Committee for Examinations
Objective Structured Clinical Examination
Station 4
Sydney April 2018

The Royal Australian & New Zealand College of Psychiatrists

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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 at 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 <u>final task</u>:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room, briefly check ID number.

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 affects 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:**
a. 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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

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:**
a. 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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

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

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