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DO NOT REMOVE FROM ROOM

ACTIVE BYE STATION 1 NOTES

The following information is provided for you. These same 'Instructions to Candidate' will be available in Station 1.

You may make notations on your notepad, which you will take with you into Station 1.

- You have **twenty (20) minutes** in this Active Bye Station to watch a DVD of the 'Strange Situation' procedure, and work on the responses to the tasks based on the DVD. The video has been shortened to 15 minutes but provides you with all the information you need to complete your tasks.
- After you leave the bye station, you have a further **five (5) minutes outside the examination room** to continue working on the responses.

You are a junior consultant psychiatrist working in a country town. You are providing a secondary consultation to the regional child protection team. You will be meeting with a social worker, Gemma Brown. She has graduated recently from university, and this is her first job. She is the long-term case worker for the family you will see in the video. She wants advice on how to interpret the interactions between Rhianna and Charlie Armstrong who have been identified as at risk.

During her pregnancy, the mother Rhianna Armstrong (whom you will see in the video) suffered a relapse of schizophrenia after her medication was ceased by the GP because of the risk to the foetus during the pregnancy.

Rhianna is a 22-year-old single woman who moved in with her parents after the birth of her son, Charlie, 14 months ago. She has a history of substance abuse prior to the pregnancy, but none since she became pregnant. Rhianna now wants to move into her own home, and live independently with Charlie. The child protection team wants to ensure that there is no risk to Charlie's welfare if this were to occur.

Your tasks are to:

- Describe the interaction between the child and his mother in this 'Strange Situation' scenario.
- Determine the likely attachment style of the dyad.
- Explain different attachment styles and their significance.
- Prioritise specific interventions to support Rhianna and Charlie.

1.0 Description summary of station:

In this long station, the candidate is a junior consultant in a country town who is providing secondary consultation to a child protection team. There is an active bye in which the candidate watches a modified (shortened) video of the 'Strange Situation' procedure, edited to fit into the time allowed. The mother and her infant have been identified as at risk due to the mother's past history of substance abuse and schizophrenia. She is a single mother who has moved in with her own parents for support after the baby was born. She is now wanting to move out of her parent's home. The candidate is expected to evaluate the interaction between the mother and her child, looking for strengths and difficulties. In the examination, the candidate also has to address the concerns of the child protection worker, who is new to this work and suggest further interventions to support them in the future.

1.1 The main assessment aims are to:

- Observe and describe the behaviour of a mother-infant dyad in the 'Strange Situation' procedure, and identify the attachment style of the dyad.
- Demonstrate an understanding of categories of attachment and behaviours that could be observed, supporting each diagnosis.
- Listen to the concerns of a junior child protection worker, and educate her about attachment theory; addressing the perceived stigma against this mother who has schizophrenia.
- Suggest interventions that can be put in place to support the mother and her child.

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

- Focus on attachment in the description of the observed behaviour of the dyad.
- Identify a generally secure attachment with some avoidant features.
- Explain all four categories of attachment.
- Advocate for the mother who is providing good enough care for her child.
- Ensure clarification of the level of involvement of the father.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Child & Adolescent Disorders, Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.)
- **Area of Practice:** Child & Adolescent
- **CanMEDS Marking Domains Covered:** Medical Expert, Health Advocate, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Formulation – Communication; Diagnosis; Management – Initial Plan), Health Advocate (Addressing Stigma), Scholar (Medical Terminology)

References:

- Ainsworth M and Bowlby J (1965) *Childcare and the Growth of Love*. London: Penguin Books
- Bowlby J. (1969) *Attachment and Loss*. London: Hogarth
- Healy S et al. Affect recognition and the quality of mother-infant interaction: understanding parenting difficulties in mothers with schizophrenia
- Mares S Newman L and Warren B (2005) *Clinical Skills in Infant Mental Health*. Camberwell: Acer
- Seeman M (2011) *Intervention to Prevent Child Custody Loss in mothers with Schizophrenia*. Schizophrenia Research and Treatment vol 2012 pp
- Zeanah C (2019) *Handbook of Infant Mental Health*. New York: Guilford

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: female aged early 20's.
- 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.

In the active by station, you have watched a video of Rhianna Armstrong and her 14-month-old son, Charlie.

You are a junior consultant psychiatrist working in a country town. You are providing a secondary consultation to the regional child protection team.

You will be meeting with a social worker, Gemma Brown. She has graduated recently from university, and this is her first job. She is the long-term case worker for the family you have seen in the video. She wants advice on how to interpret the interactions between Rhianna and Charlie Armstrong who have been identified as at risk.

During her pregnancy, the mother Rhianna Armstrong (whom you have seen in the video) suffered a relapse of schizophrenia after her medication was ceased by the GP because of perceived risk to the foetus during the pregnancy.

Rhianna is a 22-year-old single woman who moved in with her parents after the birth of her son, Charlie, 14 months ago. She has a history of substance abuse prior to the pregnancy, but none since she became pregnant. Rhianna now wants to move into her own home, and live independently with Charlie. The child protection team wants to ensure that there is no risk to Charlie's welfare if this were to occur.

Your tasks are to:

- Describe the interaction between the child and his mother in this 'Strange Situation' scenario.
- Determine the likely attachment style of the dyad.
- Explain different attachment styles and their significance.
- Prioritise specific interventions to support Rhianna and Charlie.

Station 1 - 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:

'Hello Doctor, I don't really understand what this video is about. Can you tell me a bit more?'

3.2 Background information for examiners

In this station, the candidate is providing secondary consultation to a child protection team in a rural setting. The candidate will watch a modified (shortened) video of the 'Strange Situation' procedure. The single mother and her infant have been identified as at risk due to the mother's past history of substance abuse and schizophrenia. She moved in with her own parents for support, and now wants to move out of her parents' home.

The candidate is expected to observe, evaluate the interaction between the mother and her child, and describe the behaviour of a mother-infant dyad, looking for strengths and difficulties. The candidate needs to be able to recognise the attachment style, and demonstrate an understanding of categories of attachment, and behaviours that could be observed supporting each diagnosis.

The candidate is to discuss the presentation with the child protection worker, who is new to this work and educate her about attachment theory, and address perceived stigma regarding a mother with schizophrenia. They then have to suggest further interventions to support the dyad in the future.

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

- Focus on attachment in the description of the observed behaviour of the dyad.
- Identify a generally secure attachment with some avoidant features.
- Explain all four categories of attachment.
- Advocate for the mother who is providing good enough care for her child.
- Ensure clarification of the level of involvement of the father.

A surpassing candidate will give a superior description of the interaction observed, and may refer to the Adult Attachment Interview as another method to assess and understand the attachment style of the dyad.

Candidates are expected to describe observed behaviour with a focus on proximity maintenance or avoidance of proximity and contact, gaze, vocalisation. The candidate may comment on sensitivity, contingency, marked communication (baby talk where the mother uses a higher pitched voice to describe the infants experience or give voice to the baby's experience).

Candidates are expected to identify that the infant does show signs of appropriate attachment to the mother. He does seek proximity and come to her for comfort, and he shows distress at separation. He is able to make use of the stranger for comfort. There is a somewhat avoidant tone in the interaction which may be commented on by candidates.

Attachment Theory was initially developed by John Bowlby who described that 'the young child will seek proximity to or contact with a specific figure and more so in certain situations, notably when frightened, tired, or ill'. If the child feels threatened in any way, the attachment system is activated and the child seeks proximity with the caregiver for comfort.

Attachment is a relational construct. The attachment relationship is mutually regulating for the infant and the care giver. The attachment relationship provides, warmth, nurturance and comfort at times of distress. It is through the empathic attunement of the mother that the infant comes to recognise himself, and other. It is through the attachment relationship that the infant develops capacity for emotional self-regulation through the experience of being soothed at times of distress. The child can use the attachment relationship as a secure base for exploration. The care giver provides encouragement and support for the infant to explore their world.

The attributes of an attachment relationship are:

1. The relationship provides a secure base for exploration.
2. The relationship provides a safe haven to return to at times of stress and when emotion needs to be regulated.
3. Proximity maintenance.
4. Separation distress.

Attachment is a biologically determined survival imperative which is hard-wired in all mammals, and other animals with possible phylogenetic age of over 200 million years. An understanding of attachment theory can inform psychiatric practice in perinatal psychiatry and in psychotherapy, and in understanding relationships and transference and countertransference. It is also helpful in understanding the experience of patients with borderline and other personality disorders. People with insecure attachment styles are more vulnerable to some psychiatric disorders including Post Traumatic Stress disorder. Each dyad will work out ways of being connected that feel safe.

Secure attachment is present when the child is comfortable to seek comfort and comfortable to explore. He can cue his needs directly. The inevitable ruptures in the relationship and missed cues that occur are easily repaired. Internal working models of self and other will generally be positive. Children with secure attachment will usually be able to make use of alternative care givers to provide support and regulation. In the 'Strange Situation', the child will be seen to use the parent as a secure base to explore. They will be distressed by the separation; however they are likely to be able to accept comfort from the stranger. They will seek proximity on the mother's return and settle to play quite quickly.

Insecure avoidant dyads feel more comfortable with some distance in the relationship. Mary Main describes that avoidant behaviour in the 'Strange Situation' is 'a conditional strategy, which paradoxically permits whatever proximity is possible ...by de-emphasising attachment needs'. The avoidant dyad may disregard each other on reunion or connect with just a glance or a smile. The infant may show little or no contact maintaining behaviour.

Insecure preoccupied (insecure ambivalent) infants are likely to feel most comfortable with a great deal of closeness, and uncomfortable with distance. The child may struggle to make use of the parent as a secure base and may not explore very much. They may be very wary of the stranger and not find comfort in the stranger. The preoccupied child will be very distressed by the departure of the parent.

The 'Strange Situation' Procedure (SSP)

The 'Strange Situation' is a structured observation of a carer / infant dyad that was developed by Mary Ainsworth as a research tool to investigate the qualities of attachment relationships between young children and their primary carers. Over recent years, the 'Strange Situation' has been used as a clinical assessment tool. In particular, the behaviour of the child when the caregiver leaves, the response to the stranger and especially the behaviour of the dyad when the mother returns to the room can evaluate the child's ability to use the mother as a secure base for exploration, and a safe haven at times of stress.

The procedure takes place in a room set up as a playroom, with a one-way screen that professionals can observe. It takes 21 minutes in eight stages and is videotaped. The stages are:

1. mother and child are oriented to the room.
2. the infant explores the room and toys.
3. a stranger enters.
4. first separation, the mother leaves the room, leaving the infant and the stranger together.
5. first reunion, the mother returns and the stranger leaves the room.
6. second separation, the mother leaves the infant alone in the room.
7. the stranger enters the room.
8. second reunion, the mother returns to the infant and the stranger leaves.

Trained observers are interested in whether the child uses the mother as a secure base for exploration in the initial phase of play in a new environment. Does the child feel confident to explore?

Observers look for how the dyad manage proximity and contact seeking. Can the child cue directly their need for proximity and comfort, and how does the mother respond to the cues.

How does the dyad maintain proximity and contact?

Is there resistance to contact and comforting from either or both partners?

The video used in this examination has been shortened to 15 minutes but contains all the necessary information.

The initial play session is marked by a low affective tone, relatively independent play by the infant. The mother comments on his exploration. He makes some attempt to engage his mother in the play. She comments on the green spoon which he shows to her. He holds on to this fork for much of the SSP, possibly giving him a sense of connection with his mother when she is not there. There is very little vocalisation on his part. She continues to talk to him about what he is doing.

The stranger enters and the infant welcomes her with his spoon. The infant is not disturbed by the arrival of the stranger. He continues to explore the toys without needing to approach his mother. The mother makes a general disparaging comment 'you are spoiled'. The infant does make some vocalisation. He moves a little closer to the mother and shows her the spoon. The moving closer to her probably does express his need to be connected to her while meeting the stranger. He looks from mother to the stranger, and back again and engages with the stranger by showing her the spoon.

He watches mother leave and turns himself around to face the door. He shows some uneasiness at the initial separation from his mother but is not distressed. He has a tight-lipped expression on his face. He looks to the stranger and seems to be reassured. He looks at the door where his mother left. He plays in a listless way for a few moments and goes over to the chair. He does not interact much with the stranger. He continues to hold a green spoon that he had been playing with when his mother was in the room. Later he crawls towards the door but comes back. There is more vocalisation than previously.

In the first reunion he initially does not make contact with the mother with gaze or voice, neither does she initially. He watches the stranger leave and then gazes at his mother. He lets out a sigh and she does the same (reciprocal and contingent). This is repeated in a playful way and there is some (modest) delight reciprocally in this interaction. He remains on the floor, but his play becomes a bit more structured. He approaches the mother with a toy truck, still clutching the green spoon. There is some vocalisation with more intonation than previously. He seeks some proximity to his mother with the truck. She welcomes him gently with 'Hi'. She takes the truck he offers her, and he climbs up closer to her, seeking proximity. She does not pick him up, but he does not clearly request this. She redirects him to the toys with the truck. He returns to the toys but not the truck she offers. She touches him on the back as he leaves her. He goes to stand at the chair and looks to the door. He returns to the toys. He is not very demonstrative, and neither is the mother.

In the second separation, he watches mother leave, crawls to the door and regards the room for a few seconds. He stands at the door. He quickly becomes very distressed, crying loudly and plaintively. His distress at separation is appropriate, and clearly distinguishes this dyad from an insecure-avoidant dyad. An insecure-avoidant infant would not demonstrate their distress. Markers of distress, such as heart rate variability, would indicate stress but the behaviour would not demonstrate distress in avoidantly attached infants.

When the stranger enters the room, he immediately is silent and accepts her picking him up. He has his arm around her shoulder, still clutching the green spoon. He accepts sitting on the floor with the stranger for a few moments but is not really interested in the toys. He goes to the chair near the door. He returns to the playmate and shows her the spoon. He shows her the phone that he had played with when his mother was in the room. He crawls back to the door and again to the mat. He pushes the truck that he had earlier shown to his mother but in a listless disorganised way. He looks at the door repeatedly.

In the second reunion once again there is initially little recognition. He does look up at her and smile for a moment. This is reciprocated by the mother. There is no vocalising. He turns away. He goes to a chair and she mimics his sigh again, synchronously. He goes over to a chair to stand up. His mother reaches out towards him as an invitation to proximity. He offers her the spoon and comes over to her. He is vocalising pleasure as he approaches. He stands on his toes, and she contingently and warmly picks him up. He sits on her lap and indicates the door; she reciprocally comments on. She quite quickly puts him back on the floor, but he coos with apparent pleasure. He continues to hold a spoon. Mother joins him on the floor. There is an attempt at reciprocal play with the truck. There is obvious pleasure in the interaction but not real delight. There does not appear to be reverie, the state described by British Psychoanalyst Bion where the mother and infant are fully and mutually involved with one another.

He has been able to use his mother as a secure base to explore, and has been able to indicate his need for comfort. However, the affective tone is generally restricted and vocalisations similarly restricted. He has been able to use the stranger as an alternative when only she was available, and his need for connection was extreme due to the absence of his mother. He seemed to use the green spoon as a transitional object and a vector to communicate his experience of loss and reunion. The attachment appears to be secure, however there is a generally avoidant style to this with restricted responses to reunion.

Attachment Styles

In Ainsworth's original sample, 70% of dyads showed secure attachment. Children who are securely attached show an ability to leave their mother and to play independently. They will be distressed when she leaves but are likely to be able to make use of the stranger for some comfort, although they should show some reservation. The secure child will be uninhibited in the reunion with the mother and settle quickly to play.

Children with preoccupied (resistant / ambivalent) attachment comprised 15% of Ainsworth's sample. The behaviour seen may include struggling to separate and play independently, particularly after the reunion. The child will show obvious distress on separation, may show fear of the stranger and struggle to find any comfort with the stranger, and will approach the mother on reunion but reject the contact with her.

Children with avoidant attachment may appear to be overly independent. They may appear as if they are not troubled by the separation, and may lack an obvious reaction to the reunion. However, we know from the research that these infants are physiologically stressed by the separation, but they do not indicate this in their behaviour.

All three of these attachment styles (secure, ambivalent and avoidant) are organised to facilitate maximum proximity, given the carer's own attachment style and, strengths and vulnerabilities.

The fourth style of attachment is so called Disorganised Attachment, which is understood as indicating a pattern of attachment that stems from the infant / caregiver relationship having been prone to disruption and unpredictable emotional experiences. This has been associated with Borderline Personality. It could be argued that this is where the child is very highly organised around the mother's behaviour, which may be unpredictable, and can be frightening to the child. Alternatively, the mother can be frightened of the relationship with the child. Conflicting behaviour of 'approach and avoid' will be seen. On reunion, a child with disorganised attachment may initially seek proximity, but then may run away or seem frightened or even attack the parent.

Attachment relationships are reciprocal, and the mother's behaviour will be complementary to the child's. In fact, it is the mother's attachment style, her comfort with separation and her comfort with closeness which will be mirrored in the child's behaviour and expectations of the relationship. Attachment relationships are mutually regulating. Attachment style of the infant can be predicted with 85% accuracy by the attachment style of the parent.

Evaluating the Relationship

In evaluating the relationship between a small child and the mother the observer notices the following:

Behaviour:

In relation to one another, such as body position in relation to own body parts and in relation to the 'other', muscle tone and any changes in this, activity including in particular if this is towards or away from each other and at what times movement occurs, contact, and the quality of this, the infant's state (e.g. tiredness).

- Is the behaviour **RESPONSIVE**, high responsiveness might be shown in the baby's response to encouragement by the mother?
- Is the behaviour **CONTINGENT**, the reaction being in keeping with the other's action?
- Is the behaviour **RECIPROCAL**, with appropriate turn taking and responsiveness to the interest shown?
- Is the behaviour **SYNCHRONISED**, appears to be coordinated, occurring at the same rate?
- Do they **MIRROR** each other's behaviour?
- Do they **SEEK PROXIMITY** and how do they communicate this to each other. If the baby is held, does his body mould comfortably to the mother or not?
- Are they responding in a **SENSITIVE** way to each other, or does it appear that communications are missed?

Visual Interaction:

- Do infant and parent look at each other, **GAZE**, how often, in what situations / prompts?
- What is the other persons response, do they have a 'light in their eyes', does this change when they are looking at the other?
- How long do they sustain eye contact? When do they look away?

Vocal Interactions:

- Amount, tone, prosody, developmental level, reciprocity, relationship to affective state and position to other.
- Does the mother '**MARK**' her baby's experience by putting his experience into words using a higher pitched voice e.g. 'baby talk'?

Affect Tone:

- What is the affective tone of the interaction, how is this evidenced in facial expression, movements, proximity?
- Is there **WARMTH** in the interaction? Is affect experienced **MUTUALLY**?
- Is there **REVERIE**, the condition described by Bion when the mother and baby are mutually and fully engaged in being together?
- Does the mother mirror the affect of the baby with her facial expression or gesture, and does she mark this with a slight exaggeration, in contrast to the more natural display of her own affect? It is through this marked mirroring that the baby comes to recognise his own affective experience, and can come to understand the causes and effects of affective experience, and how to communicate this with others.

Depth of Interaction:

- Are the behaviour, vocalisation and gaze attuned?
- Does the caregiver perceive, make sense of and respond in a timely manner to the actual moment to moment signals sent by the child?
- What is the intensity of the affect, including joy, in the interaction?
- What is the intensity of the interaction?

Parental Reflective Capacity:

- To what extent does the parent have this capacity? Is it consistent or do current factors appear to influence this?

Infant Reactivity:

- How does the infant respond to their parent?
- How does this compare to their responses to other significant people in their life, and how does it compare to their reaction to you and to other professionals?
- Does he seem to respond in an uncomplicated way, cuing directly what he wants or needs?

Risk:

- Is anything that you observe raise concerns for the safety of the baby, e.g. dangerous environment, significant parental lack of awareness of infant, misinterpretation of cues or anger in parent directed toward child?

There is a great deal of stigma towards mothers with schizophrenia. It has been reported that approximately 50% of mothers with schizophrenia lose custody of their children (Seeman 2012). A study in London identified that 63% of women with psychosis were parents. A study in Canada showed that 83% of parents with schizophrenia were not living with their children, although this figure included fathers and mothers, so is probably higher than it would be for mothers alone. Mothers with serious mental illness often fear that schizophrenia is equated with parental incompetence, neglect or violence. Ackerson has commented that parents with a diagnosis of psychosis are victimised twice, first by illness and then by protective removal of their children.

This perception can lead a mother to fear seeking help at times that they may need it. Removal of a child from a parent that they are attached to is a traumatic event for any child, as well as traumatic for the parent. Women who are parents are usually very often motivated to make changes in their lives on behalf of their children, and to ensure that they are able to be the best parents that they can be. Issues such as compliance with medication, self-monitoring and recognition of early signs of relapse, abstaining from drugs and alcohol, engagement with services and capacity to keep the child's real needs in mind, developing a crisis plan, making use of parenting resources.

At times it may be necessary to provide assistance with other domestic stresses, such as financial matters and housing in order to support the mental health of a parent. The presence of an engaged supportive family is very protective. The child's father and grandparents can provide supplementary attachment relationships, can provide respite and assist to ensure the mother gets adequate sleep, and can be engaged with services to help monitor the mother's mental health.

There have been deficits in parenting documented in mothers who suffer from psychiatric illness, and the quality of the interaction can be impaired particularly if the mother has difficulty in recognising the infant's cues. Of course active illness can impair sensitivity to cues. However in a well mother with schizophrenia, there may still be deficits in recognising, assessing and experiencing emotions. This could be related to negative symptoms of schizophrenia, and is consistent with the neuropsychological profile of someone with schizophrenia. Sedating medication could also contribute to the mother being less sensitive to emotional cues of an infant. Of course people diagnosed with schizophrenia are a very heterogeneous group with regard to negative symptoms.

People earlier in the course of illness and with a less severe illness, and with good premorbid personality functioning are likely to do better with regard to emotional functioning. Parents who do have difficulties in recognising babies cues may do well with programmes that address these problem which are available in the community, such as Circle of Security parenting courses or similar, or in home support or other one-on-one parenting coaching.

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 Gemma Brown, a social worker who has recently joined a child protection team in a country town (population approximately 2500) called York, which is about 100 km away from Perth. This is your first job after graduating from university with a degree in Social Work.

You are meeting a consultant psychiatrist for a secondary consultation (a process where the psychiatrist discusses a case with you but does not meet with the client personally). Your team has undertaken and filmed an assessment of a child Charlie (aged 14 months) with his mother (Rhianna Armstrong) in a process called the 'Strange Situation'.

The 'Strange Situation' process is a structured, observed and videoed process (usually over 20 minutes) where the mother and child enter a playroom, and are asked to play together. After a few minutes, they are joined by a stranger. After a few minutes, the mother leaves the room. The child is left with the stranger. A few minutes pass, the mother then returns and later the stranger leaves. The quality of the interaction is observed by a team of health professionals, looking for the child's capacity to use the mother as a secure base for exploration, and the mother's ability to provide security for her child.

The consultant psychiatrist that you are meeting has watched the video. You want to understand the significance of the behaviour observed in the video. You would like to know how they would describe what is seen in the video. You would like to know how to use this knowledge in planning for managing this case.

You have not worked with psychiatric patients previously, and you come with a strongly biased view that anyone with schizophrenia is not likely to be a safe and suitable parent. You are not convinced that she will manage, and are concerned that Rhianna should not be supported to live independently with her son. The community knows that people with mental illness and substance use cannot really be trusted to look after themselves without lots of support.

Regarding Rhianna and Charlie:

Rhianna is a 22-year-old single mother of Charlie, a 14-month-old boy. You have not met Charlie's dad, and have been told that he is not involved in the child's care. He was someone she met and dated briefly while he was on a backpacking holiday in WA, and was living in the area for a few weeks. He has now returned to Germany.

Rhianna grew up in the town of York, and is the only child of Robert and Mary Armstrong. She and Charlie currently live in their home. They are a nice, solid couple who care deeply for their daughter and grandson, and the Child Protection Service have had no concerns while they have been living together. However, Rhianna now wants to move to her own home with Charlie, and so the concerns about his welfare have been raised.

Rhianna was diagnosed with schizophrenia when she was 18 years old. At the time, she used marijuana and alcohol quite regularly, and was not very good about taking her medicines. She has had two admissions to hospital in the two year of her illness. She then did well for a period of time, and took her medicines regularly (you are unsure what the name of the tablets are).

Once she discovered she was pregnant, she went to her family doctor (GP) who advised her to stop her medicines as he was unsure what effect it would have on her child. Within a few weeks, she became unwell again and was readmitted to hospital, and restarted on medicines. After that she has remained well. She also stopped smoking and using marijuana since that time.

It is because of her mental health and drug use that Child Protection was involved since before Charlie's birth. Given that Rhianna has continued to live with her parents, that she is well and seems to be coping and that Charlie has appeared to be a happy baby, no action has been taken so far. However, you know that people with mental illnesses, especially schizophrenia, can be unpredictable and dangerous. You want to make sure that Rhianna is capable of caring for her child, and this assessment is one of the precautions you are taking.

Rhianna does not have a regular psychiatrist, and you do not know the name of the medicines she is on. She sees her GP regularly, and he monitors her health and prescribes her medicines.

At present, she appears well and healthy. She is not presently smoking, drinking alcohol or using drugs. She does not have a boyfriend.

She gets some benefits from the government, and her parents are financially comfortable and are happy to help her out with the rent, and buying things for the child.

She completed school till Year 12, and did ok but did not go to university as she became unwell.

4.2 How to play the role:

Casual working clothes. You are earnest and curious about how to understand the client and his mother.

4.3 Opening statement:

'Hello Doctor, I don't really understand what this video is about. Can you tell me a bit more?'

4.4 What to expect from the candidate:

The candidate should describe the behaviour seen in the video with reference to how the baby uses the mother as a secure base to explore the world, and a safe haven to come back to when he needs a 'top up' of a sense of connection to her. The candidate should be looking for times that the baby seeks proximity and comes closer to her, and times he moves away. The candidate should comment on how and when they look at each other. The candidate should comment on whether they seem to be sensitive to each other, whether they take turns in the interaction, whether the mother uses 'baby talk' to give a voice to the baby's experience. The candidate should describe moments in the video when there was delight in the interaction, and should pay particular attention to the child's behaviour when the mother leaves and the reunion.

The candidate should also address your beliefs that a person with mental illness cannot look after a child independently.

4.5 Responses you MUST make:

'What do you see that is most worrying?'

'Can you elaborate on the different types of attachment?'

'Is it really okay for Charlie to be brought up by someone who is mad?'

'Will he be able to be normal and make friends?'

4.6 Responses you MIGHT make:

'What do you see that is good?'

'What should I look out for to identify secure or insecure attachment?'

'What shall we do to help them?'

4.7 Medication and dosage that you need to remember:

None.

STATION 1 – MARKING DOMAIN

The main assessment aims are:

- Observe and describe the behaviour of a mother-infant dyad in the ‘Strange Situation’ procedure, and identify the attachment style of the dyad.
- Demonstrate an understanding of categories of attachment and behaviours that could be observed, supporting each diagnosis.
- Listen to the concerns of a junior child protection worker, and educate her about attachment theory; addressing the perceived stigma against this mother who has schizophrenia.
- Suggest interventions that can be put in place to support the mother and her child.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.12 Did the candidate communicate the interactions observed in the ‘Strange Situation’ video appropriately and accurately? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

communicates findings in a sophisticated manner; is able to interpret the individual interactions and put them in the context of the wider clinical situation.

Achieves the Standard by:

correctly communicating results in suitable language, with appropriate detail and sensitivity; reflecting any limitations and value of the examination; succinctly conducting presentation with accurate use of descriptive terms; commenting on behaviour, vocalisation, gaze, proximity seeking or avoidance of proximity and contact between the dyad; including appropriate positive and negative findings.

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

a. Focus on attachment in the description of the observed behaviour of the dyad.

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; inability to synthesize information in a coherent manner, incorrectly interprets observed behaviour.

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

1.12. Category: FORMULATION - Communication	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 formulate and describe relevant diagnosis / differential diagnosis? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of a single observation in making an accurate assessment; discusses deficits in emotional processing in women with schizophrenia, and how this may impact on parenting.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; adequate prioritising of conditions relevant to the obtained history and findings; including communication in appropriate language and detail in communicating with the health worker; recognising that the child does look to the mother for support and is distressed at separation, he does seek proximity with the mother and she welcomes this, even though she quickly encourages him to go and explore rather than waiting for him to cue this.

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

a. Identify a generally secure attachment with some avoidant features.

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

Below the Standard (scores 2):

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 conclusions; 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"/>

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6.0 SCHOLAR

6.6 Did the candidate explain the relevant terminology correctly according to current critical understanding? (Proportionate value – 15%)

Surpasses the Standard (scores 5) if:

provides a well-structured approach and systematically works through the process; recognises the opportunity that teaching and learning present; refers to the Adult Attachment Interview.

Achieves the Standard by:

communicating at a level and in a manner appropriate to the training of the social worker; allowing the social worker time to respond to the information provided; highlighting differences between various attachment styles; elaborating on how to recognise the different categories of attachment; providing examples or referring back to the behaviour observed in the video; referring to relevant resources.

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

- a. Explain all four categories of attachment.

A score of 4 may be awarded depending on the depth of information provided; 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; does not apply any structure to their approach; does not see provision of learning opportunities as part of their role.

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

6.6. Category: MEDICAL TERMINOLOGY	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"/>

5.0 HEALTH ADVOCATE

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

demonstrating the capacity to: identify the impact of cultural beliefs and stigma of mental illness on patients, families and carers; apply principles of prevention, promotion, early intervention and recovery to clinical practice; recognise the role of staff in the generation and maintenance of stigma; constructively address competing attitudes towards mental health; explain other protective factors available for the mother and baby, such as engagement with psychiatric and parenting services; engage with family supports; be compliant with medication; gain insight as to the need for treatment and early signs of possible relapse; recognise the importance of abstaining from drugs and alcohol.

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

- a. Advocate for the mother who is providing good enough care for her child.

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

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

5.2. Category: ADDRESSING STIGMA	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"/>

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between proposed interventions and key issues identified; recommends referral of the mother to specific programmes to assist her parenting capacity, such as Circle of Security therapy programme or Circle of Security parenting course; clearly addresses difficulties in the application of any interventions.

Achieves the Standard by:

demonstrating the ability to prioritise and implement evidence-based interventions; recommending psychiatric services monitor maternal mental state and treatment compliance; integrating child and family focussed services to promote maternal parenting capacity and child wellbeing monitoring; recognising the significant supportive role of family / close supports, recognising of their role in effective interventions; identifying potential barriers; recognising the need for consultation / referral / supervision.

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

- a. Ensure clarification of the level of involvement of the father.

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; errors or omissions will impact adversely on support for the dyad; recommended interventions lack structure or are inaccurate; plans not tailored to dyad's immediate needs or circumstances.

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

1.13. Category: MANAGEMENT - Initial Plan	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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1.0 Descriptive summary of station:

This viva station tests consultancy skills in clinical, ethical and professional realms, including how the candidate identifies and justifies important issues when making immediate decisions without having access to the full information. In this scenario, a 13-year-old boy with suicidal ideation has been referred by a Nurse Practitioner (NP) to a poorly resourced mental health service in a remote area where a locum consultant is about to fly out at the end of their contract. The boy is socially dislocated with a probability of drug use, and the NP has inappropriately commenced an antidepressant medication. Beyond the baseline of the patient's clinical safety, the candidate needs to consider interdisciplinary issues, and clinical and ethical responsibilities of other practitioners in a remote setting; boundaries of the role of a terminating locum employee; safe handover of responsibility; and the role of locums in raising concerns about resource allocation, and advocating for safe levels of service.

1.1 The main assessment aims are to:

- Demonstrate ability to make safe clinical decisions, under time contingent conditions, without full information being available.
- Determine the important underlying clinical, professional and ethical issues in the scenario.
- Identify and outline how to address the NP's prescribing competency and management of clinical boundaries.

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

- Ensure assessment of Carl within 24 hours by a suitably experienced mental health professional, either face-to-face or via videoconference / telehealth.
- Identify that prescription of escitalopram by the NP is not indicated based on the information available.
- Consider escalation to supervisor or involvement of nursing professional body regarding lack of overall competence to practise independently.
- Describe at least three ethical / professional issues (exclusive of potential boundary infringement by the NP).

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Child and Adolescent Disorders, Other Skills (Governance and Ethics)
- **Area of Practice:** Child & Adolescent
- **CanMEDS Domains:** Medical Expert, Collaborator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Therapy), Collaborator (Teamwork – Treatment Planning), Professional (Ethics, Compliance & Integrity).

References:

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- Eggs, S., Slade, D. (2015) Communication in Clinical Handover: Improving the Safety and Quality of the Patient Experience J Public Health Res, 4(3): p666
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- National Institute for Health and Care Excellence (NICE). (2017) Depression in children and young people: identification and management. Clinical guideline [CG28] Available at <https://www.nice.org.uk/guidance/cg28>
- Best Practice Advocacy Centre NZ, (2016) The role of medicines for the treatment of depression and anxiety in patients aged under 18 years. Available at <https://bpac.org.nz/BPJ/2016/March/docs/BPJ74.pdf>
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Committee for Examinations
Objective Structured Clinical Examination
Station 2
Perth September 2019



1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: nil.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

This is a VIVA station. There is no role player in the examination room.

You have been working as a locum 'Fly In Fly Out' (FIFO) Consultant Psychiatrist in a remote area. It is the end of the working day, and you have 20 minutes left before you need to get to the airport to fly out from the clinic. You are not returning here in the foreseeable future, and there will be no visiting psychiatrist for three weeks due to sickness and staffing shortages. You had offered to stay longer, but were advised that this was not possible due to 'budgetary constraints'. The three community mental health team members will be covered for emergencies / urgent advice by the base hospital psychiatrist.

One of the community clinical mental health team members brings a referral to you which has just been received from a Nurse Practitioner (NP) at a community clinic over 800 kilometres from the base hospital, and 400 kilometres away from the community clinic where you and the team are.

It reads as follows:

'Please accept this referral for 13-year-old Carl Rogers. Four weeks ago, he arrived in the area to stay with his father who is working here. He came over from Brisbane where he was excluded from his last school for selling drugs. He has been very unhappy since arrival here and has been going out alone, walking around at night, thinking about suicide. He has been skipping school and mainly playing games on his phone. Today, I started him on a low dose of escitalopram – 20mg.'

The clinical team member tells you that there is currently no GP in that area, and that the NP is also the live-in partner of the boy's father.

Your tasks are to:

- Outline how you would ensure Carl's safety is addressed.
- Elaborate on the Nurse Practitioner's practice with regard to prescribing and boundary management, and how you would address this.
- Detail a range of additional professional and ethical issues of concern in this scenario, and explain the actions you might take to address these concerns.

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
 - Pens.
 - Water and tissues (available for candidate use).

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- DO NOT redirect or prompt the candidate.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your 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.

There is no opening statement or prompt for you to give.

3.2 Background information for examiners

In this station, the candidate is expected to show a broad understanding of clinical, professional and ethical issues related to psychiatrists working in short-term contracts (locums). There is the added complexity of working in a resource-strapped remote area. Another aspect being tested is the candidate's ability to 'think on their feet', and make time-contingent decisions without having full clinical information.

The candidate is expected to identify, prioritise and justify specific clinical, organisational and boundary issues, including internal and external conflicts that may arise from their actions. There are both clinical and organisational issues to take into account when addressing delivery of ongoing clinical care.

The candidate is also expected to outline the reasons why the Nurse Practitioner's (NP) prescribing is inappropriate in this situation, and describe how this should be addressed.

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

- Ensure assessment of Carl within 24 hours by a suitably experienced mental health professional, either face-to-face or via videoconference / telehealth.
- Identify that prescription of escitalopram by the NP is not indicated based on the information available.
- Consider escalation to supervisor or involvement of nursing professional body regarding lack of overall competence to practise independently.
- Describe at least three ethical / professional issues (exclusive of potential boundary infringement by the NP).

Background:

The crucial points in answering this question are in the candidate raising ethical / professional issues and questions, then providing options for addressing these problems rather than coming to a definitive conclusion. However, in terms of the clinical decision-making, there are definitive actions which have to be taken correctly by the candidate in order to pass these sections of the question.

RANZCP Code of Ethics Principle 11

Psychiatrists shall work to improve mental health services, to promote community awareness of mental illness and its treatment and prevention, and to eliminate discrimination against people with mental illness.

- 11.1 Psychiatrists shall be prepared to contribute to improving mental health services and promoting the fair allocation of resources for the community of patients with mental illness.
- 11.2 Psychiatrists have an ethical duty to promote the welfare of their patient, while holding a parallel duty to promote justice for all mental health patients through the fair distribution of mental health resources. In meeting these combined obligations, psychiatrists shall be prepared to work with decision makers and funders in setting open and just expectations in the delivery of resources. There is a consequent duty to abide by those expectations, provided they are ethical and valid.
- 11.3 Psychiatrists shall be willing to act as advocates and join with other advocates in ensuring that the best attainable mental health care is available to people with mental health illness.
- 11.4 Psychiatrists shall acknowledge Aboriginal and Torres Strait Islander peoples and Māori as the traditional owners and custodians of Australia and New Zealand respectively and respect their diverse knowledge, culture, history and traditions as key aspects of their identity which contribute to positive mental health and social and emotional wellbeing.
- 11.5 Psychiatrists' primary responsibility is to patients. Particular care is needed when this conflicts with responsibility to an employer or government. If clinical services fall below acceptable standards, psychiatrists have a duty to advocate for services and take appropriate action. Exceptionally, they may have to dissociate themselves from such services.

According to the AMA, 'Handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.'

The aim of any handover is to achieve the efficient communication of high-quality clinical information at any time when the responsibility for patient care is transferred. Good handover is at the heart of an effective health care system and stands alongside patient clinical documentation, letters of referral and transfer and discharge documentation. Together, these make up the links in the chain of continuity of patient care. Handover requires systemic and individual attention and needs education, support, facilitation and sustained effort to ensure it maintains a position of importance in an already full working day. The candidate is expected to ensure appropriate handover to a duty doctor - at airport or next day - to enable continuity of care.

Clinical decision making:

The candidate is expected to demonstrate their ability to 'think on their feet', and make time-contingent decisions without having full information about the individual referral just prior to departure. They must address how to coordinate prompt assessment of Carl by a suitably experienced mental health professional either in person or via videoconference / telehealth.

It is most likely that Carl has an adjustment reaction rather than a major depressive disorder (MDD), it is quite possible that the presentation may be related to the impact of intoxication / withdrawal from alcohol or drugs, and he may also have a gaming addiction. As with adult MDD, psychological interventions, particularly CBT and IPT, are indicated as first-line treatments for child and adolescent MDD, especially if mild to moderate in severity. Parent / family involvement is also recommended.

Prescribing antidepressants in younger teenagers: in general, the evidence does not support the prescribing of an antidepressant for a 13-year-old, and in this circumstance, it is not indicated at such an early stage in the diagnostic and treatment process. SSRIs are most frequently recommended, with fluoxetine having the most consistent evidence of efficacy over placebo, and has been recommended as the first line antidepressant for young people in treatment guidelines (NICE, 2005).

The excerpt below from the Best Practice Advocacy Centre (bpac.org.nz/BPJ/2016/March) (The role of medicines for the treatment of depression and anxiety in patients aged under 18 years.) clearly identifies significant problems with the NP's intervention in this case. 'Psychological and behavioural approaches are the cornerstone of treatment for young people with depression or anxiety. When pharmacological treatment for a patient aged under 18 years is required due to severe or ongoing symptoms, it is almost always 'off-label'. Medicines may be initiated in secondary care, with monitoring and follow up in primary care, or they may be initiated by a general practitioner. In this final article of a three part series focussing on mental health issues for young people, the recommendations and evidence for the use of medicines in people aged under 18 years with depression and anxiety are discussed. Non-pharmacological approaches are preferred for patients aged under 18 years with anxiety disorders or depression; treatment should acknowledge the ongoing importance of family support, sleep, good nutrition and exercise. Clinicians in primary care should consider consulting with a child and adolescent psychiatrist or paediatrician before prescribing a psychoactive medicine to a patient aged under 18 years; these should only be prescribed if symptoms are severe and / or other treatments have been ineffective and they are used alongside psychological therapy. There is evidence that selective serotonin reuptake inhibitors (SSRIs) may be effective for some young people with severe or persistent anxiety or depression. These medicines are only approved for use in patients aged over 18 years, and their use in children and adolescents with depression or anxiety is almost always 'off-label'. Fluoxetine offers the greatest benefit for young people with depression, and is the only SSRI that should be initiated in primary care without consulting with a child and adolescent psychiatrist. General practitioners may be involved in continuing treatment with other SSRIs initiated in secondary care. The pharmacological treatment of mental health conditions in young people should be accompanied by increasing, rather than decreasing, clinical contact. Frequent follow-up, e.g. weekly face-to-face or telephone contact, is recommended for the first month of use.'

Escitalopram would not be the drug of choice for diagnosed depression in a 13-year-old. The NP has also erroneously said the dose is 'low'. It is also reasonable to assume that Carl has not, at this point, received any counselling input or CBT based treatment which would be indicated before initiating an antidepressant if he was to be diagnosed with MDD.

Ethical and professional issues which could be discussed include (but are not limited to):

Intrapersonal conflicts: e.g. balancing personal and clinical needs, duty of care with regard to the individual referral, needing to get to the airport on time; consideration of role in terms of professional responsibility regarding issues beyond the departure of the plane (when does a psychiatrist's professional responsibility end); not wanting to be seen as 'a trouble maker' if raising staffing deficiencies or staff competency issues which could lead to potential loss of future locum jobs; understanding of the clinical and ethical complexities of short-term locum fly-in-fly-out (FIFO) roles, and multifactorial aspects of primarily being employed by a locum agency not workplace.

Interdisciplinary issues: e.g. working out how to ensure prompt review of the patient; making plans for the ongoing management of the decisions made by the locum in the clinic and discussion of interdisciplinary issues; possible need to involve child protection as Carl is not being kept safe by father. The issues of how to address the NP clinical competency, including considering directly addressing this with the NP first or via organisational hierarchy and professional bodies / their employer / nursing council; of conflict which could ensue if a direct approach is taken; supervisory structures of the NP; issues regarding responsibility for and possible methods and legality of stopping the dispensing of the script written by NP.

Managing boundaries: boundary of own role regarding advocating for safe service provision, and raising issue of unsafe staffing levels to save money; possible involvement of service director or hospital high level management regarding the lack of provision of service following the locum leaving.

Perceived boundary infringements: e.g. the difficulty of dealing with boundary issues in remote areas with very limited staffing and resources, specific issues of the NP, compounding factors of non-disclosure of the relationship with Carl's father, allocation of responsibilities for reporting issues with the NP's competence (i.e. interdisciplinary ethical and professional responsibilities).

Nurse Practitioners (NPs):

In New Zealand, the Nursing Council established the broad scope of NPs to enable them to safely and appropriately meet changing health needs. NPs are highly skilled autonomous health practitioners who have advanced education, clinical training and demonstrated competency. They have the legal authority to practise beyond the level of a registered nurse. They combine advanced nursing knowledge, and skills with diagnostic reasoning and therapeutic knowledge, and provide care for people with both common and complex conditions. Many NPs work in primary care where, like general practitioners, they may be the lead health care provider for health consumers and their families / whānau. Some NPs own their own practice whereas others work for district health boards, non-governmental organisations, or for Māori / Iwi providers. They are often more likely to work in rural areas and in under-served communities.

NPs are authorised to provide a wide range of assessment and treatment interventions: making diagnoses and differential diagnoses; ordering and interpreting diagnostic and laboratory tests; and prescribing medicines within their area of competence with the same authority as medical practitioners. Their broad scope of practice enables them to have the same prescribing authority as medical practitioners.

NPs may be provided with admitting rights, and discharge people from hospital and other health care services. As NPs work across health care settings they can influence health services and the wider profession, including involvement in research, having leadership roles, and supervising or mentoring other senior nurses. NPs are funded and subsidised for the treatment they provide.

<https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/nurse-practitioners-new-zealand>

In Australia, a Nurse Practitioner classified as a Registered Nurse with the experience and expertise to diagnose and treat people of all ages with a variety of acute or chronic health conditions. NPs have completed additional university study at Master's degree level, and are the most senior clinical nurses in the health care system. The title of 'Nurse Practitioner' can only be used by a person who has been endorsed by AHPRA through the Nursing and Midwifery Board of Australia.

National standards for practice ensure that NPs are capable of providing high quality, patient-centred care. They are also capable in clinical research, education and leadership as applied to clinical care and health service development. NPs:

- Have practised in Australia for over 15 years.
- Provide health care in all states and territories in Australia.
- Can provide patient rebates through Medicare.
- Provide prescriptions and access to PBS medicines.
- Can refer patients to hospitals and specialists.
- Can order x-rays and diagnostic tests.
- Are registered with the Australian Health Practitioner Regulation Agency (AHPRA).

NPs work as key members of the healthcare team, and collaborate with other nurses and healthcare professionals including GPs, medical and surgical specialists, physiotherapists, dieticians, occupational therapists, social workers, and many others. They work in a variety of locations, both in hospital and community settings. The NP role aims to:

- Improve access to treatment.
- Provide cost-effective care.
- Target at-risk populations.
- Provide outreach services in rural and remote communities.
- Provide mentorship and clinical expertise to other health professionals.

<https://www.acnp.org.au/aboutnursepractitioners>

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.

STATION 2 – MARKING DOMAINS

The main assessment aims are to:

- Demonstrate ability to make safe clinical decisions, under time contingent conditions, without full information being available.
- Determine the important underlying clinical, professional and ethical issues in the scenario.
- Identify and outline how to address the NP’s prescribing competency and management of clinical boundaries.

Level of Observed Competence:

3.0 COLLABORATOR

3.2 Did the candidate appropriately involve treatment team in developing management plans? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

takes a leadership role in treatment planning; effectively negotiates complex aspects of care; works to reduce barriers to care; clearly addresses difficulties in the application of the plan in a rural area with limited resources.

Achieves the Standard by:

communicating proposed plans clearly and with good judgment to involve others; addressing the impact of remoteness in treatment planning; demonstrating the ability to prioritise and implement acute care in remote environment using appropriate technologies and interdisciplinary skills; planning for risk management in a timely manner; suitably engaging necessary other health professionals and treatment resources; expressing expectations candidly and respectfully; taking appropriate and effective leadership to ensure positive patient outcomes; recognising their role in assessment and treatment, identifying potential barriers to implementation of the plan.

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

- Ensure assessment of Carl within 24 hours by a suitably experienced mental health professional, either face-to-face or via videoconference / telehealth.

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; errors or omissions impact adversely on the finalised plan; plan not tailored to patient’s immediate needs or circumstances.

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

3.2. Category: TEAMWORK – Treatment Planning	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

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological therapies? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support treatment options; discusses major strengths and limitations of applying available evidence.

Achieves the Standard by:

demonstrating the understanding of appropriate use of medications; questioning the apparent diagnosis of MDE by NP without full assessment; describing the relevant applicability of theory to the scenario; identifying relevant specific treatment outcomes and prognosis; addressing whether the dosage of medication is considered low; outlining possible approaches; identifying role of other health professionals and treatments other than medication; providing feedback on the prescribing.

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

- Identify that prescription of escitalopram by the NP is not indicated based on the information available.

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

Below the Standard (scores 2):

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; errors or omissions impact adversely on patient care; plan not tailored to patient’s needs.

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

1.14. Category: MANAGEMENT - Therapy	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"/>	

4.0 MANAGER

4.5 Did the candidate demonstrate effective supervision and regulation usage with regard to the NP? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

demonstrates a sophisticated knowledge of legislative or regulatory requirements; takes system / organisational considerations to decision making; incorporates the compounding issue of relationship non-disclosure by NP; recognises the different approaches available to address non-compliance; balances aspects of rights to natural justice; provides tailored strategies to address areas for improvement.

Achieves the Standard by:

deliberating on the apparent lack of NP prescribing competency; recognising the importance of appropriate clinical documentation in health care; distinguishing between professional and unprofessional behaviours; justifying decisions for addressing competency; incorporating likely service policies into decision making; identifying areas for improvement like aspects of attitude and professionalism in interaction with patient; showing understanding of the subtleties and difficulties of boundary management in a rural isolated environment; applying legislative / regulatory requirements to practice.

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

- a. Consider escalation to supervisor or involvement of nursing professional body regarding lack of overall competence to practise independently.

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; discussion not tailored to the circumstances; demonstrates inadequate or inaccurate understanding of policy and / or regulatory requirement; limited knowledge of regulation usage potentially places patients at risk.

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

4.5. Category: REGULATION USAGE	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 professional and ethical conduct and practice? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

comprehensively considers major aspects of ethical conduct and professional practice; demonstrates sophisticated understanding of the complexities of the locum FIFO role regarding clinical and ethical responsibilities, and aspects of agency employment.

Achieves the Standard by

demonstrating the capacity to: identify and adhere to professional standards of practice in accordance with RANZCP Code of Ethics and institutional guidelines; integrate ethical practice into the clinical setting and apply ethical principles to resolve conflicting priorities; utilise ethical decision-making strategies to manage the impact on professional practice / patient care; explain appropriate personal / interpersonal conflict and boundaries including duty of care, financial issues, duty of management to provide safe clinical cover, tight time frames involved, handover requirements, responsibilities as a locum, duty to advocate for patients.

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

- a. Describe at least three ethical / professional issues (exclusive of potential boundary infringement by the NP).

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 including potential boundary infringement of the NP.

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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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 to 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 to 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"/>

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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: manipulateness, 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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<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
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1.0 Descriptive summary of station:

In this station, the candidate is expected to evaluate and manage new onset psychotic symptoms in a 76-year-old man referred from a nursing home. The candidate is asked to outline the process of consultation, and then to describe how to address the presentation to reach a diagnosis, and management of Lewy Body dementia which needs to be considered in the context of possible delirium.

1.1 The main assessment aims are to:

- Describe the procedural and operational processes involved in a nursing home consultation.
- Outline the psychiatric evaluation to assess a patient living in a nursing home with visual hallucinations and aggression.
- Justify appropriate diagnoses and differential diagnoses.
- Provide a brief management plan for the most likely diagnosis.

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

- Ensure communication with the nursing home staff, the General Practitioner and the family.
- Explore the chronic nature of the visual perceptual abnormalities.
- Justify the prioritisation of a diagnosis of Lewy Body dementia.
- Recommend that the family does not move the patient from the facility.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders
- **Area of Practice:** Psychiatry of Old Age
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Data Gathering Content; Diagnosis; Management – Initial Plan), Communicator (Patient Communication – Disclosure)

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Committee for Examinations
Objective Structured Clinical Examination
Station 4
Perth September 2019



1.4 Station requirements:

- Standard consulting room.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

This is a **VIVA** station: there is no role player in the examination room.

You are working as a junior consultant psychiatrist along with your registrar in the division of Psychiatry of Old Age. A team member approaches you to discuss a referral that was forwarded from a nursing home overnight.

Allan Appleton, a 76-year-old man, was admitted to the nursing home two years ago. Despite having no psychiatric history, he has developed visual hallucinations of 'people wearing hats and standing under a tree', and they have been present on and off for the past nine months, and associated with confusion, agitation and aggression.

Family members of Mr Appleton have asked for him to be relocated from the nursing home.

Your tasks are to:

- Briefly describe the process of how you would manage this referral with the nursing home.
- Explain the key areas you would focus on in your history taking and assessment.
- At **four (4) minutes**, you will receive further psychiatric history, mental state examination findings, and investigation results to justify your diagnosis / differential diagnoses and short-term management plan to the examiner.

Station 4 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - Pens.
 - Water and tissues (available for candidate use).

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that you are to provide further information to the candidate at **four (4) minutes**.
- DO NOT redirect or prompt the candidate unless scripted.
- 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 **four (4) minutes** into the station, the examiners hand over the final task to the candidate and say:
'Please review this information obtained by your registrar.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for the next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

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

There is no role player as this is a VIVA station.

At **four (4) minutes** into the station, you are to provide further information to the candidate. You are to say the following:

'Please review this information obtained by your registrar.'

You are to justify your diagnosis / differential diagnoses and short-term management plan to the examiner.

Additional Relevant History

- Inability to remember his way around the nursing home; used to play piano but not anymore; progressive loss of planning and spatial orientation.
- Slowed down movements and repeated falls.
- No alcohol or other substance use.
- No vomiting, incontinence, seizures.

Mental state examination: 14/09/19 at 08:20

Engaged; good rapport; speech: unremarkable; mood 'fine'; affect: euthymic; no delusions. Alert and orientated.

Progress notes: 10/09/19 to 13/09/19

Patient agitated; demanding to leave nursing home; varying level of alertness; confused at times says he is in a 'railway station'; other times alert and orientated.

Blood examination: No abnormality detected (NAD)

Urine and blood culture: No abnormality detected (NAD)

CT scan head: generalised atrophy otherwise no abnormality detected.

3.2 Background information for examiners

This is a viva station where the candidate is expected to describe the procedural and operational issues involved in responding to a nursing home referral to the Psychiatric Services for Older Persons. The patient referred is a 76-year-old man living in residential care with a nine-month history of visual hallucinations and aggression.

The candidate is then required to outline the psychiatric evaluation to assess his presentation, and outline appropriate diagnoses / differential diagnoses. Based on this, the candidate then should provide a brief management plan for the most likely diagnosis.

In general, the candidate is expected to address:

1. The processes involved in a nursing home consultation for an elderly patient presenting with late-onset psychotic symptoms.
2. The diagnostic evaluation of psychotic symptoms followed by the most likely diagnosis of Lewy Body dementia.
3. The short-term management including the management of family's request for removing the patient from the nursing home.

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

- Ensure communication with the nursing home staff, the General Practitioner and the family.
- Explore the chronic nature of the visual perceptual abnormalities.
- Justify the prioritisation of a diagnosis of Lewy Body dementia.
- Recommend that the family does not move the patient from the facility.

A **surpassing candidate** may demonstrate the awareness of practical difficulties in providing care to the patient and conducting this examination; articulate the need for repeated examinations of orientation to time, place and person because of possible fluctuation in presentation; demonstrate comprehensive knowledge of advanced diagnostic modalities for dementia, such as ¹⁸F-fluorodeoxyglucose PET scan; appropriately identify the limitations of diagnostic classification systems to guide treatment; describes the complex relationship between delirium and dementia; negotiate with the staff and family; and confidently discuss the changing classification of hallucinations / pseudohallucinations. They may offer education programs to the clinical staff; and quote evidence related to treatment options.

The consultative process:

Nursing home consultation is a part of Psychiatry of Old Age service. As a junior consultant, the candidate must articulate the processes involved in a nursing home consultation. It is largely a multidisciplinary process. In this context, the candidate should discuss with the team member and depending on the urgency, recommend an initial assessment by the clinician or the registrar, and then a review by the consultant.

Communication with the nursing home staff, family members and the general practitioner, and review of the nursing home notes are essential components of a nursing home consultation. The candidate must deal with a complex task of supporting the team colleagues, and nursing home staff, and addressing the demand from the family in a sensitive manner. A balanced approach of considering further evaluation of behavioural problems, severity of psychotic symptoms, risks and safety issues, pharmacological management (see below), and resources in the nursing home (e.g. dementia unit; staff trained to manage delirium and dementia symptoms) to manage the presentation against the benefits and risks of psychiatric inpatient admission is appropriate in addressing family's demand. The candidate may have to negotiate with the nursing home staff in deciding management setting, and educate the staff for a collaborative care. Support for the nursing home staff, and the family distressed by the patient's aggressive behaviour is integral part of this consultation.

Diagnostic evaluation:

The candidates must describe the set of diagnostic enquiries in the given situation. They should articulate the aspects of history enquired regardless of who conducts the assessment. The expectation is that candidates screen for symptoms of delirium specifically assessing orientation to time, place and person and attention. The line of enquiries should cover previous psychiatric and medical history, screening for common conditions that can lead to delirium, viz., infections, electrolyte derangements, drugs particularly with anticholinergic toxicity, alcohol withdrawal state, head injury, stroke and other cerebral pathologies like tumours.

The patient in this station is 76-year-old, and therefore better candidates will consider dementia as a predisposing factor for delirium. Given the chronic nature of visual hallucinations, it is appropriate for the candidates to consider chronic organic syndromes, such as dementia, and explain the screening questions for this syndrome as well.

Further information is provided **at four minutes** into the station. The visual hallucinations have a chronic onset over at least nine months. They are vivid and associated with worsening memory deficits, as well as impaired visuospatial orientation, a feature supportive of dementia with Lewy Bodies. In addition, the patient has had repeated falls and slowed movements which are indicative of Parkinsonian symptoms. In the history, there was no previous psychiatric episode. These features, specifically hallucinations exclusively in the visual modality and onset in late age, support psychotic symptoms secondary to an organic or medical condition, and stand against functional psychiatric disorders like schizophrenia and bipolar disorder.

There is no history of substance misuse, and therefore alcohol withdrawal can be excluded. Mental state examination does not show any abnormalities or features of disorientation. The candidates must take this as a fluctuating nature of delirium rather than dismiss delirium. Investigation results, except generalised atrophy in the CT scan, show no abnormality, a scenario that is not uncommon when psychotic symptoms and delirium occur in the context of dementia. The accepted differential diagnoses in this scenario are delirium, Lewy Body dementia, Parkinson's syndrome with dementia, Alzheimer's disease, vascular dementia and psychosis secondary to a medical condition. Diagnosis of a primary psychiatric disorder like schizophrenia, mood disorder or similar conditions falls well below the standard.

Diagnosis

Dementia with Lewy Bodies:

The patient in this station has delirium, but as part of dementia with Lewy Bodies (DLB). DLB accounts for 15%–20% dementia cases at autopsy. DLB arises from accumulation of a synaptic protein α -synuclein as Lewy Bodies in the brainstem, limbic cortex and neocortical regions. It is characterised by fluctuating but progressive deficits in multiple cognitive domains. This is the central and essential feature of Lewy Body dementia syndrome which often manifests as delirium in the beginning. Visual hallucinations and aggression of the patient in this scenario warrants a differential diagnosis of delirium, arguably the most common syndrome to be considered in such a situation. The candidates, however, should consider other features in the history, such as chronic progressive course, vivid visual hallucinations, extrapyramidal symptoms, and falls in arriving at the most likely diagnosis – Lewy Body dementia. In general, clinical features that support the diagnosis include repeated falls, syncope, transient loss of consciousness, severe autonomic dysfunction, depression, systematised delusions, or hallucinations in other sensory and perceptual modalities. They lack diagnostic specificity however, and can be seen in other neurodegenerative disorders.

Delirium:

Affecting attention and consciousness, delirium is the most severe form of mental disturbance. It is a syndrome that can arise from diverse aetiology, varying from medical diseases to alcohol withdrawal through Lewy Body dementia. Delirium is common, but often unidentified. Key diagnostic features include an acute onset and fluctuating course of symptoms, inattention, impaired level of consciousness, and disturbance of cognition, such as disorientation, memory impairment and alteration in language. Supportive features include disturbance in sleep-wake cycle, perceptual disturbances (hallucinations or illusions), delusions, psychomotor disturbance (hypo- or hyper-activity), inappropriate behaviour, and emotional lability. The challenges in delirium diagnosis are fluctuating nature of the symptoms, the lucid interval, lack of knowledge, and the notion that normal routine medical investigations exclude delirium. Diagnosis of delirium is clinical, and based on the syndrome. Visual hallucinations with no perceptual disturbances in other modalities, as the patient in this scenario reports, are uncommon in primary ('functional') psychiatric disorders like schizophrenia, and should rise high index of suspicion of an organic syndrome.

Other dementia syndromes, for instance, dementia arising from Alzheimer's disease can also present with psychotic symptoms. Candidates must commit this as a differential diagnosis because it is the most common form of dementia.

Management plan:

Initial plan may include further cognitive evaluation including a neuropsychological assessment. This can be bedside cognitive assessment, for instance using Montreal Cognitive Assessment (MoCA). It is not necessary that the candidates mention any particular method of cognitive evaluation.

Additional neuroimaging investigations, such as MRI scan is worth considering in order to exclude other neurological conditions, as well as support Lewy Body dementia. If available, occipital hypometabolism on ^{18}F -flurodeoxyglucose Positron Emission Tomography (PET) is suggestive of Lewy Body dementia.

Dementia with Lewy Bodies:

The management of Lewy Body dementia is essentially symptomatic, focussing on the control of distressing psychotic symptoms, addressing behavioural problems and psychosocial interventions. Evidence supports the use of cholinesterase inhibitors, such as donepezil in slowing down the progress of cognitive symptoms, as well as behavioural symptoms especially with early and assertive treatment. In fact, cholinesterase inhibitors, such as donepezil are more beneficial in Lewy Body dementia than in Alzheimer's dementia presumably because of extensive cholinergic impairment in the former. From a funding perspective, New Zealand candidates may comment that cholinesterase inhibitors are funded by the government for use in dementia. In Australia, they are only subsidised for use in Alzheimer's disease. Off label use of medications (e.g. cholinesterase inhibitors) will vary as per local practices.

In addition, certain medications need to be avoided as they can aggravate the clinical picture; for example, first generation antipsychotics which are likely to lead to exaggerated extrapyramidal signs, sedation, immobility, or neuroleptic malignant syndrome (NMS) with fever, generalised rigidity and muscle breakdown. This is an essential and integral part of the management of Lewy Body dementia in view of its serious risk. If at all used, then second generation antipsychotic medications like quetiapine are to be considered. The role of memantine is less clear.

There is also an absence of effective treatment except for medications that offer modest control of the cognitive and behavioural symptoms. There are no therapies that have proven to be curative or stop the disease progression. Physical exercise and cognitive training are, however, shown to be beneficial and recommended for patients with dementia.

Early diagnosis will also allow families and caregivers the time to plan for the expected decline. Preventive steps to improve safety in the nursing home environment should be taken, given the tendency to recurrent falls and rapid attentional fluctuations. Families will also have time to develop a better understanding of their role in patient care, including assistance with daily activities, and provision of social and cognitive stimulation. More educated candidates may talk about referral to specific dementia services, such as Dementia Behaviour Management Advisory Services (DBMAS).

Delirium:

The definitive management of delirium is the treatment of the underlying medical condition. But in this station, the patient has irreversible degenerating condition – Lewy Body disease. Symptomatic management of delirium largely relies on pharmacological and behavioural strategies. Behavioural management is an essential component of delirium treatment. Re-orientating the patient with calendar, clock and labels or signs are common strategies. Presence of family members and / or familiar people are also beneficial. Night light, low stimulus environment and reassurance are other interventions. It is vital to implement falls prevention strategies particularly when sedating medications are used. Commitment to ongoing review of improvement and / or side effects (e.g. postural hypotension); and monitoring of vital signs, hydration and mobility is also critical. Physical restraint is the last resort, and this will require the candidate discuss about legislative provisions in states and territories. Consideration of Advanced Health Directives, Power of Attorney, Guardianship under Civil and Administrative Tribunal or similar authorities is imperative.

As part of collaborative care, the candidate should address the family's request for change in management setting (inpatient admission, psychogeriatric nursing home etc.), and justify leaving the patient in his current nursing home at this time, as it is an environment with which he is familiar. The candidates must also offer supportive measures to the family with interventions that include but not restricted to referral to Dementia support program. Better candidates shall mention explanation of the patient's condition to family members, and education programs about delirium in dementia to the nursing home staff.

DMS-5 Diagnostic criteria for Delirium.

- A. Disturbance in *attention* (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced *orientation to the environment*).
- B. The disturbance develops over a short period of time (usually hours to a few days), *represents an acute change from baseline attention and awareness*, and tends to fluctuate in severity during the course of a day.
- C. An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception).
- D. *The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal such as coma.*
- E. There is evidence from the history, physical examination or laboratory findings that the disturbance is *a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e. due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple aetiologies.*

ICD-10 Diagnostic Criteria for Delirium, not induced by alcohol and other psychoactive substances

An etiologically nonspecific organic cerebral syndrome characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion, and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe.

Include:

Acute or subacute:

- brain syndrome
- confusional state (nonalcoholic)
- infective psychosis
- organic reaction
- psycho-organic syndrome

Exclude:

- F10.4 Delirium tremens, alcohol-induced or unspecified.
- F05.0 Delirium not superimposed on dementia, so described.
- F05.1 Delirium superimposed on dementia
Conditions meeting the above criteria but developing in the course of a dementia (F00-F03).
- F05.8 Other delirium
 - Delirium of mixed origin
 - Postoperative delirium.
- F05.9 Delirium, unspecified.

DSM-5: Dementia with Lewy Bodies Diagnostic Criteria

The diagnostic criteria for *probable DLB* require:

- The presence of dementia.
- At least two of three core features:
 - fluctuating cognition with pronounced variations in attention and alertness,
 - recurrent visual hallucinations that are typically well formed and detailed, and
 - spontaneous Parkinsonian (motor signs) with onset at least one year later than cognitive impairment.

Suggestive clinical features include:

- Rapid eye movement (REM) sleep behaviour disorder,
- Severe neuroleptic sensitivity, and
- Low dopamine transporter uptake in basal ganglia demonstrated by SPECT or PET imaging.

In the absence of two core features, the diagnosis of probable DLB can also be made if dementia plus at least one suggestive feature is present with one core feature.

Possible DLB can be diagnosed with the presence of dementia plus one core or suggestive feature.

3.3 The Standard Required

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

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

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

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

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.

STATION 4 – MARKING DOMAINS

The main assessment aims are to:

- Describe the procedural and operational processes involved in a nursing home consultation.
- Outline the psychiatric evaluation to assess a patient living in a nursing home with visual hallucination and aggression.
- Justify appropriate diagnoses and differential diagnoses.
- Provide a brief management plan for the most likely diagnosis.

Level of Observed Competence:

2.0 COMMUNICATOR

2.2. Did the candidate appropriately and adequately demonstrate their leadership role in the assessment and treatment? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

comprehensively applies the principles of working closely with patient / colleagues including other specialists / families, and show the awareness of ensuring respectful and open communication; demonstrates awareness of practical difficulties in providing care to the patient and conducting this examination.

Achieves the Standard by:

providing a clear and appropriate explanation of consultation in a nursing home; outlining the psychiatrist role in managing stress levels of colleagues, staffs, and family; collecting historical and collateral data; reviewing nursing home records for clarity; committing to ongoing explanation regarding features of dementia and delirium; balancing statutory obligations around management while ensuring patient's rights; seeking advice about local dementia services; reviewing current supports for the family.

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

- Ensure communication with the nursing home staff, General Practitioner and family.

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 of diagnosis and management is unclear or inadequate to meet the needs of the referral or family members.

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 describe how they would undertake an appropriately detailed and focussed assessment? (Proportionate value - enter value 20%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior explanation in a range of areas; demonstrates prioritisation and sophistication in how they would proceed; articulates advanced diagnostic modalities for dementia such as ¹⁸F-fluorodeoxyglucose PET scan.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; assessment process is hypothesis-driven; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; seeking previous psychiatric / medical history and presentation; repeated examinations of orientation because of possible fluctuation in presentation; identifying relevant investigations; demonstrating ability to prioritise assessment of risk and safety (e.g. absconding risk; 'sun downing'); screening for delirium and dementia syndrome; and outlining the key issues including cognitive examination.

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

- Explore the chronic nature of the visual perceptual abnormalities.

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 proposed content to be obtained; significant deficiencies such as substantial omissions in history or assessment process.

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"/>

1.9 Did the candidate justify a diagnosis and differential diagnoses based on the available information? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; conducts presentation at a sophisticated level; appropriately identifies the limitations of diagnostic systems; describes the complex relationship between delirium and dementia including predisposing and precipitating factors, and the low threshold for onset of delirium in dementia.

Achieves the Standard by:

demonstrating capacity to accurately integrate available information from history taking and mental state assessment; organising findings with emphasis on conditions that cause late-onset psychosis; recognising delirium syndrome as likely comorbidity; demonstrating understanding that delirium can be a manifestation of Lewy Body dementia.

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

- a. Justify the prioritisation of a diagnosis of Lewy Body dementia.

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; deficits in history and examination; inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusions; does not consider hallucinations in other modalities; does not consider delirium; or Diagnosis of schizophrenia.

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"/>	

1.13 Did the candidate describe a relevant initial management plan? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan; quotes evidence and nature of evidence (e.g. randomised controlled trials for cholinesterase inhibitors).

Achieves the Standard by:

demonstrating the ability to: prioritise and implement evidence-based care; integrating available information to formulate a treatment plan for delirium and Lewy Body dementia; planning for risk management including absconding and the impact of aggression; considering stimulus / environmental strategies; recommending judicious use of specific medications and other specific environmental and nursing interventions; articulating favourable evidence for cholinesterase inhibitors for Lewy Body dementia; stating that first generation antipsychotics should be avoided in Lewy Body dementia as a general principle; consideration of involuntary / guardianship options; record keeping and communicating to necessary others; identifying potential barriers.

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

- a. Recommend that that the family do not move the patient from the facility.

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; errors or omissions in the plan will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

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

1.13 Category: MANAGEMENT – Initial Plan	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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Overview <ul style="list-style-type: none">- Descriptive summary of station- Main assessment aims- 'MUSTs' to achieve the required standard- Station coverage- Station requirements	2
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1.0 Descriptive summary of station:

The station examines the complexity of managing a situation in which a mentally unwell man has come to visit his son, Eric, who is currently admitted to an inpatient psychiatric ward. The family member, his father Max, is presenting in a hypomanic state. The candidate engages Max, determines key features of hypomania in the mental state examination, and presents the findings to the Examiner along with their diagnosis. The candidate must then discuss ethical issues in the case, and duty of care to Max who is not their patient, but whose behaviour is impacting the inpatient psychiatric unit and the patient.

1.1 The main assessment aims are to:

- Evaluate how the candidate manages an interview with the family member, Max.
- Attribute accurate phenomenology to make a diagnosis of hypomania using a diagnostic system.
- Discuss ethical considerations raised by Max's presentation.

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

- Effectively de-escalate the initial presentation.
- Elaborate on the phenomenology of hypomania with at least three signs of hypomania.
- Justify why the presentation is more likely hypomania than mania in their diagnostic formulation.
- Elaborate on at least two of the following issues: beneficence, non-maleficence, duty of care, autonomy towards a person who is not their patient.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Mental State Examination; Diagnosis), Communicator (Patient Communication – To Patient), Professional (Ethics)

References:

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- Legal Aid Queensland (2015-2019) Duty of Care. Available at: <http://www.legalaid.qld.gov.au/Find-legal-information/Personal-rights-and-safety/Injury-loss-and-compensation/Negligence-duty-of-care-and-loss> (accessed 04 April 2019).
- Malhi GS, Bassett D, Boyce P, Bryant R, Fitzgerald PB, Fritz K, Hopwood M, Lyndon B, Mulder R, Murray G, Porter, Singh AB (2015) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Australian and New Zealand Journal of Psychiatry* Vol.49 (12): 1-185.
- RTK Ethics in Psychiatry. Available at: <https://www.slideshare.net/mentalist/ethics-in-psychiatry> (accessed 04 April 2019).
- World Health Organisation ICD 10 Chapter V Mental and behavioural disorders (F00-F99) Mood [affective] disorders (F30-F39). Available at: <http://apps.who.int/classifications/apps/icd/icd10online2003/fr-icd.htm?gf30.htm> (accessed 04 April 2019).

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Anglo-Australian male, 50 to 60 years old.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist in an inpatient psychiatric unit. The nurse in charge of the unit is concerned by Max Coombs' behaviour, and has asked you to talk to him.

Max is the father of one of your adult patients, Eric Coombs. Eric was admitted two weeks ago with mania, following a relapse of his bipolar disorder. His mental state has improved considerably since his admission, and you have no acute concerns about him. Eric is happy for you to meet his father, and this is the first time you are meeting Max.

Before you go into the ward, you can hear loud laughter and talking. When you enter the ward, you see Max, who is talking and laughing loudly, as he is shown into the interview room by nursing staff. There are no other medical staff present on the unit at this time.

Your tasks are to:

- Talk with Max to clarify why the nurse is concerned about him.
- Present Max's mental state examination findings, and justify possible differential diagnoses **to the examiner**.
- Present ethical considerations that arise in this situation **to the examiner**.

Station 5 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - Pens.
 - Water and tissues (available for candidate use).
- Do a final rehearsal with your role player.

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 role player has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

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

There are no prompts for you to give.

The role player must talk or laugh as the bell sounds at the end of the reading time.

The role player opens with the following statement:

'Wow doc, I seem to be the only sane person in here.'

3.2 Background information for examiners

In this station, the candidate is expected to deal with the uncommon, but complex scenario in which a mentally unwell man has come to visit his son who is an inpatient psychiatric ward. The father is presenting in a hypomanic state which the candidate must elicit through interview.

The candidate is then expected to accurately present the phenomenology in the mental state examination findings to the Examiner along with their diagnosis of hypomania.

Finally, the candidate must discuss ethical issues arising from the situation, and how to address any duty of care to Max, who is not their patient, but whose behaviour is impacting the inpatient psychiatric unit and the index patient.

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

- Effectively de-escalate the initial presentation.
- Elaborate on the phenomenology of hypomania with at least three signs of hypomania.
- Justify why the presentation is more likely hypomania than mania in their diagnostic formulation.
- Elaborate on at least two of the following issues: beneficence, non-maleficence, duty of care, autonomy towards a person who is not their patient.

A surpassing candidate may:

Give a comprehensive discussion of the ethical considerations of having a family member who presents to visit the patient, and is found to be mentally unwell, what needs to be considered as an appropriate approach, and how these impact on the candidate's approach to Max, and his son Eric who is the candidate's current patient.

Information for the Examiners

This station examines how a candidate deals with the complicated situation of a family member visiting an inpatient unit and presenting as mentally unwell:

The father exhibits the phenomenology for hypomania of persistent mood elevation, increased energy and activity, marked feelings of wellbeing, increased sociability, talkativeness, over-familiarity, increased sexual energy, decreased need for sleep, which has not caused severe disruption to work or social rejection. It is an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

The candidate is to consider what is the best approach to this situation. They may discuss the implications for Eric of his father's behaviour on the inpatient unit, the impact on other patients and their visitors on the ward, and the staff reaction. They may reflect on how best the staff could address the behaviour of an overtly unwell man who has no insight into being unwell, and the implications for the psychiatrist requested to address Max and the situation. An alternate consideration they may discuss could be to determine if this man is unwell or is the nurse unit manager and the nurses over reacting, possibly as a result of an unconscious or conscious bias against the patient. The candidate will likely raise the consideration if Max is unwell, is it physical or mental illness, is it drug, or alcohol related and also give consideration to personality issues.

They should determine that Max is hypomanic, with a genetic vulnerability to bipolar affective disorder. They may consider a conflict of interest as Eric is their patient. But there are times when there are few options, and the same clinician must treat family members. A management plan is not required in this station.

At this point, the candidate is not obliged to act immediately regarding admission and treatment as Max is hypomanic. It would be appropriate to ask for consent to ring his GP and inform of his illness.

Differential diagnoses

There is no evidence given for dementia or delirium; other organic illness; or psychotic illness. There is evidence of a mood disorder. There is no evidence for substance misuse. Personality factors may be taken into consideration as to whether there is any influence on the presentation.

Diagnosis

Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders: criteria for bipolar disorders (BD):

- Presence or history of mania / hypomania is the defining element of bipolar disorders and distinguishes them from depressive disorders.
- An individual is diagnosed with BD I if they have experienced a full manic episode.
- One manic episode is sufficient to qualify for the diagnosis, but most individuals will also have experienced one or more major depressive episodes, which often precede the onset of mania.
- BD II is diagnosed if an individual has experienced both an episode of major depression and hypomania in their lifetime but has never had a manic episode.
- The phases and stages of bipolar disorder are associated with varying degrees of functional impairment.

DSM-5 Hypomania Criteria

A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behaviour, and have been present to a significant degree:

1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only three hours of sleep)
3. more talkative than usual or pressure to keep talking
4. flight of ideas or subjective experience that thoughts are racing
5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
6. increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation
7. excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- The disturbance in mood and the change in functioning are observable by others.
- The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalisation. If there are psychotic features, the episode is, by definition, manic.
- The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).
- Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

ICD-10 Criteria for Bipolar

- F31 Bipolar Affective Disorder
- F30 Manic Episode
- F30.0 Hypomania

Mood [affective] disorders (F30-F39)

Disorders in which fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity.

F30	Manic episode All the subdivisions of this category should be used only for a single episode. Hypomanic or manic episodes in individuals who have had one or more previous affective episodes (depressive, hypomanic, manic, or mixed) should be coded as bipolar affective disorder (F31.-). Includes: bipolar disorder, single manic episode
F30.0	Hypomania A disorder characterised by a persistent mild elevation of mood, increased energy and activity, and usually marked feelings of wellbeing and both physical and mental efficiency. Increased sociability, talkativeness, over-familiarity, increased sexual energy, and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit, and boorish behaviour may take the place of the more usual euphoric sociability. The disturbances of mood and behaviour are not accompanied by hallucinations or delusions.
F31	Bipolar affective disorder A disorder characterised by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classified as bipolar. Includes: manic-depressive: <ul style="list-style-type: none">• illness• psychosis• reaction Excludes: bipolar disorder, single manic episode (F30.-) cyclothymia (F34.0)
F31.0	Bipolar affective disorder, current episode hypomanic The patient is currently hypomanic, and has had at least one other affective episode (hypomanic, manic, depressive, or mixed) in the past.

Ethical considerations

Medical ethics comprises four basic principles of health care ethics when evaluating the merits and difficulties of medical treatments. Ideally, for a medical practice to be considered 'ethical', it must respect all four of these principles: autonomy, beneficence, non-maleficence and justice. Including duty of care, confidentiality and informed consent makes the process more complete.

Beneficence

This requires being bound with the intent of doing good for the patient. It demands that health care providers develop and maintain skills and knowledge, continually update training, consider individual circumstances of all patients, and strive for net benefit. Psychiatric patients may not necessarily consider themselves to be ill, and this has impact on beneficence. If requiring more intensive approach it may need to occur against their will. These considerations come under the principle of beneficence.

In respect of beneficence, the candidate is bound with the intention to do good for Max. They should consider the individual circumstances of Max and Eric. Max does not necessarily consider himself to be ill. However, he is hypomanic, which means in respect of beneficence and good psychiatric practice, he does not require admission to an inpatient psychiatric unit. But as he is disruptive on the unit, this has a negative impact on his beneficence and that of Eric, his son. Considering the obligation to do good, the candidate may seek to explore Max's beliefs and history. Bringing Max's attention to the impact of his behaviour on Eric is reasonable to explore. All these considerations come under the principle of beneficence.

Non-maleficence

This requires to do no harm to the patient involved or others in society. To operate under the assumption to do no harm or at least minimising harm by pursuing the greater good. However, because of the nature of the treatment, the emotional state of the patient may be impacted negatively. The aim for each patient is that their wishes are respected, and the aim of treatment is towards an early restoration of the functioning of the individual.

In respect of non-maleficence, the candidate is aware for Max, the intention is to do no harm to him. To operate under the assumption to do no harm or at least minimising harm by pursuing the greater good. However, because of the nature of the interview and assessment, Max's emotional state may be impacted negatively. The aim for Max is that his wishes are respected, and the aim of the interview with the candidate is to establish if Max is at risk of harm from his elevated mood and unusual behaviour. It is established he has hypomania rather than mania, so does not currently require the candidate to be coercive towards an early restoration of the functioning of Max. These considerations come under the principle of non-maleficence.

Duty of Care

The principle of duty of care is an obligation to avoid acts or omissions, which could be reasonably foreseen to injure or harm other people. This means that you must anticipate risks for your clients, and take care to prevent them coming to harm. The law says we all have a duty of care to take reasonable care not to cause foreseeable harm to other people or their property. This is also known as the law of negligence.

The candidate may discuss the obligation to avoid acts or omissions, which could result in injury or harm to Max. His presence on the ward is a risk to his reputation and potential risk of harm. His behaviour may cause his son shame and embarrassment. The potential counter-transference from the staff, and co-clients and their families and friends, may impact adversely on his son. The risk of further harm due to deterioration in mental state may be considered. The aim would be to reduce his risk to self and others due to his hypomanic state. All these considerations come under the principle of duty of care.

Autonomy

Requires that the patient have autonomy of thought, intention, and action when making decisions regarding health care treatments. Therefore, the decision-making process must be free of coercion or coaxing. For a patient to make a fully informed decision, they must understand all risks and benefits of their illness, potential treatments and the likelihood of success. Given the complexity of treatment and diagnosis, it is difficult to expect patients to be operating under fully-informed consent.

The candidate may discuss the obligation to maintain Max's autonomy, and ability to make his own decisions in respect of his health and wellbeing.

Confidentiality

Anything learned during the professional relationship should not be revealed to others without the consent of the patient. There are specific incidences when confidentiality may be breached as risk usually outweighs confidentiality.

Informed Consent

This covers the information to be provided, competence of the patient to comprehend the information provided and freedom to choose. The consent can be withdrawn whenever the patient wishes. There are specific incidences when informed consent may be breached.

Competence

Refers to the ability to understand the nature and severity of presenting problems, and the need for suggested therapeutic help and its limitations, the ability to demonstrate comprehension of the information given, and the ability to make judgement based on this information.

Justice

The idea that the burdens and benefits of treatments must be distributed equally among all groups in society. This requires that treatments uphold the spirit of existing laws and are fair to all involved. The health care provider must consider four main areas when evaluating justice: fair distribution of scarce resources, competing needs, rights and obligations, and potential conflicts with established legislation.

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 all 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 Max Coombs, a 58-year-old Anglo-Australian man. You are a widower and live in your own home, independently in the small coastal town of Albany with your adult son, Eric.

You have come to visit Eric, who is in an acute mental health unit. Eric was admitted two weeks ago with a relapse of his bipolar (manic depressive) illness. He is getting better now, and you had planned to talk with the psychiatrist about how things were going towards discharge.

Recent history

In general, people who meet you and people who know you have always described you as energetic and eccentric. You reckon they mean you are different, of course cleverer than most, obviously richer than most and you have been quite successful.

One month ago, you started to worry about your finances. The accountant said there were no problems, but you couldn't seem to get the thought out of your mind. You checked and re-checked all the businesses, and it seemed all was well. Then Eric got sick, and you stayed up with him, because he kept leaving the house, and going down to the marina to check the boats. You told him it was okay, but he wouldn't listen to you. During this time, you had an altercation with Eric, trying to stop him going out. You had to call the police and Eric was taken to hospital. In the end, you had very poor sleep over four nights.

After that you couldn't settle and couldn't sleep. You noticed that you didn't need sleep, and you didn't need feel hungry. You felt wonderful, you felt powerful and energetic.

Your children are worried about you, including Eric. You spoke to him just now, and he said you weren't right, '**the silly boy**'. What nonsense, of course you are fabulous. Eric has tried to suggest that you are unwell, even now that you are visiting him on the psychiatry ward. That has amused you, and now these nice nurses and doctors want to talk to you.

If asked what you are doing with your time: you can still function reasonably at work. Lately you have noticed that your thoughts are racing, but you seem to be coping okay. You have noticed ideas have started flowing so beautifully in you; and you knew you had to write a book. You had to do your autobiography, because your life is so fascinating. You would only be able to sit to write for about a few hours, over the past three weeks you can't sit still – there is too much to do.

You met a woman, others would describe as a '**lady of the night**', but you know Priscilla is your soul mate. You have been visiting her regularly, and even proposed marriage to her. She has said '**no, you silly old coot!**'

You have been thinking about buying a new car, because your suggestion to buy a boat as a new financial investment was not met with support from the family. You just saw a great boat in Fiji when you visited your sister. You wanted to go back, and you wanted to buy it. The car would be an upgrade for the one you have, so you are thinking about that now. But your kids, your accountant and lawyer did not think it was good business sense. You did get into an argument with your lawyer about it, but you are glad you have such caring people around you. After seeing the lawyer, you decided to come and see your boy, Eric, so drove to the hospital.

In the last few days, you have been feeling happier than usual. If asked, you admit that you have more energy to do all the things you have been planning to do, people have been saying you seem happier, and more energetic than usual. You feel there's nothing wrong with you, you feel you have never been better. You are enjoying meeting new people wherever you go. You can't help it if you are so popular suddenly.

The other day, when you were driving you have to admit you were a bit distracted, but you stopped the car, so you could have a rest – no harm done.

Past History

You do recall in your late teens having a period of six months when you felt depressed. Your mood was low, and your parents took you to see the GP. You were started on an antidepressant, you can't remember the name, but after three days you felt '*really good*'. Then after two weeks, you became so happy and high, you weren't sleeping, you couldn't focus at school, you forgot to go to school because you had so many projects on the go, you spent all your time doing them, you forgot to eat or to sleep. In the end, your parents called for help. You were admitted to a psychiatric unit, and later you were told you had been manic. They told you that you were very sick, but you didn't feel sick, you felt wonderful. In hospital, they gave you a medication called LITHIUM and after three weeks, you felt like your normal self. Since then, you have had periods of fluctuations in your mood, but never like that time.

You have never required further admission to a psychiatric unit. You stopped the medication years ago, maybe three months after they gave it to you. You do not believe you have a mental illness, and in fact you feel wonderful, full of life and you simply live life passionately. Why clinicians must label it as an illness irritates you. You think your son should exercise more, and he will stay well.

You have never heard voices or seen things that others do not. You know you are special, but do not have any special powers or special connection with God. You love Priscilla and are not interested in other women, and have not been having indiscriminate relationships or an abnormally high sexual drive. You have been wanting to buy a few things as described above, but have been reluctantly talked out of this by your children or lawyer. You have never been in trouble with the law. You have never been in physical fights.

You do not remember much of the time when you were depressed, but you can say with confidence that you were not suicidal at the time, and you have never attempted self-harm or had a desire to die.

You have never smoked cigarettes, or cannabis, or used any other illicit substances. You have enjoyed alcohol, and there have been times when you have drunk too much, but it has never caused any problems for you. You are fit and healthy, and have no physical illnesses.

Family History:

As far as you know, your father, sister and brother all have Bipolar Disorder ('*bipolar*'). Your eldest son, Paul, has no mental health problems. Your daughter is overly emotional, but does not have Bipolar Disorder or require medication, other than occasional sleeping tablets when she has trouble sleeping. Your son, Eric, developed Bipolar Disorder when he was 25 years old. When he is well, he works for you. Eric has had both depressive and manic episodes, and you have tried to support him as best you can. You know that he is in hospital now for mania. You know you are nothing like any of the others, in fact, you are simply too busy to be bothered with being unwell.

Personal History

You were born and bred in Albany, Western Australia.

Your wife, Nancy, died 10 years ago from an asthma attack. You have missed her greatly since.

You own two businesses, and your three children work with you (Paul 38, Rose 36, and Eric 34 years old respectively). Your first business is your cattle farm which brings in a steady return. You have a Whale Watching tour business with two large boats. Recently, you have found that the stress of running two relatively successful busy enterprises difficult.

4.2 How to play the role:

You are feeling happy, and you are brightly dressed in a suit and hat. You initially laugh and move your head, lean in closer to the candidate and then back again into your seat, smiling at the candidate and waiting for them to speak. You continue to be loud at times and laughing at times, talking quicker at times, using your hands in gestures to emphasise what you are saying. You are enjoying talking with the doctor.

You can talk on a range of topics in no particular sequence, talk about the weather, the drive, the clothes you are wearing, the colour of your clothes, how great you are feeling, how energetic and healthy you are, probably healthier than the candidate. You are relaxed and happy, and enjoying the interview.

You let the candidate interrupt you and answer the questions as best you can, from the information provided. But you don't really link any of the information to you being elevated in mood, you just feel 'happy'.

4.3 Opening statement:

'Wow doc, I seem to be the only sane person in here.'

4.4 What to expect from the candidate:

The candidate should engage you in respectful conversation, with a focus on trying to engage with you to try to understand how things are going for you, and not follow your tangents of conversation. They are expected to try and take a history of your life in summary to look for details of bipolar disorder, drug use, and other relevant history.

The candidate is then expected to talk to the examiner about how they will manage the situation you are in.

4.5 Responses you MUST make:

'I feel amazing – check me out.' (hit upper arms and do pose, lean forward and smile at the candidate)

'There's nothing wrong with me, doc' (lean forward and look into the candidate's eyes but NOT in a threatening manner)

'I'm just here to see my boy-'

4.6 Responses you MIGHT make:

If the candidate asks about any thoughts of harm to self (suicidal or self-harm) or others (homicidal)?

Scripted Response: ***'No, never.'***

If the candidate asks about low mood or depression?

Scripted Response: ***'No, there's nothing wrong with me, I'm great.'***

If the candidate asks if you would consider taking medication?

Scripted Response: ***'No, there's nothing wrong with me, I'm great.'***

If the candidate asks if you are willing to come into hospital?

Scripted Response: ***'No, there's nothing wrong with me, I'm great.'***

If the candidate asks you questions you do not have answers for:

Scripted Response: ***'That doesn't matter.'***
'I don't know.'

4.7 Medication and dosage that you need to remember:

None.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate how the candidate manages an interview with the family member, Max.
- Apply accurate phenomenology to make a diagnosis of hypomania using a diagnostic system.
- Discuss ethical considerations raised by Max's presentation.

Level of Observed Competence:

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information on Max? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the client taking regard of culture, gender, ethnicity, mental illness, etc.; providing education; communicating plans and discussing acceptability; effectively managing challenging communications; containing conflict or behavioural abnormalities; recognising confidentiality and bias.

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

- Effectively de-escalate the initial presentation.

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; errors or omissions materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

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

2.1. Category: PATIENT COMMUNICATION - To Patient	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

1.3 Did the candidate demonstrate adequate proficiency in undertaking a mental state examination for hypomania? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

able to conduct mental state examination relevant to the patient's problems and circumstances; it is conducted / presented at a sophisticated level.

Achieves the Standard by:

demonstrating capacity to: conduct and present an accurate mental state examination for hypomania; assess key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; decide on the importance of a cognitive assessment; present succinctly with accurate use of phenomenological terms; include appropriate positive and negative findings. Hypomania: mild elevation in mood, increased energy, increased activity, marked feelings of wellbeing, talkativeness, overfamiliarity, increased sexual energy, decreased need for sleep, lack of insight.

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

- Elaborate on the phenomenology of hypomania with at least three signs of hypomania.

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 in technique, organisation, accuracy and / or presentation.

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

1.3. Category: ASSESSMENT – Mental State Examination	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 candidate formulate and describe 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.

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; identifying relevant predisposing, precipitating, perpetuating and protective factors; aiming to exclude coexisting physical illness, substance use, personality factors.

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

a. Justify why the presentation is more likely hypomania than mania in their diagnostic formulation.

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 - 40%)

Surpasses the Standard (scores 5) if:

comprehensively considers all major aspects of ethical conduct and practice.

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; integrate ethical practice into the clinical setting; apply ethical principles to resolve conflicting priorities; utilise ethical decision-making strategies to manage the impact on professional practice / patient care; maintain appropriate personal / interpersonal boundaries; recognise the importance and limitations of obtaining consent and keeping confidentiality.

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

a. Elaborate on at least two of the following issues: beneficence, non-maleficence, duty of care, autonomy towards a person who is not their patient.

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

Below the Standard (scores 2):

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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Marking Domains	14-15

1.0 Descriptive summary of station:

The candidate is expected to empathetically assess a refugee woman presenting with Medically Unexplained Symptoms (MUS) in the form of a Conversion Disorder with unconscious collapses, and inability to weight-bear. This was precipitated in context of acute chronic back pain following a relatively minor real injury, against a background of some depressive symptoms, and multiple psychosocial stressors. The case also illustrates some of the difficulties encountered by the refugee population. The candidate is expected to provide a diagnosis, and an explanatory model for her symptoms, before suggesting possible treatment options.

1.1 The main assessment aims are to:

- Empathetically undertake a focussed assessment of Medically Unexplained Symptoms, in order to demonstrate an understanding of potential predisposing, precipitating and perpetuating concerns, whilst taking other psychiatric co-morbidities into account.
- Provide a diagnosis and coherent explanatory model for the patient in order to provide a link between psychosocial factors and physical symptoms.
- Demonstrate an awareness of treatment modalities including a MDT (multi-disciplinary team) patient-centred approach, as well as specific options including psychological treatment (like CBT or ACT) and antidepressants.

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

- Validate the patient's distress through direct assertion that the symptoms are real in order to facilitate engagement.
- Accurately make a diagnosis of Conversion Disorder / Functional Neurological Symptom Disorder as the primary diagnosis.
- Use a model to link the somatic symptoms to the relevant psychosocial stressors.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders (DSM-5: Somatic Symptom and Related Disorders)
- **Area of Practice:** Consultation Liaison
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Diagnosis; Management – Therapy), Communicator (Patient Communication – To Patient)

References:

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- World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization
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- Grover S, Kate N. Somatic symptoms in consultation-liaison psychiatry. *International Review of Psychiatry*. Feb 2013; 25(1):52-64
- Mayer LJ, Groleau D, Looper KJ, Dao M. Explaining Medically unexplained Symptoms. *Can J Psychiatry* 2004; 49: 663-671
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Committee for Examinations
Objective Structured Clinical Examination
Station 6
Perth September 2019



1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female aged 23 to 35.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You work as a junior consultant psychiatrist in a suburban mental health service, and are providing cover for your colleague doing Consultation-Liaison psychiatry. You are about to see the following patient who has been referred from one of the medical teams:

Dear colleague,

Thank you for seeing Zara, a 32-year-old woman, to consider for transfer to the psych ward.

Admitted 2 weeks ago to the medical ward with acute lower back pain, and now claims she cannot walk. She also started to have unresponsive episodes.

No cause has been found and all investigations including routine bloods, MSU, MRI Brain and EEG have been normal. MRI of the Back did show L4 / L5 disc bulging with possible impingement of the right L4 root.

Neurology and Neurosurgery suggested conservative management only, and pathology on scan, and clinical findings are not able to explain current symptoms.

We feel it is behavioural, and she is not participating in rehab; she cries when the physiotherapist tries to work with her.

? Personality disorder ? Depressed and needs treatment.

With thanks

Your tasks are to:

- Take an adequate history to enable you to formulate her presentation in order to make a diagnosis.
- Explain your diagnostic opinion **to the patient** by providing an explanatory model to help her understand her situation.
- Suggest possible treatment options.

You are not required to examine the patient.

Station 6 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - Pens.
 - Water and tissues (available for candidate use).
- Do a final rehearsal with your role player.

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 role player has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

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

There are no prompts.

The role player opens with the following statement:

'I am so frustrated. Nobody seems to believe me.'

3.2 Background information for examiners

In this station, the candidate is expected to demonstrate the ability to empathetically do a focussed and patient-centred assessment of Medically Unexplained Symptoms (MUS) in a female refugee. The patient presents in context of a two-week hospital stay, with an inability to walk and recurrent unresponsive episodes not accounted for by underlying pathology after extensive investigation.

The onset of symptoms followed an actual injury (spinal disc herniation, annular tear, nerve root compression) obtained whilst bending to pick up her baby. This is a very common mechanism of injury for mothers with infants given the laxity of ligaments post-partum, and also the repetitive lifting required with infants.

The injury occurred in context of some background depressive and numerous psychological stressors including difficulty passing the citizenship test (denying her a sense of permanency, security and belonging), as well as ongoing distress about her loved ones scattered around the world with little prospect of reuniting. It is clear that she is struggling with the demands of parenting five children on her own with no other supports, and being fairly isolated in the community. There are financial stressors, and also heightened anxiety about the implications of her injury resulting in her being incapacitated, with her husband being unable to get to work, and being at risk of losing their source of income; she also has an underlying fear that if she is unable to perform her duties at home, he will divorce her. A sense of being dismissed, not believed and not listened to by medical professionals are further acting to perpetuate the situation.

It is expected that a successful candidate will elicit sufficient information to be able to formulate this problem and to establish a diagnosis of Conversion Disorder, in the context of understanding the predisposing, precipitating and perpetuating factors leading to the current presentation. The process of engagement of the patient is important so as to not contribute to the patient's sense of not being listened to or not being believed by medical professionals with a dismissal of her symptoms. The candidate will be expected to explain the diagnosis in easy to understand language to the patient, and should include validating the reality of the symptoms and distress experienced by the patient, and reassuring the patient that it is not uncommon to be unable to find an exact cause for symptoms. The candidate is asked to provide an explanatory model linking behavioural, psychological, and emotional factors to the onset and / or exacerbation of somatic symptoms. A patient-centred approach with the aim of strengthening the patient-doctor relationship by listening carefully to the patient's presentation and concerns, validating concerns through direct assertion that the symptoms are 'real', exploring psychological cues and responding to emotions should be followed.

A positive stance with regards to recovery and the expectation of a full return to function is important, and the candidate is expected to have some knowledge of specific treatment modalities including the use of SSRI's in MUS, especially where there are underlying depressive symptoms, as well as Reattribution strategies, CBT, short term dynamic psychotherapy, mindfulness based interventions, and the importance of practical supports (for example around child care, finances), and rehabilitation.

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

- Validate the patient's distress through direct assertion that the symptoms are real in order to facilitate engagement.
- Accurately make a diagnosis of Conversion Disorder / Functional Neurological Symptom Disorder as the primary diagnosis.
- Use a model to link the somatic symptoms to the relevant psychosocial stressors.

A surpassing candidate may also identify underlying depressive symptoms, and will show a sophisticated understanding of more than one explanatory models for MUS enabling linkage between MUS and psychological stressors. The candidate will also establish sophisticated connections between a family history of vague somatic symptoms (her sister with recurrent abdominal pain), as well as her own history of chronic headaches with a psychosomatic component, and her current situation when helping the patient to make sense of her presentation. The process of empathetic engagement and validating the patient's distress will be exemplary and may include exploration of the meaning of the symptoms from the patient's perspective.

Background:

Context

At the dawn of the psychoanalytic era, Breuer and Freud developed the concept of 'conversion', a process whereby intra-psychic activity putatively brings about somatic symptoms. Their work introduced the idea of early emotional trauma or intra-psychic conflict as the cause of physical symptoms, and an unconscious form of communication. Medically unexplained symptoms, including Conversion Disorder, remains one of the most puzzling phenomena encountered by health care providers.

Medically Unexplained Symptoms (MUS) are considered an important problem in primary care (between 25% and 50% of primary care patients present with MUS), as well as in specialist clinics where prevalence rates of 53%, 42% and 32% in gastroenterology, neurology and cardiology respectively have been shown. They account for a high consumption of healthcare resources, and often result in frustration for both physicians (feeling disempowered, inadequate and irritated), and patients (feeling disbelieved and not taken seriously). About half of all patients with MUS also suffer from depressive and anxiety disorders.

In general, the literature suggests that MUS are more common in women, young subjects, patients from low socio-economic status, and possibly in patients with poor educational achievement. A background of family dysfunction, trauma or abuse is often associated with MUS. The role of ethnicity is unclear and prevalence vary across countries in an inconsistent pattern.

MUS have been linked with disorders of affect regulation, specifically alexithymia where difficulty in identifying feelings, and distinguishing between feelings and bodily sensations, difficulty describing feelings and an externally focussed cognitive style is present. Somatic symptoms are traditionally thought of as 'idioms of distress', and often seen as the bodily expression of depression and / or anxiety, although this view tends to be simplistic and inadequate.

Prognostically, a significant proportion of patients have a poor outcome with between 50% and 75% of patients improving over time regardless of intervention, but up to 30% of patients deteriorating. The amount of MUS at baseline predicts the outcome with especially more than five symptoms associated with significantly increased morbidity, and physical disability over time. Studies evaluating expectations of patients with MUS suggest that rather than looking for medical treatment, these patients seek support, a convincing explanation (rather than just reassurance and normalisation based on negative test results), emotional support and reassurance. Interestingly inappropriate medical interventions contributing to the risk for iatrogenic harm is more often than not physician driven, rather than by the patients.

Management

At the centre of addressing the notion of MUS (and in this case the Conversion Disorder as an example thereof), stands the doctor-patient relationship with the 'Assessment' being already part of any intervention, exploring predisposing, precipitating and perpetuating factors, with this following a patient-centred approach characterised by listening carefully to the patient, exploring the patient's belief systems around the symptoms and – very importantly – validating the patient's concerns through direct assertion that the symptoms are real, and exploring emotional cues around that. Doctors should reiterate familiarity with the symptoms / condition and practical advice regarding interventions around any disability or addressing stressors (e.g. physiotherapy, social interventions etc.), creating an expectation of recovery, and encouraging an eventual return to normal activity, and coping with symptoms that may wax and wane, are all helpful.

Following from that, reattribution (providing clear explanations that link physical to psychological issues) with a goal of broadening the agenda beyond physical symptoms and negotiating further treatment, is important. In this regard, various explanatory models for MUS have been described, including:

<i>Somatosensory Amplification theory</i>	Initially developed for hypochondriasis and later adjusted for MUS, suggests that when a physical sensation arises, patients focus attention on this and as a consequence develop certain cognitions and attributions which further amplify the perception of physical signals, becoming a vicious circle in a way that the symptoms are reinforced by the patient's thoughts and concerns.
<i>Sensitisation theory</i>	Repeated pain experiences and symptoms lead to memory traces at a neuronal level increasing sensitivity for future stimulation. This results in benign stimuli being perceived as pain. For MUS wider memory complexes may play a role activated by single symptoms and resulting in various physical symptoms.
<i>Sensitivity theory</i>	Certain individuals are more vulnerable due to personality traits, such as neuroticism and negative affect. Early childhood traumatic experienced and insecure attachment play a role in these vulnerabilities.
<i>Immune System Sensitisation theory</i>	Early life stressors lead to sensitisation of the immune system resulting in MUS. Normally, the brain cytokine system is activated by the immune system which mediated the subjective, behavioural and physiological components of illness (leading to the sick role). However, if the immune system is sensitised, it reacts to non-immune stimuli too, reacts faster and is less likely to shut down again once the initial stimuli has been eliminated. This results in chronic immune activation with cytokine production and feeling sick.
<i>Endocrine Dysregulation theory</i>	Based on the stress model, according to which stress in early life leads to dysregulation of the hypothalamo-pituitary-adrenal axis and hypercortisolemia, frequently present in patients with MUS.
<i>Signal Filter theory</i>	The sensory noise from various parts of the body is not filtered by the brain, and results in overstimulation from physiological processes and external processes, and as a result a large number of physical sensations are experienced and increased, manifesting as MUS.
<i>Illness Behaviour theory</i>	Patients' behaviour is influenced by their beliefs and affects physiology and symptoms, resulting in a vicious circle and maintaining symptoms. Avoidance of activity results in more symptoms.
<i>Autonomic Nervous System Dysfunction theory</i>	Proposes a dysfunctional autonomic system, where after a mentally distressing task the heart rate activity does not decrease as normally would happen, resulting in longer term increased heart rate and stress burden.
<i>Abnormal Proprioception theory</i>	Increased or abnormal proprioception in patients with MUS leading to even small benign physiological sensations being interpreted as signs of physical disease.
<i>Cognitive Behavioural Therapy model</i>	This is a meta-model incorporating aspects of sensitivity, sensitisation, somatosensory amplification, endocrine dysregulation and illness behaviour models. It proposes a self-perpetuating vicious circle taking into account genetics, early life experiences, the HPA axis dysregulation, attention bias and response to illness.

Collaborative care between health care professionals and a multi-disciplinary team approach is helpful, in particular with regards to a rehabilitation focus, and the use of physiotherapy and occupational therapy input and an expectation of recovery. Iatrogenic harm through excessive medical investigations and interventions should be guarded against, and communication between medical professionals is essential. Co-morbid depression / anxiety should be identified and addressed.

Psychological interventions with some evidence include CBT, which result in modest improvements although outcomes are limited by patient and symptom heterogeneity. Common aspects of CBT include systematic relaxation training, psycho-education, and exploring of dysfunctional beliefs regarding the symptoms, followed by problem solving / coping skills training.

Integration of mindfulness approaches and ACT (acceptance and commitment therapy) are increasingly shown to be helpful.

The use of SSRIs has been shown to be helpful regardless of underlying symptoms of depression or not, and should be considered as part of any intervention. The evidence base for other antidepressants is less robust, although also thought to be helpful regardless of class; a mild side effect profile is desirable though to avoid further somatic symptoms arising.

The candidate is expected to demonstrate sensitive consideration of barriers to implementation of any interventions - especially practicalities around childcare, poor mobility; identification of role of other health professionals in regard to ongoing rehabilitation and the social / financial stressors.

DSM-5 diagnostic criteria for Functional Neurological Symptom Disorder (300.11):

- A) The patient has at least one symptom of altered voluntary motor or sensory function.
- B) Clinical findings provide evidence of incompatibility between the symptoms and recognised neurological or medical conditions.
- C) The symptom or deficit is not better explained by another medical or mental disorder.
- D) The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Specify type of symptom or deficit as:

- With weakness or paralysis
- With abnormal movement (e.g. tremor, dystonic movement, myoclonus, gait disorder)
- With swallowing symptoms
- With attacks or seizures
- With amnesia or memory loss
- With special sensory loss symptoms (e.g. visual blindness, olfactory loss, or hearing disturbance)
- With mixed symptoms.

Specify if:

- Acute episode: Symptoms present for less than six months
- Persistent: Symptoms present for six months or more.

Specify if:

- Psychological stressor (conversion disorder)
- No psychological stressors (functional neurological symptom disorder).

ICD-10 diagnostic criteria for dissociative (conversion) disorders (F44):

The common themes that are shared by dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements.

All types of dissociative disorders tend to remit after a few weeks or months, particularly if their onset is associated with a traumatic life event. More chronic disorders, particularly paralysis and anaesthesias, may develop if the onset is associated with insoluble problems or interpersonal difficulties. These disorders have previously been classified as various types of 'conversion hysteria'. They are presumed to be psychogenic in origin, being closely associated in time with traumatic life events, insoluble and intolerable problems, or disturbed relationships. The symptoms often represent the patient's concept of how a physical illness would manifest. Medical examination and investigation do not reveal the presence of any known physical or neurological disorder. In addition there is evidence that the loss of function is an expression of emotional conflicts or needs. The symptoms may develop in close relationship to psychological stress, and often appear suddenly.

F44.2 Dissociative stupor

Dissociative stupor is diagnosed on the basis of a profound diminution or absence of voluntary movement and normal responsiveness to external stimuli such as light, noise, and touch, but examination and investigation reveal no evidence of a physical cause. In addition, there is positive evidence of a psychogenic causation in the form of recent stressful events or problems.

F44.4 Dissociative motor disorders

In the commonest varieties there is loss of ability to move the whole or part of a limb or limbs. There may be close resemblance to almost any variety of ataxia, apraxia, akinesia, dysarthria, aphonia, dyskinesia, seizures, or paralysis.

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 Zara, a 32-year-old married woman, originally from a war-torn country. You live with your husband, Mohammed, and five children (two boys and three girls) aged between five months and 10 years. You arrived as a refugee in Australia about two years ago after living in a refugee camp for 10 years.

You are currently in hospital, and the medical team have referred you to a psychiatrist because they do not believe you have a physical illness.

Current situation:

Two weeks ago (one day after you again failed the citizenship test), you bent over to pick up your 5-month-old baby daughter, and suddenly felt a sharp pain in your back going down your legs. After this, you felt a lot of pain and unable to walk or move properly. You did not want to go to the hospital initially, but then had an episode the next day where you collapsed to the ground unable to walk, and apparently did not respond to your husband – you can't remember this. He brought you to hospital where you have been since.

You have continued to be unable to walk, and despite standing up sometimes, you end up with your legs collapsing. On three occasions, you collapsed unresponsive and remember waking up after some minutes with an 'emergency team' around you on the floor. The pain has been coming and going, but with medication it has made it a bit better. The main issues now are that you still can't seem to walk, and that you 'black out'.

You had an MRI scan of your back which apparently showed that you had 'a slipped disc' in your lower back that is 'pressing on the nerves'. Lots of blood tests and a urine test have been done which you were told were 'all normal'; you also had a brain scan which was 'normal'. You have seen 'many doctors', all said 'there is nothing wrong with me', and you remember a neurosurgeon told you 'it is not that bad, just get on with it', and that they do not need to operate your back. You feel nobody believes you when you say you can't walk, and they get impatient when you don't feel you could do physiotherapy because of pain. You overheard a member of the staff make a comment that 'she's faking it' which made you cry. And now, you are upset because having to see a psychiatrist means they think you are crazy too.

You worry about your husband who had to take time off work to care for the children whilst you are in hospital. You worry he might lose his job as a result if you don't recover soon. You are still breastfeeding, and feel helpless because you can't even pick up your baby at the moment. If only you could have your sister to help you, it might have been easier - you even wondered if the doctors couldn't write to the Immigration department to ask whether she could get a visa to come and help you.

Medical history:

In terms of your back, you have had some intermittent back pain over 'a few years', but never this bad and never going down your legs or causing you not to walk. It never was bad enough for you to see a doctor. You have never had these 'black outs' or seizures (epilepsy) in the past.

You also have regular headaches – at times this can happen daily, at other times weeks can go without one. If you are asked, they are 'dull all over' and you have noticed that they seem to start when you feel stressed, or if things are not going well at home. They are worse when you feel stressed. When you are relaxed, you don't get these headaches. Your headaches have been much worse in the last few months, and have also been a bother in hospital.

You have generally otherwise been in good health, and don't normally take medication. You don't smoke and do not drink alcohol or take drugs.

Psychiatric history and symptoms:

If you are asked about any of the following: you were never diagnosed with, or treated for a mental illness, and have never seen a psychiatrist or psychologist.

In the last six months, you often lay awake worrying about the family at night. You feel a bit sad most days and often cry when you feel overwhelmed. You mostly enjoy playing with your baby and the rest of your children, and feel that you have a good bond with them, but occasionally feel you just can't be bothered. Your appetite and concentration are normal. You have never wished that you could die or thought of suicide. You don't feel worthless or guilty about anything. You just feel overwhelmed by everything. You worry about the family and the finances, but you are not normally anxious about anything else; you never have panic attacks and you are normally not shy around other people. You never have nightmares, and never think about the war or get flashbacks about your time in the camps. You never hear voices or see things that others can't; you never felt threatened or persecuted or held beliefs that other people thought were not true. You normally get along well with people, and never got into trouble with the police.

Your personal background:

You left your country with your parents and family, because the village came back under the control of rebels during an insurgency. You know of many family members and friends that got killed in the war, but your life was never in direct danger. You remember the bombs falling far away, and the sound of gunshots during the war, but it was all over fairly soon when your family decided to flee the country. You met your husband in the refugee camp in a neighbouring country and got married. It was an arranged marriage but it has been a good partnership and he has been a kind, supportive and hardworking husband that has taken good care of his family through all the difficult times.

Things have been difficult for you as a family in the last two years, and re-settling in Australia was harder than expected. Your husband is doing long hours as a tiler apprentice, which is what he did previously back home, but had to retrain in Australia. You barely make ends meet on his salary, and are under financial stress. The mosque and some kind people from the local community are helping out here and there with groceries, clothes, and other support, but it is not the same as having family or close friends around. You fell pregnant again soon after you arrived in Australia, and have been mainly looking after the household and the children for the last two years. As a result, you have not had much opportunity to meet people or make new friends.

None of the rest of either of your extended families are in Australia – most of them are back in your home country, but some are still in refugee camps or in Canada and Europe. You are very happy and grateful that you could come to Australia, and have enjoyed the freedom of life here, but you miss your family, and especially your mother and older sister, and wish they could also come to Australia. Unfortunately they previously had their visa applications rejected. You worry a lot about them because you know they are struggling. You also worry about other family members left behind in your country. You are the middle of five siblings, two of whom remain in your country of birth, one who is in Canada and your oldest brother died in the war. Your father never recovered from that loss, and now has to be cared for by your mother and sister. You Whatsapp and Skype with them regularly, but it is not the same.

You have been attending English language classes, but this has been difficult because you are breastfeeding and have to take the baby with you which is distracting. You were not allowed to go to school during the war, and had to learn how to read and write as an adult which makes learning harder. You feel this is why you are finding the citizenship test so difficult. You have sat the exam five times already, and failed each time – you just seem to ‘shut down...can’t think’ when you have to do the test. You feel guilty about that and feel ‘stupid’; you worry that unless you are a citizen, the government could ‘kick me out again sometime’; you also hope that being a citizen might help you to bring your sister to Australia, and now you feel this might never happen.

Family history:

You are not aware of any history of formally diagnosed mental illness in your family, but you think your father might be depressed since your brother died. You don’t know of specific medical problems in your family, but your older sister has struggled with lots of abdominal pain and seen a few doctors for it, you don’t know whether she has been diagnosed with anything.

4.2 How to play the role:

Casually but modestly dressed. Initially more reserved and clearly stressed, then more spontaneous and forthcoming if you feel comfortable, reassured and being listened too. Present as cooperative but somewhat anxious, worried, and a bit depressed.

It is clear that you feel overwhelmed and isolated with no relatives in the country to support you, and you have not been here long enough to make close friends. You miss your friends and relatives from back home very much. You wish you could get your sister to come to Australia to help you with the children. You are scared that your husband might leave you if you can’t do your housework or be a good wife to him. You feel guilty because he is currently unable to work because he needs to look after the children whilst you are in hospital, and you know it will add financial strain, and worry he might lose his job. You are very worried about the citizenship exam, and worry that you will never pass it, and as such will not be able to become Australian.

4.3 Opening statement:

‘I am so frustrated. Nobody seems to believe me.’

4.4 What to expect from the candidate:

The candidate will need to explore your current symptoms and problems leading to the presentation, including the background history and psychological factors leading to your presentation. The candidate should be able to make you feel listened to and understood. The candidate is expected to provide you with a diagnosis, as well as a brief and easy to understand explanation of why this has occurred, and importantly be able to draw links between psychological distress and the symptoms occurring. They should be able to mention what treatments could be offered to help.

4.5 Responses you MUST make:

'I can't seem to walk and I black out.'

'Do you believe me when I say I can't walk, doctor?'

'Will I ever be able to walk again?'

'Why has this happened to me?'

4.6 Responses you MIGHT make:

If the candidate asks where you are from:

Scripted Response: 'I don't want to talk about home.'

If the candidate asks to, or attempts to examine you physically:

Scripted Response: 'All those other doctors told me it won't be necessary for you to examine me again.'

If the candidate asks what you think you need to help you get better:

Scripted Response: 'Can't you write to immigration asking that my sister come over here; I need her here. The pain is not so bad, it's just I can't walk.'

4.7 Medication and dosage that you need to remember

You are taking 'pain killers' since being admitted to hospital, but you can't remember which ones. They have been helpful although you still have some discomfort.

You are otherwise healthy and do not take any regular medication.

STATION 6 – MARKING DOMAINS

The main assessment aims are to:

- Empathetically undertake a focussed assessment of Medically Unexplained Symptoms, in order to demonstrate an understanding of potential predisposing, precipitating and perpetuating concerns, whilst taking other psychiatric co-morbidities into account.
- Provide a diagnosis and coherent explanatory model for the patient in order to provide a link between psychosocial factors and physical symptoms.
- Demonstrate an awareness of treatment modalities including a MDT patient-centred approach, as well as specific options including psychological treatment (like CBT or ACT) and antidepressants.

Level of Observed Competence:

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard by:

demonstrating a patient-centred approach by showing empathy, active and attuned listening, and the ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the patient taking regard of culture, gender, ethnicity etc.; sensitively managing the patient's address; communicating plans and discussing acceptability; negotiating alternatives; accommodating minor inappropriateness; recognising confidentiality and managing cognitive / cultural bias.

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

- Validate the patient's distress through direct assertion that the symptoms are real in order to facilitate engagement.

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; errors or omissions materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

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

2.1. Category: PATIENT COMMUNICATION - To Patient	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

1.9 Did the candidate formulate and describe the relevant diagnosis / differential diagnosis? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment.

Achieves the Standard by:

integrating available information in order to formulate a diagnosis / differential diagnosis; demonstrating understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; adequate prioritising of conditions relevant to the obtained history and findings; identifying co-morbid depressive symptoms; utilising a biopsychosocial approach placing the diagnosis in the context of psychosocial circumstances; identifying relevant predisposing, precipitating perpetuating and protective factors; including communication in appropriate language and detail and according to good judgment.

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

- Accurately make a diagnosis of Conversion Disorder / Functional Neurological Symptom Disorder as the primary diagnosis.

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

Below the Standard (scores 2):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; the candidate is unable to explain the diagnosis / formulation to the patient in easy to understand language and / or only uses complex terminology and language.

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"/>

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological / psychological / social therapies? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support treatment options; demonstrates an in-depth awareness of treatment modalities; takes breastfeeding into consideration if suggesting pharmacotherapy.

Achieves the Standard by:

demonstrating the understanding of the importance of both psychological and pharmacological treatments especially given the depressive component; using at least one explanatory model to provide a coherent explanation of the symptoms to the patient as a therapeutic intervention; choice and rationale for specific psychotherapies as a priority; describing medication choices (SSRI), dosing and monitoring; demonstrating application of psychoeducation; considering sensitively barriers to implementation; identifying the roles of other health professionals in regards to ongoing rehabilitation and the social / financial stressors; identifying specific treatment outcomes and prognosis.

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

- a. Use a model to link the somatic symptoms to the relevant psychosocial stressors.

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; the candidate is aware of a range of psychotherapeutic modalities.

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; errors or omissions impact adversely on patient care; plan lacks structure and / or is inaccurate; plan not tailored to patient's needs or circumstances.

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

1.14. Category: MANAGEMENT - Therapy	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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<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
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1.0 Descriptive summary of station:

Mr Henderson is a 33-year-old man who has been treated with lithium for seven years for Bipolar Disorder. The candidate is expected to obtain relevant history, and interpret laboratory tests to diagnose hyperthyroidism and lithium toxicity due to interactions with pain medications commenced recently by his GP. He developed side effects prior to experiencing drug interactions.

1.1 The main assessment aims are to:

- Take relevant history to diagnose hyperthyroidism, which is likely to be lithium induced, and drug interactions leading to lithium toxicity.
- Integrate and interpret findings from history and laboratory tests to make accurate diagnosis.
- Communicate with the patient regarding the nature of his problems and the implications for treatment.

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

- Identify that the onset of hyperthyroidism was prior to commencement of pain medications.
- Confirm hyperthyroidism from elevated T3 and low TSH.
- Elicit at least four symptoms of lithium toxicity.
- Diagnose hyperthyroidism and lithium toxicity due to interactions between celecoxib, ibuprofen and lithium.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Medical Disorders in Psychiatry
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Diagnosis – Investigation Analysis, Diagnosis)

References:

- The Science and Practice of Lithium Therapy. Gin S Malhi, Marc Masson, Frank Bellivier, 2017
- The Maudsley prescribing guidelines in Psychiatry, 12th edition, David Taylor, Carol Paton, Shitij Kapur
- Lishman's Organic Psychiatry, A Textbook of Neuropsychiatry, 4th edition, Anthony S David, Simon Fleminger, Michael D, Kopelman, Simon Lovestone, John D.C. Mellers, 2009
- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders, 2015. Gin S Malhi et al., Australian And New Zealand Journal of Psychiatry 2015, Vol 49 (12) 1-185
- Hansen HE, Amdisen A (1978) Lithium intoxication. Report of 23 cases and review of 100 cases from the literature. Q J Med 47: 123-144
- Sheean GL (1991) Lithium neurotoxicity. Clin Exp Neurol 28: 112-127
- McKnight RF, Adida M, Budge K et al (2012) Lithium toxicity profile: a systematic review and meta-analysis, Lancet 379:721-728

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Results of blood investigations – laminated and available outside, as well as in the exam room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male aged 30–35 years, casually dressed.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist working in community mental health clinic. A GP has referred Mr Simon Henderson for an urgent review.

The GP letter states:

Dear Dr,

I would appreciate your urgent opinion and management for Simon, a 33-year-old man with a 7-year history of Bipolar Disorder. He has been on lithium carbonate for seven years, and his current dose is 500mg mane and 750mg nocte. His condition has been stable for nearly five years. I have known him for the last six months. I commenced him on pain medications three weeks ago for possible arthritis in his knees.

He has now been complaining of poor sleep, feeling tired and weakness in his arms. His family reported that he has been irritable, and that he is losing weight. He recently complained of being nauseous. I feel that his lithium dose will need increasing.

I have attached copy of recent blood results.

Yours sincerely

Dr Connor
General Practitioner

Your tasks are to:

- Take a focussed history with regard to Mr Henderson's physical symptoms.
- Interpret blood investigation results.
- Present differential diagnosis **to the examiner**.

You are **not** required to perform a mental state examination or a physical examination.

A copy of the instructions and the blood investigation results will also be available inside the examination room.

BLOOD INVESTIGATION RESULTS

ELECTROLYTES (serum) 11/09/19			
Sodium	142	mmol/L	(134-146)
Potassium	3.7	mmol/L	(3.4-5.5)
Chloride	74	mmol/L	(95-78)
Bicarbonate	28	mmol/L	(22-32)
Urea	3.4	mmol/L	(3.0-8.0)
Creatinine	55	mmol/L	(30-70)
Calcium	2.8*	mmol/L	(2.2-2.6)
LIVER FUNCTION TESTS (serum) 11/09/19			
Total Bilirubin	4	umol/L	<16
Alk.Phos.	52	U/L	20-75
Gamma GT	22	U/L	<31
ALT	22	U/L	<31
Albumin	39	U/L	38-50
Total Protein	69	U/L	65-85
FULL BLOOD EXAMINATION 11/09/19			
HAEMOGLOBIN	140	g/L	(120-160)
RCC	4.3	$\times 7^{12}/L$	(3.80-5.30)
PCV	0.37	L/L	(0.340-0.450)
MCHC	340	g/L	(320-360)
MCV	90	f/L	(81-97)
MCH	29	Pg	(27.00-33.50)
RDW	14	%	(<16)
PLATELETS	289	$\times 7^9/L$	(150-400)
WHITE CELL COUNT	7.6	$\times 7^9/L$	(4.0-11.0)
Neutrophils	5.2 (68%)	$\times 7^9/L$	(1.8-7.5)
Lymphocytes	1.8 (24%)	$\times 7^9/L$	(1.3-4.0)
Monocytes	0.4 (5%)	$\times 7^9/L$	(0.1-1.2)
Eosinophils	0.2 (3%)	$\times 7^9/L$	(0.0-0.6)
ESR	4	Mm/hour	(0-20)
THYROID FUNCTION TESTS 23/05/19			
TSH	1.09	mIU/L	(0.30-5.00)
Free T4	16	pmol/L	(9-19)
Free T3	5.5	pmol/L	(2.6-6.0)
THYROID FUNCTION TESTS 11/09/19			
TSH	<0.03*	mIU/L	(0.30-5.00)
Free T4	18	pmol/L	(9-19)
Free T3	9.1*	pmol/L	(2.6-6.0)

Station 7 - Operation Summary

Prior to examination:

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

During examination:

- Please ensure mark sheet 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 is no cue / time for any scripted prompt to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

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

There is no opening statement.

3.2 Background information for examiners

In this station, the candidate is expected to obtain relevant history to diagnose lithium induced hyperthyroidism, as well as more recent drug interactions leading to lithium toxicity. This history is to be supported by the interpretation of findings from laboratory tests to make accurate diagnoses.

The candidate is required to communicate with the examiner regarding the differential diagnosis of Simon's presenting symptoms. The candidate should be able to discern that the hyperthyroidism most likely dates from 2–3 months prior to the presentation, based on the onset of symptoms such as nocturnal diarrhoea, heat intolerance, tremor, accelerated weight loss despite good appetite, worsening mood symptoms, anxiety, panic attacks with palpitations since that time, and normal thyroid function tests nine months earlier.

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

- Identify that the onset of hyperthyroidism was prior to commencement of pain medications.
- Confirm hyperthyroidism from elevated T3 and low TSH.
- Elicit at least four symptoms of lithium toxicity.
- Diagnose hyperthyroidism and lithium toxicity due to interactions between celecoxib, ibuprofen and lithium.

Background

Lithium is a gold-standard treatment for prophylaxis in bipolar disorder. Lithium has become established as a valuable and effective agent in the treatment of acute mania and in the prophylaxis of bipolar and unipolar affective disorders (*Geddes et al. 2004; Cipriani et al. 2005; Geddes and Miklowitz. 2013*). Its clinical usefulness is reflected by the fact that it features prominently across all international guidelines for the treatment of bipolar disorder, particularly for prophylaxis (*Malhi et al. 2015*). It has a narrow therapeutic index.

Lithium plasma levels:

- For prophylaxis, a concentration of 0.4–0.8 mmol/L may be optimal.
- A range of 0.8–1.2 mmol/L is suggested for acute mania.
- Toxicity is common above 1.2 mmol/L and may be severe.
- Lithium clearance is reduced with renal impairment.

Side effects:

Lithium is often associated with side effects of varying degree and duration. Most side effects are dose-related (and therefore plasma level). The side effects tend to be experienced in up to 80% of patients, although much fewer are considered moderate to severe. It has wide ranging effects on multiple organ systems, including kidney thyroid, parathyroid and weight / metabolism.

Short-term effects of lithium therapy:

The most common minor side effects – usually occurring within hours to days of administration are – fine tremor, mild gastrointestinal upset (especially nausea, diarrhoea), ankle oedema, increased thirst and urination (*Vestergaard et al. 1980; Dols et al. 2013*). Many patients also complain of fatigue, general slowing (or cognitive blunting) of thought processes and poor concentration. There is a dose-response relationship between the severity of GI symptoms and plasma Lithium: keeping to the recommended 0.5–0.8 mmol/L helps to minimise symptoms (Persson 1977).

Fine tremor is a frequent finding in patients taking lithium, with approximately half of treated individuals reporting it when specifically asked (*Lydiard and Gelenberg 1982*). The fine tremor relating to therapeutic lithium levels should be distinguished from the coarse tremor found in intoxication. The former is benign, whereas the latter requires urgent treatment.

Increased thirst and urination (polydipsia and polyuria) are reported by majority of patients on chronic lithium therapy (Duncavage et al. 1983).

Medium to long-term effects of lithium therapy:

The side effects include neuroendocrine changes, such as hypo- and hyperthyroidism and hyperparathyroidism. Lithium is taken up into the thyroid gland and accumulates there at high concentrations (*Berens et al. 1970; Lazarus 1998*). The effects of lithium do not appear to be dose dependent or related to the length of treatment with lithium. Uptake into the thyroid gland occurs from the first administration, but not all patients develop thyroid disorders. How the cellular level effects of lithium lead to the clinical manifestations are still uncertain especially case of hyperthyroidism (Rebecca F McKnight et al. 2017).

Hypothyroidism (diagnosed by a raised TSH and low T4/T3) is a common condition affecting approximately 2% of women and 0.5% of men in west Europe (Boelaert 2005). Bochetta and colleagues undertook a prospective longitudinal study of 150 patients on lithium therapy, and concluded that lithium increases the risk of hypothyroidism, and increases the likelihood of having positive thyroid autoantibodies (Bochetta et al. 2007).

The evidence linking lithium to hyperthyroidism is of high quality, but until recently there has been much less available evidence surrounding hyperthyroidism (Rebecca F McKnight et al. 2017). At least 30 case reports have been published since the 1970s, but there have been no larger scale epidemiological studies (Rosser 1976).

Lithium causes two types of renal toxicity – decreased renal concentrating ability and chronic renal failure. Nephrogenic diabetes insipidus is observed in 40–50% of patients. Chronic renal failure is observed in patients treated for more than 7–20 years.

McKnight and colleagues' systematic review identified four case-control studies which reported the prevalence of hyperthyroidism in patients with lithium compared to controls and found a non-significant increase in rates of hyperthyroidism in lithium-treated patients (*McKnight et al. 2012*). When it presents, it tends to be short-lived painless thyroiditis. This may be related to a direct toxic effect of lithium upon the thyroid in some patients (Miller and Daniels 2001). As in multinodular goitre disease, a single patient may move between being euthyroid, hypothyroid and hyperthyroid whilst on lithium.

Symptoms of hyperthyroidism:

Loss of weight despite adequate diet, difficulty swallowing, heat intolerance, sweating, diarrhoea, tremor, irritability, proximal muscle weakness, palpitations, emotional lability, difficulty sleeping, psychosis, itch, reduced libido, sexual dysfunction and infertility.

Thyroid associated ophthalmopathy (grittiness, increased tear production, swelling, visual loss, double vision).

Lithium toxicity:

Lithium poisoning remains relatively rare, but when it occurs, it is often life threatening. In the acute overdose setting, lithium is responsible for neurological, renal and cardiac compromise, thus frequently admission and monitoring in an intensive care unit. Lithium toxicity can occur at therapeutic doses, generally after a prolonged period of treatment. Nephrotoxicity is the major consequence in chronic setting (*S. El Balkhi and B Megarbane. 2017*). Most risk factors for toxicity involve changes in sodium levels or the way the body handles sodium. Examples include low salt diets, dehydration, drug interactions and some uncommon physical illnesses, such as Addison's disease.

Three patterns of lithium toxicity are distinguished in relation to the ingested dose, and to the duration of exposure to lithium. They are:

- Acute toxicity (poisonings in lithium naïve patients, in whom symptoms may be absent or minor, despite high serum lithium concentrations)
- Acute-on-chronic toxicity (occur after acute lithium self-overdose in a previously lithium-treated patients)
- Chronic toxicity (occurs insidiously due to lithium accumulation in a chronically lithium-treated patients) (*S El Balkhi and B Megarbane. 2017*).

Lithium toxicity may also occur at therapeutic doses, generally after a prolonged period of treatment. Acute toxicity is often associated with gastrointestinal symptoms (nausea, vomiting and diarrhoea), and slight neurological symptoms (drowsiness, slurred speech, apathy and confusion). Severe toxicity may result in a mortality rate of up to 15%, and a 7% rate of neurological sequelae (Sheean 1991).

Interactions with other drugs:

As lithium has relatively narrow therapeutic index, pharmacokinetic interactions with other drugs can precipitate lithium toxicity. It takes few days to several weeks to develop signs of toxicity.

Angiotensin converting enzyme inhibitors (ACE inhibitors – captopril, enalapril, lisinopril, perindopril, ramipril etc), Thiazide diuretics (Bendroflumethiazide, indapamide etc), NSAIDs (or COX 2 inhibitors) – diclofenac, celecoxib, ibuprofen, indomethacin, meloxicam, naproxen etc., cause clinically relevant drug interactions. Care is also required with angiotensin II receptor antagonist and SSRIs.

Classification of lithium toxicity (Hansen and Amdisen 1978)

GRADE	SEVERITY OF POISONING	SIGNS AND SYMPTOMS
Grade 1	Mild intoxication	Nausea, vomiting, tremor, hyperreflexia, agitation, muscle weakness and ataxia
Grade 2	Moderate intoxication	Stupor, muscular hypertonicity, rigidity and hypotension
Grade 3	Severe intoxication	Altered mental status, convulsions, myoclonus and collapse

Severe lithium toxicity may result in a mortality rate of up to 15%, and a 10% rate of neurological sequelae (Sheean 1991).

BLOOD INVESTIGATION RESULTS

ELECTROLYTES (serum) 11/09/19			
Sodium	142	mmol/L	(134-146)
Potassium	3.7	mmol/L	(3.4-5.5)
Chloride	74	mmol/L	(95-78)
Bicarbonate	28	mmol/L	(22-32)
Urea	3.4	mmol/L	(3.0-8.0)
Creatinine	55	mmol/L	(30-70)
Calcium	2.8*	mmol/L	(2.2-2.6)
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Total Bilirubin	4	umol/L	<16
Alk.Phos.	52	U/L	20-75
Gamma GT	22	U/L	<31
ALT	22	U/L	<31
Albumin	39	U/L	38-50
Total Protein	69	U/L	65-85
FULL BLOOD EXAMINATION 11/09/19			
HAEMOGLOBIN	140	g/L	(120-160)
RCC	4.3	$\times 7^{12}/L$	(3.80-5.30)
PCV	0.37	L/L	(0.340-0.450)
MCHC	340	g/L	(320-360)
MCV	90	f/L	(81-97)
MCH	29	Pg	(27.00-33.50)
RDW	14	%	(<16)
PLATELETS	289	$\times 7^9/L$	(150-400)
WHITE CELL COUNT	7.6	$\times 7^9/L$	(4.0-11.0)
Neutrophils	5.2 (68%)	$\times 7^9/L$	(1.8-7.5)
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THYROID FUNCTION TESTS 11/09/19			
TSH	<0.03*	mIU/L	(0.30-5.00)
Free T4	18	pmol/L	(9-19)
Free T3	9.1*	pmol/L	(2.6-6.0)

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 all 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 Simon Henderson, a 33-year-old electrician. You live with your mother who is supportive towards you.

You are attending this appointment today because you have developed a range of physical complaints, which your GP thinks should be reviewed by a psychiatrist.

You were diagnosed with Bipolar Disorder (manic depression) seven years ago. You have had two psychiatric admissions so far since you were diagnosed seven years ago. You were commenced on mood stabilising medication called lithium seven years ago. After the second admission, the dose was increased five years ago, and since then your condition has been stable.

Physical symptoms:

The candidate is expected to ask you questions regarding your physical health. You should not volunteer the following information until asked.

Over the last 4–6 months, you have noticed some physical symptoms. You did not take note of it until your mother started to express concerns about weight loss one month ago.

You last weighed yourself two weeks ago, and noticed that you have gradually lost seven kilograms of weight over six months. There has been no change in your diet. You feel excessively hungry.

You have been sweating excessively, and have found that you are now unable to tolerate heat, and occasionally feel agitated and irritable. Your sleep has been disturbed. You struggle to fall asleep, and you overall sleep for 4–5 hours / night. You thought it could be work stress.

If questioned about any eye problems – you have noticed that you are teary, puffy, and you feel grittiness in your eye.

You suffered severe pain in your knees four weeks ago which your GP diagnosed as arthritis, and started you on pain medications three weeks ago. You have noticed a response to pain medications, and you are not in pain anymore, but have noticed that you feel sick / nauseous, occasional diarrhoea, mentally sluggish, anxious, experience occasional tremors of your hands, and feel quite weak overall. The symptoms have been worse for the last two weeks, and you have been on sick leave.

You have been seeing your GP, Dr Connor regularly. He recently ordered blood tests, and you are not sure about the results.

Psychiatric history:

Seven years ago, you presented with irritable mood, reduced concentration levels, poor sleep and increased energy levels. You were admitted in the hospital for a week, and the doctor told you that you had something called hypomania and started you on lithium tablets, one every morning and two at night. These seemed to help, but made you thirsty and you felt well so you stopped the tablets in six months.

Your second admission was five years ago when you experienced mania which meant you felt very happy for long periods of time, had reduced need for sleep, often felt elated, had racing thoughts, felt restless, overconfident, and spend excessive amounts of money on unwanted things. You were admitted involuntarily for two weeks. At that time, you were restarted on lithium on a higher dose – two tablets in the morning and three at night, you have felt well since and have been taking your tablets regularly. You were monitored by community mental health team for 12 months, and were discharged to GP care. Your GP does a blood test every six months for you, and has said you results are fine, except this last time, when he asked you to see a specialist.

You don't believe you are currently manic or depressed. You are not suicidal. If questioned about psychosis (hearing voices, strange thoughts etc.) – you have never experienced them. You have never been depressed or had a persistently sad mood with loss of energy and enthusiasm, and poor sleep and appetite.

Medical history:

You have not experienced any of these symptoms in the past. You clearly started to notice few physical symptoms 2–3 months ago, but it has been worse over the last three weeks.

You are not allergic to medications.

You are a smoker (20 cigarettes a day). You never used illicit drugs. You drink alcohol socially, 1–2 beers in a fortnight.

4.2 How to play the role:

You will be dressed in casual clothes.

You should present slightly anxious but not uncooperative. Questions regarding your physical health should be answered as scripted. If there is no scripted response to the question you are asked, then you should inform the candidate that you have not experienced that symptom.

You present with some weakness in your arms, and have occasional tremors in your hands. This will be explained to you during the training session.

4.3 Opening statement:

None required by role player.

4.4 What to expect from the candidate:

The candidate should introduce themselves, explain their role and summarise the information they already have about you. They should enquire about some relevant past, current physical symptoms, medications and its side effects. The candidate is to try to link your physical symptoms to medication side effects. They should not ask a detailed history about your previous or current psychiatric history apart from how the medications affected your symptoms and caused side effects.

If the candidate decides to perform a physical examination, say that you are not comfortable. If they continue to perform examination, follow their instructions.

Following their discussion with you and a review of some investigations, the candidate then needs to speak to the examiner to explain their assessment.

4.5 Responses you MUST make:

'I noticed some physical problems six months ago.'

'My physical health has been worse for the last two weeks.'

'I think I have lost seven kilograms in six months.'

'My GP thought I should increase the lithium.'

4.6 Responses you MIGHT make:

If you are asked about your mood or psychiatric history:

Scripted Response: 'I am not depressed or manic now.'

If asked about the 'side effects' or 'signs of lithium toxicity':

Scripted Response: 'What do you mean?'

(do not offer symptoms until the statement is phrased in a way you believe you would understand as a lay person)

If asked about taking your medications:

Scripted Response: 'I take them regularly.'

4.7 Medication and dosage that you need to remember:

Your current medications are:

- Lithium carbonate 500 milligrams mane and 750 milligrams nocte (2 tablets morning, 3 tablets night).
- Paracetamol 1 gram three times / day.
- Celecoxib 70 milligrams twice / day for pain – started four weeks ago by your GP.
- Ibuprofen 200 milligrams, as needed for pain (using most days) – started four weeks ago by your GP.

STATION 7– MARKING DOMAINS

The main assessment aims are to:

- Take relevant history to diagnose hyperthyroidism, which is likely to be lithium induced, and drug interactions leading to lithium toxicity.
- Integrate and interpret findings from history and laboratory tests to make accurate diagnosis.
- Communicate with the patient regarding the nature of his problems and the implications for treatment.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed medical history? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

clearly achieves the standard with fluent performance in a range of aspects; demonstrates prioritisation of relevant history related to lithium impact on thyroid functions; identifies that lithium can induce hyperthyroid states; shows in depth knowledge of gathering history of side effects.

Achieves the Standard by:

demonstrating ability to take a focussed history using systemic approach; eliciting relevant history of experience with lithium including side effects, toxicity, adherence, medical history; prioritising the range of hyperthyroidism symptoms; screening questions relating to other physical systems – GIT, CVS, RS and CNS; clarifying important positive and negative features; clarifying timeframes; establishing symptom effect on function.

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

- Identify that the onset of hyperthyroidism was prior to commencement of pain medications.

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 or lack of specificity.

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"/>

1.10 Did the candidate interpret the tests / investigations correctly? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance in correctly identifying the absence of an inflammatory response; identifies hypercalcemia indicative of hyperparathyroidism.

Achieves the Standard by:

accurately interpreting the results as diagnostic of hyperthyroidism, correctly identifying remaining results as normal; considering whether normal ESR & WCC could be significant.

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

- Confirm hyperthyroidism from elevated T3 and low TSH.

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 interpretation of investigations; errors or omissions are significant and do materially adversely affect conclusions.

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

1.10. Category: DIAGNOSIS – Investigation Analysis	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"/>

1.2 Did the candidate take focussed medication history? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

obtains a comprehensive history related to lithium induced drug interactions; demonstrates broad knowledge of specific interactions.

Achieves the Standard by:

demonstrating ability to take a focussed medication history; conducting a detailed and targeted assessment of relevant medications linked to lithium toxicity; eliciting key interactions with recently commenced pain medications; demonstrating ability to differentiate symptoms of lithium side effects and drug interactions; identifying the onset of recent symptoms following the commencement of pain medications.

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

a. Elicit at least four symptoms of lithium toxicity.

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 or lack of focus on interactions.

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"/>

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

Surpasses the Standard (scores 5) if:

Demonstrates a superior performance; formulates a differential diagnosis of hyperthyroidism, lithium toxicity due to drug interactions and hypercalcemia – hyperparathyroidism.

Achieves the Standard by:

demonstrating ability to integrate available information in order to formulate a diagnosis; adequately prioritising conditions relevant to the obtained history and findings; explaining relevant predisposing and precipitating factors; accurately outlining the timelines for lithium toxicity development; demonstrating capacity to integrate the early physical symptoms in order to formulate a diagnosis of lithium induced side effects and drug interactions with lithium leading to lithium toxicity.

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

a. Diagnose hyperthyroidism and lithium toxicity due to interactions between celecoxib, ibuprofen and lithium.

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, incomplete 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"/>

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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
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1.0 Descriptive summary of station:

In this station, the candidate will assess a 27-year-old RANZCP Stage 1 psychiatric trainee. He has been referred to a private psychiatrist for diagnostic clarification due to concerns of a possible depressive disorder. The candidate must differentiate between burnout and a clinical depressive disorder, and then provide a response to the trainee's concerns regarding the medical regulatory body.

1.1 The main assessment aims are to:

- Perform a brief diagnostic assessment to establish that the trainee is experiencing workplace burnout rather than a depressive illness.
- Offer a range of immediate and medium-term suggestions on how to resolve workplace burnout.
- Elicit that the trainee will be concerned about reporting to a medical regulatory body, and demonstrate an understanding of mandatory reporting principles.
- Demonstrate an approach to the trainee which is supportive, professional and empathetic in manner.

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

- Elicit at least two of the core symptoms of workplace burnout including emotional exhaustion, depersonalisation and / or reduced personal accomplishment.
- Confirm that the trainee does not meet the criteria for a depressive disorder AND that the trainee is not suicidal.
- Outline a minimum of four actions or strategies to support the trainee in resolving burnout.
- State clearly and empathetically that the trainee does not need to self-report or be reported to the regulatory body.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis; Management – Initial Plan), Communicator (Patient Communication – To Patient / Family / Carer)

References:

- Forbes M et al (2017) Psychiatric trainee welfare – from words to actions Australasian Psychiatry 1 – 3.
- Gerada C (2018) Doctors, suicide and mental illness. BJPsych Bulletin 42, 165 – 168
- Jenkins K (2017) Access to healthcare by psychiatrists, psychiatric trainees and overseas trained psychiatrists: finding from the RANZCP welfare study. Australasian Psychiatry 2017, Vol 25 (2) 175 – 177.
- Kumar S (2006) Burnout in Psychiatrists. World Psychiatry; 6: 186 – 189)
- American Psychiatric Association Well-being resources. Available at: www.psychiatry.org/psychiatrists/practice/well-being-and-burnout/well-being-resources
- Royal Australian and New Zealand College of Psychiatrists' members support information. Available at: www.ranzcp.org/publications/support-for-members#peer
- Australian Health Practitioner Regulation Agency. Available at: www.ahpra.gov.au
- Medical Board of Australia – information on mandatory reporting. Available at: www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx
- Medical Council of New Zealand - Fitness to Practice information. Available at: www.mcnz.org.nz/fitness-to-practise/health-concerns/
- Royal Australian and New Zealand College of Psychiatrists' Code of Ethics (Principle 9). Available at: www.ranzcp.org/files/about_us/code-of-ethics.aspx
- Royal Australian and New Zealand College of Psychiatrists' Guidelines on appropriate Acute in-patient workload. Available at: www.ranzcp.org/files/prefellowship/assessors-and-supervisors/guidelines-for-appropriate-adult-acute-inpatient-n.aspx

Committee for Examinations
Objective Structured Clinical Examination
Station 8
Perth September 2019



1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male in his late 20's or early 30's
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist in a private practice clinic, and are about to see a patient referred by a General Practitioner (GP).

Dear Colleague,

Thank you for seeing Doctor Mitch Graham for an urgent assessment.

Dr Graham is a 27-year-old man who lives with his partner and is in the first year of training in Psychiatry. He currently works at Armadale Hospital on an inpatient ward.

Dr Graham was encouraged to come and see me today by the nurse in charge of the ward he works on. She had taken him aside to say she had noticed he appeared irritable, exhausted and frustrated.

- *He is not on regular medications and has no allergies.*
- *There is no relevant past psychiatric or medical history.*
- *There is no relevant family psychiatric history.*

Thank you for your diagnostic opinion.

Your tasks are to:

- Gather a focussed history from the patient.
- Explain your findings to the patient.
- Outline a management plan to the patient.

You are not required to complete a physical examination or suggest any investigations as part of their management.

Station 8 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - Pens.
 - Water and tissues (available for candidate use).
- Do a final rehearsal with your role player.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there are no cues / time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the role player has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

There are no prompts.

The role player opens with the following statement:

'Hi, I can't believe I've ended up here.'

3.2 Background information for examiners

In this station, the candidate is a Junior Consultant Psychiatrist based in private practice. They are expected to take a history from a patient, who is a Stage 1 psychiatric trainee in his first year of training. The focus of this station is trainee welfare and managing a doctor presenting with workplace burnout.

The station requires the candidate to recognise that the trainee has experienced significant workplace burnout due to having changes in supervisors; a consistently high-case load of complex patients, and working longer than expected hours. This history should reveal a hard working doctor with high standards with a good track record. The candidate should communicate with the trainee in a professional manner as they are assessing a colleague, and address the concern that the trainee has about reporting to a medical regulatory body. Candidates should be supportive and empathetic in their approach. Candidates should address the trainee's concerns about reporting to the regulatory body, and state that it is not necessary in this case because he is not depressed.

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

- Elicit at least two of the core symptoms of workplace burnout including emotional exhaustion, depersonalisation and/or reduced personal accomplishment.
- Confirm that the trainee does not meet the criteria for a depressive disorder AND that the trainee is not suicidal.
- Outline a minimum of four actions or strategies to support the trainee resolve burnout.
- State clearly and empathetically that the trainee does not need to self-report or be reported to the regulatory body.

A surpassing candidate may:

- Quickly understand that the trainee is suffering from workplace burnout, and provide a succinct explanation of this including all its main features: emotional exhaustion, depersonalisation and reduced personal accomplishment.
- Describe that burnout can translate into more serious mental illness.
- Confidently explain that there are no grounds with which to either self-report / be reported to the regulatory body.
- Suggest as an immediate action that the trainee takes some urgent recreational leave / sick leave.
- Direct the trainee to some useful resources relating to wellbeing and burnout e.g. American Psychiatric Association.
- Offer to talk to the partner.
- Organisational welfare program or welfare officer / Employee Assistance Program / RANZCP Member Welfare Support line which support doctor's welfare.

Trainee Welfare

In October 2013, Beyondblue released its National Mental Health Survey of Doctors and Medical Students which revealed that doctors reported substantially higher rates of psychological distress and attempted suicide compared with both the Australian population and other Australian professionals (3.4%, 2.6% and 0.7% respectively). The levels of psychological distress in doctors aged 30 years and younger was significantly higher than individuals aged 30 years and younger in the Australian population and other professionals (5.9%, 2.5% and 0.5%, respectively). 21% of doctors reported having ever been diagnosed with or treated for depression and 6% had a current diagnosis. 10.4% of doctors reported having suicidal thoughts in the previous 12 months. Compared to older doctors (51-60 years), younger doctors reported higher rates of burnout across three domains of emotional exhaustion (47.5 vs. 29.1), low professional efficacy (17.6% vs. 12.8%), and high cynicism (45.8% vs. 33.8%).

In February 2015, RANZCP reported to its members that three psychiatric trainees working in Victoria had died unexpectedly. This brought focus on trainee mental health and training intensity.

Burnout

Psychiatrists as a group are vulnerable to experience burnout, more so than other physicians and surgeons. Burnout can be defined as a work-related syndrome involving emotional exhaustion, depersonalisation and a sense of reduced personal accomplishment. Burnout symptoms can have an adverse effect on patient care, healthcare workforce costs, and the health of doctors.

Emotional exhaustion: feeling 'used up' at the end of the workday, and having nothing left to offer patients from an emotional standpoint.

Depersonalisation: feelings of treating patients as objects rather than human beings, and becoming more callous towards patients.

Reduced personal accomplishment: feeling of ineffectiveness in helping patients with their problems, and a lack of value of the results of work-related activities, such as patient care or professional achievements.

Other symptoms can include:

- Reduced efficiency and energy
- Lowered levels of motivation
- Fatigue
- Headaches
- Irritability
- Frustration
- Suspiciousness
- More time working with less being accomplished.

Some factors that make psychiatry stressful include:

- Patient violence and suicide
- Limited resources
- Crowded inpatient wards
- Changing culture in mental health
- High work demands
- Poorly defined roles of consultants
- Inability to effect system change
- Isolation.

RANZCP has a number of resources focussed on assisting psychiatrists and trainees in looking after their health and wellbeing. This includes a web page dedicated to self-care for psychiatrists and trainees; advice around recognising stress and burnout, building effective coping mechanisms and maintaining an effective support network. There is also a confidential RANZCP Member Welfare Support Line.

Doctors and Suicide

Doctors are as exposed as anyone else to risks associated with genetic predisposition, early traumatic life events, later bereavements, illnesses or relationship breakdowns.

Doctors also have additional risk factors. They are chosen for personality traits that predict good doctoring – perfectionism, obsessiveness and even elements of martyrdom – traits that can act against them. From an early age they are driven, competitive, compulsive, individualistic and ambitious – features that can go into overdrive when stressed. As doctors work harder, they blame themselves for not being able to deliver the care required by their patients, and feel guilty for events beyond their control. Consequently, doctors can suffer from a triad of guilt, low self-esteem and a persistent sense of failure. To survive a lifetime in medicine, doctors also have to develop psychological defences that include depersonalisation and dissociation. This can make it harder to create attachments to others or to recognise when the emotional burden of their work becomes too much, and thus contributes to the spiralling of discontent and increased risk of suicide.

Physicians' relative suicide risk is at 1.1–3.4 for men and 2.5–5.7 for women compared with those for the general population, and at 1.5–3.8 for men and 3.7–4.5 for women compared with those for other professionals. Psychiatrists appear to be associated with higher risk. In an Australian survey, approximately a quarter of doctors reported having had thoughts of suicide prior to the past 12 months (24.8%), and 10.4% reported having had thoughts of suicide in the previous 12 months. Thoughts of suicide are significantly higher in doctors compared with the general population and other professionals (24.8 vs. 13.3 vs. 12.8).

Workload

Accreditation committee Guidelines: Appropriate Acute Adult inpatient workloads for RANZCP trainees (March 2018) Standards:

- 3.5.1** The workload for trainees within each post is such that time spent in clinical service delivery does not compromise training and trainee welfare.
- 3.5.2** The working conditions for trainees within each post are such that the working conditions are conducive to training and trainee welfare.
- 3.5.3** Fatigue management programs are in place to diminish the impact of fatigue on the training experience, incorporating automatic mechanisms for sending trainees home or considering shift or night duty options.

Proposed Appropriate Acute Adult Inpatient Workloads for RANZCP Trainees

Trainee Acute Inpatient Duties	Recommended Inpatient Numbers
Full-time	8 – 10
Half-time	4 – 5

- The recommended inpatient numbers is consistent with projections produced by the National Mental Health Service Planning Framework.
- A maximum number of inpatients approaching 15 patients for full-time trainee or 8 for half-time trainee flags to the trainee and services when workload is excessive, and should be flagged to Service Managers, Clinical Directors, Training Committees and Directors of Training to urgently review the training post's workload.
- Workloads above the recommended inpatient numbers should be monitored closely by the supervisor, and discussed with the Service Manager / Clinical Director. If workload concerns cannot be addressed satisfactorily, the post should be referred to the Director of Training and / or training committee.
- Whilst noting there may be short periods when inpatient numbers may temporarily increase beyond the recommended numbers, the relevant Training Committee should be notified if the maximum number is reached for more than 14 days.

Reporting to Regulatory Bodies

Australian Health Practitioner Regulatory Authority (AHPRA)

1. Self-notification

Doctors are able to self-notify to AHPRA if they believe that they have a mental health concern that could impact on their clinical work.

2. Notifiable conduct

Section 140 of the National Law defines 'notifiable conduct' as when a practitioner has:

- a) *practised the practitioner's profession while intoxicated by alcohol or drugs; or*
- b) *engaged in sexual misconduct in connection with the practice of the practitioner's profession; or*
- c) *placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or*
- d) *placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.*

Medical Council of New Zealand

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

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

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

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

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

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

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

Actions or strategies to manage burnout may include:

Immediate:

1. Speak to seniors for support e.g. reducing case load, fatigue leave, temporarily coming off on-call roster, extra supervision.
2. Take urgent recreational or sick leave.
3. Welfare officer or welfare programme at place of work.
4. Contact person in charge of RANZCP training e.g. Chief Training Supervisor / Director of training.

Short – medium term:

1. Mindfulness or meditation including the use of apps.
2. Lifestyle choices: reducing or eliminating alcohol intake, reducing caffeine; sleep, diet, exercise.
3. Taking regular holidays.
4. Making time for friends and family.
5. Starting new hobbies.
6. Getting a mentor.
7. Regular therapy / counselling.

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 all 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 Dr Mitch Graham, and you are 27 years old, and currently work as a training registrar at Armadale Hospital in Perth. You were born and raised in Manchester, UK.

You have come to see the psychiatrist today following a referral from your GP, whom you went to see because a senior nurse at work raised concerns about your coping at work. You were staying late trying to complete your discharge summaries and the Nurse in Charge, whom you get on well with, came into see you a couple of days ago. She asked if you were okay, and said that she was worried about you as she had noticed that you looked tired, and she had noticed that you had been short with a couple of the nurses; seemed frustrated, and also appeared impatient when talking to some patients.

She suggested that it might be a good idea to see your GP. You spoke to your partner, Tom, who 'dragged' you to a GP. The GP worried that you were becoming depressed, and referred you to see the psychiatrist urgently.

Recent Work Experiences:

You are currently mid-way through on your second (six month) inpatient rotation in the first stage of training to be a psychiatrist. Your first rotation was busy, but you had a consistent Consultant Psychiatrist, and received regular supervision. Then a few consultants left the service recently, and there has been a reliance on locum inpatient consultants, and there has also been a shortage of other registrars as they have struggled to get overseas doctors here quickly. You have had five different locums in the last three months. The unit on which you work is a 35 bedded mixed gender acute adult psychiatric inpatient unit in a general hospital setting. When fully staffed, there are four registrars, and an intern working as junior doctors on the ward, and three full-time consultants. At present you are two registrars and an intern. The on-call roster can be busy, and you do night shifts every three weeks.

You do receive regular supervision, and you are meeting all of your College training requirements which is a good thing. Due to the shortage of doctors, you are often left to cross cover other teams which means that you consistently have to manage 16 to 18 inpatients at any one time which is very stressful, and you are worried about making mistakes. The turn-over of patients is high which means you have endless numbers of discharge summaries to complete. You sometimes feel out of your depth with patients having complex needs, and this is making you feel overwhelmed even though you pride yourself as being a hard worker. You often feel like you are not making good progress at work or effectively helping your patients. You also have nobody to discuss your patients with.

You have also noticed that you are not getting as much satisfaction from work. You tend to find seeing patients a chore, and feel like you are just going through the motions. You have started to feel detached from work, and the process feels mechanical. You have even found yourself being short with patients, and nursing staff which is unlike you.

You have been staying at work late to complete medical reports and discharge summaries, and you have started to find the prospect of doing them sickening. Recently you have noticed that you are '*emotionally spent*' by the time you get home, and it takes you much longer to relax. You have a glass of wine after work which helps you unwind. You never drink more than one glass on working days as you do not want to risk getting drunk. You have at least one alcohol free day every week. Your partner, Tom, is understanding but you do not want to be discussing work at home every night, and he is studying for his examinations, and feeling stressed out.

You have not had leave since you started working at the hospital because doctors are short. You would feel bad taking leave because it would put pressure on your colleagues. You have not felt unwell so have not taken sick leave. You don't really know where else to turn. You have not discussed the way you feel in supervision, and have not approached the Director of Training or the Medical Director with your concerns.

If you are asked:

- Your mood is *'just tired, I feel exhausted'*.
- Your sleep has been a little disrupted but no major sleep disturbance or insomnia.
- Your appetite has been fine, and you have not experienced any weight loss.
- There have been no significant changes to your sex drive.
- You have felt weary after work, and have tended to stay at home and catch up on sleep, and haven't had the energy to see friends for drinks and dinner.
- You absolutely do not feel suicidal.
- You do not feel paranoid or suspicious about others, and do not hear voices in the absence of people.
- You have never had an elevated mood or been impulsive or done dangerous things.

One of your main concerns is that you will be referred to the medical regulatory body if the psychiatrist thinks you are unwell (Medical Board of Australia / Australian Practitioner Regulatory Body (AHPRA) / Medical Council of New Zealand), and are worried that you could then lose your licence to practice medicine.

If asked, there have been no complaints about your performance and you believe that, even though you are stressed out, you are continuing to practise safely. You were not keen on seeing a psychiatrist because you think this will jeopardise your career.

About your family and personal life:

You have a loving family and a good upbringing. You do not have any family history of mental illness. You attended public school and excelled. You completed medical school at University College London. You knew wanted to do psychiatry after your first clinical rotation in medical school. You met partner (Tom Seaton, aged 34) at medical school. He was in his final year at the time. Tom is an intensive care trainee, and is in the middle of doing his examinations. You were always keen to move to Australia after doing your medical elective here in Western Australia. You initially moved to the Perth, and worked in a non-training position in psychiatry before being accepted into the training program. You have a good friendship group, and your relationship with your partner is solid.

You usually drink alcohol socially at weekends with your friends or at home with your partner, and party occasionally. You do not use illegal drugs. You have increased the amount of coffee you consume in order to keep you awake, and are now having about five to six double espressos per day. You are not on any prescribed medication. You have never seen a psychiatrist or psychologist in the past for treatment.

Although you still get enjoyment out of things, you have probably been watching more Netflix recently rather than going out. You are still going to the gym when you have time. You are hopeful about the future, and your mood is generally okay.

4.2 How to play the role:

You are dressed neatly but casual. You are well groomed.

You are cooperative but appear a little uncomfortable because you are nervous about the implications of the assessment. You will answer the questions asked to you specifically, but not necessarily volunteer information. You will consider the opinion and options that the candidate offers.

4.3 Opening statement:

'Hi, I can't believe I've ended up here.'

4.4 What to expect from the candidate:

The candidate should ask you some historical information, but should focus on your current situation and symptoms. If asked questions that are not covered by the script, you will respond that you **'can't really remember'**.

Towards the end of the interview, the candidate is expected to provide an explanation of your symptoms and a plan, which you will agree with. If you are asked if you have any questions about the plan, reply **'No'**.

4.5 Responses you MUST make:

'I'm finding it a real chore to be at work.'

'My boyfriend thinks I'm depressed. Do you?'

'Are you going to report me to the medical board?'

'What can I do to change this situation?'

4.6 Responses you MIGHT make:

If asked about workplace burnout:

Scripted Response: 'I don't really know what that is. Can you explain?'

If asked about additional professional support that could be available through the workplace / Employee Assistance Programs:

Scripted Response: 'I know there's something. They told us about it at induction.'

If asked if they talk to one of the senior doctors in the hospital or training supervisor:

Scripted Response: 'If you have to. I can't lose my job.'

If asked if they can talk to your partner:

Scripted Response: 'Yes, that's fine. He dragged me here!'

4.7 Medication and dosage that you need to remember:

You are not on any medication.

STATION 8 – MARKING DOMAINS

The main assessment aims are to:

- Perform a brief diagnostic assessment to establish that the trainee is experiencing workplace burnout rather than a depressive illness.
- Offer a range of immediate and medium-term suggestions on how to resolve workplace burnout.
- Elicit that the trainee will be concerned about reporting to a medical regulatory body, and demonstrate an understanding of mandatory reporting principles.
- Demonstrate an approach to the trainee which is supportive, professional and empathetic in manner.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history including information required to recognise that the trainee is experiencing workplace burnout? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues in the history; completing a risk assessment relevant to the individual case

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

- Elicit at least two of the core symptoms of workplace burnout including emotional exhaustion, depersonalisation and / or reduced personal accomplishment.

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 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"/>	

1.9 Did the candidate formulate and describe the relevant diagnosis? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

provides a sophisticated and appropriate explanation of the diagnosis to a colleague.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a 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.

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

- Confirm that the trainee does not meet the criteria for a depressive disorder AND that the trainee is not suicidal.

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"/>	

1.13 Did the candidate describe a relevant initial management plan? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified including the trainee, the hospital and the workload; current challenges of taking leave with a lack of other doctors; clearly addresses difficulties in the application of the plan.

Achieves the Standard by:

demonstrating the ability to prioritise; plans for risk management; recommend that medication is not necessary; safe skilful engagement of appropriate treatment resources / support; safe, realistic time frames / risk assessment / review plan; communication to necessary others; recognition of their role in effective treatment; identification of potential barriers; recognition of the need for consultation / referral / supervision.

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

a. Outline a minimum of 4 actions or strategies to support the trainee in resolving burnout.

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; errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

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

1.13. Category: MANAGEMENT - Initial Plan	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"/>

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from a patient who is a psychiatric trainee? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

able to generate a complete a sophisticated understanding of a doctor presenting to see a private psychiatrist; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to a psychiatric trainee as a patient; communicating plans and discussing acceptability; negotiating alternatives; effectively managing challenging communications; recognising confidentiality and bias.

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

a. State clearly and empathetically that the trainee does not need to self-report or be reported to the regulatory body.

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; errors or omissions materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

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

2.1. Category: PATIENT COMMUNICATION - To Patient	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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CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
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Station Operation Summary	5
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	6 6-10 10
Instructions to Role Player	11-12
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1.0 Descriptive summary of station:

In this station, the candidate is expected to be able to discuss the three stages of a cognitive behaviour plan for the treatment of a single phobia, fear of flying, with a 62-year-old married woman who wants to fly to her daughter's wedding in Canada.

1.1 The main assessment aims are to:

- Evaluate the candidate's understanding of the typical structure and components of Cognitive Behaviour Therapy (CBT) for anxiety disorders.
- Assess the candidate's ability to engage the patient with a simple relaxation strategy.
- Evaluate the candidate's ability to explain how cognitive behaviour therapy breaks the anxiety cycle.

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

- Explain how treatment of a simple phobia will include all aspects of graded exposure for his patient.
- Demonstrate an understanding of at least one relaxation skill: either a breathing technique or progressive muscle relaxation.
- Describe how the practice of relaxation reduces subjective distress linked to flying.

1.3 Station covers the:

RANZCP OSCE Curriculum Blueprint Primary Descriptor Category: Anxiety Disorders

Area of Practice: Psychotherapy

CanMEDS Marking Domains Covered: Medical Expert, Scholar

RANZCP 2012 Fellowship Program Learning Outcomes: Medical Expert (Management - Therapy, Assessment – Physical – Technique), Scholar (Application of Knowledge).

References:

- Andrews G, Bell C et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder. First published in the Australian and New Zealand Journal of Psychiatry 2018, Vol. 52(12) 1109-1172.
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- Davis, M., Echelman, E. and McKay, M. 'The Relaxation & Stress Reduction Workbook, 5th Edition' 2000 Raincoast Books illustrated at.
- Dryden W, Branch R eds. *The CBT handbook*. London: SAGE Publications, 2012.
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- Wright JH, Ramirez Basco M, Thase ME. *Learning cognitive-behaviour therapy: an illustrated guide*. Arlington: American Psychiatric Publishing, 2006.

Committee for Examinations
Objective Structured Clinical Examination
Station 9
Perth September 2019



1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: middle-aged woman in her 50s.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior psychiatrist in a psychotherapy outpatient service. Mrs Jane Pearlman is a 62-year-old married woman who has a fear of flying.

You have seen her for the initial assessment and treatment planning, and have confirmed that she has a simple phobia.

She has only flown once. At times she has taken long train rides or used buses or cars when a flight would have been more convenient. However, her only daughter is getting married in Canada, and the only way to get there is by flying.

You have already negotiated a treatment plan, and today is the first session of Cognitive Behaviour Therapy (CBT) with the final goal of Mrs Pearlman being able to fly to the wedding in six months.

Your tasks are to:

- Confirm that the patient understands the stages of CBT for their phobia.
- Choose specific skills to demonstrate how to control the patient's anxiety.
- Explain techniques that you will be using as part of CBT to manage the patient's phobia.

Station 9 - Operation Summary

Prior to examination:

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

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE there are no cues / times for any scripted prompt to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

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

The role player opens with the following statement:

'Doctor, it's good to see you again as I'm keen to start my treatment.'

3.2 Background information for examiners

Anxiety disorders are the most prevalent and costly mental health problems. The goal of this station is to assess the candidate's ability to explain Cognitive Behaviour Therapy (CBT), and the link between thoughts, feelings and behaviours, indicating to the patient that this treatment is very efficacious for a specific phobia. The candidate is expected to be able to explain the three stages of a cognitive behaviour plan for the treatment of a fear of flying with a 62-year-old married woman who wants to fly to her daughter's wedding in Canada.

They are expected to be able to give examples of cognitive restructuring, how graded exposure is conducted and the importance of being able to recognise and reduce arousal. Candidates are also expected to explain how CBT breaks the anxiety cycle. They will also explain at least one straight forward breathing technique to help the patient reduce their arousal.

The candidate is not expected to diagnose the phobia nor take a directed history to elicit the symptoms of a flying phobia.

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

- Explain how treatment of a simple phobia will include all aspects of graded exposure for his patient.
- Demonstrate an understanding of at least one relaxation skill: either a breathing technique or progressive muscle relaxation.
- Describe how the practice of relaxation reduces subjective distress linked to flying.

The surpassing candidate will confidently explain that this problem can be easily resolved with CBT. They may also provide the patient with a brief formulation about how her exposure to fire while in a plane has caused the belief that all planes are dangerous; and that this person has now filtered all the reports of plane crashes, fires or other problems to represent all planes. The surpassing candidate may effectively incorporate the clear link between the thoughts, and the body's automatic responses has been proven in experimental and clinical research since the 1950's.

Cognitive Behaviour Therapy

CBT is a structured psychotherapy which was first described by Aaron Beck in the 1960s when he was looking for an alternative manner of conceptualising depression rather than the psychoanalytic concepts (Beck Institute). The basic concept is that the patient learns to identify distorted thinking, understand how these impact on their behaviour / emotions and physiology, and learns to challenge the distorted thinking and have changed responses. The focus is on solving problems and starting behavioural change.

The length of therapy can vary, and is a collaborative process between the therapist and patient. The therapy begins with development of a formulation of the problems, and development of goals for this therapy. The length of therapy then is determined by regularly reviewing goals.

Generally, in CBT there are outcome measures used or developed with the patient at the beginning of therapy and throughout the process. When using CBT for simple phobias there might be a weekly use of arousal symptom measure that the patient and therapist review to see change. Outcome measures are very important to assist the patient see objective change in their symptoms.

For a simple phobia, the formulation is usually quite straight forward – a combination of characterological traits, experience that has given them the overwhelming fear (phobia), and the avoidance behaviours which are acting to maintain the fear. The treatment plan from the formulation is then logical to the patient.

The stages of the treatment of a simple phobia are to provide the person with an understanding of how their problems developed, what is the biological response to the anxiety, and to foster skills for managing the anxiety and associated over arousal, as well as being able to notice early warning signs.

Graded exposure is key to resolving a simple phobia. This is generally a process where the patient is first educated to how anxiety feels in their body, how to reduce the feelings and then have exposure to the anxiety stimulus in session, use the relaxation technique and learn that they can reduce the response. It must be graded to prevent flooding which acts to reinforce the anxiety cycle.

The patient is taught to describe their experience of distress using subjective unit of distress (disturbance) scale (SUDS) (Wolpe, 1958), which is generally 1–10 with 10 being the worst and 1 the least distress. In the session, the patient then uses imagery to elicit an anxiety response – feel the anxiety in their body and grade it.

Then the patient is taught a simple relaxation techniques which can include:

Progressive muscle relaxation – the person relaxes into the chair, closes their eyes and starting with the feet clench them as tightly as they can, release noticing the change. They progress up the whole body finishing with the facial muscles.

Abdominal Breathing (square breathing / deep breathing / box breathing) – placing one hand on the abdomen and another on their chest, the person inhales through the nose and exhales through their mouth. The breathing must be deep enough so the hand on the abdomen moves rather than the one on the chest. Inhale for a count of four – hold for a count of four, and exhale for a count of four – hold for a count of four, this is one cycle. Usually ask them to do just a few (four or five times) while they are learning.

Breath Counting – breathe in through the nose for a count of five and out through the nose for a count of five, and this is one breath. Repeat counting each breath until five rounds have been completed.

There are a multitude of simple breathing techniques to help people focus and reduce anxiety. There are also a variety of names for similar techniques within the literature, some from behavioural psychology, yoga, mindfulness, and likely other sources. The aim is to assist the person to relax using a focus on breathing as these are practices which are incompatible with the body's response to anxiety (Wolpe, 1958).

The clinician then asks the person to rate the SUDS with imagery alone, then again after one of the relaxation techniques. The experiment is continued until the SUDS have been reduced by the relaxation technique.

Once the person has developed capacity to reduce their arousal, it is important to begin cognitive restructuring.

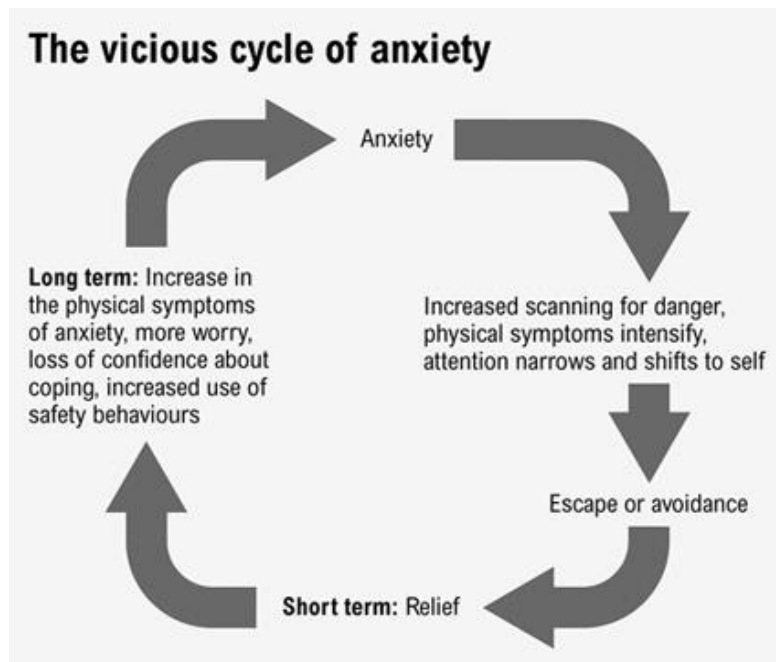
Cognitive restructuring is when a patient explores where a certain thought / belief comes from, which is triggered when they are anxious, and challenge the validity of the cognitive drives for the phobia. For example, the person believes that all spiders are deadly; may ask them to find out how many spiders are actually deadly, where they are found, and what percentage of all spiders does this represent? Thus, the cognitive truth can become something which is now questionable, and can be used to challenge the automatic thought 'all spiders are deadly'.

Typical structure and components of CBT for anxiety disorders

Stage 1	Goals		
	<p>Assist patient awareness. Develop formulation. Provide education about the anxiety disorder and treatment rationale.</p> <p>Monitor symptoms. Address factors that facilitate or hinder therapy.</p>		
Stage 2	Goals	Components	Targets and effects
	Reduce physical symptoms through relaxation and exercise.	Arousal management	Relaxation and breathing control to help manage increased anxiety levels.
	Reduce cognitive symptoms and drivers of ongoing anxiety by challenging unhelpful thinking styles and using structured problem solving.	Cognitive strategies	<p>Cognitive restructuring, behavioural experiments and related strategies:</p> <ul style="list-style-type: none"> • Targets patient's exaggerated perception of danger (beliefs around the likelihood and extent of feared consequences); • Provides corrective information regarding level of threat; • Can also enhance self-efficacy beliefs.
	<p>Increase engagement in activities that represent mastery over fears:</p> <p>2.1 Reduce behavioural avoidance through graded exposure to avoided situations and activities, and relinquishment of safety signals;</p>	Graded exposure	<p>Encouraging patient to face fears:</p> <ul style="list-style-type: none"> • Patient learns corrective information through experience; • Extinction of fear occurs through repeated exposure; • Successful coping enhances self-efficacy.
2.2 Restrict anxiety reducing behaviours;	Safety response inhibition	<p>Patient restricts anxiety-reducing behaviours (e.g. escape, need for reassurance) that maintain anxiety cycles:</p> <ul style="list-style-type: none"> • Restriction of these behaviours decreases negative reinforcement; • Coping with anxiety without using anxiety-reducing behaviours enhances self-efficacy. 	
2.3 Relinquish safety signals.	Surrender of safety signals	<p>Patient relinquishes safety signals (e.g. presence of a companion or mobile phone, or knowledge of the location of the nearest toilet):</p> <ul style="list-style-type: none"> • Patients learn adaptive self-efficacy. 	
Stage 3	Goal		
	Relapse prevention		

FROM: (Page 1121) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder. Andrews G, Bell C et al. First published in the Australian and New Zealand Journal of Psychiatry 2018, Vol. 52(12) 1109-1172.

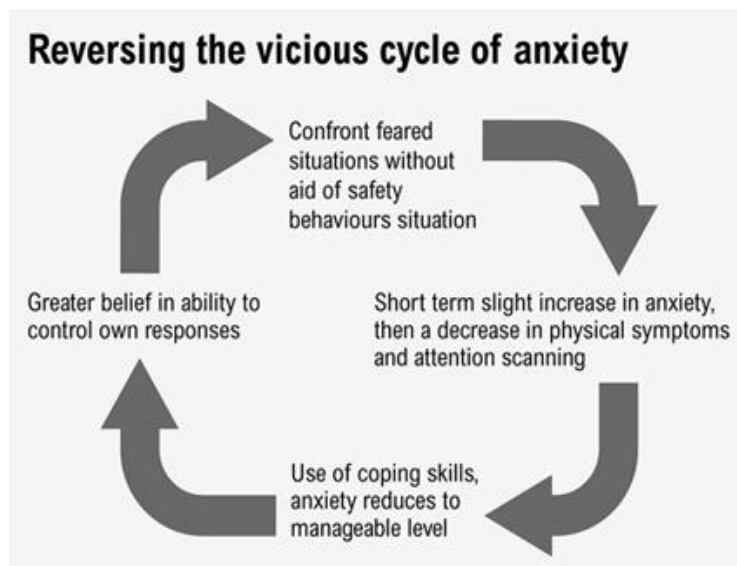
The Anxiety Cycle



https://healthywa.wa.gov.au/Articles/A_E/Anxiety-reversing-the-vicious-cycle

Using diagrams like the anxiety cycle, and how to reverse the cycle are very useful therapeutic tools for CBT for a phobia.

Reversing the anxiety cycle



https://healthywa.wa.gov.au/Articles/A_E/Calming-techniques-breathing-training

Specific Phobia

Fear of flying is a specific phobia and in DSM-5 the Diagnostic Criteria are:

- A. Marked fear or anxiety about a specific object or situation (e.g., **flying**, heights, animals, receiving an injection, seeing blood). Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.
- B. The phobic object or situation almost always provokes immediate fear or anxiety.
- C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
- E. The fear, anxiety, or avoidance is persistent, typically lasting for six months or more.
- F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in post-traumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

Specify if: Code based on the phobic stimulus: e.g. flying, blood, birds, clowns.

In ICD-1: Specific Phobia F40.2

These are highly specific fears of individual situations, such as animals, thunder, heights (this being 'acrophobia' and not the commonly misused term 'vertigo'), darkness, flying, closed spaces (claustrophobia), injury, the sight of blood, needles, the fear of exposure to specific diseases etc. The themes occurring in disease phobias often reflect the times, the prevailing ones being radiation sickness, venereal disease and AIDS.

Specific phobias usually arise in childhood or early adulthood, and can persist for years if untreated. The degree of disablement they cause, however, depends on how easy it is for the person to avoid the object or situation.

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 Mrs Jane Pearlman, a 62 year-old married mother of three (3) adult children. You have sought treatment of your fear of flying. Your daughter, Jemina (28 years old), is getting married in Ottawa, Canada in six months' time, and you are determined to attend her wedding. You are aware that you can take a really long boat and road journey to get there, but are determined to get over your fear of flying, and get there by airplane in one day rather than spend weeks travelling by ship and road, and spend a lot more money in the process.

This is the reason you are seeing the psychiatrist today. You have negotiated a treatment plan, and today is the first session of Cognitive Behaviour Therapy (CBT) which you have read about and agreed to.

About your symptoms:

Over the years, you have managed to not fly since you were 28 years old. You were in a small plane flying from Burnie in Tasmania, to Moorabbin in Victoria, and there was a small fire on the wing which you could see as the plane made a bumpy landing. It was scary at the time, but no one was hurt, and you did not think too much of it. However, over the next year or so, you seemed to worry more and more about the safety of flying in airplanes, and the risk it could involve. You managed to avoid going on airplanes as you lived in a town in Tasmania, and all your family were in driving distance. Most of the times your husband planned a trip to see family in Victoria, you avoided going saying you were busy, and at the times you had to go, you convinced them that it would be more fun to go by ferry and car. Your family found your concerns rather amusing, and it has never been a huge problem till now, just an inconvenience. It would have been nice to see a little more of the world, though.

You have collected evidence to support your phobia from all airplane crashes, accidents, problems and groundings in a file at home. You have managed to avoid flying since your terrifying experience. You are determined to attend this wedding, and so very motivated to resolve your fear, however, at the moment you become completely overwhelmed with anxiety when you see a plane flying overhead.

If you are asked:

You have never taken any treatment for this condition before. When your daughter decided to get married, you went to your family doctor to get some help. He talked about taking a pill, but you think that this is something you should be able to overcome without chemicals. You are willing to consider medicines at a later date, but want to give the talking treatment a really good shot first.

You are a healthy person, and have never had any major illnesses. You have never been admitted to hospital, except to deliver your children years ago – all normal uneventful deliveries. Your family doctor did a bunch of blood test before sending you to see the psychiatrist, and has told you everything was fine.

You are generally not an anxious person. You consider yourself a regular, hard working woman. You do not worry excessively, are not unduly neat, do not have repeated worrying thoughts, do not have any quirky behaviours. You know that this fear is silly, but it has only become a problem that needs solving now.

You do not hear voices or see things that others do not, and do not have fears of being harmed or possessed.

You do not smoke or use drugs. You drink alcohol socially and have never got drunk.

You have been happily married to Roland for 35 years, and have lived and worked in a regional town in Australia for all your life. You and Roland met at school and married once you had completed teacher training. He works as an agricultural economist. You are financially secure and have no other medical problems.

4.2 How to play the role:

You are an educated woman, who is smartly dressed with conservative hair and make-up.

You are easily engaged and keen to work with the psychiatrist. You are well dressed.

You have met the doctor over the four sessions for assessment, and have enjoyed the appointments. You feel comfortable with this doctor, and believe they can help you conquer your phobia. Although you have planned to start CBT, when you arrive at the clinic you are very scared that it won't work, and need some reassurance and immediate help with being too aroused.

4.3 Opening statement:

'Doctor, it's good to see you as I'm keen to start my treatment.'

4.4 What to expect from the candidate:

The candidate should be able to engage you straight away. They should explain how using first behavioural and then cognitive techniques, you will be able to overcome this phobia and attend the wedding.

They should educate you to aspects of the CBT process, including identifying how the phobia feels in your body, and use this to develop some kind of measurement scale for assessment of the fear, explain about simple techniques to reduce biological response to anxiety. The candidate should demonstrate a relaxation technique, and ask you to practise between sessions.

Expect them to discuss homework and / or practising between sessions, and measuring the amount of distress / arousal / distress with imagery of flying, and then how it feels after practising the relaxation technique.

4.5 Responses you MUST make:

'I can't see with all the planes crashing in the world how I'm going to catch a plane to Canada.'

'I can't see how I'm going to be able to get on a plane when I can't even look at one.'

'Oh my goodness, I can feel my breath being taken away.'

'What can I do right now?'

4.6 Responses you MIGHT make:

If the candidate does not demonstrate any specific skills to you:

Scripted Response: 'I'm not sure I understand; I'm not sure it will help me get things under control.'

4.7 Medication and dosage that you need to remember:

None.

STATION 9 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate the candidate's understanding of the typical structure and components of Cognitive Behaviour Therapy (CBT) for anxiety disorders.
- Assess the candidate's ability to engage the patient with a simple relaxation strategy.
- Evaluate the candidate's ability to explain how cognitive behaviour therapy breaks the anxiety cycle.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of Cognitive Behaviour Therapy? (Proportionate value - 45%)

Surpasses the Standard (scores 5) if:

confidently explains that this problem can be easily resolved with CBT; effectively uses an explanatory diagram; provides a brief formulation about the role of previous exposure to fire impacted on beliefs related to dangerous situations; reports how plane crashes, fires or other problems are being filtered.

Achieves the Standard by:

ensuring that the patient clearly understands CBT, and the goal is to uncouple the anxiety response from the thoughts about planes; incorporating reminders of the core components of CBT, namely regular sessions, homework, exposure and review; confirming the patient understands the stages of CBT for the specific phobia; using the anxiety cycle to show where CBT interventions will assist; discussing cognitive restructuring (thought challenging / thought catching).

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

a. Explain how treatment of a simple phobia will include all aspects of graded exposure for his patients.

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; errors or omissions impact adversely on patient care; plan lacks structure and / or is inaccurate; explanation not tailored to patient's needs or circumstances.

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

1.14. Category: MANAGEMENT – Therapy	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"/>	

1.5 Did the candidate demonstrate adequate technique in the demonstrating breathing strategies? (Proportionate value - enter value 25%)

Surpasses the Standard (scores 5) if:

easily explains what relaxation techniques are; links to behavioural psychology theory that practising a relaxation technique affects the sympathetic nervous system such that body can no longer have a high anxiety response; provides a detailed and comprehensive approach linking the SUDS to the imagery of flying and the relaxation intervention.

Achieves the Standard by:

Talking about the key role of relaxation techniques in the treatment plan; explaining relaxation techniques; considering value of diagrams to assist the patient to practise out of session.

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

a. Demonstrate an understanding of at least one relaxation skill: either a breathing technique or progressive muscle relaxation.

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; incorrect technique is utilised; incorrect demonstration is applied.

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

1.5. Category: ASSESSMENT – Physical – Technique	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"/>

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge of CBT based on available literature / research / clinical experience? (Proportionate value - enter value 30%)

Surpasses the Standard (scores 5) if:

provides guidance into explanations in a sophisticated manner; explains the evidence available to link between the thoughts and the body's automatic responses; acknowledges their own gaps in knowledge.

Achieves the Standard by:

identifying key aspects of the available literature as it pertains to a simple phobia; commenting on the voracity of the available strategies explained in the evidence; covering major strengths and limitations of available evidence; describing the relevant applicability of theory to the scenario; incorporating behavioural theory into the explanation of behavioural (relaxation) techniques; explaining and identifying the cognitions (ideas / thoughts maintaining the phobia) and how they will be challenged during the treatment; identifying the importance of allocating homework tasks which may include practice of breathing techniques, downloading and using apps to assist breathing techniques; starting to capture thoughts that occur automatically when thinking of flying; allocating time to induce the anxiety and monitor the subjective units of distress (SUDS).

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

- a. Describe how the practice of relaxation reduces subjective distress linked to flying.

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; unable to demonstrate adequate knowledge of the literature / evidence relevant to the scenario; inaccurately identifies or applies literature / evidence.

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

6.4. Category: APPLICATION OF KNOWLEDGE	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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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
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1.0 Descriptive summary of station:

This is a short core skills station that examines the ability of the candidate to perform and present a focussed mental state examination (MSE) and clarify the findings of a MSE recorded by a junior doctor on a patient who presents with ideas of persecution, and non-psychotic hallucinations / pseudo-hallucinations, which have been incorrectly recorded as persecutory delusions, auditory and visual hallucinations respectively.

1.1 The main assessment aims are to:

- Demonstrate the ability to conduct a focussed mental state examination (MSE).
- Present and justify the discrepancies with previous MSE findings provided by a trainee.

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

- Explore thought content to clearly establish that the patient does not experience a pathological sense of persecution.
- Correctly present at least 3 of the following mental state findings: dysphoric mood / affect consisting of depression, distress or instability; absence of formal thought disorder; absence of delusions; possible non-psychotic hallucinations / pseudo-hallucinations.
- Justify their findings for disorder of thought content and perception.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders, Core Psychiatric Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - Mental State Examination), Scholar (Application of Knowledge)

References:

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- Harrison, P., Cowen, P., Burns, T., Fazel, M. (2018). *Shorter Oxford textbook of Psychiatry* (seventh Edition). Oxford University Press
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1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1 role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: young woman in her early 20s, dressed in casual clothes.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist in a busy Emergency Department (ED) of a large general hospital, and are about to assess 22-year-old Ilana Jenkins. Ilana has recently been assessed in the ED by new first year psychiatry trainee, Dr Jason Drummond. He called and informed you that Ilana presented to ED early this morning following an argument with her boyfriend.

Dr Drummond tells you that he has diagnosed Ilana with schizophrenia, and on mental state examination she is flat in her affect, she is thought disordered, has delusions of persecution and reference, as well as auditory and visual hallucinations.

You are now going to assess Ilana in the ED.

Your tasks are to:

- Conduct a focussed assessment to clarify the phenomenology findings reported by the registrar **from Ilana**.
- Present your mental state findings in light of those reported by the trainee and justify them **to the examiner**.

You are not required to do a cognitive assessment.

Station 10 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your role player.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there are no cues / time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the role player has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can'.
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

There are no prompts.

The role player opens with the following statement:

'Doctor, I think I am ready to go home.'

3.2 Background information for examiners

In this station the candidate is expected to perform a mental state examination on the patient specifically focussing on the findings presented by the trainee. They are expected to establish the psychopathology by asking appropriate set of questions to the patient, and then present and justify their mental state examination (MSE) findings which may differ from those reported by the trainee.

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

- Explore thought content to clearly establish that the patient does not experience a pathological sense of persecution.
- Correctly present at least 3 of the following mental state findings: dysphoric mood / affect consisting of depression, distress or instability; absence of formal thought disorder; absence of delusions; possible non-psychotic hallucinations / pseudo-hallucinations.
- Justify their findings for disorder of thought content and perception.

A surpassing candidate should be able to do a focussed MSE, and demonstrate their interview skills of establishing various phenomena such as delusions, hallucinations. The candidate would be able to demonstrate their depth of understanding of phenomenology by asking appropriate questions to the patient, including carefully and sensitively challenging the persecutory beliefs. A better candidate will be able to confidently challenge the findings presented by the trainee, and give justification for their opinion.

Background:

The mental status examination (MSE) is a structured assessment of the patient's behavioural and cognitive functioning. It includes descriptions of the patient's appearance and general behaviour, level of consciousness and attentiveness, motor and speech activity, mood and affect, thought and perception, attitude and insight, the reaction evoked in the examiner, and, finally, higher cognitive abilities.

The MSE can be regarded as a psychological equivalent of physical examination. It includes both objective observations by the clinician (signs), as well the subjective descriptions provided by the patients (symptoms). However, an MSE must not be regarded as a replacement for good physical exam.

The skill in examining patient depends on a sound knowledge of how symptoms and signs are defined, and elicited. Without such knowledge, the psychiatrist is liable to misclassify phenomena, and thereby make inaccurate diagnoses (Oxford shorter textbook chapter 1).

A standard mental state examination should include the following:

1. Level of consciousness
2. Appearance and behaviour
3. Speech
4. Mood and affect
5. Thought form and content
6. Perception
7. Insight and judgement
8. Detailed cognitive examination

The level of consciousness refers to the state of wakefulness of the patient, and depends both on brainstem and cortical components. Alteration in sensorium is highly suggestive of an organic pathology.

Appearance and behaviour: It generally includes observations regarding the patient's build, posture, dress, grooming, prominent physical abnormalities, and their attitude toward the examiner (cooperative / uncooperative). It may also include comments regarding rapport and eye contact with the examiner. Patient's psychomotor activity is often described here.

Speech: Physical characteristics of speech is described here. It can be described in terms of its quantity, rate of production and quality. Speech can be rapid or slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, staccato or mumbled. Speech impairments such as stuttering are also included in this section. Any unusual rhythms (dysprosody) or accent should also be described here.

Mood and affect: Mood is defined as a pervasive and sustained emotion that colours the person's perception of the world. Statements about the patient's mood should include depth, intensity, duration and fluctuations. Common adjectives that can describe mood include depressed, despairing, irritable, anxious, angry, expansive, euphoric, empty, guilty, hopeless, futile or frightened.

Affect is defined as the patient's present emotional responsiveness, inferred from the patient's facial expression. It can be described under various subheadings:

- Type / quality: euthymic (normal mood), dysphoric (depressed, irritable, angry), euphoric (elevated, elated) anxious etc.
- Range: full (normal), restricted, blunted or flat. The range is often commented upon after a reasonable conversation that includes topics that would normally evoke a range of emotional responses. Lability of affect can also be commented upon in this section to describe.
- Appropriateness / Congruence: The appropriateness is assessed in the context of the subject the patient is discussing. The term inappropriate affect can be used for a quality of response in which the patient's affect is incongruent with what the patient is saying. For example, laughing while talking of a loved one's death.

Thought form: Formal thought disorder is abnormality in the mechanism of thinking described by the patient introspecting into his own process of thought; that is, the patient describes in his own words a process of thinking that is clearly abnormal to the outside observer. Types include:

- Circumstantiality: over-inclusion of trivial or irrelevant details that impede the sense of getting to the point.
- Clang Associations: thoughts are associated by the sound of words rather than by their meaning.
- Derailment / loosening of association: A breakdown in both the logical connection between ideas and the overall sense of goal-directedness. The words make sentences, but sentences do not make sense.
- Flight of ideas: A succession of multiple associations so that thoughts seem to move abruptly from idea to idea; often expressed through rapid, pressured speech.
- Neologism: the invention of new words or phrases or the use of conventional words in idiosyncratic ways.
- Perseveration: repetition of words, phrases or ideas, out of context.
- Tangentiality: replies to questions are off-point or totally irrelevant.
- Thought blocking: a sudden disruption of thought or a break in the flow of ideas.

Thought content: Disturbances in content of thought include delusions, overvalued ideas, preoccupations, obsessions, compulsions, phobias, plans, intentions, recurrent ideas about suicide or homicide, hypochondriacal symptoms, and specific antisocial urges.

Delusion is a belief that is firmly held on inadequate grounds, is not affected by rational argument or evidence to the contrary and is not a conventional belief that the person might be expected to hold given his educational and cultural background. The definition of delusion remains controversial and debatable.

Rather than suggesting a unitary definition for delusion, Kendler et al (1983) proposed several dimensions of delusional severity:

- Conviction: the degree to which the patient is convinced of the reality of the delusional beliefs.
- Extension: the degree to which the delusional beliefs involves the area of patient's life.
- Bizarreness: the degree to which the delusional beliefs depart from the culturally determined consensual reality.
- Disorganization: the degree to which the delusional beliefs are internally consistent, logical and systematized.
- Pressure: the degree to which the patient is preoccupied and concerned with the expressed delusional beliefs.
- Affective response: the degree to which the patient's emotions are involved with such beliefs.
- Deviant behaviour resulting from delusion: Patients sometimes act on their delusions.

Types of delusions:

According to Onset:

Primary: also called autochthonous delusion, is the one that appears suddenly and with full conviction, but without any mental events leading up to it.

Secondary: these are apparently derived from preceding morbid experiences like a hallucination, change of mood or an existing delusion.

According to Theme:

Persecution: delusion that persons or organizations are trying to inflict harm on the patient, damage their reputation or make them insane.

Reference: delusion that objects, events or people unconnected with the patient have a personal significance for them.

Grandiosity: delusion of exaggerated self-importance.

Guilt and worthlessness: most often found in depressive illness. Typical themes are that of minor infringement of laws in the past will be discovered and bring shame.

Nihilism: delusion that some person or thing has ceased or is about to cease to exist. When occurs in a severe depressive disorder, the condition is known as **Cotard's Syndrome**.

Hypochondriacal: the patient believes wrongly despite all the evidence to contrary that they are suffering from a disease.

Religious: a firmly held abnormal religious belief.

Delusion of jealousy: related to spouse's infidelity. They are particularly important because they may lead to dangerously aggressive behaviours

- a) Delusion of love: usually occur in women. The person believes that she is loved by a man who is usually inaccessible to her, and often of higher social status.

Delusion of Control: Delusion that one's actions, impulses or thoughts are controlled by an outside agency.

Misidentification: they are of four types

- a) Capgras' delusion: person believes that a closely related person has been replaced by an exact double / imposter.
- b) Fregoli's delusion: the person misidentifies an unfamiliar person as a familiar one, despite no physical resemblance.
- c) Intermetamorphosis: belief that others undergo radical changes in physical and psychological identity, resulting in a different person altogether.
- d) Doppelganger: Delusion of subjective doubles

Delusion concerning the possession of thought / thought alienation: They are of three types:

- a) Thought insertion: beliefs that certain thoughts are not the patient's own and implanted by an outside agency.
- b) Thought withdrawal: beliefs that thoughts have been taken out of patient's mind.
- c) Thought broadcasting: beliefs that unspoken thoughts are known to other people through radio, telepathy or in some other way.

Overvalued ideas: It is an isolated preoccupying belief which is neither delusional nor obsessional in nature and comes to dominate a person's life and sometimes affect their actions. The belief itself may be understandable when the person's background is known.

Obsessions: these are recurrent and persistent unwanted thoughts, impulses or images. They are recognised as one's own and are regarded as senseless distinguishing them from delusions.

Compulsions: these are repetitive and seemingly purposeful behaviours performed in a stereotyped way. They are accompanied by a subjective sense that the behaviour must be carried out and by an urge to resist. They may be associated with an obsession where they serve the purpose of relieving the anxiety generated by the obsession (for example, compulsion of washing hands repeatedly accompanied with obsession of contamination).

Perception: the abnormalities mainly include illusions and hallucinations and pseudo-hallucinations.

- a) *Illusions* are misperceptions of external stimuli. They occur when the general level of sensory stimulation is reduced and when attention is not focussed on the relevant sensory modality.
- b) *Hallucinations* are, phenomenological, the most significant type of false perceptions. Here are five definitions of hallucination:
 - A perception without an object (Esquirol, 1817).
 - Hallucinations proper are false perceptions that are not in any way distortions of real perceptions but spring up on their own as something quite new and occur simultaneously with and alongside real perception (Jaspers, 1962).
 - A hallucination is an exteroceptive or interoceptive percept that does not correspond to an actual object (Smythies, 1956).
 - According to Slade (1976a), three criteria are essential for an operational definition:
(a) percept-like experience in the absence of an external stimulus; (b) percept-like experience that has the full force and impact of a real perception; and (c) percept-like experience that is unwilling, occurs spontaneously and cannot be readily controlled by the percipient. This definition is derived from Jasper's formal characteristics of a normal perception.
 - A hallucination is a perception without an object (within a realistic philosophical framework) or the appearance of an individual thing in the world without any corresponding material event.

Hallucinations can be classified according to:

Complexity:

- a) Elementary: refers to experiences such as whistles, bangs, flashes.
- b) Complex: refers to voices, music, seeing faces and scenes.

Sensory Modality involved:

- a) Auditory
- b) Visual
- c) Olfactory
- d) Gustatory
- e) Somatic

Special features:

- a) Auditory
 - Second person: voices talking to the patient
 - Third person: voices talking about patient in third person
 - Audible thoughts: hearing once own thoughts aloud
 - Thought echo: hearing once own thoughts immediately after thinking them
 - Extracampine: voices coming from long distance which are impossible to be heard otherwise due to geographical separation.
- b) Visual
 - Extracampine: hallucinations located outside the field of vision, usually behind the head or in a different place altogether

Autoscopic hallucinations: experience of seeing one's own body projected into external space, usually in front of oneself, for short periods.

Reflex hallucinations: stimulus in one sensory modality results in hallucination in another modality.

Functional hallucinations: in this type, an external stimulus is necessary to provoke hallucinations.

'Pseudo-hallucinations': Pseudohallucination is one of the least understood phenomena in psychopathology.

Part of the confusion over the meaning of the term pseudohallucination has arisen because it is often used in two different and mutually contradictory ways, according to Kräupl Taylor (1981). On the one hand, it refers to hallucinations with insight (Hare, 1973), and on the other hand to vivid internal images.

Hallucinations with insight would be those hallucinatory experiences in which the subject is aware that the hallucinatory percepts do not correspond to external reality despite the perceptions being veridical, and in external objective space. Vivid internal images are those phenomena that have all the clarity and vividness of a normal percept except that they occur in inner subjective space.

Jaspers identified pseudohallucination as similar to normal perception except that it occurs in inner subjective space. It shares this characteristic with imagery. However, it has all the vividness and clarity of a normal perception.

A recent work by Wearne and Genetti recommends that 'pseudohallucinations' or hallucinations described in non-psychotic illness like PTSD and complex trauma are often difficult to differentiate from hallucinations in Schizophrenia phenomenologically. However, hallucinations in Schizophrenia are more likely accompanied by complex delusional system. The voices were also more likely to be critical and negative towards the individual, consistent with the experience of abuse in people with PTSD.

Insight

In psychopathology, the term insight refers to awareness of morbid change in oneself, and a correct attitude to this change including a realisation there is a mental illness. Insight is best understood as a continuum rather than simply absent or present. The degree of insight can be best determined by asking following question:

1. Is the patient aware that there is a problem? (insight into symptom)
2. If so, do they understand the problem is attributable to the mental illness? (insight into illness)
3. If so, do they think it needs treatment?

Based on above, six levels of insight have been described:

- i. Complete denial of illness
- ii. Slight awareness of being sick and needing help, but denying at the same time
- iii. Aware of being sick but blaming it on others, or external factors like physical illness
- iv. Awareness that illness is caused by something unknown
- v. Intellectual insight: awareness that there is mental illness without applying this knowledge to future experiences
- vi. Emotional insight: emotional awareness into the feelings and illness and ability to modify behaviour accordingly.

Determining the degree of insight helps in predicting likelihood of compliance with treatment.

Judgment. It is the ability to anticipate the consequences of one's behaviour and make decisions to safeguard their well-being and that of others.

Importance of correct elicitation and interpretation of psychopathology

While it is extremely important to have a clear understanding of the psychopathology, correct elicitation is equally important. Jumping to conclusions regarding a presence of a phenomenon without proper elicitation poses a risk of over-diagnosis. For example, a poorly conducted mental state examination may incorrectly reveal presence of delusions and hallucinations when in reality, the person might only have these beliefs at an idea level, and the hallucinatory experiences are non-psychotic in nature (commonly related to past trauma).

A recent study by Coulter et al concluded that potential overdiagnosis of schizophrenia is of considerable concern, given the treatment and prognostic implications of schizophrenia compared with alternative diagnoses. An important reason for overdiagnosis was identified as literal interpretation of patients' self-reported symptoms, especially 'hearing voices'. There is evidence that the experience of hallucinations, which may be common in the general population, is categorically different for individuals with schizophrenia. In addition, the term 'hearing voices' may be used imprecisely by patients to emphasize extreme emotional distress. This may be particularly common in individuals with cognitive, communication, language, or cultural limitations in their capacity for self-description.

An abnormal belief should therefore be carefully explored to establish it as a false, firm unshakeable belief which is held with extraordinary conviction before it is labelled as a delusion.

Similarly, reported 'hearing voices' should be sufficiently and carefully explored to establish presence of a hallucination. Despite increasingly blurred definition of pseudo-hallucination, a skilled candidate should be able to differentiate between psychotic and non-psychotic types of hallucinations.

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 all 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 Ilana Jenkins, a 22-year-old woman. You do not have a regular job, but you sometimes do casual work as a cleaner. You live locally with your stepfather and mother in a rented 2-bedroom unit. You are on unemployment benefits for the last 2 years.

Current Presentation to the Emergency Department (ED):

You have been in a relationship with Mark, a 34-year-old man. Mark lives in his unit with a flatmate. You have known Mark for the last 6 months after you met on a social website. You began chatting with him on Facebook and started dating two months ago. Mark is unemployed and on government benefits as well.

For the last 2 weeks Mark has been avoiding you and not answering your calls. You have recently seen a few of his Facebook posts and you are concerned that he might be seeing another girl. You fear that he is going to leave you for her.

You met him today in his unit and had a verbal argument. He asked you to leave and you returned home. Your parents were not home, and you were feeling terrible. When your parents got home you were very upset and were crying. They could not get you to stop so they called the ambulance. The nice lady in the ambulance thought it may be better for you to see a doctor and so they brought you to ED.

You have been seen by the ED staff and told that you would be seeing a doctor from mental health for further assessment. You saw the junior doctor who then asked the psychiatrist to see you. You know that you are going to see a psychiatrist now.

Background information:

The candidates have the specific task of asking you about your mood and experiences in the last few weeks.

If they ask how you are feeling now or how your mood is now: say, **'I feel like crying'** and then start getting teary.

When asked if people laugh or talk about you, you sometimes feel people on the street are laughing at you. For example, when you were driving home back from Mark's home yesterday, it felt as if everyone was laughing at you. If asked further, you wonder why a stranger would laugh at you, so you are not sure they actually do so. You do feel similarly when you are stressed. You have never been 100 percent sure of this.

When asked if someone wants to harm or kill you, you mention that when you are alone at home or on the street at night, you feel that someone will come to sexually assault you or kill you. You remain very anxious and vigilant. If asked if this is a fear or if you are sure someone will assault you, you say you are not sure.

When asked about hearing voices, you say that sometimes, you feel that there is a devil that lives around you. When stressed, you can hear him saying bad things to you. He calls you names and tells you to go kill yourself. When probed more, you say you can hear him clearly, but his voice comes from inside your head. When asked, you say that it sounds like a human voice and maybe sound similar to your biological father's voice. The voice does not last long and comes and goes specially around stressful times. It also happens when you are lying in bed just before you go to sleep. You have no control over the voice. If asked why you hear them, you say **'Maybe I have schizophrenia'**. You don't hear any voices continuously coming from outside. You don't hear voices arguing about you or commenting on your actions. You don't hear your own thoughts out loud.

When asked if you see things others cannot, you say that sometimes, you can see the devil and you get frightened. Only if asked, you say that it happens when you are half asleep at night and you suddenly hear your name. You open your eyes and you think you can see a black shadow looking at you. You are very vague in your description of the shadow. It fades away quickly, and this has happened maybe 5 times in the last 6 months.

You don't think anybody can read your mind or people know your thoughts. Nobody can put thoughts into your head or take them out of your head. No one can control your body or feelings from outside. You don't think radio / TV or newspapers play your personal information / news. If asked these questions, you can say **'I am not crazy, doctor.'**

You do feel anxious when you are meeting strangers or new people. You avoid meeting them because you feel they will judge you.

You don't have any fear of any specific things or situations. You don't wash your hands or check things repeatedly.

Your sleep has never been good. You often get nightmares that you don't clearly remember later. You don't get any flashbacks of your childhood trauma (see below).

Regarding your mood, it has always been **'up and down'** as far as you can remember. However, you do enjoy life sometimes and go out with your mates. Your ups and downs don't last for more than few hours and your mood changes very quickly depending on your surroundings.

You are not suicidal. You don't want to harm yourself. You feel bad about what happened last night. You now want to go home and rest.

You don't use any drugs. You drink alcohol only occasionally and socially.

You have never been in trouble with the police.

If asked about your childhood, you say **'don't remember much'**. However, you remember that your childhood was very traumatic. Your own father sexually abused you between 6-10 years of age. When you told your mother, she initially did not believe you. However later, she did find the truth and that led to their separation. Your father is now uncontactable. You blame yourself for your parents' separation. You started believing that you were worthless. You started thinking of suicide and harming self frequently each time you would be in some kind of emotional pain. You started cutting yourself in your thighs very often. You found it difficult to make close friends and most of your relationships have been short lived and superficial due to you having difficulty trusting them.

If asked, you say you don't think you are impulsive, but look annoyed and say **'I don't know'** if probed further.

If asked whether you have any mental illness, say you think you have depression, anxiety and schizophrenia, because you have read about these on the internet, and the description matches your symptoms.

You have never seen a psychiatrist in the past and never been on any medication.

4.2 How to play the role:

You are dressed in casual clothes (jeans and a T-shirt / appropriate to the weather) and you look distraught.

Your hair is not groomed given you have spent night in the ED. You don't have any make up on.

You are cooperative but not very forthcoming until you are asked specific questions.

You get upset and annoyed if the candidate asks a lot about your childhood.

You can get teary on a few occasions but that should not interrupt the conversation.

You are fairly organised in your thoughts and talk at normal pace. You are neither loud nor too soft in your voice.

4.3 Opening statement:

'Doctor, I think I am ready to go home.'

4.4 What to expect from the candidate:

Candidates are expected to ask you about your mood and recent experiences. They should particularly explore experiences like hearing voices, seeing things that others don't see, feelings of being watched or talked about. They are not expected to ask details of your childhood and other personal information.

4.5 Responses you MUST make:

'The devil sometimes calls me names and I hate that.'

'I feel like crying.'

'Sometimes at night I worry that someone is going to hurt me.'

4.6 Responses you MIGHT make:

If asked about your mood recently:

Standard response: **'Up and down.'**

If asked why you think you hear voices:

Standard response: **'Maybe I have schizophrenia.'**

If asked about unusual experiences like associations with the TV / radio, etc:

Standard response: **'I am not crazy, doctor.'**

4.7 Medication and dosage that you need to remember

None

STATION 10 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate the ability to conduct a focussed mental state examination (MSE).
- Present and justify the discrepancies with previous MSE findings provided by a trainee.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.3 Did the candidate demonstrate adequate proficiency in undertaking a mental state examination? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

the mental state examination is relevant to the patient's problems and circumstances; it is conducted at a sophisticated level to demonstrate establishment of psychopathology.

Achieves the Standard by:

demonstrating capacity to: conduct a organised and accurate focussed mental state examination; assess key aspects of observation of mood and affect, thought (stream, form, content, control) and perception; specifically focus on the findings provided by the junior doctor and probe them in greater depth in order to establish the psychopathology.

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

- Explore thought content to clearly establish that the patient does not experience a pathological sense of persecution.

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. Or if explores the psychopathology only superficially without demonstrating that patients beliefs are shakeable.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; significant deficiencies in technique, organisation, accuracy and / or presentation; did not explore the psychopathology at all.

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

1.3 Category: ASSESSMENT – Mental State Examination	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"/>

1.3 Did the candidate demonstrate adequate proficiency in presenting the discrepancy in the findings reported by the trainee? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

the mental state examination is relevant to the patient's problems and circumstances; it is presented at a sophisticated level in detail.

Achieves the Standard by:

demonstrating capacity to: present a focused and accurate findings of psychopathology; assess and present key aspects of mood and affect, thought (stream, form, content, control) and perception; specifically mentioning the psychopathology reported by the junior doctor.

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

- Correctly present at least 3 of the following mental state findings: dysphoric mood / affect consisting of depression, distress or instability; absence of formal thought disorder; absence of delusions; possible non-psychotic hallucinations / pseudo-hallucinations.

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 in technique, organisation, accuracy and / or presentation.

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

1.3 Category: ASSESSMENT – Mental State Examination	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"/>

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on clinical experience for justification of their findings? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

candidate acknowledges that concept of pseudo-hallucinations and hallucinations is in a state of debate; acknowledges that growing literature is supportive of describing pseudo-hallucinations and hallucinations on a continuum; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:

discussing differences in the available evidence provided by the patient; providing appropriate justification for their opinion of psychopathology based on the standard definitions of various psychopathologies;

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

- a. Justify their findings for disorder of thought content and perception.

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; if they infer that patient has delusions, clear hallucinations or a formal thought disorder.

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

6.4 Category: APPLICATION OF KNOWLEDGE	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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1.0 Descriptive summary of station:

The candidate is expected to demonstrate their competence in utilising motivational skills and strategies (e.g. readiness ruler, importance / confidence, good-less good, etc.) to assist a 37-year-old man who has been a heavy user of cannabis for ten years, and is currently in a stage of contemplation to move into action after being charged with driving while intoxicated.

1.1 The main assessment aims are to:

- Demonstrate knowledge and understanding of Motivational Interviewing (MI) skills and strategies.
- Effectively engage a patient utilising Motivational Interviewing techniques in a manner that encourages their willing participation.

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

- Avoid confronting the patient about the need to stop cannabis.
- Utilise at least three of the 'OARS' skills relevant to this scenario (open-ended questions, affirmation, reflective reasoning, summarising).
- Accurately apply at least two MI strategies.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Substance Use Disorders
- **Area of Practice:** Psychotherapies
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Therapy, Assessments – Strategies, Selection), Communicator (Conflict Management).

References:

- DiClemente, Carlo C, Hughes, S.O. Stages of change profiles in outpatient alcoholism treatment. *Journal of Substance Abuse*, Vol 2, Issue 2, 1990, Pages 217–235
- McConaughy, Eileen A.; DiClemente, Carlo C.; Prochaska, James O.; Velicer, Wayne F. Stages of change in psychotherapy: A follow-up report. *Psychotherapy: Theory, Research, Practice, Training*, Vol 26(4), 1989, 494-503.
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford press.
- Morton, K., Beauchamp, M., Prothero, A., Joyce, L., Saunders, L., Spencer-Bowdage, S., Dancy, B. and Pedlar, C., 2015. The effectiveness of motivational interviewing for health behaviour change in primary care settings: a systematic review. *Health Psychology Review*, 9(2), pp.205-223.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male in mid-30s, casually dressed.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are a junior consultant psychiatrist working in a community alcohol and drug treatment service.

Your next patient is Gary Fletcher who is a 37-year-old man presenting with ambivalence about his cannabis use. He was recently charged with driving under the influence after a camping weekend, and he now risks losing his licence which will affect his occupation. In a session last week, he admitted to being a heavy regular user of cannabis for at least ten years.

Your task is to:

- Demonstrate a brief intervention for cannabis use focussing on motivational interviewing techniques to assist Gary to shift to the action stage of change.

Station 11 - Operation Summary

Prior to examination:

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

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your 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.

There is no opening statement or prompts for you to give.

The role player opens with the following statement:

'So doc, you going to give me a lecture?'

3.2 Background information for examiners

In this station, the candidate is expected to engage a 37-year-old man (Gary) who presents with a chronic cannabis dependence, and assist him to move towards making changes to his pattern of use. They are to demonstrate their competence in utilising motivational skills and strategies (e.g. readiness ruler, importance / confidence, good-less good, etc.) with the patient, who is currently in a stage of contemplation to move into action after being charged with driving while intoxicated.

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

- Avoid confronting the patient about the need to stop cannabis.
- Utilise at least three of the 'OARS' skills relevant to this scenario (open-ended questions, affirmation, reflective reasoning, summarising).
- Accurately apply at least two MI strategies.

The candidate is expected to be able to effectively communicate with the patient to facilitate a good rapport by demonstrating a balanced use of open-ended questions and reflective reasoning. The candidate is expected to be able to create an atmosphere in which the patient's ambivalence can be gently explored. The candidate needs to demonstrate their ability to become an ally in Gary's recovery, and work with him to come up with a plan the patient is happy to implement.

A surpassing candidate would skilfully engage Gary in a non-judgemental manner, and specifically not get into an argumentative approach with him, and demonstrate clear expertise in MI by accurately applying a range of strategies tailored to the specific aspects of the scenario.

The candidate is expected to demonstrate their knowledge of generally accepted Motivational Interviewing skills and strategies used to support a patient to shift from the contemplation to the action stage of the wheel of change.

The 'stages of change' (James Prochaska & Carlo Diclemente) is a useful model of working out how to look at changing something significant in a person's life.

Change is associated with different thoughts and feelings – excitement, hope, fear, uncertainty, anticipation, vulnerability, worry, relief, enthusiasm, anger, a desire to be in control, fear of losing relationships.

Considering responses to certain kinds of questions can confirm the contemplation stage: Do you think you have a problem with alcohol or other drugs? Are you clear about why you want to quit / stop smoking cannabis?

MI is collaborative in that the candidate needs to ask questions or make statements that will affect the willingness of the patient to disclose information about their use. Being confrontational (argumentative, aggressive, antagonistic) is unhelpful, and generally leads the patient to become defensive and to withhold important information.

A more person-centred approach of engaging that fits with recovery, and has regard to the person's behaviour as their own personal choice, letting them decide on the size of the problem, i.e., how important it is for them to quit, and avoids argumentation and confrontation, encourages discrepancy / inconsistency from where the patient can initiate change, and helps patients re-evaluate their substance use.

Validating the patient's lack of readiness:

- Clarifying that the decision to make changes is the patient's.
- Encouraging the evaluation of pros and cons of behaviour.
- Identifying and promoting new positive outcome expectations.

MI **skills** can be used for raising sensitive issues like alcohol use, and encourage the use of open-ended questions, affirming the patient, listening reflectively and summarising throughout (often called *OARS*).

- *Open-ended* questioning encourages ongoing exploration.
- *Affirmation* of personal successes and helpful coping strategies aims to build a sense of personal capacity to achieve their goals, and recognition of the patient's strengths and resilience. Assessing capacity of the candidate to affirm (e.g. through compliments and statements of appreciation or understanding) indicates their ability to express empathy and support the patient. Affirmations can be statements or gestures that identifies the patient's strengths, and amplifies behaviours that push the patient towards positive change.
- *Reflective* listening, checks whether what the candidate has 'heard' what the patient meant, and allows the patient to correct any wrong understanding, and add more information. It also provides feedback on the patient's concerns. It is potentially one of the most powerful interviewing skills. Reflection makes an estimation as to what the person means, it is not a question, but is a statement which reflects or amplifies the meaning of what the patient has said.
- *Summarising* helps to ensure there is a clear communication between the doctor and the patient. It can be a launching pad for change. Summaries are an extended application of reflective reasoning. Summaries are used at several points during a clinical review but are very important at transition points, such as after the patient has concluded their conversation about a subject or discussed a personal experience or when the clinical review is about concluding. Summaries should be concise, emphasise change statements, should include relevant clinical information and should end with clarifying question such as "did I miss anything?"

The candidate needs to demonstrate capacity to reflect: using exact repeating, rephrasing with no new meaning, paraphrasing including inference of meaning and reflection of feeling (often regarded as the deepest form as it aims to capture the way the patient is feeling). When using a reflection of feeling, it is generally better to understate rather than overstate the strength of the feeling.

To '*Achieve*', the candidate must be able to listen, understand and summarise the information provided by the patient. The candidate must demonstrate capacity to provide a brief overview of what has been discussed, tie up what has been covered and allow for a shift to another topic, or to start a new approach. This skill involves the ability to highlight the main discoveries, encourage exploration of more detail, give patients the opportunity to hear their own concerns or reasons for change and highlight ambivalence (to change). A better candidate will use summarising as a way to show 'discrepancy', where the candidate mirrors back to the patient a summary of their position in a way that highlights the discrepancies in how the patient sees themselves.

The candidate must demonstrate through their approach that they are familiar with the main elements of motivational interviewing (Miller and Rollnick, 2002). They should express empathy with more listening, and less 'telling'. They should show some capacity to develop discrepancy, and take opportunities to focus the patient's attention on any discrepancy developed.

Any level of argument is likely to reduce the candidate's capacity to '*Achieve*' as the aim of MI is for the patient, and not the candidate, to argue for change. Resistance is strongly determined by the style of the clinician - when dealing with people who are unsure if they want to change or are feeling overwhelmed, there is a tendency for the clinician to deny, or become frustrated or angry. The candidate should avoid increasing their efforts to try to persuade the patient that they have a serious problem which needs committed effort to change: this then leads to further resistance and defensiveness in the patient. The aim is to 'roll with the resistance.'

The candidate should try not to provide solutions, rather respond and acknowledge the patient's perceptions (roll with the resistance). A better candidate will be able to provide an opportunity for the patient to identify their own solutions in the time available. MI may be 'confrontational' in its purpose (to increase awareness of problems and the need to do something about them), but this is a different kind of confrontation to arguing or convincing. If the patient resists, the better candidate will recognise this as indication that they are taking the wrong approach and shift.

The candidate's intervention should also support of self-efficacy, eliciting the patient's confidence in their ability to implement, and sustain changed behaviour (as self-efficacy influences whether or not they attempt and persist with efforts of change).

The candidate should use a neutral low-key interviewing style – as if they are curious to find out exactly what happens, and how their use of substances fits in their broader life context. The MI strategies express the 'spirit' of MI in that they are collaborative, evocative (suggestive), and encourage autonomy.

Through their interview the candidate should be able to demonstrate some capacity to undertake one or more of generally accepted MI **strategies** which could include:

1. Good Things / Less Good Things (Decisional Balance)
2. Looking Back, Looking Forwards
3. A Typical Day
4. Exploring Concerns
5. Readiness Ruler
6. Ask, Tell, Ask.

1. Good Things / Less Good Things (Decisional Balance)

Aim: to explore people's feelings about their substance use, without putting the clinician's own assumptions and beliefs about whether use is problematic. The patient needs to identify potential problem areas.

Function: often used at first session to build a relationship and test a person's level of concern. It is useful in assessing readiness for change. Resistance is minimised when the discussion commences first with the 'good things' about ongoing substance use then moves to talk about the 'less good things' or concerns. Using terminology like 'bad' things should be avoided. The responses and associated identified consequences are often tabled in a decision-making matrix so as to provide a visual representation for the person; alternatively in the 4-column diagram (Birmingham 1986) of likes and dislikes of ongoing use or abstinence.

2. Looking Back / Looking Forward

Aim: to assist the patient to consider how substance use has changed things in their lives, and to consider what things they could do to change to have a better future.

Function: it incorporates personal experiences that can stand alongside good and less good things. The person tells their own story without a judgemental approach from the clinician.
Looking Back: sometimes it is useful to have a person remember times before the problem started, and to compare this with the present situation: 'Do you remember when...?', 'What were things like before...?', 'How has alcohol stopped you from...?'.
Looking Forward: Helping people to picture a changed future, asking the person to describe how things might be after a change.

3. Typical Day / Session

Aim: to explore the person's substance use by going through one particular recent day or session in detail, exploring the details of what happened, and how the person felt about the events.

Function: often used near the beginning of the first session, this strategy serves to strengthen the relationship and keeps the discussion within a positive non-judgemental atmosphere. It gives the beginning indications of the function of substance use in their life, and provides a way of gaining the amount and type of use. It assists in exploring all the concerns they identify (in contrast with 'good things').

4. Exploring Concerns

Aim: to help people express and elaborate on what concerns they have about their substance use.

Function: this is often the foundation for building motivation. It highlights ambivalence, and can lead to the development of discrepancy – a sense of discomfort – which often precedes the decision to make a change, e.g. the alcohol use is not in keeping with their own self-image. Looking at past experiences of quitting can assist in building confidence.

5. Readiness Ruler

Aim: to help people talk about whether they are willing and able to change.

Function: assists in identifying how *important* making a change would be to that person, and then assessing the patient's level of *confidence*, which then helps them to make positive changes. The focus is therefore placed on highlighting positive changes already made, regardless of how small they are, and encouraging the person to identify their own self-positives, or positive self-talk. It should help to highlight exceptions or times when they have managed well, and successes of setting small achievable goals. A critical technique is asking the person to explain why a lower number was not picked, encouraging the patient to justify their level of importance / confidence against your lower suggestion.

6. Ask, Tell, Ask (or similar approach) – often considered more part of a Brief Intervention than MI.

Aim: to provide factual information, without telling the person something they know already, and to offer further opportunities for discussion.

Function: this is often the opening conversation in raising awareness without causing offence. Also known as Elicit, Provide, Elicit and is used to emphasise personal choice and control, work out existing knowledge / experience, ask permission to provide information / feedback / recommendations, and obtain the patient's reactions / interpretations. Sometimes MI strategies can be linked together to get a better outcome, especially if that is where the conversation with the patient is taking the clinician. MI requires the identification of a specific target behaviour for change, and 'change talk' is unique to MI: this is what the patient says in the sessions with the clinician, eliciting self-change talk in the context of being ready, willing and able (want, able, need). Change talk can be positive which supports change or negative which tends to maintain the status quo.

NZ laws for drug testing

According to the Ministry of Transport in New Zealand, it is an offence to drive while impaired, and with evidence in the bloodstream of a qualifying drug. The presence of a qualifying drug alone is not sufficient for an offence; there must first be impairment as demonstrated by unsatisfactory performance of the compulsory impairment test. It is also an offence to drive or attempt to drive while under the influence of drink or drugs to the extent of being incapable of proper control of a motor vehicle.

Police can test for the presence of qualifying drugs (*Misuse of Drugs Act 1975*) if a driver fails a compulsory impairment test. Parliament agreed that the law should also cover benzodiazepines, and these medications can be found in the Medicines Regulations 1984

<http://www.legislation.govt.nz/regulation/public/1984/0143/latest/DLM95668.html>.

In analysing the results of the blood test, police target most likely drugs including opiates, amphetamines, cannabis, sedatives, antidepressants and methadone.

Where a police officer has 'good cause to suspect' that a driver has consumed a drug or drugs, the officer may require the driver to take a compulsory impairment test. Grounds for having good cause to suspect include erratic driving or, if the driver has been stopped for another reason, appearing to be under the influence of drugs, e.g., a person stopped at an alcohol checkpoint is behaving in an intoxicated manner but passes a breath alcohol test. The compulsory test includes:

- an eye assessment – pupil size, reaction to light, lack of convergence, nystagmus (i.e. abnormal eye movement - irregular eye movement can be a marker for drug impairment)
- a walk and turn assessment
- a one leg stand assessment.

If the driver does not satisfactorily complete the compulsory impairment test, the police officer may forbid the driver to drive, and require the driver to provide a blood sample. Forbidding the person to drive deals with the immediate road safety risk represented by the impaired driver, for up to 12 hours (the period of prohibition applied to a driver who is over the legal adult breath alcohol limit), but this may vary depending on the discretion on the police officer.

The procedure for taking a blood sample is the same as for drink drivers who opt for a blood test. When the blood test results are known, police make a decision whether or not to charge the driver. The penalties for drug impaired driving are aligned with the penalties for drink driving offences.

Australia laws for drug testing

In Australia, roadside drug testing can be performed randomly similar to testing for alcohol. It is performed using a saliva sample.

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 all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

4.1 This is the information you need to memorise for your role:

You are a Gary Fletcher, a 37-year-old man, who was pulled over by the 'booze bus' (police) while driving intoxicated with cannabis three weeks ago. You have decided to attend an alcohol and drug service to see what they have to say.

You work as a civil engineer in a construction firm in the city. You had been camping for the weekend with some of your mates from work, and were driving home that evening when you went through a random drug test. Your lawyer suggested you go to an addiction treatment service as part of preparation for your possible pending court case. You are uncomfortable about being here, but recognise that you do need to do something about your cannabis use even though you really enjoy it, including the social aspects associated with smoking with your friends.

You started smoking cannabis when you were in your mid-teens (about 21 years old) and have slowly increased your use over the years. You had not had any major concerns about smoking as most of your friends tend to use in the same pattern as you. For instance, university was one big party with drinking and drugs, and you managed to pass with ease. Looking back, those were great days – and you like to reminisce about how great things were.

You met your partner, Amy, after you left university and have been together since then. Earlier this year, she started complaining that your ('stoned') weekend trips with the guys; it was not where she saw herself going in her life. She has been getting 'clucky', and wanting to settle down and have kids – you think that you would like to have kids one day as well, but are really enjoying your current laid-back lifestyle. Amy got annoyed with your refusal to take life more seriously, and surprised you by threatening to leave you just before your birthday in April.

She moved out three months ago, and you often can't believe she has gone. You have not been happy getting home after work to an empty house, which is why you went away this weekend. You have a friend, Jack, who lives down the road, and have started spending more time over there since she left. You and Jack sit together and share bongos, and occasionally you have fallen asleep at Jack's house, and also been getting to work late because you can't get up on time in the mornings.

There are also a few things that concern you about your cannabis use – this is the second time you have been caught driving under the influence in two years; you think you have lost Amy, and you really thought she was 'the one'; over the last few months since she left, you have been spending even more time at Jack's or camping out in the bush as you hate being at home alone; you are spending more money on cannabis; you are getting into trouble with your boss for absenteeism.

Physically, you have recently been feeling 'crook', and have become worried about a cough that just won't seem to go away. You have never previously been concerned about any health-related problems. You used to play in a social touch rugby team with mates from work, and enjoyed the comradeship associated with this, but you have let that go by the wayside. You can grudgingly admit that you are putting on weight, and blame this on spending so much time sitting around smoking bongos, and eating junk food.

You do not want the candidate to think that everything is bad about smoking cannabis. There are many things you really like; it relaxes you, you feel more comfortable and relaxed, and have been told you are really funny when you are high. You have a close group of friends dating back to university, and your social lives revolve around smoking with them. You have never really considered giving up or cutting down before.

The following information should only be provided if the candidate asks you.

Your pattern of use:

At present, you are smoking almost every day, and prefer hydroponics than naturally grown. You think you smoke about 5 to 10 cones per night, usually sharing with Jack (and sometimes one or two other friends). You usually drive home after spending the evening smoking with these friends. Apart from Amy, one of your closer friends has made snide remarks about you losing control, and sometimes you know they are mocking you for being a 'stoner'.

This second driving while intoxicated is a bit of a wake up as you are really worried about the charge. The first time was at the end of last year, and you did not think that it was that much of a worry, and just became more careful. You have never previously thought you should look at your habit before this, but at the back of

your mind, you have to admit that you have stated wondering what it would take to get your relationship with Amy back.

If you are asked what goals you have, they would be to spend less time stoned, and not go to work feeling wasted most days (you admit that it could end up costing you your job if you can't keep on top of your tasks). You can see yourself settling down, and having a family, but are also anxious about such a big commitment. You would like to lose some weight, and definitely want to be sure that you do not end up an addict like your grandfather.

You can admit now it is *important* for you to address your use, (if you are asked you would rate the importance, put it at about 7/10 (10 being very important). You would not rate it lower because you realise you really want to get Amy back, and to stop spending most evenings on Jack's couch or putting your job at risk.

As most of your close friends smoke cannabis, it is a strong socialising activity for you - you are not sure that you feel that *confident* about stopping / reducing (4/10): you worry about your will power, what would you do with yourself instead of smoking / socialising! If asked what would help shift your confidence from a '4' to a '5', respond that having more support from your friends would help. You have never stopped for a prolonged period of time. Most recently, you stayed off cannabis for one day only, and that was the day after you had been caught by the police.

If you are asked, you do have a family history of alcohol problems, with your paternal grandfather being described as a violent alcoholic. You are aware that he died of alcoholic cirrhosis. Your brother, Steve, used to smoke cannabis, and drink heavily when he was younger. He ended up being charged for drug dealing, and barely managed to escape a custodian conviction on a legal technicality.

4.2 How to play the role:

You are to be casually dressed, and can be slightly scruffy in your grooming. You think of yourself as a 'regular kind of guy' who is hoping to 'beat' this charge.

You must initially be defensive and avoidant (because you are embarrassed and worried), and you don't want health professionals telling you what to do. You feel that you are in control – most of the time – and can initially be a bit sarcastic if the opportunity arises.

If the candidate takes time to listen and does not tell you what to do, you will become more pleasant, as you are a pretty straightforward kind of person, and deep down, you know that you probably need to get more control over your cannabis use. You will be happy to engage with the candidate if they don't lecture you on the dangerousness of your lifestyle, but try to work with you to look at what is important to you about considering decisions about cannabis use.

4.3 Opening statement:

'So doc, you going to give me a lecture?'

4.4 What to expect from the candidate:

The candidate is expected to encourage you to shift your current use of smoking cannabis, to consider at least cutting down and making some changes to your current lifestyle. They should do this by trying a range of strategies which could include talking about what you like about your smoking, what are the good things about smoking or not smoking – and what are less good. They may ask you how confident you are about quitting (which you do not want to do) or cutting down (which you may consider), or what things used to be like in the past, and where you see yourself going when you look forward to your future. Candidates should quickly move to encouraging you to talk about why you might want to quit / control your smoking.

They may advise you that you have cannabis use disorder, but no other mental illness. At present, you are prepared to consider ways that you could manage your cannabis use, and are happy to answer reasonable questions. They should spend little time taking a history but focus more on working with you to identify your own reasons for changing your cannabis use habits, then may move to provide you with some suggestions and a plan for follow-up. It is not expected that candidates will focus on any medication options or spend too much time on your drug use history.

4.5 Responses you MUST make:

'I don't think I'd ever stop completely.'

'I have got a bit of a cough.'

4.6 Responses you MIGHT make:

If the candidate asks about your past psychiatric / mental health history:

Scripted Response: 'I don't have any mental problems.'

If the candidate asks about your physical health:

Scripted Response: 'I feel fit and healthy most of the time except for my cough.'

If the candidate asks if you use other drugs.

Scripted Response: 'I don't doc.'

4.7 Medication and dosage that you need to remember:

There are no medications for you to remember.

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate knowledge and understanding of Motivational Interviewing (MI) skills and strategies.
- Effectively engage a patient utilising Motivational Interviewing techniques in a manner that encourages their willing participation.

Level of Observed Competence:

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to manage challenging communication? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

constructively de-escalates the situation; positively promotes engagement; demonstrates sophisticated reflective listening skills.

Achieves the Standard by:

recognising challenging communication; listening to differing views; utilising communication techniques to effectively promote positive outcomes.

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

- Avoid confronting the patient about the need to stop cannabis.

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; any errors impair attainment of positive outcomes; inadequate ability to reduce resistance.

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

2.3. Category: CONFLICT MANAGEMENT	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

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

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support treatment options; demonstrates a clear strategy.

Achieves the Standard by:

application of supportive therapy and general psychoeducation; demonstrating understanding of motivational interviewing; considering sensitively barriers to application; avoiding using only generic forms of motivational conversation.

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

- Utilise at least three of the 'OARS' skills relevant to this scenario (open-ended questions, affirmation, reflective reasoning, summarising).

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; errors or omissions impact adversely on patient care; approach lacks structure and/or is inaccurate; plan not tailored to patient's needs or circumstances.

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

1.14. Category: MANAGEMENT - Therapy	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"/>

1.8 Did the candidate make an appropriate choice of MI strategies? (Proportionate value - 45%)

Surpasses the Standard (scores 5) if:

expertly applies the most appropriate strategies and incorporates them in a skilful manner to achieve the desired outcome.

Achieves the Standard by:

prioritising and selecting the optimal range of MI strategies; adapting range of available options in response to the interaction with the patient; choosing strategies that suit the conversation; not attempting to incorporate too many strategies.

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

a. Accurately apply at least two MI strategies.

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; incorrectly chooses even routine / standard range of therapeutic strategies; unable to prioritise relevant MI strategies.

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

1.8. Category: ASSESSMENT – Strategies, Selection	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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