Committee for Examinations
Objective Structured Clinical Examination

Station 2
Brisbane September 2016

The Royal
Australian &
New Zealand
College of
Psychiatrists

1.0   Descriptive summary of station:

The candidate is expected to describe the management of a 54-year-old man, James Dennis, with treatment-resistant depression who has been referred to a Community Acute Care Team by a private psychiatrist. The candidate is to focus on identifying treatment-resistant depression and addressing polypharmacy. They are to consider their communication with the patient and to elaborate on the ethical issues associated with discussing polypharmacy prescribing with the private psychiatrist.

1.1   The main assessment aims are:

- To complete an assessment to confirm treatment resistant depression.
- To review the history leading to polypharmacy in the patient with treatment resistant depression.
- To discuss the range of treatment options to be considered.
- To identify the need to communicate treatment plans and goals with the patient (possibly the family) and private psychiatrist.
- To consider ethical issues related to unusual prescribing by another practitioner and reflect on the issues that should be discussed.

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

- Seek to establish rapport.
- Elicit key aspects to diagnose treatment-resistant depression.
- Explain to the patient the alternative options for psychopharmacology.
- Demonstrate consideration of contemporary clinical practice guidelines for treatment-resistant depression.
- Expect to identify rationale for treatment choices in consultation with the private psychiatrist.
- Be clear that current medication regimen is not typical and is high dose polypharmacy.

1.3   Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Mood disorders, Other Skills (Ethics)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS domains:** Medical Expert, Collaborator, Communicator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Process; Data Gathering Content; Management - Initial Plan), Collaborator (External Relationships), Professional (Ethics).

    References:
- Malhi, GS, Bassett, D, Boyce, P, Bryant, R, Fitzgerald, PB, Fritz, K, Hopwood, M, Bill Lyndon, Mulder, R, Murray, G, Porter R, Singh, AB. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. JANZCP. 2015, Vol. 49(12) 1087–1206. DOI: 10.1177/0004867415617657
- Daihui Peng, D, Fang, Y. Evaluation of antidepressant polypharmacy and other interventions for treatment-resistant depression http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311112/
- Treatment Resistant Depression: A Roadmap for Effective Care. edited by John F. Greden, M.D., Michelle B. Riba, M.D., M.S., and Melvin G. McInnis, M.D.; Washington, D.C., American Psychiatric Publishing, 2011, 364 pages
- *Suicide Over the Life Cycle: Risk Factors, Assessment & Treatment of suicidal patients, By Susan J. Blumenthal, David J. Kupfer*
- Pharmacologic *Approaches to Treatment Resistant Depression: A Re-examination for the Modern Era* Philip, NS., Carpenter, LL., Tyrka, AR., Ph.D., and Price, LH
- Berlim MT, Turecki G. Definition, assessment and staging of treatment-resistant refractory major depression: a review of current concepts and methods. *Can J Psychiatry.* 2007;52:46-54

1.4   Station requirements:

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, candidate x 1, role player x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – man in early 50s, casual and slightly dishevelled dress and demeanour.
- 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 a junior consultant psychiatrist working with a Community Acute Care Team of a mental health service, which is attached to a large teaching hospital. From time to time, private psychiatrists refer their patients to your service for crisis management and psychiatric admissions in the public sector.

You have received a referral letter from a senior private psychiatrist Dr Smith regarding James Dennis, who has an outpatient appointment to see you now.

Dear colleague,

Thank you for taking over the interim care of Mr. James Dennis as I am in the process of retiring and he needs ongoing specialist care. James is a 54-year-old school teacher with a treatment-resistant depression. He has been very depressed for 24 months that has progressively worsened since the separation from June, his wife of 28 years, and recent loss of his employment. In addition to feeling depressed, James also complains of insomnia, lethargy, lack of concentration and lack of motivation. He has described increasing intrusive thoughts of suicide with no clear plans or intent. There is also a strong family history of depression and suicide.

James's current medications are Clomipramine 225mg nocte, Mirtazapine 90mg nocte, Lamotrigine 200mg bd, Chlorpromazine 100mg nocte and Quetiapine 100mg prn. He has been taking all of these medications for more than 3 months but made no progress.

Please do not hesitate to contact me before the end of next week when I go on leave.

Regards,
Dr C Smith FRANZCP
Consultant Psychiatrist

Your tasks are to:

- Take a focussed history in keeping with treatment-resistant depression and associated polypharmacy from James.

- Outline and negotiate your recommended treatment plan with James.

- Reflect on the issues related to diagnosis and prescribing to be discussed with the private psychiatrist and present your communication strategy/goals **to the examiners**.

If you have not commenced the third task by twelve (12) minutes you will receive a prompt.

Station 2 - Operation Summary

Prior to examination:
- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' and any other candidate material specific to the station e.g. investigation results.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient and co-examiner.

During examination:
- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- 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.'
- TAKE NOTE of the cue/time for the scripted prompt you are to give at **twelve (12) minutes** and say
    '*Please proceed to the third task.*'
- 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 <u>final task</u>:
- You are to state the following:
    'Are you satisfied you have completed the tasks?
    If so, you <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings.'
- If the candidate asks if you think they should finish or have done enough etc. refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0   Instructions to Examiner

3.1   In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

You have no opening statement.

The role player opens with:

> *'Hello, my doctor is retiring and I am not sure what is going to happen to me.'*

There is a scripted prompt at **twelve** (**12) minutes** if the candidate has not commenced the third task. Please say:

> '*Please proceed to the third task.*'

3.2   Background information for examiners

In this station the candidate is essentially taking over the care of a male patient who has been diagnosed with treatment-resistant depression by a private psychiatrist. The candidate is to focus on confirming the diagnosis, reviewing the treatment to date including psychotherapy which would be a critical feature of any work up towards the diagnosis of treatment-resistant depression (TRD). In order to do this the candidate is expected to query the veracity of the information provided and demonstrate their clinical skills in eliciting history that supports the diagnosis, reflecting on what is known and then feed all this back to the role player.

The candidate is then to discuss a treatment plan with the patient including specifically addressing polypharmacy.

The candidate must then outline a communication plan to use when contacting the private psychiatrist with regard to further information collection. It is expected that the candidate will speculate as to what else to enquire on and how they would go about it when contacting the private psychiatrist. Having identified some aspects of the current care as being outside of generally recommended practice, this needs to be sensitively addressed.

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

- Seek to establish rapport.
- Elicit key aspects to diagnose treatment-resistant depression.
- Explain to the patient the alternative options for psychopharmacology.
- Demonstrate consideration of contemporary clinical practice guidelines for treatment-resistant depression.
- Expect to identify rationale for treatment choices in consultation with the private psychiatrist.
- Be clear that current medication regimen is not typical and is high dose polypharmacy.

Defining Treatment-Resistant Depression

Treatment-resistant depression (TRD) typically refers to inadequate response to at least one antidepressant trial of adequate doses and duration. TRD is a relatively common occurrence in clinical practice, with up to 50% to 60% of the patients not achieving adequate response following antidepressant treatment. A diagnostic re-evaluation is essential to the proper management of these patients. In particular, the potential role of several contributing factors, such as medical and psychiatric comorbidity, needs to be taken into account. An accurate and systematic assessment of TRD is a challenge to both clinicians and researchers, with the use of clinician-rated or self-rated instruments being perhaps quite helpful. It is apparent that there may be varying degrees of treatment resistance. Some staging methods to assess levels of treatment resistance in depression are being developed, but need to be tested empirically.

The lack of a globally accepted operational definition of TRD or guidelines for the treatment of TRD has made it difficult for clinicians and researchers in this area. Responding to this issue, in 2002 the European agency for the evaluation of medical products committee for proprietary medical products (EMACPMP) defined TRD as an insufficient treatment effect after full-dose and full-course treatment with at least two types of antidepressants.

Treatment for TRD

Clinical regimens of combined treatment with multiple antidepressants for TRD typically consist of the use of selective serotonin reuptake inhibitors (SSRIs) and another type of antidepressant such as bupropion, trazodone, venlafaxine, dutoxetine, or mirtazapine. Mirtazapine, bupropion, and agomelatine are generally well tolerated and have few drug-drug interactions. Therefore, they are the first choices for combined treatment. Other non-antidepressant drugs can also be used in combination with antidepressants to treat TRD, including anti-anxiety drugs (e.g. buspirone and tandospirone) and some atypical antipsychotics (e.g. olanzapine, aripiprazole and quetiapine). Besides medications, non-pharmacological treatment, including cognitive behavioural therapy and physical therapies (e.g. modified ECT and rTMS), have shown good treatment effect for TRD. In summary, the best treatment outcome is usually achieved after a detailed evaluation of the clinical characteristics of the patient, and the correct identification and management of core risk factors that affect the course of depressive illnesses.

Currently available treatments have limited efficacy for TRD, a state of affairs that is complicated by a lack of consensus on the definition of TRD itself. However, although there is no clear 'magic bullet' to address TRD, there are a wide variety of pharmacological options available with established, even if modest, efficacy. Several novel therapeutic options, targeting neurotransmitter systems outside of the standard monoamine hypothesis, are currently being investigated as promising alternatives.

According to the RANZCP CPG: Assessing and Managing TRD

- The first step when faced with non-response should be to re-evaluate the formulation in particular the diagnosis.
- The clinical assessment of a patient with treatment-resistant depression should include a review of their treatment history, in particular their engagement with psychotherapy, and adherence to medication at the dosages prescribed. A re-evaluation of potential personality, psychiatric and medical comorbidities, and ongoing psychosocial stressors is also necessary. If the diagnosis is uncertain, or the reason for treatment non-response is not evident, then (where possible) a second opinion should be promptly sought.
- In instances where a partial response has been achieved, if feasible an increase in antidepressant dose should be considered.
- If after a partial response has been achieved further improvement does not occur, then (where possible) first consider augmentation and/or combination therapy prior to considering alternative strategies such as switching/substitution.
- Optimal treatment for both acute severe depression and chronic depression is a combination of pharmacotherapy and psychotherapy. The combination can consequently be considered first line for treatment-resistant depression.
- If inexperienced in using medication doses above the recommended maximum, then consider seeking a second opinion. If symptoms have not significantly improved after a few weeks of treatment, re-evaluate the diagnosis.

The RANZCP guidelines outline first- and second-line indications for ECT for MDD.

First-line treatment

- Severe melancholic depression, especially when the patient is refusing to eat/drink.
- High risk of suicide.
- High levels of distress.
- Psychotic depression or catatonia.
- Previous response, patient choice.

Second-line treatment

- Patients who have not responded to several trials of medication, including for example TCAs, MAOIs.

ECT and rTMS in TRD

Electroconvulsive Therapy (ECT) is an effective therapy for medication resistant depression that should be considered after one or more unsuccessful medication trials.

Repetitive Transcranial Magnetic Stimulation (rTMS) utilises an insulated coil held in contact with the scalp in order to influence cerebral electrical activity by a pulsed magnetic field. While ECT is regarded as highly efficacious there is some research suggests that under certain circumstances, rTMS can achieve results similar to ECT, without the impact on memory that ECT has (Pridmore, S. *International Journal of Neuropsychopharmacology*). It is an effective therapy that may be considered when patients have failed one or more trials of medication prior to moving to ECT, if it is available. The option of using ECT before or after rTMS is a matter for clinical judgment; the evidence supporting the effectiveness of ECT is stronger but the side effect profile is better for TMS. Despite this ECT should not be regarded a treatment of last resort and its administration should be considered on the basis of individual patient and illness factors.

The candidate should undertake a clinical assessment and review of previous psychiatric history and then identify guidelines for treatment-resistant depression. Their management strategy is expected to demonstrate their knowledge and clinical skills in managing a patient with treatment-resistant depression and recognise barriers to management. Identify the importance of monitoring risks in the process of rationalising the medication.

The candidate is expected to explain the issues related to polypharmacy including clinical problems and potential serious consequences, and then outline the principles and strategies they intend to put in place to address polypharmacy. The strategies should incorporate the patient's clinical needs.

Review of polypharmacy

In this scenario the retiring psychiatrist appears to have added medications which have led to polypharmacy. The choice of medications is unusual and not in keeping with current guidelines and algorithms. Medico-legal evidence shows that elderly sole practitioners are most vulnerable to not keeping up to date and for making clinical decisions that may be outside of best practice norms.

The candidate should consider a range of aspects when obtaining the history from the patient; how closely the diagnosis has been reviewed and whether physical causes have been excluded, previous clinical plans, the acceptance of the plan by the patient and how closely the patient complied with the plans. The candidate may inquire as to whether the patient was advised of potential benefits and risks, including side effects and medication interactions.

When reviewing polypharmacy, consideration should be made of any non-pharmacological treatments, social supports and alternative interventions discussed and prioritised. Careful exploration could be undertaken to exclude any harm sustained by the patient.

In their presentation to the examiners the candidate is expected to present their reflection of the issues that they would like to explore. It is likely that they will recognise the difficulty a Junior Consultant will face in challenging the practice of a colleague, particular a more senior colleague. The way they decide to approach this conversation in a sensitive manner may come across in their presentation. A better candidate will acknowledge that there may be a need for some form of intervention, particularly if the psychiatrist was not retiring. They may also raise concerns about the treatment and wellbeing of other patients from Dr Smith's practice.

A surpassing candidate may

- Identify complex biopsychsocial contributions to treatment-resistant depression and alternative diagnoses
- Identify a comprehensive range of treatment options, including importance of non-pharmacological aspects
- Consider ethical dilemmas of non-typical treatment and high dose or polypharmacy in the engagement with the private psychiatrist.

3.3 The Standard Required

In order to:

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 James Dennis, a 54-year-old man who has been separated from his wife, June, for the last 18 months. You now live on your own in the family house, your two sons (Matt, 22 years; Clive, 26 years) moved out years ago when they went to university. You had been married for 28 years when your wife left you after she said she didn't think she was in love with you anymore. This really affected your depression as you had already been made redundant due to staff changes at the school where you had worked for many years.

You have been struggling with low mood, which is worse when you wake up. You don't want to get out of bed as you feel there is nothing worth getting up for. Since your wife left you have not had the energy to cook properly and, when you do get around to eating, you tend to order takeout pizza or something similar. You have not been looking after your home, even though you spend almost all the day at home. You can't be bothered to tidy up and haven't had any motivation to wash your clothes regularly. You tend to spend most of the day in front of the TV or playing video games. You can't get to sleep as your head doesn't shut off, you think of everything that has gone wrong and how bad things always happen to you. You can't see any good in anything and have thoughts of suicide but won't act on it as you don't want to hurt your family. You become anxious and have emotional outbursts of anger and frustration.

You were first diagnosed with depression when you were 20 but you have felt low since late teens. The GP put you on PROZAC and it worked for a few years, and you were able to get through university and also have a relationship and marriage. You had your second depressive episode at 28 years old which led you to be hospitalised for 2 weeks. This was not long after your son was born, there was multiple stressors including financial and family. The doctors changed the medication to SERTRALINE and you were stable on this for a few years until you had another admission for 2 weeks 15 years ago. That time you were stabilised on a new medication called EFEXOR and the GP decided to refer you to your psychiatrist, Dr Cornelius Smith, because you were on your third medication. EFEXOR is the medication you have previously been on for the longest time (over 10 years).

You have been able to function in your job as a teacher but in the last few years, since your kids left home, you have found coping with work and life to be more and more difficult, to the point you were made redundant last year. In the last 18 months things have been getting worse since your wife left you and it has been really bad for the past 3 months.

Dr Smith prescribed some other medications – the names of which you can't remember because '*there have been so many*'. You tried each of these for many weeks at a time before you and Dr Smith decided to change them. Then Dr Smith started adding medication and there was improvement for a while and then it stopped. You are now on a range of medications that Dr Smith built up over a period of time. He said it was important to keep the effects that had already been gained but to add another medication to get further benefit for specific symptoms.

If asked specifically about the Chlorpromazine, inform the candidate that Dr Smith started it in the last four months, because '*it is one of the longest standing effective drugs we have and it works for everything*'.

If asked whether you experience side effects, you do, but don't really know which drug causes which side effect. You often tend to feel '*foggy'* and tired, even though you sleep for about 8 hours at night. You also have noticed you are very constipated.

If asked, Dr Smith did once mention ECT [Electroconvulsive therapy]. You said it sounded '*a bit grim' – 'all those shocks that you need to have an anaesthetic for*' and he never brought it up again.

Dr Smith works in a solo practice and is flexible, in that he is always able to fit you in to see him if you feel you need an earlier appointment. Dr Smith has worked very hard to try to get you better, but you can imagine you must be a bit of a challenge for him as things are not going that well.

If asked, you have not had any psychological/talk therapies (e.g. CBT – cognitive behavioural therapy). If the candidate asks you about something that sounds like one, ask them if they mean '*talk therapy'.* However, you and Dr Smith do meet often and you feel he is a good listener about your problems. You are really going to miss him now that he is retiring.

You have a lot of family members with mental illness, two of your sisters have been diagnosed with Bipolar illness, you believe your dad suffered depression as you walked into him attempting to hang himself when you

were 13. That was a very stressful event for you that has stuck in your mind all these years. You know your dad had problems with gambling and alcohol.

You had a rough childhood being the youngest of 4 with 3 older sisters. Mum and your sisters live in Sydney now and your dad lives in Cairns. You grew up in Sydney but moved to Brisbane when you were 11 because of dad's job. You experienced bullying in high school because of being the new kid in school. You were shy mostly and had only 2 friends. You were smart in school and went on to university to do a degree in teaching. Your parents separated when you left home at 18, they had always been fighting, mostly due to dad's gambling. You have amicable relationships with your family members now.

You met your wife, June, at university and married a couple of years later. You have always been a hard worker and provided for the family. You prioritised spending time with the kids as you wanted to make sure they had a good childhood. June worked intermittently in accounting during your marriage and most recently she started working full time. This is where she met George, her new partner, with whom she lives on the Sunshine Coast.

4.2 How to play the role:

You are casually dressed but a bit poorly kempt. You have not shaved prior to your appointment. You are anxious about the outcome of the interview because you know your psychiatrist has referred you on. Your mood is low and you don't know if you can keep going.

You are anxious but agreeable to the interview with the new doctor and will provide information as scripted in response to questions asked.

4.3 Opening statement:

'Hello, my doctor is retiring and I am not sure what is going to happen to me.'

4.4 What to expect from the candidate:

The candidate should ask you about your symptoms of depression and how long you have had them. They will also check on your past and current treatment, and should check how you think you responded to them. The candidate should also check whether you are currently feeling suicidal – which you are not.

The candidate is expected to discuss treatment options with you, which you are willing to consider but are afraid that any changes will not work. The candidate may suggest obtaining information from your last doctor, Dr Cornelius Smith. They should try to engage you in a respectful manner and aim to gain your support for any change of treatment.

4.5 Responses you MUST make:

'Do I have more than depression?'

'Do you think I might get better?'

'Did Dr Smith do something wrong?' (when the candidate asks you about all your previous medications)

4.6 Responses you MIGHT make:

If asked about your physical health: you have high blood pressure and take one *Cilazapril* a day. You also have some arthritis in your knees and left hip for which you occasionally take *Panadeine*.

If asked whether you are suicidal; your response is not right now, but you do have increasingly had times when you wish you were dead, and don't believe you can keep going. Because of your experience with your father you have never actually tried to kill yourself though there have been times when it has been tough not thinking about hanging yourself, driving your car into a pole and ideas like that.

If asked about cigarettes, drugs or alcohol; you have always been a drinker – mainly beer – and will drink about 3 cans 4-5 times a week. You don't believe you have problems like your father. You used to smoke but thought it was a bad image for a teacher, and you have never taken drugs except a bit of cannabis while at university.

If asked if you are violent towards others or property; your response is no, but you have periods when you feel agitated and irritable and just shout at people for no reason. You do not wish to hurt your wife, her new partner or anyone else.

If asked about finances; you received a redundancy package which is likely to run out by the end of this year. If you are not better you will apply for the benefit. You can't see yourself getting employed as a teacher again because of your age.

If asked whether you have ever experienced hearing voices or other unusual sensory experiences; or any feelings of paranoia; you have not.

You have never experienced mania, the opposite of depression, where you felt unduly happy, had too much energy, spoke of thought very fast or believed that you had supernatural powers.

4.7   Medications:

Current psychiatric medications:

- Clomipramine 225 milligrams at night (KLOM-IP-RA-MEEN)

- Mirtazapine 90 milligrams at night (MURT-AZ-A-PEEN)

- Lamotrigine 200 milligrams twice a day (LA-MOT-RI-GEEN)

- Chlorpromazine 100 milligrams at night (KLOR-PROM-AZEEN)

- Quetiapine 100 milligrams as required when you feel anxious or more depressed (KWET-I-A-PEEN)

- *Cilazapril one tablet daily for blood pressure (SIL-AZ-A-PRIL)*

- *Panadeine when needed for pain (PAN-A-DEEN)*

STATION 2 – MARKING DOMAINS

The Main Assessment Aims are:

- To complete an assessment to confirm treatment-resistant depression.
- To review the history leading to polypharmacy in the patient with treatment-resistant depression.
- To discuss the range of treatment options to be considered.
- To identify the need to communicate treatment plans and goals with the patient (possibly the family) and private psychiatrist.
- To consider ethical issues related to unusual prescribing by another practitioner and reflect on the issues that should be discussed.

Level of Observed Competence:

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:
clearly achieves the standard overall with a superior performance in a number of areas; sensitively investigates the ambiguity of diagnosis of treatment-resistant depression.

Achieves the Standard by:
engaging the patient as well as can be expected in a first assessment; demonstrating flexibility to adapt the interview style as the patient changes their level of engagement; prioritising information to be gathered; recognising the emotional significance of the patient's material; sensitively evaluating the quality and accuracy of the information; summarizing.

To achieve the standard *(scores 3)* the candidate **MUST**:
a. Seek to establish rapport.

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 significant deficiencies such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach; openly querying the practice of a colleague with the patient.

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

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

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; identifies information to exclude alternative causes and misdiagnosis of treatment-resistant depression in a sensitive manner.

Achieves the Standard by:
taking hypothesis-driven history; demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; clarifying important positive and negative features; assessing for typical and atypical features.

To achieve the standard *(scores 3)* the candidate **MUST**:
a. Elicit key aspects to diagnose treatment-resistant depression.

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.13   Did the candidate formulate and describe a relevant initial management plan? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard and provides a sophisticated link between the plan and key issues identified; clearly addresses barriers and difficulties in the application of the plan; uses the evidence persuasively to enable the patient to address polypharmacy; shows respect the patient's choice of treatment.

Achieves the Standard by:
demonstrating ability to prioritise and implement treatment within an acute care setting; outlining the need for a more thorough clinical assessment and review of previous psychiatric history; planning for risk suicide management; considering the role of ECT or rTMS; outlining the principles and strategies of addressing polypharmacy; monitoring risks in the process of rationalising the medication; selecting treatment environment; skilful engagement of appropriate treatment resources/support; agreeing to safe, realistic time frames and review plans; identifying potential barriers; recognising of the need for consultation/referral/supervision.

To achieve the standard *(scores 3)* the candidate **MUST:**
a. Explain to the patient the alternative options for psychopharmacology.
b. Demonstrate consideration of contemporary clinical practice guidelines for treatment-resistant depression.

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

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) or (b) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
errors or omissions 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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

3.0   COLLABORATOR

3.3   Did the candidate demonstrate an appropriately skilled approach to liaising with the private psychiatrist? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard and recognises complexity of the liaison; manages potential conflicts of interest; recognises the delicacy of the situation.

Achieves the Standard by:
demonstrating the need for clarity and professional courtesy when contacting colleague; respecting, acknowledging and understanding differing viewpoints; identifying appropriate techniques to approach the topic of polypharmacy; clarifying alternatives; effectively managing challenging communications; recognising confidentiality and bias.

To achieve the standard *(scores 3)* the candidate **MUST:**
a. Expect to identify rationale for treatment choices in consultation with the private psychiatrist.

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:
inadequately reflects on importance of information to be obtained; errors or omissions that adversely impact on collaborative relationships.

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

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
above the standard of achieved and does not discuss and attribute blame or fault.

Achieves the Standard by:
demonstrating capacity to: identify and adhere to professional standards of practice in accordance with College Code of Conduct/Code of Ethics; apply ethical principles to resolve conflicting priorities and information; utilise ethical decision-making strategies to manage the impact on patient care; effectively liaise with senior colleague psychiatrists in the complex clinical situation.

To achieve the standard *(scores 3)* the candidate **MUST:**
a. Be clear that current medication regimen is not typical and is high dose polypharmacy.

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

Below the Standard (scores 2 or 1):
scores 2 if the candidate does 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 address the ethical factors in this scenario.

7.1. Category: ETHICS	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