surpassing candidate may:

- Address the issue of splitting not only amongst nursing staff but also the team hierarchy, and splitting doctors versus nurses.
- Mention the possibility that he may not be having adequate pain management because of punitive attitudes by staff to patients with personality disorders and self-inflicted wounds.
- Demonstrate exceptional skill in engagement of nurse in charge, and sensitive discussion of issue of stigma and effect on care of mental health patients in general hospital.

Borderline personality disorder (BPD)

The most prominent features of BPD are self-harm / suicidality, emotional instability (unpredictable variations in mood, both sad / happy and angry / irritable), impulsivity (doing things on impulse without due consideration of the consequences), and disordered attachment (stormy relationships, very strong feelings of abandonment when a close relationship ends). It is the first two of these that most commonly lead to people seeking help.

International Classification of Diseases 10 of the World Health Organisation (ICD-10)

Description of emotional unstable personality disorder:

F60.3 Emotionally unstable personality disorder

A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or 'behavioural explosions'; these are easily precipitated when impulsive acts are criticised or thwarted by others. Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

F60.30 Impulsive type

The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.

F60.31 Borderline type

Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises, and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).

Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 5)

Specifies 5 out of the following 9 symptoms must be present for the diagnosis to be made:

1. *Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.*
2. *A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.*
3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
4. *Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.*
5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.*
6. *Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).*
7. *Chronic feelings of emptiness.*
8. *Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).*
9. *Transient, stress-related paranoid ideation or severe dissociative symptoms.*

BPD differs from the other PDs in important ways. It is probably less stable than other PDs, although this may be an artefact of the larger body of research devoted to BPD. It appears to be less pervasive, meaning people with BPD do not tend to present in the same way in different situations. This is curious, as pervasiveness is a central element of the personality disorders. People with BPD are also more likely to seek treatment than people with other PD diagnoses; most people receiving treatment in specialist centres suffer from BPD, often with one or more other PDs.

There is some debate about whether BPD should continue to be regarded as a single entity, as it can appear to be a collection of symptoms which happen to occur together in a group of people but perhaps as commonly occur separately, and that labelling them as a syndrome when occurring together does not add much to our understanding. A similar argument occurs about PDs as a whole, as comorbidity is so common (i.e. if you have one you are very likely to have more than one), and statistical experiments sometimes fail to identify the PDs (or indeed BPD) in the population (through for example cluster analyses).

The patient with borderline personality hospitalised on a medical or surgical ward has a disorganising effect on the staff, who may themselves regress in response to the patient's impulsivity, dependency, entitlement, and rage.

The candidate is expected to elaborate on defence mechanisms and other psychodynamic factors underlying the problems between staff and patient, as on the following page, and may name them and explain their meaning to the nurse in charge or clearly describe without naming (as they are talking to a health professional who is not trained in mental health). As this is not an exhaustive list, if a candidate describes another defence or psychodynamic factor not mentioned here, but the candidate clearly justifies its importance in the scenario then that may be accepted.

<p>Splitting</p> <p>The division or polarisation of beliefs, actions or persons into good or bad, and focussing on only either positive or negative qualities. Idealisation and Devaluation are opposing mechanisms of splitting.</p>
<p>Regression</p> <p>Reverting to an earlier developmental stage in the face of unacceptable thoughts or impulses.</p>
<p>Acting Out</p> <p>Performing an extreme behaviour to show thoughts or feelings which the person cannot express verbally</p>
<p>Denial</p> <p>The refusal to accept or acknowledge a reality or fact, and acting as if it did not exist.</p>
<p>Distortion</p> <p>Changing the facts, thoughts etc to make them more easily acceptable and bearable.</p>
<p>Projection</p> <p>The misattribution of a person's own (usually negative) feelings, thoughts or impulses to others.</p>
<p>Reaction Formation</p> <p>Converting unwanted or dangerous thoughts or feelings into the opposite and behaving as such.</p>
<p>Rationalisation / Justification</p> <p>Making excuses, explaining away or justifying negative or dangerous behaviour / thoughts / feelings which them less threatening.</p>
<p>Other psychodynamic factors which may be affecting the patient-staff interaction, and which may be considered and explained by candidate include:</p> <p>Help rejecting behaviour</p> <p>Passive-Aggressive behaviour</p> <p>Sense of entitlement</p> <p>Transference and Counter-transference</p>

The consultation-liaison psychiatrist's role in the management of such a patient should consist of a specialised type of consultee-oriented approach in which countertransference, hatred and fear typically generated in the staff by the borderline patient, are drawn away from the patient and strategically processed within the staff-consultant relationship. The consultant should actively promote a behavioural management plan, placed in the medical chart for reference and as a symbol of the psychiatrist's helping presence, which discusses: a) clear communication with the patient and among staff, b) understanding the patient's need for constant personnel, c) dealing with the patient's entitlement without confronting the patient's needed defences, and d) setting firm limits on the patient's dependency, manipulateness, rage, and self-destructive behaviours. The consultant should work to counteract feelings of helplessness in the staff, to neutralise punitive superego in the staff, and to diminish fearfulness toward the patient.

It is important for the candidate to outline a range of acceptable interventions that staff can utilise to enhance clinical care delivery to this patient with BPD. They could specify the need for clear rules and expectations, with boundary identification and enforcement, and avoidance of conflict with the patient.

In this scenario, successful interventions are likely to depend on provision of education to staff about BPD and how this patient is affecting staff, encouraging a team approach including team responsibility for all decisions, need for empathy and staff awareness of their own responses.

Of great importance will be working towards consistency of staff working with patient, involvement of medical staff in this plan, consistency of messages to be given to patient about treatment, having the plan discussed with the team at the start of each shift, having an identified nurse per shift to communicate any decisions or changes, provision of clear information to patient and avoidance of individualised staff approaches to treatment. It may include written information for the staff and a written management plan to promote consistency.

The candidate could highlight the importance of the role of the nurse in charge in managing staff conflict, encouraging the team to stick to the plan, and demonstrating excellent inter-team staff communication.

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 Joe, and you are the nurse in charge on a busy surgical ward. Danny is a young 25-year-old male patient on your ward with severe burns to his legs, which he admits to having caused himself. You feel his presence and behaviour is disrupting your ward team and the other patients. You are aware he has a history of repeated visits to the emergency department with self-harm including overdoses of pills, and his clinical file says he has a Personality Disorder.

You have asked to meet the psychiatrist who consults to the surgical ward so they can '*sort him out*', as you are concerned about the effects of the conflict and disruption on your staff and the other patients.

You find Danny to be very demanding as he is requesting to be nursed by only certain nurses because he has identified some as '*horrible and nasty*,' and others as '*incompetent*'. He says he is not receiving enough pain relief, and you suspect he is '*drug seeking*'. His mother is spending a lot of time on the ward, and is also very vocal about what she sees as poor treatment and staff's bad attitude. She has threatened to call the media.

Danny is needing to go to theatre for dressing changes because of his complaints about excessive pain, however most patients would be having this procedure done on the ward at this point in their recovery. Despite these demands, Danny is often not ready, or he is out of the ward smoking when he is due to go to theatre, and this causes disruption to the theatre schedule which then affects other patients. This is really frustrating for staff.

Danny rings his bell frequently with complaints about issues such as thirst, hunger, being too hot or too cold, and general pain and discomfort. He often complains that he is being ignored. He is not following the ward rules about visitors, but some staff also do not enforce them, e.g. allowing friends to come late at night with takeaway food. However, when staff do enforce the rules he becomes very loud and agitated which disturbs other patients.

There is a lot of conflict between team members about how Danny should be treated, and the enforcement (or not) of rules. Some staff have been ringing the on-call doctors to get more pain relief for Danny, and others think he needs to '*toughen up*'. The on-call doctors also have had varying ideas of what to do. Some say to be strict, and others want to give him what he thinks he needs so he will be quiet. Some staff are refusing to work with him, and some think he needs more sympathy and leeway as he has had a tough life.

You have asked to meet the psychiatrist who consults to the surgical ward so they can '*sort him out*', as you are concerned about the effects of the conflict and disruption on your staff and the other patients. You want the psychiatrist to organise a transfer to a mental health ward, as he is '*one of yours*' or at least to talk to Danny and make him be "*more reasonable*".

4.2 How to play the role:

Wear smart shirt and trousers - tidily groomed; no tie is necessary.

You are quite angry, and feeling busy and stressed. You have strong feelings about Danny and his frustrating behaviour, and especially how it is impacting on the ward that you are responsible for.

4.3 Opening statement:

'I'm glad you are here at last - we really need you to sort this man out.'

4.4 What to expect from the candidate:

The candidate should acknowledge your role in the ward, and proceed to ask questions about how the patient is disrupting the ward, and what the problems are. They should attempt to make you feel listened to, so you can calm down.

The candidate should then provide you with an explanation about how the patient might be feeling, and why and how this relates to his behaviour through what are called unconscious mechanisms (i.e. these are not conscious, deliberate behaviours), and how this relates to his diagnosis of a personality disorder.

The candidate is expected to give you an explanation of how the staff's reactions to the patient are also affected by unconscious responses (called defence mechanisms), and how the unpredictability of different staff responses to him is probably inflaming the situation.

The candidate should then negotiate a plan involving the team, including education, either by the candidate directly or via yourself, and strategies of how the staff need to behave as a team and with the patient.

Better candidates may enter into a brief discussion of stigmatising attitudes from general hospital staff against mental health patients and / or the stigmatising nature of some of your own comments.

4.5 Responses you MUST make (and can be repeated):

'We don't have time for this behaviour – we have got really sick patients here.'

'Why is he behaving like this?'

'So aren't you going to go and see him then? He's one of yours you know.'

4.6 Responses you MIGHT make:

'He brought this on himself you know.'

4.7 Medication and dosage that you need to remember:

If asked about specific pain medications or dosages, state that you don't know this information off the top of your head. However (as per the above information) there is a problem with varying approaches to pain relief especially among on-call doctors.

Danny is not taking any psychiatric medications.

STATION 7 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate knowledge of the psychodynamic mechanisms and factors which may be underlying the problems encountered on a surgical ward when treating a patient with a borderline personality disorder.
- Assess the appropriateness of strategies suggested by the candidate to help the team to work effectively in treating this patient.
- Assess ability to de-escalate and engage the nurse in charge, and achieve acceptance of a plan involving education of team members as a mainstay.
- Assess candidate's ability to address stigmatising attitudes when encountered in interactions with other health professionals.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.11 Did the candidate generate an adequate formulation to describe the psychodynamic factors underlying the presentation and referral? (Proportionate value 35%)

Surpasses the Standard (scores 5) if:

provides a sophisticated explanation; interprets the interplay of patient and team defences and dynamics with escalation of problems; utilises terminology that enables understanding by a general trained nurse; discusses possible punitive stance taken by staff resulting in ineffective dosing of pain medication.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the presentation; synthesising information using a biopsychosocial framework; integrating medical and psychological information; presenting hypotheses to make sense of the patient's predicament; accurately describing recognised theories and evidence; analysing vulnerability and resilience factors; describing how reactions or defence mechanisms from team members as well as the patient are involved in evolution or escalation of the problems.

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

- Describe at least three mechanisms, defences or other psychodynamic factors underlying the problems being experienced by staff and patient.

A score of 4 may be awarded depending on the depth and breadth of 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 including inability to synthesise and present defence mechanisms; providing an inadequate description of specific defences or does not include the role of staff defences and reactions.

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"/>

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant therapeutic approaches? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

discusses the role of medical staff including on-call doctors; includes a clear understanding of levels of evidence to support interventions; raising the possibility of the need for consistent and higher doses of pain relief.

Achieves the Standard by:

taking an educational approach towards staff to address patient needs; considering training via the nurse in charge or via team-based education sessions by the psychiatrist / registrar; explaining the need for and use of specific strategies in the education and plan; prioritising an ongoing indirect advisory and educative role for the psychiatrist; specifying the roles of other health professionals; identifying specific outcomes of interventions; putting monitoring processes for interventions; considering barriers to implementation.

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

- Identify and clearly explain key strategies through which the problems can be addressed.

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:

mainstay of plan relies on psychiatrist's direct intervention with patient, e.g. engaging patient in therapy; plan lacks structure and / or is inaccurate; plan not tailored to patient's needs or circumstances.

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"/>

3.0 COLLABORATOR

3.1 Did the candidate demonstrate an appropriately skilled approach to a multidisciplinary team member? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

demonstrates exceptional skill in acknowledging, and de-escalating the anger and arousal levels of the nurse in charge; takes a leadership role; works to reduce conflict.

Achieves the Standard by:

facilitating collaboration within group settings; demonstrating respect; acknowledging and understanding other roles and contributions; listening to differing views; maintaining open communication while providing leadership; actively encouraging contributions; demonstrating awareness of interpersonal issues that affect functioning.

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

a. Engage the nurse in charge in a manner which would be reasonably expected to de-escalate his level of arousal.

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:

using a patronising, bullying, denigrating, hostile or other unhelpful style likely to lead to a failure of the intervention.

3.1. Category: TEAMWORK	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"/>

5.0 HEALTH ADVOCATE

5.2 Did the candidate appropriately seek to address stigma? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

recognises the important role of psychiatrists in addressing stigma; reflects on personal behaviours that increase stigma.

Achieves the Standard by:

identifying the impact of cultural beliefs and stigma of mental illness on patients, families and carers; recognising the role of staff in the generation and maintenance of stigma; applying principles of recovery to clinical practice.

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

a. Attempt to address stigma against mental health patients in a general hospital setting.

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:

limited capacity to identify impact of stigma on wellbeing of people with mental illness; does not actively seek to address stigma.

5.2. Category: ADDRESSING STIGMA	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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	5 5-7 7
Instructions to Role Player	8-10
Marking Domains	11-12

1.0 Descriptive summary of station:

Peter, a 30-year-old male with an intellectual disability has been brought to the Emergency Department by his carer after an episode of self-harm. There has been a recent history of increasingly challenging behaviour by Peter. The candidate is to take a collateral history from the carer to identify the presence of symptoms of anxiety as a potential mental illness. The carer will ask for an explanation, and the candidate is to explain the situation in layman's terms.

1.1 The main assessment aims are to:

- Assess, via collateral history, the presence of an acute psychiatric presentation in a person presenting with challenging behaviour in the context of intellectual disability.
- Explain the presentation and possible diagnoses to the carer.
- Use effective communication skills with the carer.

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

- Elicit the precipitants of the self-injurious behaviour.
- Explain that the behavioural changes are most likely occurring in response to the presence of the new resident.
- Use at least one of the following communication skills during the interview: reflection, summarising, clarification.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - data gathering content, formulation); Communicator (Patient communication - carer)

References:

- Ervin Davis, Sy Ateaz Saeed, Diana J. Antonacci. Anxiety Disorders in Persons with Developmental Disabilities: Empirically Informed Diagnosis and Treatment Reviews Literature on Anxiety Disorders in DD Population with Practical Take-Home Messages for the Clinician. *Psychiatr Q* (2008) 79:249–263.
- Moss S, Emerson E, Kiernan C, Turner S, Hatton C, Alborz A. Psychiatric symptoms in adults with learning disability and challenging behaviour *Br J Psych* (2000) 177: 452-456.
- Hurley AD. Mood disorders in intellectual disability. *Curr Opin Psychiatry* (2006) 19:465–469.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female in mid-30s, dressed casually and neatly.
- 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 covering the Emergency Department.

Peter, a 30-year-old with an intellectual disability has been brought to hospital by his carer after an episode of self-harm - hitting his head against a table resulting in a laceration which needed stitches.

The Emergency Department doctor has asked you to assess Peter as his disturbed behaviour has been increasing over the last 2 months.

Peter has gone for a head CT scan, and you are about to speak with his carer, Claire.

Your tasks are to:

- Take a focussed collateral history from Peter's carer about the changes in behaviour, and the presence of any psychiatric disorder.
- Explain your understanding of the presentation to the carer.

You will not receive any time prompts.

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'
 - Pens.
 - Water and tissues (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 is no opening statement or scripted prompt for you to give.

The role player opens with the following statement:

'Peter hit his head on the table. There was blood everywhere!'

3.2 Background information for examiners

The aims of this station are to assess the candidate's ability to elicit a collateral history about recent onset of increasingly challenging behaviour in a man with intellectual disability. The candidate is to also assess for the presence of a psychiatric disorder then explain the presentation to the carer.

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

- Elicit the precipitants of the self-injurious behaviour.
- Explain that the behavioural changes are most likely occurring in response to the presence of the new resident.
- Use at least one of the following communication skills during the interview: reflection, summarising, clarification.

A surpassing candidate may: identify the similarity between this episode and his past episode (father's death and mother being in hospital); inquire about the patient's risk or abuse history whilst at his day program; indicate how using a psychometric scale may be helpful to identify the presence of a psychiatric disorder.

Anxiety and self-injurious behaviour associated with intellectual disability

According to the American Association on Intellectual and Developmental Disabilities, Intellectual Disability (ID) starts before the age of 18. People with ID can present with significant limitations in both intellectual functioning, and in how they adapt and behave to their environment, including having problems with everyday social and practical skills. *Intellectual function* is also called *intelligence* and refers to general mental capacity, such as learning, reasoning and problem solving. A way to measure intellectual functioning is an IQ test. Generally, an IQ test score of around 70 to 75 indicates a limitation in intellectual functioning. ID can range in levels from being mild, moderate, severe to profound.

In the small number of available studies mental retardation has been associated with higher levels of self-reported fears in children and adults. Cognitive deficits experienced by people with intellectual disability can affect their ability to interpret and deal with life's challenges. Increasing support for people with intellectual disability to live and work in the broader community may expose them to potentially fearful stimuli.

Self-injury or aggressive behaviour is common amongst those with intellectual disability (17%). This can be caused or exacerbated by underlying psychiatric morbidity, and is a frequent reason for referral for psychiatric assessment. These behaviours can occur at any age but peak in the 15-34-year age group. The prevalence of disturbed behaviours increases with severity of intellectual impairment, and is more likely with people with little to no speech. There is also a notable sex difference, as disturbed behaviour is more likely to occur in males. Self-injurious behaviour is more likely to be associated with anxiety than mood disorders, and overall, behavioural disturbance increases with increased psychiatric symptoms.

Anxiety symptoms most commonly associated with self-injury include both phobic anxiety and non-situational anxiety. Typical features that may be present will include increased stress, increased anxiety, panic, agoraphobia, OCD, and GAD symptoms. Higher rates of sleep disturbance and selective mutism can also occur. Anxiety is particularly prevalent in those with autism or autism spectrum disorder (14%).

People with intellectual disability are often sensitive to change in their environment; adjustment disorders are, therefore, a relatively common presentation in this population. Adjustment disorders occur in the context of a stressor or life event and involve extreme emotions, such as depression and anxiety and actions that cause problems in work and at home.

Adjustment disorder is a stress-related, short-term, non-psychotic disturbance. The discomfort, distress, turmoil, and anguish to the patient are significant, and the consequences (e.g., suicidal potential) are extremely important.

Signs and symptoms

As the term adjustment disorder implies, symptoms develop when the person is responding to a particular event or situation, for example a loss, a problem in a close relationship, an unwanted move, a disappointment, or a failure. The pathogenic stressors may be single events, or persistently stressful circumstances. They may be recurrent or continuous. Typical stressors include disruptions of close relationships (except bereavement), events that disrupt general adaptation (emergencies or disasters), and occupational failures or losses. Characteristic symptoms include the following:

- Low mood
- Sadness
- Worry
- Anxiety
- Insomnia
- Poor concentration
- Anger, disruptive behaviour
- Other typical manifestations - loss of self-esteem, hopelessness, feeling trapped, having no good options, and feeling isolated or cut off from others.

Diagnosis

The specific **DSM-5** diagnostic criteria for adjustment disorder are as follows:

- Emotional or behavioural symptoms develop in response to an identifiable stressor or stressors within 3 months of the onset of the stressor(s) plus either or both of (1) marked distress that is out of proportion to the severity or intensity of the stressor, even when external context and cultural factors that might influence symptom severity and presentation are taken into account and / or (2) significant impairment in social, occupational, or other areas of functioning.
- The stress-related disturbance does not meet criteria for another mental disorder, and is not merely an exacerbation of a pre-existing mental disorder.
- The symptoms do not represent normal bereavement.
- After the termination of the stressor (or its consequences), the symptoms persist for no longer than an additional 6 months.

The following 6 specifiers are used to identify subtypes of adjustment disorder:

- With depressed mood
- With anxious mood
- With mixed anxiety and depressed mood
- With disturbance of conduct
- With mixed disturbance of emotions and conduct
- Unspecified.

ICD 10 diagnostic criteria for adjustment disorder differ in that the symptoms develop within 1 month of the identified stressor. Further symptoms include: subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event.

The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine.

Conduct Disorders may be an associated feature of ID, particularly in adolescents. The predominant feature may be a brief or prolonged depressive reaction, or a disturbance of other emotions and conduct. Anxiety Disorders are common in people with intellectual disability. There can be difficulty in making a diagnosis especially in view of communication difficulties and the presence of behaviours not necessarily related to mental illness. It can be difficult for individuals with intellectual disability to describe internalising symptoms of anxiety because of deficits in communication, social skills, and intellectual functioning. Invariably, significant clinical collateral must be obtained from interviews with carers and other key stakeholders to assist with diagnostic clarification of Anxiety Disorder in all such cases.

Psychometric instruments have been used to assist in the identification of Anxiety Disorders in this population; these include the Mood and Anxiety Semi-Structured Interview (MASS), and the Fear Survey for Adults with Mental Retardation (FSAMR). For instance, the MASS asks adults with moderate to severe intellectual disability to identify the occurrence of 'behavioural descriptions', which correspond to symptoms of Mood Disorders (including anxiety, worry, depressed mood and anhedonia).

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 Claire. You work as a disability support worker (see below for role description) at a supported housing unit in the city. You have been working in your role for just under six months, and feel relatively inexperienced. The supported house is the home to 5 residents with intellectual disability (see below for a description).

You have brought one of the residents, whose name is Peter, to the Emergency Department (ED) today. He is a 30-year-old man with intellectual disability and has been a resident at the home for about 5 years.

This morning Peter hit his head on the table in the kitchen on purpose. He had a large cut on his forehead, and you brought him to the ED for treatment. The cut will need stitching up. They have sent him for a brain scan just as a precaution. The doctors in the ED have seen him, and have told you that he will be okay.

Background to today's event:

For the last 2 months, Peter has been doing things to himself that have been causing him harm (called self-injurious behaviour). He has been banging his head, also pinching and scratching himself. He has numerous scars and bruises upon his arms and hands from past actions. There have been times when he has become agitated and damaged property - breaking a cup and throwing a chair against a wall. He has not threatened or made an attempt to injure anyone else.

Peter has appeared aware of his surrounding before, during and after his episodes of self-harm; and he has not appeared confused or disoriented. You are not aware of him collapsing or having any fits (you know about these as some of the other residents have them).

This kind of behaviour has apparently occurred intermittently over the years in Peter. The last time though, was a few years ago following the death of his father. To the best of your knowledge it settled within a few weeks, without any treatment.

Peter's intellectual disability (abbreviated to ID):

ID starts before the age of 18. People with ID present with significant problems in both intellectual functioning and in how they adapt and behave to their environment. They can have problems with everyday social and practical skills. *Intellectual function* is also called *intelligence* and refers to general mental capacity, such as learning, reasoning and problem solving. An IQ test can measure intellectual function: normal or average range is 90-100 and scores of around 70 to 75 indicate limitations in intellectual functioning. ID can range in levels from being mild, moderate, severe to profound.

You are not sure what Peter's IQ is, but you are able to describe his level of functioning. Peter has simple communication / language skills: identifying basic feelings of being well or unwell, whether he is too hot or too cold, when he needs help with something and, so he can communicate simple needs. He has no problems with his mobility. He will often need prompting for complicated activities but can dress himself and prepare simple foods such as a chocolate spread sandwich. He does need supervision when showering but only to make sure that he washes himself well. He is able to toilet himself with minimal assistance.

During the day he attends a supported program that includes working in a flower nursery, car washing, a walking group and participating in a games club. Every week he visits his elderly mother for the afternoon: he usually looks forward to this.

Peter's physical health:

If asked, Peter did not lose consciousness, vomit or appear confused after the injury today.

He has not suffered from any physical health problems that you know of. He has not complained of physical discomfort or headache, and you are not aware of any urinary or bowel disorder. There is no history of Peter having seizures / epilepsy.

Peter's psychological health:

Peter can sometimes talk to himself, and it will often involve him describing what he is doing. This has been a lifelong mannerism (habitual gesture or way of speaking or behaving), and this has not escalated during the last 2 months. He does not appear to be hearing voices or responding to voices no one else can hear. Although he can be quiet and more withdrawn at times he has not appeared depressed. He can still enjoy simple activities (like listening to music), and still enjoys some of his day program.

Recent changes in Peter's life:

If asked what has been going on in Peter's life; a new resident, called Angus, has moved into the home about 3 months ago. He is a large young man who will shout, and bang on the walls and table. He does this for fun and often laughs loudly. Angus does not actively seek to threaten or hurt anyone but he can be disruptive. Peter has taken to staying in his room when this resident is about. At meal times Peter will stay in his room until encouraged to come out. This can precipitate agitation, and he will try to find excuses to stay away - such as playing with his cars or reading his magazines (looking at the pictures). When he does sit at the table he will sit as far away from Angus as he can.

His visits to his mother have only recently restarted: he is taken to see her weekly for an hour at her home. Last month, she had to have a hospital admission and rehabilitation after she had a hip replacement. Peter was distressed when his mother went into hospital. As he was so distressed after the first hospital visit, the staff decided not to take him back to there. He would rock and pinch himself and frequently say '*Don't like it*', and when he got home he was more withdrawn and less interested in activities. At other times he would be his normal self.

Peter has become more disturbed when attending the nursery for his day program. He has become resistant to leaving the house on those mornings. He has shut himself in his room, run around the house and thrown things, and needed redirecting and distracting by staff. He can be more agitated in the evening or before the day program, and the self-harm behaviours have occurred at this time. At other times he will rock and again say, '*Don't like it*' repeatedly. The staff at the day program report no major problems with Peter once he is there except that he is quieter than his normal self, is less involved in the activities at the nursery, and is more likely to be found with one of the staff members.

Overall, in the last couple of months Peter has been varied in how he presents himself. He can be worried and fretful. At such times he can be distracted by staff through simple measures or taken out for a walk. If this does not settle his state the anxiety will increase, and he will pace, rock, scratch or even bang his head.

Although he usually sleeps well, his sleep has been more unsettled. He can sometimes be restless a night, and will rummage and move clothes from his drawers and wardrobe. The GP recently prescribed a medication called quetiapine XR which Peter takes every night, and this has helped settled him for much of the time but there are times when this does not calm him down, and the staff have to try their best to contain his agitation. He is now anxious and agitated most days in the week but he can still often be his old self, interacting in a friendly manner.

Peter does not use any alcohol or drugs.

He was treated with a medication called fluoxetine a few years ago for depressed mood after his father's death.

You don't know of any family history of mental illness.

Given that you are quite new at the service you do not know a lot about his past or early history.

About supported housing

Community service organisations (non-government organisations) are usually funded to provide a range of supported accommodation services including group homes and community residential units for people with a disability. The support is based on the individual's needs and promotes community participation, relationship building, skill development and maintenance.

Accommodation is usually offered in shared housing with the residents supported by a team of staff who usually work according to a roster. Supported accommodation facilities aim to provide a safe, stable community environments for people with various life challenges. Essentially, clients require assistance with daily living skills which is provided in an environment that should be respectful and caring.

4.2 How to play the role:

You are to dress casually but neatly. You work as a disability support worker and provide personal, physical and emotional support to disabled people who require assistance with daily living. Disability support workers can provide assistance with showering, dressing and eating, and basic household chores, and often facilitate or assist with outings and other social activities.

You are concerned about Peter's worsening behaviour, and are interested in trying to find out what is causing it. You will take a helpful interaction style with the candidate.

4.3 Opening statement:

'Peter hit his head on the table. There was blood everywhere!'

4.4 What to expect from the candidate:

The candidate is expected to explore the nature of Peter's behaviour, and work to see if they can identify the cause. The candidate will also ask questions to assess for the presence and nature of any symptoms that would indicate that Peter may have a psychiatric disorder. The candidate will then explain the diagnosis and findings to you.

4.5 Responses you MUST make:

'I don't know what set off this behaviour today.'

'There have been a number of changes in Peter's life in the last few months.'

'It's now been harder to get him out of his room sometimes.'

4.6 Responses you MIGHT make:

If asked any question that is not in the script reply:

'I am not able to answer that. Sorry.'

4.7 Medication and dosage that you need to remember:

Quetiapine (KWET-I-APINE) XR 50 milligrams at night.

STATION 8 – MARKING DOMAINS

The main assessment aims are:

- Assess, via collateral history, the presence of an acute psychiatric presentation in a person presenting with challenging behaviour in the context of intellectual disability.
- Explain the presentation and possible diagnoses to the carer.
- Use effective communication skills with the carer.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed collateral history? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; explores possibly changes in the staff, clients and environment at the nursery day program; explores past losses and grief.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; taking hypothesis-driven history; integrating key social issues relevant to the assessment; demonstrating ability to prioritise; eliciting precipitants for self-injurious behaviour; completing a risk assessment relevant to the individual case; assessing for phenomenology; clarifying important positive and negative features; eliciting the history of avoidance behaviours in the patient.

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

- Elicit the precipitants for the self-injurious behaviour.

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 substantial omissions in 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 to make sense of the presentation?

(Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; indicates the usefulness in using psychometric tools in diagnosing anxiety disorders in those with intellectual disability.

Achieves the Standard by:

identifying and succinctly summarising relevant aspects of the presentation; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological information; identifying relevant predisposing, precipitating perpetuating and protective factors; demonstrating good judgment when providing appropriate detail to the carer; accurately linking limited coping repertoire in the formulation of events; identifying differential diagnoses: anxiety disorder, depressive episode, adjustment disorder, or behavioural disorder.

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

- Explain that the behavioural changes are most likely occurring in response to the presence of the new resident.

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 including inability to synthesise information obtained; providing an inadequate formulation or diagnostic statement; errors or omissions are significant and do materially adversely affect conclusions.

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"/>	

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to communicating with the carer? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport; provides succinct and professional information.

Achieves the Standard by:

demonstrating ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the carer; recognising confidentiality and bias; prioritising and synthesising information; providing accurate and structured verbal report / feedback; demonstrating discernment in selection of content.

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

- a. Use at least one of the following communication skills during the interview: reflection, summarising, clarification.

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 provided; unable to maintain rapport.

2.1. Category: PATIENT COMMUNICATION - 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"/>	

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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-7</p> <p>7</p>
Instructions to Role Player	8-10
Marking Domains	11-12

1.0 Descriptive summary of station:

This is a station that tests a candidate's ability to manage a difficult interview with a young man, Jesse James, who has been admitted with a relapse of psychosis in the context of substance use. The patient wants to go home but it is not safe for him to do so.

1.1 The main assessment aims are to:

- Display confidence in speaking with an emotionally dysregulated patient by demonstrating the ability to effectively assess Jesse James, and manage the situation by attempting to de-escalate him.
- Manage a difficult interview and decline the request of an agitated man who wants to go home.
- Explain the short-term management of acute distress, anticipate problems that may arise, and provide advice how to manage the situation over the next 24 hours of on-call accordingly.

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

- Focus on the assessment of symptoms of psychosis.
- Clearly state that it is not safe for Jesse James to go home, and their reasoning behind this.
- Discuss pros and cons of prescribing regular antipsychotics.
- Highlight the importance of supporting nursing staff having to manage the behaviour.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – data gathering content; Management – Initial plan), Communicator (Conflict management); Collaborator (Teamwork – treatment planning).

References:

- Mavroggiorgou, P., Brune, M. and Juckel, G. The management of psychiatric emergencies, *Deutsches Arzteblatt International* 2011; 108 (13) 222-30.
- Newman, M. and Ravindranath D. Managing a psychiatric emergency, *Psychiatric Times* July 9th 2010.
- Mantovani, C. et al. Managing agitated or aggressive patients. *Revista Brasileira de Psiquiatria*. 2010; 32 (Suppl II) 96-103.

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 male in his early 20s, physically fit, irritable edge.
- 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.

It is Saturday, and you are working as the on-call junior consultant psychiatrist in the local inpatient mental health unit.

Jesse James, aged 19, was admitted last night with a relapse of a drug induced psychosis after being arrested trying to pick a fight with two bouncers of a local night club. He believes he is the reincarnation of Bruce Lee, and needs to prove his reincarnation to Connor McGregor, a Mixed Martial Arts fighter. Since admission Jesse James has been irritable, not slept, and has spent his time pacing around and wanting to go home.

He has been demanding to be discharged, and has been told that he needs to speak to you first.

Your tasks are to:

- Undertake a brief assessment of Jesse James.
- Manage the situation including responding to Jesse about his demands to go home.
- Explain your immediate pharmacological and non-pharmacological strategies to manage acute distress **to the examiner.**
- Outline your weekend management plan (including the role of other staff) for Jesse James **to the examiner.**

If you have not commenced, you will be given a time prompt to present the third and fourth task to the examiner at **five (5) minutes.**

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 (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 prompt you are to give at **five (5) 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 **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 is no opening statement.

The role player opens with the following statement:

'About effing time..... I want to go home.....'

If the candidate has NOT commenced the third and fourth task at **five (5) minutes** you are to give a time prompt. This is your specific prompt:

'Please proceed to the third and fourth task.'

3.2 Background information for examiners

In this station the candidate is expected to engage a young man presenting with psychosis in the context of substance use. The patient has required admission and is angry about being detained. The candidate is to manage problems as they arise, and then outline an initial management plan to the examiner.

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

- Focus on the assessment of symptoms of psychosis.
- Clearly state that it is not safe for Jesse James to go home and their reasoning behind this.
- Discuss pros and cons of prescribing regular antipsychotics.
- Highlight the importance of supporting nursing staff having to manage the behaviour.

A surpassing candidate will be able to successfully defuse the situation to the extent that Jesse James quickly calms down, and develops some level of rapport with the candidate.

Basic Aspects in the Management of Psychiatric Emergencies

Acutely mentally ill individuals often have limited insight into their illness and limited ability to cooperate with their treatment, and this needs to be taken into account when speaking with them and managing any emergency situation.

In the initial evaluation, the clinician has two essential responsibilities during a psychiatric emergency:

- to maintain the physical safety of everyone involved and
- to assess the patient's mental status to determine the subsequent care of that patient.

The appropriate action to maintain the safety of staff and other patients varies with the situation. A severely depressed or quietly delirious patient can be directed to a private room for further evaluation and management. On the other hand, a psychotic or otherwise agitated patient is unpredictable and potentially dangerous to others if cornered.

Initial assessment should focus on factors that can elevate the patient's risk of intentional or unintentional danger. In addition to assertions of suicidal or homicidal ideation, notable risk factors for imminent danger include evidence of intoxication, expressions of hopelessness, irritable affect, thought disorganisation, dishevelled appearance, and psychomotor agitation.

In an emergency situation, the clinician must talk with the patient but take the history more rapidly and in more structured fashion than in a non-emergency psychiatric or medical interview, both because of the intensity of the patient's state and because of the possible danger to the patient or others. Along with noting the patient's main subjective complaints, the clinician must observe the patient's behaviour closely while examining them, paying attention to spontaneous movements and any signs of psychomotor agitation, tension, or impulsiveness.

Laying down clear structures, including telling the patient what type of behaviour is expected of them, is a more sensible and probably more successful approach than simply applying restrictive measures without any critical thought behind them. Firmness, goal-orientation, rationality, and empathy are very important when one is dealing with acutely mentally ill individuals, and this basic attitude should be communicated to the patient both verbally and non-verbally through the examiner's behaviour. The establishment of a personal approach to a highly excited patient, or to a fearful and suicidal one, through a friendly, empathetic, respectful, and understanding attitude is a vital component of the initial treatment and opens the way to the therapeutic steps that will be taken afterward.

Therapeutic measures

The main objective in treating acute states of excitation and agitation is to keep the patient from inflicting harm on themselves and others. This is generally accomplished with pharmacotherapy (most often by sedation), which must not, however, be allowed to stand in the way of a further differential-diagnostic evaluation. 'Talking down' is often successful: this is the attempt to calm the patient verbally by speaking with him or her in a friendly way, in an even tone, and maintaining conversational contact.

An excited state may wear off over a short period of time only to come back rapidly and become even more severe than before ('the calm before the storm'), giving a misleading picture of the actual danger. One should, therefore, always try to have trained staff in the room during the initial contact with an aggressive, tense patient. Dealing with the patient too forcefully may only increase their aggressiveness, and a clinician should beware of overestimating oneself, as patients in excited states can muster great strength. In such cases, the examiner's first duty is to see to their own safety.

A range of substance induced disorders can present with highly excited states, both during intoxication or withdrawal. 'Drug induced psychosis' is considered only when the psychotic symptoms are above and beyond what would be expected during intoxication or withdrawal, and when the psychotic symptoms are severe.

Most substance-induced symptoms are considered to be short lived, and to resolve with sustained abstinence along with other symptoms of substance intoxication and withdrawal. These kinds of guidelines are challenged by practical difficulties in distinguishing between substance-induced and independent psychiatric disorders (psychoses).

One of the most common challenges for psychiatric diagnosis is posed by patients who experience the onset of psychotic symptoms during episodes of current or recent psychoactive substance use. There is a particularly high association between bipolar disorder or schizophrenia, and substance use disorders.

Agitated states in patients taking stimulants and hallucinogenic drugs are best treated with benzodiazepines or antipsychotics. These treatments can be seen to be of short term value while central emphasis is placed on addressing the substance use issues.

In agitation due to withdrawal of alcohol, opioids, or sleeping medication, benzodiazepines are the medication of first choice to prevent delirium, or to treat delirium that is already present. Clonidine or a beta-blocker could be added to treat any accompanying autonomic manifestations, while an antipsychotic may be added to treat psychosis.

When taking patients off benzodiazepines, one should take care not to lower the dose too quickly. Psychomotor excitement with aggressive behaviour as a component of schizophrenic psychosis, a problem often necessitating police intervention can be treated effectively with antipsychotic drugs.

Psychomotor excitement and agitation are also typical features of agitated depression, although, in this situation, the depressive mood is usually obvious, pointing the way to the correct diagnosis. In agitated depression, as in other types of depression, antidepressants take effect only after a delay; thus, a benzodiazepine or low-potency antipsychotic drug should be commenced, to provide immediate relief.

Excited states caused by panic attacks are best treated with benzodiazepines, if pharmacotherapy is the treatment chosen. States of excitement and agitation can be seen in acute stress reactions, too, or as a manifestation of diseases from the anxiety disorder spectrum; benzodiazepines are indicated in such cases as well, but they should be replaced as soon as possible with targeted psychotherapy because of the potential for abuse.

It should not be forgotten that a state of agitation can also be caused by antipsychotic or other dopaminergic medication, e.g., by metoclopramide. This type of agitation, called akathisia, is characterised by restless movements of (mainly) the legs when the patient either sits or stands, often accompanied by a distressing feeling of unrest.

If akathisia is misinterpreted as a psychotic manifestation, a vicious circle can arise in which akathisia leads to an increase in the antipsychotic dose, leading to yet more akathisia. The first-line treatment of acute akathisia is with anticholinergic drugs, benzodiazepines, amitriptyline, or the beta-blocker propranolol. Moreover, the antipsychotic drug that induced akathisia should be changed, or its dose lowered.

Many services have guidelines on the management of acute behavioural disturbance or rapid neuroleptisation. Donlon et al (1979) defined rapid neuroleptisation as a 'method of administering repeated doses of neuroleptic medication under close clinical supervision that provides rapid control of acute functional psychotic symptoms'.

Non-pharmacological strategies for the management of acute agitation include verbal de-escalation strategies (speaking in a calm manner and adopting a non-threatening body posture) as well as management of the physical environment so that the availability of weapons is minimised and there is plenty of space. Ensuring that any potential aggravating people are kept away and primary interaction between patient and clinician is kept to as few people as possible.

From an organisational perspective, ensuring that front line staffs are trained and comfortable with a variety of de-escalation techniques as well-being competent in safe restraint techniques is of utmost importance. Close communication links with security staff and the police are also necessary in case initial attempts at safe management of the situation are unsuccessful.

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 Jesse James, a 19-year-old man who has been admitted to an acute psychiatric ward.

Your religious, racial and cultural affiliations are generic for the Australasian community.

Last night you were out on the town and were offered some methamphetamine by your friends as they think you are entertaining when under the influence of the drug, and you have to admit you enjoy using it. But this frequently ends up with you being arrested for violent behaviour or being admitted to the local psychiatric unit.

On this occasion after smoking methamphetamine you suddenly realised that you are the reincarnation of Bruce Lee and began to pick a fight with the two bouncers of the nightclub you were at. Eventually the police were called who took you to the cells. You have been told that whilst in the cells you were noticed to be talking to yourself. You were stating that you needed to prove yourself to the fighter Connor McGregor in order to become a MMA (Mixed Martial Arts) fighter. That's when they brought you to hospital.

Currently you feel '*on top of the world*' and have beliefs that you are an accomplished MMA fighter. Although you have never done any martial arts you have been in a number of fights especially when you are under the influence of methamphetamine. These beliefs are false but are fixed when you are intoxicated (these are called delusions).

When asked if you have done any martial arts reply in the negative '*but I have watched every Connor McGregor fight, and I know his moves*' through the shows you have watched.

You have a history of getting into fights and are not afraid to take on people who are bigger than you.

Every now and again during the interview you take clearly audible deep breaths and stare intently at the candidate. If they ask you what you are doing reply '*I am sizing you up*'.

Different symptoms:

If you are asked direct questions about:

Depressed mood, empty or hopeless feelings, losing interest and pleasure, problems with eating, sleeping or past attempts to kill yourself - answer quickly and definitely in the negative.

Euphoria, excessive energy / talking / plans / activity or decreased sleep – answer in that you feel '*on top of the world*' and don't need sleep as you need to train for your next fight.

Whether people are out to get you (paranoia) or similar - reply in the negative but instead offer that people are scared of you.

Worries / fears – reply in the negative.

Hearing voices that others can't, or feeling watched / followed / commented upon - answer that you feel Connor McGregor is watching you and you can hear him giving you tips. If asked for examples say that you can hear Connor telling you to '*fight those losers*' and '*show them who is boss*'.

Alcohol / drug use - you do not drink alcohol. You habitually smoke cannabis daily – about 6 cones and use methamphetamine at weekends with your friends - smoking '*a point*' most Fridays after work. You have been doing this since you started at the car workshop, one of your customers supplies you with both cannabis and methamphetamine in exchange for some '*under the counter work*' you do for them. This is generally clocking speedometers and doing some work on stolen cars ready for sale.

History:

Medical History – You were knocked unconscious once 6 months ago after a fight in town, comment: '*but show me a fighter who has not been knocked sparko*'. You have no other medical problems, comment: '*they wouldn't let me into the ring if I did*'.

Psychiatric History – You have presented to the emergency department on one or two occasions before when intoxicated on methamphetamine. One Saturday night they admitted you into a '*mental ward*' but they discharged you on the Monday morning.

Forensic History - You have a history of minor offending - speeding and parking offences. Despite being involved in numerous fights (at the weekends when under the influence of methamphetamine) you have never been charged. You have no weapons offences and you do not own any weapons.

Personal History - You work at a car workshop in Blacktown, for a boss whom you know accepts a lot of 'under the table work'. This has given you confidence in dealing with rough characters and you are not afraid to associate with criminals. The methamphetamine exaggerates some of the character traits that are useful in your workplace (overconfidence and being cocky and bragging at the expense of your co-workers).

You have contact with your parents and sister regularly, they live in the same suburb as you and your father works in the same car workshop (and is your role model), your mother is a stay at home mother to raise you and your sister. Your sister, Julie, is 17 and still at school.

You completed school but did not do well in exams. The car workshop took you on 2 years ago after you left school as a favour to your father. You are currently living with 3 male friends, all similar backgrounds and all in similar manual jobs. Your friends use drugs in a similar social manner to you.

4.2 How to play the role:

The aim of this station is to determine the candidate's ability to calm a hostile situation, engage with a patient showing difficult behaviour and to diffuse the situation. After approximately 2 minutes of the interview, if the candidate has established a good relationship with you, you can begin to warm to them, if they have not you can continue to reply in yes / no format.

You are casually dressed.

It is important to give the impression of agitation and hostility to the interview process, at least for the first part of this scenario. This should be done by being physically restless – initially refusing to sit, getting up and pacing around every few minutes, clenching and unclenching fists, refusing to look at the candidate or 'eye-balling' them.

If the candidate handles the situation in a calm, respectful and firm manner you should become less agitated but remain somewhat irritated and uncooperative until the end.

You are NOT to be openly aggressive towards the candidate. Do not go so far as to stand over the candidate or look like you are going to walk out. It is important not to say anything personally threatening to the candidate. You must be consistently irritable so that candidates have the opportunity to demonstrate their capacity to deal with this.

You must answer any direct questions accurately but do not volunteer more. Answer their questions but do not give additional history too spontaneously.

4.3 Opening statement:

When the candidate enters the room you are pacing around and clearly do not want to be there. As soon as the candidate enters the room state:

'About effing time.....I want to go home.....'

4.4 What to expect from the candidate:

Expect an introduction and the candidate's need to complete a sufficiently comprehensive psychiatric assessment in order to determine if you need treatment. So expect questions about psychotic symptoms as described above (auditory hallucinations, delusions, difficulty with thoughts), and questions about your mood (and in particular elevated mood).

Expect questions about your drug use (and probable focus on methamphetamine).

Expect the candidate to be nervous. Stronger candidates will try to be non-threatening, and seem open to your point of view and not be intimidated by you. They will aim to be respectful of you and ask you to sit down and if so, follow their request but continue to remain hostile in manner. If they do not ask you to sit down, continue to do short karate type movements with some Bruce Lee 'hiya's' before sitting back down.

Stronger candidates will use your name a lot in order to build rapport. They may also explain how your actions appear confronting. In both cases these actions will help defuse some of the tension you are feeling, and you will respond positively.

4.5 Responses you MUST make:

You must initially punctuate the interview with phrases:

'I hear you Connor.'

'Yeah I know I can take him.'

'I am sizing you up.'

4.6 Responses you MIGHT make:

If asked if you have done any martial arts reply in the negative:

Scripted Response: *'But I have watched every Connor McGregor fight, and I know his moves.'*

If asked if you are feeling suicidal:

Scripted Response: *'Of course I am not suicidal!'*

If asked orientation questions, give the whole answer quickly and scornfully:

Scripted Response: *'It's Saturday, 14th April, 2018 and I'm with some jerk of a doctor at the hospital!'*

Words such as *'naf'* and *'bloody'* could be substituted for real swear words to give a more realistic impression of belligerence.

4.7 Medication and dosage that you need to remember:

You do not know the names of any medications the hospital is giving you.

STATION 9 – MARKING DOMAINS

The main assessment aims are:

- Display confidence in speaking with an emotionally dysregulated patient by demonstrating the ability to effectively assess Jesse James and manage the situation by attempting to de-escalate him.
- Manage a difficult interview and decline the request of an agitated man who wants to go home.
- Explain the short-term management of acute distress and anticipate problems that may arise and provide advice how to manage the situation over the next 24 hours of on-call accordingly.

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 (scores 5) if:

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

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; focussing on illicit substance use; eliciting the pre-contemplative nature of his substance use; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; demonstrating psychotic and other phenomenology; clarifying important positive and negative features; assessing for typical and atypical features.

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

- Focus on the assessment of symptoms of psychosis.

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 substantial omissions in 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"/>

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

approaching challenging communications by verbally de-escalating the patient; competently applying a range of non-verbal de-escalation strategies (e.g. calm voice, non-threatening body posture); listening to differing views; effectively managing the psychiatric emergency with due regard for safety and risk.

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

- Clearly state that it is not safe for Jesse James to go home and their reasoning behind this.

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"/>

1.0 MEDICAL EXPERT

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

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; elaborating on appropriate pharmacological and non-pharmacological strategies; planning for risk management; selecting level of observation in treatment environment; engaging safely and skilfully appropriate resources; outlining safe, realistic time frames to review plan; communicating to necessary others; recognising their role in effective treatment; outlining expectations for escalation to them over the weekend; identifying potential barriers.

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

a. Discuss pros and cons of prescribing regular antipsychotics.

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"/>

3.0 COLLABORATOR

3.2 Did the candidate appropriately outline the roles of other team members in the management plan? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

takes a leadership role in treatment planning; effectively negotiates complex aspects of care; works to reduce conflict.

Achieves the Standard by:

taking appropriate and effective leadership to ensure positive patient outcomes; identifying what they would communicate to involve others regarding proposed plans; suitably outlining handover processes to other health professionals; dealing effectively with potential disagreement; specifying observations and any investigations; explaining the need for regular communication between medical and nursing staff over the duration of their on-call; acknowledging that the nursing staff play a significant role in safe management of the situation.

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

a. Highlight the importance of supporting nursing staff having to manage the behaviour.

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 impact adversely on the finalised plan.

3.2. Category: TEAMWORK - Treatment Planning	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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-7</p> <p>8</p>
Instructions to Role Player	9-11
Marking Domains	12-13

1.0 Descriptive summary of station:

The candidate is required to assess a 58-year-old man, presenting with significant anxiety in the context of a deteriorating, agitated, major depressive episode with somatic delusions. This presentation is on the background of longstanding generalised anxiety disorder. The candidate is then to present a preferred diagnosis with a short-term management plan.

1.1 The main assessment aims are to:

- Assess the interplay between anxiety and agitation, and identify those features as manifestations of a severe major depressive episode with psychotic features.
- Manage the immediate risks arising out of assessment of severe and deteriorating depression with psychotic symptoms.

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

- Reassure that help is available.
- Explore at least 2 risks associated with his somatic delusion, e.g., reduced oral intake, medication compliance, reduced urine output.
- Justify a preferred diagnosis of a major depressive episode with psychotic features.
- Recommend one of the following: hospital admission or the benefit of electroconvulsive therapy.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Communicator, Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – data gathering content; Diagnosis; Management – initial plan), Communicator (Patient communication – to patient)

References:

- Akiskal, HS. In Sadock, Sadock and Ruiz (editors) Kaplan and Sadock's Comprehensive textbook of psychiatry. 10th edition. Wolters Kluwer. Philadelphia. 2017.
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- Akiskal, HS., Benazzi, F., Perugi, G., et al. Agitated unipolar depression re-conceptualised as a depressive mixed state: Implications for the antidepressants-suicide controversy. J Affect Disord. 2005; 85: 245-58.
- Koukopoulos, A., Sani, G., Koukopoulos, AE., et al. Melancholia agitate and mixed depression. Acta Psychiatr Scand. 2007; 115(S433): 50-57.
- Maj, M., Pirozzi, R., Magliano, L., et al. Agitated unipolar depression: prevalence, phenomenology and outcome. J Clin Psychiatry. 2006; 67(5): 712-9.
- Schatzberg, AF., Rothschild, AJ. Psychotic (delusional) major depression: should it be included as a distinct syndrome in DSM-IV? Am. J Psychiatry. 1992; 149: 733-45.
- Swann, AC., Secunda, SK., Katz, MM., et al. Specificity of mixed affective states: clinical comparison of dysphoric mania and agitated depression. J Affect Disord. 1993; 28: 81-89.

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: male in his 50s, untidily dressed as if having difficulty dressing neatly.
- Pen for candidate.
- Timer and batteries for examiners.

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 adult community mental health clinic. Mr Patterson has been brought in by his wife for an urgent appointment on the request of his GP.

The GP letter for this patient states:

Dear Doctor,

Thank you for seeing Paul Patterson, a 58-year-old man who has a long history of excessive anxiety. Until recently this was quite well controlled by sertraline 200mg daily. For the past 1-2 months he has become increasingly anxious. I added quetiapine 50mg nocte but his mental condition seems to have deteriorated further. Can you please assess him and manage his condition?

Your opinion will be highly appreciated.

Kind regards

*Dr David Deakins
Riverside Medical Clinic*

Your tasks are to:

- Assess the presenting symptoms **in the patient**.
- Justify your preferred diagnosis and outline your short-term management **to the examiner**.

No physical examination is required.

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

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'.
 - Pens.
 - Water and tissues (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 a scripted prompt for you 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 **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:

- 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:

'I don't know what is happening to me.'

If the candidate has not commenced the second task please provide the following prompt at **six (6) minutes**:

'Please proceed to the final task.'

3.2 Background information for examiners

Detailed Assessment Aims

This station is intended to assess the competency of candidates to diagnose and acutely manage agitated depression with somatic delusions. The candidate is asked to assess a 58-year-old agitated man originally referred by a general practitioner (GP) with history of anxiety and identify that the worsening anxiety is actually part of agitated depression with somatic delusions.

The GP started quetiapine 50 mg daily, but the patient lately refused to take the medications as he is worried about bowel rupture. The depressive syndrome is superimposed on comorbid long-standing generalised anxiety disorder for which the patient has already been taking sertraline 200 mg prescribed by the GP.

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

- Reassure that help is available.
- Explore at least 2 risks associated with his somatic delusion, e.g., reduced oral intake, medication compliance, reduced urine output.
- Justify a preferred diagnosis of a major depressive episode with psychotic features.
- Recommend one of the following: hospital admission or the benefit of electroconvulsive therapy.

Therefore, candidates are to take a history related to anxiety and agitation and identify those features as manifestations of a severe depressive episode with psychotic features – mainly somatic delusions. Identification of concerns of bowel rupture / soap in meals is crucial in this patient as they are associated with food refusal and acute fluid and nutritional depletion. The candidates should identify this as a very serious risk and the basis for immediate management considerations.

Better candidates will very clearly distinguish the emergence of a distinct depressive syndrome against the background of long-term anxiety. The patient in this scenario had a depressive episode approximately 20 years ago following job loss, but it did not present with psychotic features. The candidate may also acknowledge that the patient's added anxiety occurred because depressive symptoms are deteriorating despite adequate dose of antidepressant.

Following this assessment, the candidate is to address the immediate risks for a 58-year-old man who is not drinking or eating adequately in the past few days and make plans to admit the patient. This initial treatment plan is to be outlined by the candidate to the examiner.

Assessment details to consider:

Because of the distressing beliefs of bowel rupture and that the patient's condition is deteriorating with potentially fatal consequences from metabolic derangements and azotaemia, hospitalisation is the most appropriate response in this scenario.

Treatment details to consider:

Candidates are expected to articulate an immediate plan that should cover hospitalisation, need for urgent physical review, options for emergency psychiatric treatment, capacity to consent to treatment, and need or otherwise for compulsory treatment. Liaison with the family, local mental health services and GP is also relevant.

Candidates are not required to outline specific choices of medication management for depressive symptoms but should mention electroconvulsive therapy (ECT) as a frequently preferred option in such circumstances, ECT is likely to be a lifesaving treatment in this instance and typically administered following hospital admission for a severe major depressive episode.

A surpassing candidate may elaborate on the urgency of treatment interventions and other possible specific physical complications, namely azotaemia and metabolic derangements from reduced fluid and food intake. They could identify the need for physical review in light of these possible consequences.

A surpassing candidate will interact in a highly sensitive way to foster the therapeutic alliance and pick up very early that this is likely a psychotic depression. They may address the relevance of the Mental Health Act in a nuanced way and may show experience of the practical difficulties involved in getting this patient to hospital.

Agitated depression is a subtype of depression in which depressed and anxious mood along with inner psychic restlessness dominate the clinical picture (Koukopoulos, et al 2007). Its prevalence in mood disorder community clinics has been estimated as 16.5-26% (Maj, et al 2006; Spitzer, et al 1978). In contrast to typical retardation of activity, agitated depression manifests with increased activity with loss of purpose.

While anxiety in typical depression can be interpreted as an emotional reaction to painful arousal, anxiety in agitated depression appears to be a form of excitation or arousal and inherent in agitation. Agitation is often tormenting to patients. Anhedonia and initial and intermittent insomnia rather than terminal insomnia tend to be marked in agitated depression. Various delusions often accompany this type of presentation.

Delusional depression that develops for the first time after 50 years of age often presents with severe agitation (Akiskal 2017). Agitation signifies a high risk of suicide (Angst, et al 1999). Many patients suffering from agitated depression reported a train of thought called 'crowded' or 'racing thoughts'. It may be difficult to differentiate the clinical presentation of agitated depression from mania and sometimes clinicians consider a diagnosis of Mixed Affective State.

The nosological status of agitated depression is debatable; some authors consider it as part of bipolar mixed state (Schatzberg & Rothschild 1992), and others disagree (Swann, et al 1993) placing it in the affective spectrum (Akiskal, et al 2005). Increased activity in mania is goal directed and triggered by external cues, whereas agitation in depression is internal and purposeless. Unlike in mania agitated depression does not present with pleasurable activities, grandiosity, external distractibility or decreased need for sleep.

Antidepressants particularly Serotonin Specific Reuptake Inhibitors (SSRIs) may make agitated depression worse. The patient in this scenario is taking sertraline 200 mg. It poses enormous challenge to psychiatrists in view of the acuteness of symptoms, severe agitation and serious risks of both deliberate and accidental self-harm (in this case severe fluid and nutritional depletion). Antipsychotics and benzodiazepines are often beneficial in the treatment of agitated depression. Electroconvulsive therapy (ECT) is usually rapidly effective.

DSM-5 criteria for Major Depressive Episode

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.

ICD-10 criteria for a depressive episode

Diagnostic criteria for depression ICD-10 uses an agreed list of ten depressive symptoms.

Key symptoms:

At least one of the following, most days, most of the time for at least 2 weeks:

- persistent sadness or low mood; and / or
- loss of interests or pleasure; and / or
- fatigue or low energy.

If any of above present, ask about associated symptoms:

- disturbed sleep.
- poor concentration or indecisiveness.
- low self-confidence.
- poor or increased appetite.
- suicidal thoughts or acts.
- agitation or slowing of movements.
- guilt or self-blame.

The 10 symptoms then define the degree of depression, and management is based on the particular degree:

- **not depressed** (fewer than four symptoms)
- **mild depression** (four symptoms)
- **moderate depression** (five to six symptoms)
- **severe depression** (seven or more symptoms, with or without psychotic symptoms)

Symptoms should be present for a month or more, and every symptom should be present for most of every day.

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 Paul Patterson, a 58-year-old married man living with your wife, Mary, in your own home. You are a carpenter and have worked in this trade for the past 38 years.

Today you are going to be assessed by a psychiatrist at a community mental health clinic. You are very unwell at the moment. Your mood is very low, and you are feeling very agitated and anxious. You are also feeling so tired today, although you have just managed to attend the clinic as your wife is insisting for this consultation.

Recent anxiety symptoms:

While you have suffered from increased feelings of anxiety and body tension for a long time, approximately 35 years, in the past 2-3 weeks, your anxiety has gone sky high. You have noticed that you can't settle. This is associated with a terrible inner sense of '*not being stable*', and not feeling at ease or at peace. Since last weekend, your restlessness has worsened. You are very worried that something bad is happening.

You feel exhausted, but that does not offer any relief for your restlessness or agitation. It is an awful state for someone to have to experience.

Recent mood symptoms:

In the past 1-2 months you have felt down, as you experienced during your previous episode of depression 20 years ago, but not as bad as this. Your mood has been low almost every day. You also find it difficult to concentrate and you move around with inner turmoil. You have lost interest in things you habitually did before these symptoms developed (like walking, meeting friends, camping with your wife, reading).

If asked about these symptoms: Your sleep has been disturbed; taking longer than before to get to sleep. You go to bed by around 9pm but can't go to sleep as you are worrying all the time, '*tossing and turning*', until about midnight. Then you wake several times through the night until you wake up for good by 7am, which is your usual time. You don't feel well rested. You have also noticed that lately you are not hungry. You believe you have lost a bit of weight, but you are unsure how much.

Patients with depression often have negative views of the world and themselves. You have recently started viewing the world as an unsafe place for reasons that you can't explain. You feel like there is a dark hole in front of you; nothing appeals to you. You don't see a future; an experience which is terrifying. You occasionally get thoughts of '*what is the point of life, not just mine, everyone's life*', but you have never thought of actually committing suicide.

Other recent symptoms:

You have terrible feeling that your intestines (bowel) are bursting / rupturing inside, and your other organs are degenerating / disintegrating. You believe this has led to bad gas being released from your gut. You are worried and ashamed that the bad gas is emitting from your intestine because it is rupturing, and it is making other people sick. You feel really bad about this, and this is actually your worst worry at the moment.

You decided to stop eating four days ago and have been only drinking a small amount of orange juice, altogether approximately a small cup in a day (200ml). You don't feel the need for food anyway. In the last one week, you have felt there has been something unusual in your meals which you cannot explain. You wonder if it may be soap in your meals, and you think this could be the reason why your bowel is rupturing. You do not have concerns that anyone is trying to poison you but are unsure why the food tastes strange.

If specifically asked, your urine output is much less than what was usual for you, and it seems to be concentrated (dark in colour), but your urine does not have any strange smell.

Recent medications:

You feel as if the above symptoms are getting worse day by day. Your wife is particularly worried that your mood continues to drop even though you have been on a high dose of antidepressant medication (called sertraline) for the last 20 years. You don't see the point of continuing medication because you believe your bowel is rupturing. What is worse, you have no clue what brought on these symptoms or changes. They appear to have come from nowhere as you have not noticed any recent stressors, or changes in your life like any losses, and this is perplexing.

As your symptoms have been worsening your general practitioner (GP) started another medication called quetiapine 50 mg at night, two weeks ago, but you don't feel that it helped.

Your mental health history:

Approximately 20 years ago a GP started sertraline for your anxiety, and the dose was gradually increased to 200 milligrams in the morning. If asked about the history of your symptoms, your response can initially be vague as it started a long time ago; but your anxiety started in your 20s. You worry too much about many things for no clear reasons. For example, you worry whether you might have accidents when you travel; whether you will be ridiculed by others in social settings; whether you will get an infectious disease; and whether robbers will break in to your house with weapons. You know that these are unreasonable worries, and the probability of them occurring are remote. Despite this you are still worried, and sometimes you feel tense and unable to relax. It is of course, an unpleasant experience. Long ago you have learned to live with this, and the sertraline really did help for a long time. You know that your condition is called Generalised Anxiety Disorder.

You do not experience panic attacks: which are described as sudden onset intense brief anxiety spells which often have physical symptoms like shortness of breath and rapid heartbeat. You never had recurrent, intrusive distressing thoughts, other than described above, or any need to have to complete repetitive behaviours, like cleaning things excessively or checking things over and over (these are symptoms of a disorder known as Obsessive Compulsive Disorder, which you do not have). You are usually an emotionally stable person.

Except for taste of soap in your meals, you do not have any strange perceptions (e.g. hearing voices without seeing people or seeing things, which others cannot see). You did not experience any unusual smells (taste of soap in meals is something new). You do not have any paranoia or unusual / strange beliefs other than your belief that your bowel is rupturing.

You do not blame yourself for your situation, but do feel guilty about possibly making others sick from the bad gas emitting from your intestine. You do not have any other unusual beliefs, for instance, the world is going to end.

You never experienced periods of mania (mood state opposite to depression) which often involves excessive happiness, increased energy levels, thoughts of having special powers, big unrealistic plans or strange behaviour (for e.g. increased unnecessary spending) or no need for sleep.

You do not drink alcohol or use any other intoxicating or recreational substances / drugs. You do not smoke cigarettes.

There has been no problem with your memory, although you are currently feeling a bit dull.

Your general health:

You have regular health checks with your GP, Dr David Deakins. Your physical health is unremarkable.

About your personal life:

You have taken time off from work for the past one month. If asked about any of these: you haven't had problems driving; you have never got into any physical fights or violence; you have no legal charges against you. You have been living with Mary for the past 26 years. It is mutually supportive and stable relation. You have no children.

Over the last few weeks you have been unable to go to work due to these distressing symptoms.

There is no history of mental illness in your family.

4.2 How to play the role:

Overall you appear distressed, mostly restless in your seat and occasionally turning, or getting up and walking around, but easily redirected by the candidate. If the candidate asks you about your anxiety symptoms, then go on to describe your symptoms of anxiety but do not volunteer mood symptoms. When the candidate asks you for mood symptoms then you freely volunteer them as scripted above under 'Recent mood symptoms'. You answer all questions by the candidate as best as you know.

Although your bowel concerns, and your belief that they are rupturing, are very important, DO NOT volunteer information of changes in your bowel, urine or eating pattern unless asked.

4.3 Opening statement:

'I don't know what is happening to me.'

4.4 What to expect from the candidate:

The candidate needs to learn about your symptoms so that they can establish a diagnosis to guide treatment. To do this, they may ask about a range of symptoms, and the details of what medications you have been taking.

They should also ask you about your mental wellbeing like thoughts of suicide. The candidate may also ask you about your personal life like your relationships, and work history (answer as per previous page). If the candidate asks you about your early life, personal history or any other information then you may say *'that was all fine'*.

4.5 Responses you MUST make:

'I can't rest; I am rotten.'

Within first two (2) minutes *'There just seems to be no hope at all.'*

"It's not safe for me to eat anything."

4.6 Responses you MIGHT make:

If the candidate asks you what makes you worried or anxious or is there anything else troubling you then Scripted Response: *'I think my bowel is rupturing.'*

If the candidate asks about your wife you may say:

Scripted Response: *'I don't want to worry her with this.'*

4.7 Medication and dosage that you need to remember:

- Sertraline (SIR-TRA-LEEN) 200 milligram (2 tablets) in the morning
- Quetiapine (KWE-TI-APEEN) 50 milligrams at night.

STATION 10 – MARKING DOMAINS

The main assessment aims are to

- Assess the interplay between anxiety and agitation, and identify those features as manifestations of a severe major depressive episode with psychotic features.
- Manage the immediate risks arising out of assessment of severe and deteriorating depression with psychotic symptoms.

Level of Observed Competence:

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from the patient? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of complexity; rapidly tailors interactions to establish and maintain rapport; recognises patient's views of possible admission; genuinely acknowledges patient's dilemma of experiencing deterioration despite antidepressant and anti-anxiety treatment.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; acknowledging the patient's anxiety and agitation; listening to patient's concerns and forming a partnership using language and explanations tailored to the patient's capacity; effectively using open ended questions rather than leading questions; validating the patient's experiences; acknowledging the impact of anxiety and depression on concentration and rational thinking; encouraging a conversation related to capacity to consent.

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

- Reassure that help is available.

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 and information gathered; inadequately reflects on relevant information obtained; unable to maintain rapport; disengages the patient by 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 candidate take appropriately detailed and focussed history? (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 in assessing physical and psychological symptoms.

Achieves the Standard by:

demonstrated use of tailored biopsychosocial approach; prioritising a history relevant to the patient's problems and circumstances; exploring the range of symptoms required to make a diagnosis; conducting a focussed assessment to establish a diagnosis of major depressive episode; eliciting key issues including agitation; assessing for typical and atypical features; completing a risk assessment relevant to the individual case.

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

- Explore at least 2 risks associated with his somatic delusion, e.g., reduced oral intake, medication compliance, reduced urine output.

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 (e.g. does not exclude manic symptoms).

Does Not Achieve the Standard (scores 0) if:

omissions adversely impact on obtained content; significant deficiencies in exploring depressive and psychotic symptoms; does not rule out risk of suicide; does not specifically enquire the risk of medical complications from reduced food and fluid intake.

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"/>

1.0 MEDICAL EXPERT

1.9 Did the candidate formulate and describe relevant diagnosis? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

explicitly identifies recent emergence of a new syndrome against the background of long-term anxiety; includes differential diagnoses like organic mood disorder or akathisia; provides accurate detail of potential physical complications of nutritional depletion (azotemia, metabolic derangements).

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis; demonstrating detailed understanding of diagnostic systems to justify a diagnosis; identifying agitation and delusions as part of a major depressive disorder; indicating severity of depression; acknowledging lack of a clear precipitating factor and overt predisposing factors; considering high risk of suicide in the context of agitation; offering a differential diagnosis of akathisia or mixed affective state.

To achieve the standard (score of 3) the candidate **MUST:**

a. Justify a preferred diagnosis of a major depressive episode with psychotic features.

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; diagnosis is not supported by presenting symptoms elicited; errors or omissions are significant and 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 - 30%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified; addresses difficulties in the application of the plan; clearly balances compulsory care with capacity to consent; identifies barriers in implementing care including resistance to admission, stigma of ECT, medical clearance.

Achieves the Standard by:

demonstrating the ability to prioritise and implement evidence-based acute care; planning for risk management; considering the patient's capacity to consent in the context of severe agitation and delusional beliefs; considering alternative medication options; outlining physical and psychiatric treatment needs; communicating with local mental health service and GP; incorporating the wife in the treatment planning; having realistic time frames for plan review.

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

a. Recommend one of the following: hospital admission or the benefit of electroconvulsive 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 Achieve the Standard (scores 0) if:

errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan is 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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
Instructions to Candidate	3
Station Operation Summary	4
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-6</p> <p>6</p>
Instructions to Role Player	7-8
Marking Domains	9-10

1.0 Descriptive summary of station:

This is a short core skills station that examines the abilities of a candidate to present a Mental Status Examination (MSE) of a patient, and correctly interpret observed psychopathology in the context of what appears to be a psychotic disorder with hallucinations and behaviour associated with persecutory thinking.

1.1 The main assessment aims are to:

- Demonstrate an ability to clinically observe a non-communicative patient in order to describe a mental state examination.
- Present a systematic mental status examination.
- Present an interpretation of the patient's psychopathology.

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

- Attempt to engage the patient using both open and closed questions.
- Accurately present the patient's appearance and behaviour.
- Accurately interpret response to unseen stimuli being driven by hallucinations.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Clinical Assessment Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – mental state examination, examination accuracy); Communicator (Conflict management).

References:

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), American Psychiatric Association Press. (2013).
- Kaplan HI, Saddock BJ. Synopsis of Psychiatry, Eighth Edition, Williams & Wilkins. (1998).
- Scully JH. NMS Psychiatry, Third Edition, Williams & Wilkins. (1996).
- Endicott J, Spitzer RL. A diagnostic interview: the schedule for affective disorders and schizophrenia. Arch Gen Psychiatry 35:837-844 (1978).
- Nurnberger JI Jr, Blehar MC, Kaufmann CA, York-Cooler C, Simpson SG, Harkavy-Friedman J, Severe JB, Malaspina D, Reich T. Diagnostic interview for genetic studies. Rationale, unique features, and training. NIMH Genetics Initiative. Arch Gen Psychiatry 51:849-59 (1994).
- Trzepacz, P, Baker R. The Psychiatric Mental State Examination, Oxford University press (1993).

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: healthy looking male in his early 20's of average build; he must look dishevelled, with dirty hair, nails and clothes.
- 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 public hospital.

Your ward registrar has requested that you review a 20-year-old patient, Sam, as the registrar was unable to establish any rapport with the patient. The patient did not want to engage or talk to the registrar. You are seeing the patient for the first time.

No further details of the patient are available.

Your tasks are to:

- Assess the patient to be able to complete a Mental Status Examination (MSE).
- Present the MSE of the patient **to the Examiner**.
- Interpret key findings of the MSE **to the Examiner**.

You are not expected to physically examine the patient.

You will be given a time prompt to commence the second task at **five (5) minutes**, if you have not already done so.

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'.
 - Pens.
 - Water and tissues (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 prompt you are to give the candidate at **five (5) minutes**.
- DO NOT redirect or prompt the candidate.
- If the candidate asks you for information or clarification or if the candidate touches the patient 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.

There is NO opening statement for the role player.

If the candidate has NOT commenced the second task, at **five (5) minutes** you are to give a time prompt. This is your specific prompt:

'Please proceed to the second task.'

3.2 Background information for examiners

In this core skills station the candidate is expected to assess a primarily non-communicative patient, and demonstrate their observational skills in their ability to present a Mental Status Examination (MSE) for someone who displays mostly non-verbal psychopathology.

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

- Attempt to engage the patient using both open and closed questions.
- Accurately present the patient's appearance and behaviour.
- Accurately interpret response to unseen stimuli being driven by hallucinations.

The candidate should initially attempt to verbally engage the patient in a gentle manner, and when it is clear that the patient does not want to communicate, the candidate should take a respectful approach to the patient in order to complete the task, in order to complete a mental state based on observation. From time to time, the candidate may try to engage the patient by asking them questions, making suggestions or appealing to the patient.

The candidate is expected to present a comprehensive mental status examination in a standard format, providing the observable features, in a structured manner. Positive findings and relevant negative or aspects of the MSE that cannot be determined should be mentioned.

A surpassing candidate is likely to contain their own anxiety in a professional manner. A better candidate will clearly note the aspects of the MSE that are observable but at the same time also correctly identify those aspects that cannot be determined without communicating with the patient.

The following is a description of the patient:

- 20-year-old male who looks his age, and generally looks physically healthy.
- He is fully conscious.
- He is dishevelled (but not malodorous), hair, hands and cloths are dirty as if he has neglected himself.
- He does not respond to social cues, does not shake hands and essentially ignores candidate.
- He mainly maintains a sitting posture with his hands on his knees – jiggles his knees a little from time in an agitated fashion.
- He mainly keeps a downward gaze and tends to look around him as if looking for someone or something; but has little eye contact with the candidate.
- He is silent except for the period of mumbling, where he makes minimal monosyllabic sounds / grunts vaguely in response to the candidate's efforts to engage then returns to focussing on internal experiences.
- It is not possible to engage him in conversation or to obtain any information from him.
- He occasionally looks a bit suspiciously / fearfully at the candidate, and around the room (*so the candidate can postulate paranoid ideation*).
- On at least two separate occasions he seemed to be responding to unseen stimuli: looks up and mumbles to himself as if he is hearing voices or responding some type of non-apparent stimulus.

- At about 3 minutes he gets up, walks to the door, appears to be listening and abruptly says 'stop that at once' clearly and angrily, and then returns to his seat, and to his uncommunicative state.
- He has a restricted affect with minimal reactivity displayed, making it difficult to fully evaluate.
- It is not possible to determine his form of thought, mood, content of thoughts including delusions / passivity phenomena.
- It is not possible to determine major aspects of risk to self or others, but his non-verbal communication does not indicate any imminent risk.
- It is not possible to evaluate the cognitive functioning.
- Insight is likely poor given a person who is probably psychotic, and in the midst of an acute phase.

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

- 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).
- they can act as a **communicator** who effectively facilitates the doctor patient relationship.
- they can **collaborate** effectively within a healthcare team to optimise patient care.
- 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.
- they can act as **health advocates** to advance the health and wellbeing of individual patients, communities and populations.
- 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.
- 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 young 20-year-old male named Sam, who is about to be interviewed by a psychiatrist, but you will not actively engage with them. The key aspect is to be as quiet as possible except for the brief periods of activity as explained below.

You are playing the role of a person who is acutely psychotic, which means that you are not in touch with your usual reality but are experiencing things that have led you not to speak or engage with anyone, as you are completely involved (preoccupied) with what is going on in your head. You are also feeling quite suspicious of others and so may look a bit fearful. As a result of your psychosis, you have not looked after your grooming over the past week or two.

Your main and most prominent experiences are that you are hearing a voice that is doing the following – please imagine how this would make you feel and act:

- the male voice is talking to you all the time.
- the voice describes what you are doing in a continuous manner, like a commentary.
- from time to time, the voice also instructs you on how to behave.
- the voice has been telling you not to talk to the doctor.
- it is instructing you to sit quietly on a chair, look downwards and maintain that posture (your hands are on your knees, as if you are holding your knee caps).

4.2 How to play the role:

It is important to look dishevelled: poor grooming is a clinical feature of this patient and your clothing should look dirty. Your hair has to be obviously untidy and not recently washed. Consider applying wax or gel in hair to make it look dirty.

Your clothes should not be matched, and look haphazard. Do not wear any cologne. It is crucial not to smell in any way either pleasant or unpleasant (malodorous).

When the candidate walks in, do not get up from your chair, shake their hand or acknowledge them. Keep focussed on your own internal world.

Do not look at the candidate or move about too much. Mainly keep a sitting posture with your hands on your knees, you can jiggle your knees a little from time in an agitated fashion. Spend most of the time looking blankly down towards the floor; or looking around the room as if you are searching for someone or something. Do not respond to the candidate's questions, except briefly acknowledge the candidate with a few grunts, otherwise try to ignore the candidate.

In the first four minutes, with each candidate, you must briefly look up to your right, as if you are listening to someone on the roof:

- without uttering any sensible sounds, mumble by moving your lips in response to that someone.
- do this for about 5-10 seconds then stop.
- please do this twice during the first four minutes.

At these times when you will mumble below your breath – it should appear as if you are saying something, but the words should not be able to be understood or heard properly by the people in the room.

Occasionally briefly look a bit suspiciously / fearfully at the candidate and around the room. At about 3 minutes get up, walk to the door, appear to be listening and abruptly whisper '*stop that at once*' clearly, and then return to your seat and to your uncommunicative state.

4.3 Opening statement:

There is no opening statement for you to make; you are not required to acknowledge the candidate as they commence the station.

4.4 What to expect from the candidate:

The candidate will greet you, introduce themselves and clarify your name. The candidate may want to shake your hand, but they are not expected to touch you in any other way at all.

They will try to engage you and obtain details of why came to the clinic. The candidate will endeavour to obtain information from you by asking various questions, possibly in a repetitious manner.

The candidate may become quiet and observe you: maintain you sitting posture, mainly staring down throughout, no matter what the candidate does.

4.5 Responses you MUST make:

With each candidate the role player must look up to the right, twice during the first four minutes. Mumble for about 5-10 seconds, without making any sensible sounds, while looking up.

Remember to also stand up, go to the door and say, "*stop that at once*" in a clear voice such that the candidate knows you are not mute.

4.6 Responses you MIGHT make:

None

4.7 Medication and dosage that you need to remember:

None

STATION 11 – MARKING DOMAINS

The main assessment aims are to:

- Demonstrate an ability to clinically observe a non-communicative patient in order to describe a mental state examination.
- Present a systematic mental status examination.
- Present an interpretation of the patient's psychopathology.

Level of Observed Competence:

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

effectively tailors interactions that aim to facilitate rapport; constructively aims to de-escalate the situation; treats the patient with positive regard throughout.

Achieves the Standard by:

recognising challenging communications; attempting to form a partnership using language and explanations tailored to the situation; demonstrating capacity to apply alternative engagement strategies; effectively managing the situation with due regard for safety and risk; utilising a non-confrontational style.

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

- Attempt to engage the patient using both open and closed questions.

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 reduce likelihood of attaining any positive outcomes; inadequate ability to manage responses to the situation.

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"/>

1.0 MEDICAL EXPERT

1.3 Did the candidate demonstrate adequate proficiency in assessing the mental state examination, including a cognitive assessment? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

MSE is presented at a sophisticated level; clearly notes all aspects of MSE that cannot be accurately determined without verbal communication.

Achieves the Standard by:

demonstrating capacity to: present an organised and accurate mental state examination; describe key aspects of observation of rapport and affect, postulating on content and control, considering perceptual abnormalities; succinctly present accurate use of phenomenological terms; comment on likely insight and judgement, including appropriate positive and negative findings.

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

- Accurately describe the patient's appearance and behaviour.

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, accuracy and presentation.

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"/>

1.6 Did the candidate report on the physical findings accurately for this case? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

overall physical findings are accurately elicited.

Achieves the Standard by:

correctly identifying key physical findings in relation to the mental state; identifying the unkempt nature and poor self-care of the patient; observing the patient's level of consciousness; recognising that the patient does not pose an imminent risk, seems afraid and preoccupied with internal experiences, does not respond to stimuli from the outside.

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

a. Accurately interpret response to unseen stimuli being driven by hallucinations.

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

incorrectly interprets observations; errors or omissions of findings affect the conclusions.

1.6. Category: ASSESSMENT – Examination Accuracy	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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