

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 5-10 10
Instructions to Role Player	11-13
Marking Domains	14-16

1.0 Descriptive summary of station:

The candidate will interview Robert Graham, a 45-year-old single male working in management at a local council. Robert is due to appear in court facing charges of animal cruelty. His GP has asked for an opinion. Robert has suffered an acrimonious separation from his long-term de facto partner. This followed the discovery that he had been involved in another intimate affair. He feels that he is 'being taken to the cleaners' following the separation of assets. He also believes his ex-partner had informed his employer about 'inappropriate expenses claims' that are now being questioned at work. Robert is angry and frustrated, but does not display any pervasive symptoms of a mood disorder. He has a history of regular binge drinking. There are several features in the history that indicate Robert has antisocial personality disorder. The candidate will need to take a focussed history to develop a formulation, and identify the diagnosis and differential diagnoses. During the risk assessment, Robert will make a statement clearly threatening harm to his ex-partner. He will then retract the statement. The candidates are required to present their findings to the examiner.

1.1 The main assessment aims are to:

- Assess for the presence of psychiatric disorder including personality disorder in a person who is soon to attend court to face criminal charges.
- Develop and present the formulation to the examiners.
- Demonstrate awareness of the limitations of doctor / patient confidentiality.

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

- Clearly establish the confidentiality of the assessment and its limitations in regard to risk to self or others.
- Elicit a lifelong history of antisocial personality characteristics.
- Identify personal history of abuse as a possible etiological factor.
- Identify two of the four pathological 'antagonism' traits of antisocial personality disorder: manipulativeness, deceitfulness, callousness, hostility.
- Outline the principles of the 'Tarasoff decision' as the core ethical dilemma faced when considering breach of confidentiality for possible risk to others.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Personality Disorders, Other Skills (e.g. confidentiality, consent, capacity)
- **Area of Practice:** Forensic Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Diagnosis, Formulation), Communicator (Patient Communication – Disclosure), Professional (Ethics)

References:

- AMA Code of Ethics 2004. Editorially Revised 2006. Revised 2016
- Code of Ethics, Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2017
- Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013)
- *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d, 334, 131 Cal. Rptr. 14
- World Health Organisation (WHO). ICD-11 Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders. 2018.
- World Health Organisation (WHO). ICD-10 Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders 1990

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: smartly dressed middle-aged male.
- 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 in a private practice. You have received this referral from a GP regarding Robert Graham:

Dear Doctor,

Thank you for accepting this referral for Robert Graham. He is a 45-year-old single male working in management at the local council. He has been angry, and drinking more following a recent separation from his de facto, Sally. Robert is due to appear in court facing charges of animal cruelty as he is accused of harming Sally's dog. He is keen to get a psychiatric opinion as he is concerned about criminal charges he is due to face in court.

The court case is a major stressor but he has some other difficulties in his life at the moment too.

He does have a history of regular drinking and I'm sure he is drinking more now. There is no clear history of substance dependence. He has previously run a number of successful businesses. I don't think there have been problems with the police recently (until now), but he apparently had some 'minor issue' in his youth.

I am concerned about such dramatic changes in his life. He is relatively well known in our community, and others have described him in the past as charming and charismatic. I am concerned that I may be missing a major psychiatric illness.

Physical examination and cognitive testing including executive functioning reveal no abnormalities.

*Yours sincerely,
Dr Gavin Penno*

Your tasks are to:

- Take a history to understand his current situation **from Robert**.
- Present your formulation **to the examiners**.
- Justify possible diagnosis and differential diagnoses **to the examiners**.
- Outline any key ethical issues you have identified during the assessment **to the examiners**.

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.
- TAKE NOTE there are no cues / time 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 **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.

The role player opens with the following statement:

'Nice to meet you Doctor. I've been told you are the best in town'.

3.2 Background information for examiners

In this station, the candidate is expected to take a history from a 45-year-old man who is facing criminal charges, and assess for the presence of psychiatric disorder including personality disorder, formulate the case and present this to the examiners, and address the ethical issue of breaching confidentiality due to risk to others.

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

- Clearly establish the confidentiality of the assessment and its limitations in regard to risk to self or others.
- Elicit a lifelong history of antisocial personality characteristics.
- Identify personal history of abuse as a possible etiological factor.
- Identify 2 of the 4 pathological 'antagonism' traits of antisocial personality disorder: manipulativeness, deceitfulness, callousness, hostility.
- Outline the principles of the 'Tarasoff decision' as the core ethical dilemma faced when considering breach of confidentiality for possible risk to others.

A surpassing candidate may:

- Identify the presence of a possible Conduct Disorder in childhood.
- Identify that this man has successfully used deceit and lack of responsibility, and that the rewards of such behaviour have encouraged him to further use these throughout his life.
- Have a sophisticated understanding of personality disorder and the differences occurring within newer classifications.
- Demonstrate an understanding that despite guiding Code of Conduct regarding ethics from professional organisations the law is unclear in this area; it may equally be found that a doctor is liable for having made an unauthorised disclosure to a third party.

DSM-5: General Criteria for a Personality Disorder

The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose a personality disorder, the following criteria must be met:

- A. Significant impairments in self (identity or self-direction) and interpersonal (empathy or intimacy) functioning.
- B. One or more pathological personality trait domains or trait facets.
- C. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
- D. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.
- E. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

DSM-5: Criteria for Antisocial Personality Disorder

The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose antisocial personality disorder, the following criteria must be met:

A. Significant impairments in personality functioning manifest by:

1. Impairments in self-functioning (a or b):

- a. Identity: Ego-centrism; self-esteem derived from personal gain, power, or pleasure.
- b. Self-direction: Goal-setting based on personal gratification; absence of prosocial internal standards associated with failure to conform to lawful or culturally normative ethical behaviour.

AND

2. Impairments in interpersonal functioning (a or b):

- a. Empathy: Lack of concern for feelings, needs, or suffering of others; lack of remorse after hurting or mistreating another.
- b. Intimacy: Incapacity for mutually intimate relationships, as exploitation is a primary means of relating to others, including by deceit and coercion; use of dominance or intimidation to control others.

B. Pathological personality traits in the following domains:

1. Antagonism, characterised by:

- a. Manipulativeness: Frequent use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends.
- b. Deceitfulness: Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
- c. Callousness: Lack of concern for feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others; aggression; sadism.
- d. Hostility: Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behaviour.

2. Disinhibition, characterised by:

- a. Irresponsibility: Disregard for – and failure to honour – financial and other obligations or commitments; lack of respect for – and lack of follow through on – agreements and promises.
- b. Impulsivity: Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans.
- c. Risk taking: Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard for consequences; boredom proneness and thoughtless initiation of activities to counter boredom; lack of concern for one's limitations and denial of the reality of personal danger

C. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.

D. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio- cultural environment.

E. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

F. The individual is at least age 18 years.

ICD 10: Classification of Personality Disorder

The personality disorder classification includes a variety of conditions and behaviour patterns of clinical significance which tend to be persistent, and appear to be the expression of the individual's characteristic lifestyle and mode of relating to himself or herself and others. Some of these conditions and patterns of behaviour emerge early in the course of individual development, as a result of both constitutional factors and social experience, while others are acquired later in life. Specific personality disorders (F60.-), mixed and other personality disorders (F61.-), and enduring personality changes (F62.-) are deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems of social performance.

Specific Personality disorders

These are severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood.

Dissocial (antisocial) personality disorder

Personality disorder characterised by disregard for social obligations, and callous unconcern for the feelings of others. There is gross disparity between behaviour and the prevailing social norms. Behaviour is not readily modifiable by adverse experience, including punishment. There is a low tolerance to frustration and a low threshold for discharge of aggression, including violence; there is a tendency to blame others, or to offer plausible rationalisations for the behaviour bringing the patient into conflict with society.

ICD 11

The ICD-11 nomenclature for Personality Disorders focusses on the impairment of self and interpersonal personality functioning, which may be classified according to degree of severity ('Personality Difficulty', 'Mild Personality Disorder', 'Moderate Personality Disorder', and 'Severe Personality Disorder'). Furthermore, the diagnosis may also be specified with one or more prominent trait qualifiers (Negative Affectivity, Detachment, Dissociality, Disinhibition, and Anankastia), which contribute to the impairment in personality functioning. Unlike the polythetic ICD-10 criteria for Personality Disorders (e.g., five out of nine criteria) which set the disorder / non-disorder threshold based on the number of criteria that are met, the ICD-11 diagnostic requirements for Personality Disorders base the diagnosis on a global evaluation of personality functioning. Given that personality functioning might be impaired in various ways, the trait qualifiers are available to describe the specific pattern of traits that contribute to the global personality dysfunction.

Disregard for the rights and feelings of others, encompassing both self-centredness and lack of empathy are features of the core definition of the trait domain for Dissociality in regard to the diagnosis of personality disorder (ICD11).

Specific features include: *Self-centredness* including entitlement, grandiosity, expectation of others' admiration, and attention-seeking. *Lack of empathy* including being deceptive, manipulative, exploiting, ruthless, mean, callous, and physically aggressive, while sometimes taking pleasure in others' suffering. For example, such individuals respond with anger or denigration of others when they are not granted admiration.

The Royal Australian and New Zealand College of Psychiatrists Code of Ethics

Confidentiality

Psychiatrists shall maintain the privacy and confidentiality of patients and their families:

1. Psychiatrists shall instil confidence in patients that whatever information they reveal will not be used improperly or shared.
2. Information about a patient obtained from other sources shall be shared with the patient by the psychiatrist unless it is judged that harm may result from sharing such information. Psychiatrists shall also acknowledge and manage the conflict that may prevail between serving the best interests of the patient and respecting the confidentiality of the source.
3. Psychiatrists shall be aware of and manage potential conflicts of interest when treating separate patients who have a close personal relationship with each other.

4. A breach of confidentiality may be justified where there are public interest considerations, in order to protect the safety of the patient or of other people.
5. Psychiatrists may need to share clinical information with colleagues and should take into account patient preferences of what can be shared.
6. If required to disclose clinical information, such as by subpoena, psychiatrists shall limit such disclosure to what is necessary.
7. Safeguarding confidentiality applies even if the psychiatrist–patient relationship has ceased or the patient has died, except in specific circumstances such as a relative’s need to ascertain a hereditary risk or when required by law.
8. Psychiatrists shall maintain confidentiality when using clinical information about their patients for teaching or publishing; the information should be disguised so that the patient is not identifiable.
9. Psychiatrists shall respect a patient’s right to privacy. In the case of teaching, valid consent shall be obtained from patients and / or their families who are involved. Patients shall be informed that refusal to participate or a request to withdraw will not jeopardise their treatment in any way.

Australian Medical Association’s Code of Ethics that deals with confidentiality states:

Maintain your patient’s confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal issues.

This may justify a doctor breaching confidentiality in the ‘public interest’ in order to protect third parties (such as warning the sexual or needle-sharing partner of an HIV positive patient) but does not impose an obligation to warn them. The Code of Ethics does not have the same legal validity as statute or common law, but it is an indication of accepted medical practice that would provide some defence to a doctor who breached confidentiality in good faith to avoid harm to a third party.

However, the law is unclear in this area; it may equally be found that a doctor is liable for having made an unauthorised disclosure to a third party.

Tarasoff case:

Tatiana Tarasoff was murdered by Prosenjit Poddar in 1969. Poddar had described his plan to murder Tarasoff to his psychologist. Legal principle:

- When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.
- The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case.
- Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

Formulation

Some years ago, the Committee for Examinations published a document entitled ‘Formulation’ to assist candidates in preparation for the past Observed Clinical Interview. The need for current candidates to develop skill in formulation remains. The following information is directly drawn from the document on Formulation (on the internet referred to as ‘P:Exams/New Clinicals/Formulation Guidelines 0304’:

‘...the ability to formulate a case is one of the more important skills of a consultant psychiatrist. ... The formulation is a set of explanatory hypotheses or speculations that link the findings on history and mental state examination with the putative diagnosis, and as such should precede the diagnostic statement.’

*‘In the context of the RANZCP Clinical Examination, formulation is a set of **explanatory hypotheses** (or speculations) which address the question: ‘Why does this patient suffer from this (these) problem(s) at this point in time?’ The formulation is an **integrated synthesis** of the data. It should demonstrate an **understanding of this unique individual**, with his / her vulnerabilities and resources and how he / she comes to be in the current predicament.’*

*'The essential task in formulation is to **highlight possible linkages** or connections between different aspects of the case. The focus upon these inter-relationships adds something new to what has already been presented. In this sense, the formulation **is more than a summary**. (case writer's emphasis added).'*

'... there is no expectation that the formulation will necessarily be a dynamic one. The use of more than one framework is often appropriate. Models which have been utilised for the process of formulation have included: - Biological (e.g. genetic predisposition, physical illness, etc.) - Psychodynamic (Freudian, Kleinian, Self-Psychology) – Behavioural / Cognitive Behavioural - Social (e.g. family systems theory, role theory, etc.). The Committee accepts that many models and frameworks can contribute to our understanding of the development of psychiatric disorders. For example, Erikson's Life Stages or the notion of 'Coping Mechanisms' may be appropriately incorporated in a formulation. Most formulations will utilise several frameworks. The candidate is not required to describe the models he / she is using, nor to explicitly state which models are being used.'

It should be noted that the present OSCE case is being examined at the Junior Consultant level which means that the candidates are expected to display a reasonable degree of sophistication in the formulation they present. What constitutes a good enough formulation should be discussed by examiners.

Acknowledging that there is no one single way to formulate a case, the following attempt at formulation is presented for consideration. This was composed by a consultant psychiatrist shortly after reading the OSCE material for the first time.

Example of a Formulation / Sample Formulation

Robert Graham is a 45-year-old man working in management at the local council. He was referred by his local GP due to concerns about recent major changes in Robert's life. This referral occurs in the context of recent separation from his partner of seven years and upcoming legal charges, on a background of long-term difficulties in interpersonal relations.

Since the separation six months ago, Robert acknowledges more frequent episodes of anger and binge alcohol drinking. He denies any symptoms of anxiety, mood or neuro-vegetative disturbance or psychosis. There is no evidence of physical or cognitive change.

Robert is currently facing police charges for animal cruelty, and has been questioned regarding a fire at his ex-partner's home. His work expense accounts are also under investigation by his employer. Regarding his separation and the resultant stresses, Robert tends to project blame onto others, and minimise the seriousness of his own behaviour. Recounting these events, he takes no personal responsibility, instead accusing others for his predicament. For example, he discounts that his sexual affairs might have contributed to the breakdown, blames and seeks revenge against his ex-partner, and makes veiled threats toward her future safety. Characteristically he was quick to minimise, then contradict his prior threat.

In past dyadic relationships, he tends to denigrate his partners, exercise control and domination strategies, and admits to past episodes of physical violence and psychological abuse.

His work history is marked by some successes in the sales areas but frequent changes; buying and selling businesses. His self-employment ultimately ended in business failure for which he blames his partner. He has settled into a less competitive, more protective work environment of government employment where his honesty is currently being questioned.

He tends to portray himself as intelligent and talented, recounting a habitual pattern of getting his own way by using his 'smarts' to outwit others. He tends to see relationships in terms of interpersonal power, and repeatedly exploits others to his own gain / benefit.

Developmentally, he portrays his father as a stern and strict disciplinarian given to physical abuse to enforce his dominance. His mother is seen as distant and avoidant with little perceived nurturing. His early years were marked by bullying and physical abuse by his two older brothers. This may have laid the groundwork for a life-long antagonism toward authority figures. Given his paternal role model, he may have identified with the aggressor and sought to replicate this domineering posture in future intimate relationships in a type of repetition compulsion. One might further speculate that a perceived lack of maternal care and warmth led to failure to develop a secure sense of self or an empathic connection to others. To escape psychological pain and bullying, he found that deception and deceit could decrease social pressure and bring rewards. This coping mechanism appears to have become one of his habitual manners of dealing with threatening situations.

In subsequent intimate relationships, he tended to denigrate, find fault and abuse his chosen partners, and seems incapable of true reciprocity. He tends to bolster his fragile sense of self-esteem by an inflated perception of his own abilities, powers and importance, while devaluing the contribution of others. He recounts coping with adversity by avoidance, and acting out behaviour aimed at harming and undermining his perceived antagonists. While he can present as superficially charming and seductive, there is an underlying sense of entitlement. He has little insight into his own interpersonal function or the effect of his own behaviour on others. He denies psychological symptoms and displays few emotions other than irritability and anger.

The precipitant to Robert's current presentation was his long-term partner leaving their relationship due to his repeated affairs. This may have been experienced as a narcissistic insult to his fragile self-esteem, perhaps arousing past feelings of rejection triggering a defensive outpouring of primitive rage. Rather than accepting some responsibility for the breakup, Robert projected blame onto his ex-partner, adopting what has been called a paranoid posture. Unable to contain the recurrent anger may have led him to acting out aimed at hurting his perceived persecutor by destroying her loved pets. Further anger was fuelled by subsequent police charges, causing him to threaten the man who reported him.

Possible biological / genetic contributions are unclear from the available history. Robert's period of past illicit drug use may be seen as a manifestation of his risk-taking behaviour, his impulsivity or attempts at self-soothing. Ongoing alcohol use and binge alcohol abuse may also contribute to the acting out excesses, and increased frequency of anger affects.

Diagnostically, Robert has displayed maladaptive and self-defeating behaviour in a variety of settings since his childhood. While it is difficult to make a personality disorder diagnosis on the basis of such a brief encounter, there does appear to be sufficient evidence to suggest the presence of significant personality pathology in Robert's case.

Robert's characteristic of personality traits appear to lie mainly in the antisocial realm: deriving self-esteem from power, pleasure in the discomfort of others, failure to conform to lawful / ethical behaviour, lack of concern for others, exploitative relationships and using dominance / intimidation to control others, manipulateness and deceitfulness, vengeful behaviour as evidenced by hostility and anger, and potentially self-damaging risk taking behaviour.

There are also some traits suggesting narcissistic spectrum and borderline pathology which cannot be discounted.

His use of alcohol would warrant a diagnosis of Alcohol Abuse, Binge Type. The possibility of Alcohol Dependence should be borne in mind, despite the patient's denials.

A masked depressive disorder might also be present, suggested by his anger and alcohol use.

An Adjustment Disorder was also considered, but made less likely by the presence of other diagnoses that might explain the presentation, and the ongoing symptoms six months after his separation.

Robert's risk to others must be considered moderately high. There is an ongoing risk of violence to his ex-partner in that he has violent thoughts toward her, and has voiced the wish to 'squeeze the life out of her'. He has a past history of physical abuse toward past partners, and has killed his ex-partner's dogs on purpose recently. He demonstrates no remorse, and continues to feel the need for vengeance and retribution toward her. His past history of domestic abuse, and animal cruelty lend further support to significant safety concerns about Robert.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in 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 Robert Graham, a 45-year-old man who lives in Perth, and works at a local council. You hold a middle level management position in the Human Resources department, and have worked there for over 10 years. You are attending the appointment as you are due to attend court, and are hoping that '**seeking help**' will assist your case.

Your General Practitioner wondered if you had mental health problems even though you are sure that you are not crazy. However, you have figured you may be able to use this visit to your advantage. You do not require the psychiatrist to write a report for the hearing at this time.

Recent events

The charges for the court case relate to animal cruelty. You were caught on camera by a passing cyclist tossing a bag into a lake. The bag was found to contain two dead dogs that belonged to your ex-partner, Sally. The dogs have been assessed as being alive when thrown in the water. You still feel angry towards Sally. She made you carry out this act because of all that she has done to you over the years, and more so in recent times. She deserves to be taught a lesson.

You also feel angry towards the cyclist, especially as he was '**one of those idiots that block the road**' – he had obstructed your drive to the lake.

Sally left home about six months ago. You had been together for seven years, and she is 10 years younger than you. You '**don't know why she left**' but if asked, you will admit to having another intimate affair recently, and you have had others in the past. You felt she was making a big mistake, and thought that she would not survive without you. You saw her as a useless housewife who was always making mistakes; she was '**dim**', and you could not trust her with the finances so you didn't think she would manage by herself. The main positive point in your relationship was that '**She was hot and every man in the room was jealous**'.

Sally could get you angry, and make you shout sometimes. You admit that there was physical violence in your relationship about five years ago – but you only slapped her a couple of times – '**it was nothing really**'. She was never violent towards you and when you were angry, she would listen to what you had to say, and then apologise for what she had done to upset you – and that is how it should be because she was wrong, and you were right every time!

Since your separation, there have been a number of difficulties in your life. Sally has employed a top lawyer, and you are amazed at how ruthless they are, and how they have been able to find money that you thought was well hidden in clever investments. You can't believe how a girl that dumb is going get so much of your money that she doesn't deserve.

You also think Sally contacted your employer about work expenses. The council offices started an investigation into expenses on your work credit card soon after the separation. You feel that people at work are '**blowing it out of proportion**', and are '**going to make an example**' out of you over just a few bottles of gin, and the odd trip to a massage parlour when out of town. The prospect of losing your job, and losing your hard earned capital makes you even more angry toward Sally.

You can feel down sometimes, and you certainly feel angry more often. Both of these feelings tend be transient. The anger is present more frequently as it is precipitated by reminders of your current problems. You tend to deal with your anger by playing squash, and thrashing your opponent (you are very good and should have been the state champion if you had bothered to show up at all the matches).

You also think of ways to even the score with those who have done you wrong (like Sally and the cyclist who reported you), and that makes you feel better for a while. You have thoughts of knocking the cyclist off his bike if ever you saw him again – although you can't remember what he was wearing when riding, and have to admit that you would not recognise him.

You have violent thoughts towards Sally, including going to her place to teach her a lesson – to beat her and '**squeeze the life out of her**'. You know where she lives, and you have driven to her place '**a couple of times**', but she either was not in or had visitors (there were cars that you did not recognise parked in the driveway). It was on one of those visits that you took the dogs from the backyard – but will '**do a proper job**' soon. If asked what you mean by this, you must back track on these revelations, and state that the doctor misunderstood you.

If asked about any other interactions with the police recently, they are investigating a small fire on the side of Sally's property that occurred on the same day that the police noted the dogs were taken. You deny any involvement in this, and claim that it is probably Sally trying to get you into trouble as she is malicious.

Other symptoms and health history

If you are asked about any of the following:

You are able to enjoy things, you sleep well and eat well.

There are no problems with your self-esteem.

You are concerned about the future – losing your job and going to court – but you do have hopes (including that seeing the doctor can help with the court problem).

You have no thoughts of self-harm or thoughts to end your life.

You have no problems with fear or anxiety.

You have never had a period of time when you felt unduly happy for a long period of time, spending excessively or believing that you have special powers.

You do not experience any strange things, such as hearing voices when no one is around.

Although people like Sally and your dumb employer are out to get you, you do not believe that people you do not know watch you or follow you. You do not receive special messages from the TV or radio – **'isn't that what happens to crazy people?'**

You have never seen a psychiatrist before – **'shrinks are for crazies'**, and have never been prescribed any medicines for depression or anxiety.

You do not have any physical illnesses **'I am as fit as they come'**, and have never been hospitalised.

Drug and alcohol history

You drink red wine or gin most evenings – previously with Sally. You drink about three bottles of wine per week, and a bottle of gin a month. This is shared with your latest partner, Kate. You can have at least one day per week where you will drink more – up to two bottles of wine in one sitting. This will most often be when you are socialising with friends.

You do not use marijuana or any other drugs at present. You had experimented with marijuana and speed when you were younger, but have not used any for years.

You do not gamble regularly and do not watch pornography.

You are not interested in internet gaming.

Personal history

You have been together with Kate for five months. You met her a few days after Sally left you, and she is really a **'top girl'** but can be also be a bit dumb at times.

You see yourself as a confident, intelligent leader and winner. You enjoy playing squash and socialising. You have many friends and all of them think you are really cool.

Forensic (Criminal) history

If asked about a past criminal history, you will admit to it as you think the doctor has access to your police file. You can say **'I am sure the coppers will send you my records if you ask for them so...'**

When 17, you were found guilty of animal cruelty for drowning a neighbour's dog. Your neighbour had knocked you to the ground in front of your friends over an argument about loud music at a party you had hosted at your parents' home. The dog kept barking while your party was in progress – and that was what probably kept the neighbour awake. So, the mutt deserved to die. You were given a short community-based order for that offence.

A previous partner went via the courts to get an order against you about 10 years ago because she claimed you were threatening and abusing her. You will claim that she was a liar, and had fabricated the story of threats and physical abuse. You feel this was vindicated by the police dropping the assault charges. You admit that you have had a number of speeding fines, parking fines and a 'driving under the influence' 10 years ago.

Family history and early life

You are the youngest of three boys. Your older brothers, Simon and Ethan, were from your father's first marriage. Your father was a partner in a firm of financial advisors. Your mother was a university lecturer. Your parents were often away long hours, and both would spend time away when they were travelling from home because of work. You were often bullied, and beaten by your older brothers when you were very young. Your father was also a harsh disciplinarian, and would often use his belt or a cane on all of you. Mom never interfered as she found the three of you boys too difficult to manage, and would usually walk away when dad was having a go at you. If asked, you have never been sexually abused.

You realised you could use your '**smarts**' to lie, and manipulate about situations to get your brothers into trouble. You saw this as great fun and a good way to prove how clever you were. Your brothers still bullied you at times until you got them into major trouble by setting fire to a sofa in one of their bedrooms with a cigarette and magazine.

You carried on using your '**smarts**' at school as the teachers were '**dim and easy to fool**'. You are happy to boast that you were able to fool them all, and avoid homework for a whole year of school! You told them that your mother was unwell, and you had to do a whole lot of the housework, and they believed you. How stupid were they!

You were a naughty child but were '**too smart to be caught**'. You did not think that stealing from shops was a problem, and you often helped yourself to things you needed but did not want to buy. It was also fun to hit animals and watch them try to run away.

After leaving school, you travelled and worked around Europe for two years. On return, you started work in sales and found the work easy and financially rewarding. You prospered and ended up running a business. You have moved between states a number of times as you have sold businesses, and taken over others.

You moved into administration at the council after your last business went into liquidation as your business partner had made a high-risk decision that failed, and so the company went bust. You started on a lower level, and have been promoted a number of times, because of your intelligence and skill, and enjoy your job because '**there are plenty of perks and you don't have to put in much effort**'.

You have two daughters from a first marriage that ended after three years when you were 28. They live in NSW, but you don't have contact with them '**because my ex has poisoned them against me**'.

4.2 How to play the role:

Smartly dressed, charming man. You are confident and forth coming with information that is positive about you or negative about others. You are less forthcoming about negative information about yourself. You become angry when discussing your 'ex'.

4.3 Opening statement:

'Nice to meet you Doctor. I've been told you are the best in town.'

4.4 What to expect from the candidate:

The candidate is expected to establish a professional relationship, and ask questions that will explore areas of mental illness, and issues pertaining to the current charges of animal cruelty. They may explore other areas, such as the problems at work, with relationships and areas of risk. The candidate will ask some questions related to experiences in the past. In regard to risk, the candidate will explore further the nature of the 'threats to kill'.

4.5 Responses you MUST make:

'I do think about squeezing the life out of her.'

Soon afterwards:

'You misunderstood me. I was joking. I wouldn't hurt anyone.'

4.6 Responses you MIGHT make:

If the candidate asks about any past animal cruelty or past criminal history:

Scripted Response: 'I am sure the coppers will send you my records if you ask for them so...'

4.7 Medication and dosage that you need to remember:

None.

STATION 3 – MARKING DOMAINS

The main assessment aims are:

- Assess for the presence of psychiatric disorder including personality disorder in a person who is soon to attend court to face criminal charges.
- Develop and present the formulation to the examiners.
- Demonstrate awareness of the limitations of doctor / patient confidentiality.

Level of Observed Competence:

2.0 COMMUNICATOR

2.2 Did the candidate appropriately and adequately explain their role and assessment purpose to the patient? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

appropriate and comprehensive application of the principles of working closely with patient, and demonstrates the importance of ensuring respectful and open communication.

Achieves the Standard by:

providing a clear and appropriate explanation; demonstrating capacity to balance patient safety / rights and community safety; recognising the importance of explanations in consultations outside the usual doctor-patient / treatment relationship; candidate informs the patient that the candidate does not have access to police records.

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

- Clearly establish the confidentiality of the assessment and its limitations in regard to risk to self or others.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; approach is disrespectful; explanation is unclear or inadequate in meeting the needs of the patient.

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

2.2. Category: PATIENT COMMUNICATION - Disclosure	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.0 MEDICAL EXPERT

1.2 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; conducting a detailed but targeted assessment; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; history taking is hypothesis-driven; integrating key sociocultural issues relevant to the 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**:

- Elicit a lifelong history of antisocial personality characteristics.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

provides a superior performance in a number of areas; identifies possible conduct disorder as a child; applies prioritisation and sophistication – success and positive results following the application of traits of deceitfulness, and lack of responsibility have rewarded such behaviour, and encouraged further use throughout his life; applies a sophisticated sociocultural formulation.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history, observation and examination; synthesising information using a biopsychosocial framework; identifying a past history of multiple episodes of risk including arson and harm to animals increasing the possibility of future risk; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient's predicament; accurately describing recognised theories and evidence; commenting on missing or unexpected data; accurately linking formulated elements to any diagnostic statement; including a sociocultural formulation; analysing vulnerability and resilience factors.

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

- a. Identify personal history of abuse as a possible etiological factor.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; significant deficiencies including inability to synthesise information obtained; failure to question veracity where this is important; providing an inadequate formulation or diagnostic statement.

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

1.11. Category: FORMULATION	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.9 Did the candidate justify the relevant diagnosis / differential diagnosis? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment; have a sophisticated understanding of personality disorder and the differences occurring with newer classifications.

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, and / or identifying relevant predisposing, precipitating perpetuating and protective factors; including communication in appropriate language and detail; considering substance use disorder, psychotic illness, a mood disorder and narcissistic personality disorder as possible differential diagnoses.

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

- a. Identify two of the four pathological 'antagonism' traits of antisocial personality disorder: manipulativeness, deceitfulness, callousness, hostility.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusions.

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

1.9. Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

comprehensively considers all major aspects of ethical conduct and practice; understands that despite guiding Code of Conduct regarding ethics from professional organisations, the law is unclear in this area; acknowledges that a doctor may equally be found liable for having made an unauthorised disclosure to a third party.

Achieves the Standard by:

demonstrating the capacity to: identify and adhere to professional standards of practice in accordance with College Code of Conduct / Code of Ethics and institutional guidelines; integrating ethical practice into the clinical / non-clinical setting; 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.

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

- a. Outline the principles of the 'Tarasoff decision' as the core ethical dilemma faced when considering breach of confidentiality for possible risk to others.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; did not appear aware of or adhere to accepted medical ethical principles.

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

7.1. Category: ETHICS	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the level of a junior consultant psychiatrist?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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