Committee for Examinations
Objective Structured Clinical Examination
Station 8
Auckland September 2018

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

In this station the candidate is to take a history from a 56-year-old married man who has developed psychiatric symptoms following the recent administration of corticosteriods to treat exacerbation of asthma. They are to elicit sufficient information to make a diagnosis of steroid induced mood disorder (depression with psychotic features) which the candidate needs to explain to the patient. The candidate is then expected to present a treatment plan to the examiner.

1.1 The main assessment aims are to:

- Obtain a focussed history from an asthmatic patient of symptoms and treatment since being in hospital in order to identify steroid induced mood disorder.
- Synthesise the findings and appropriately communicate the diagnostic explanation to the patient.
- Explain the management plan for steroid induced mood disorder including management of suicide risk associated with this patient.

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

- Elicit the paranoid belief about his wife and the doctor planning euthanasia.
- Explain the direct link between initiation of oral steroid and the development of the mood disorder.
- Prioritise the monitoring of suicide risk until the mood disorder settles.
- Recommend tapering of prednisolone and prescription of an antipsychotic.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Medical Disorders in Psychiatry
- **Area of Practice**: Consultation Liaison
- **CanMEDS Domains**: Medical Expert, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content; Diagnosis; Management – Initial Plan), Collaborator (Teamwork – Treatment Planning).

References:

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing
- Australian Asthma Handbook. www.asthmahandbook.org.au/acute-asthma/clinical
- New Zealand Asthma Guidelines https://www.nzasthmaguidelines.co.nz
- Bhangle SD, Kramer N, Rosenstein ED. Corticosteroid-induced neuropsychiatric disorders: Review and contrast with neuropsychiatric lupus. Rheumatology international. 203; 33. 10.1007/s00296-013-2750-z.
- Dubovsky AN, Arvikar S, Stern TA, Axelrod L. The Neuropsychiatric Complications of Glucocorticoid Use: Steroid Psychosis Revisited. Psychosomatics 2012:53:103–115
- Fardet L, Petersen I, Nazareth I. Suicidal Behavior and Severe Neuropsychiatric Disorders Following Glucocorticoid Therapy in Primary Care, American Journal of Psychiatry 2012 169:5, 491-497
- Gorton HC, Webb RT, Kapur N, et al. Non-psychotropic medication and risk of suicide or attempted suicide: a systematic review. BMJ Open 2016;6:e009074. doi:10.1136/bmjopen-2015- 009074
- Judd LL, Schettler PJ, Sherwood Brown E et al. Adverse Consequences of Glucocorticoid Medication: Psychological, Cognitive, and Behavioral Effects American Journal of Psychiatry 2014 171:10, 1045-1051
- Kanna HA, Poon AW, de los Angeles P, Koran LM. Psychiatric complications of treatment with corticosteroids: Review with case report. Psych and Clin Neurosciencecs 2011:65, 549-560
- Lewis DA, Smith RE: Steroid-induced psychiatric syndromes: a report of 14 cases and a review of the literature. J Affect Disord 1983; 5:319–332

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Middle aged (50 - 60 years) man in casual attire.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant liaison psychiatrist in a large metropolitan hospital.

You have been asked to review Mr Harold Rainbow, who was admitted to the respiratory ward a week ago for treatment of community acquired pneumonia, and associated exacerbation of asthma.

He is a 56-year-old married non-smoker, with mild asthma since childhood, who is on a regular inhaled bronchodilator and a corticosteroid inhalant suspension.

His pneumonia was improving with intravenous antibiotic ceftriaxone and oral steroids. He was due to begin oral antibiotic clarithromycin yesterday. However, for the past two days he has refused to talk to his wife or treating team, and is refusing any oral antibiotics. The nurses have made significant efforts to try to persuade him to take any of the prescribed oral medications.

Your tasks are to:

- Take a relevant history from Harold to ascertain the diagnosis.
- Explain your findings to Harold.
- Explain your management recommendations, including risk management, **to the examiner.**

You will not receive any time prompts.

Station 8 - Operation Summary

Prior to examination:

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

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there is no cue / time for any scripted prompt for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:

  'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

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

If a candidate elects to finish early after the <u>final task</u>:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?
  If so, you <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings.'

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player will open with:

'Doctor, why do you need to talk to me?'

3.2 Background information for examiners

In this station the candidate is expected to take a history from a man who has developed psychiatric symptoms following the recent administration of corticosteriods to treat exacerbation of asthma. They are to elicit sufficinet information to make a diagnosis of steroid induced depression with psychosis which the candidate needs to present to the patient.

Following this, the candidate is to develop a treatment plan to present to the examiner. This should include four (4) phases to treatment:

1. Identify the role of providing a specialist opinion to the treating physician.
2. Recommend that the steroids are tapered as soon as possible.
3. Suggest commencement of treatment with an antipsychotic – olanzapine; risperidone or quetiapine.
4. Provide daily review including risk management – may need ECT or psychiatric special.

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

- Elicit the paranoid belief about his wife and the doctor planning euthanasia
- Explain the direct link between initiation of oral steroid and the development of the mood disorder
- Prioritise the monitoring of suicide risk until the mood disorder settles
- Recommend tapering of prednisolone and prescription of an antipsychotic.

When assessing for corticosteroid adverse effects, a better candidate may aim to exclude alterations in mood and behaviour as a response to adjusting to illness, or as a consequence of the underlying disorder itself.

Surpassing candidates may also highlight that depressive syndromes, sometimes complicated by psychotic features, have been reported during corticosteroid withdrawal or after dosage reductions. They may also know that corticosteroid withdrawal may also account for depressive symptoms emerging during the switch from systemic to inhaled corticosteroids. This risk would need to be taken into account when making recommendations for reduction of steroids.

Background

The first reports of psychiatric side effects from the use of steroids were in the 1950s; for many years side effects used to be summarised as steroid psychosis yet the presentation can include depression, mania, delirium, panic disorder and psychosis (Bhangle et al., 2013). The evidence for mood disorders is the most robust, with hypomanic / manic symptoms being more common than depressive symptoms in acute settings.

Some studies have suggested that the risk of depression increases with prolonged or chronic exposure and that those experiencing a corticosteroid-induced depression in one session may develop mania in a subsequent treatment and vice versa.

There are other common neuropsychiatric effects of corticosteroids including agitation, insomnia, depersonalisation and cognitive difficulties. Other psychiatric adverse effects can be mild and not necessarily clinically significant.

As up to 10% of medical and surgical inpatients receive corticosteroids during their admission it is important for psychiatrists to be able to diagnose and advise about effective management, particularly as the psychiatric effects can be unpredictable. Isolated symptoms of euphoria, irritability, anger, increased talkativeness, sleep disturbance or appetite disruption can be common and not related to a specific diagnosable disorder.

Several reviews have found the most common psychiatric disorders are:

Depression	35%
Mania	31%
Psychosis	14%
Delirium	13%
Mixed states	6%
Suicide	3%

(Lewis & Smith, 1983; Fardet et al 2012; Dubovsky et al 2012)

According to DSM-5 corticosteroid confusional states should be diagnosed as delirium, features of which can be characterised by disturbance of consciousness with deficits in attention, other cognitive impairments and perceptual disturbances such as transient delusions, hallucinations and illusions.

Neuropsychiatric effects may occur with any steroid preparation, and have been reported after a variety of non-systemic modes of administration including single intra-articular injection. Lower dosages have been recommended for the elderly, and in patients with liver failure, chronic renal failure, renal transplant recipients and those taking estrogen containing oral contraceptives or ketoconazole. Drug related effects can be expected if associated medications increase circulating levels of corticosteroids (e.g. clarithromycin – a CYP 3A4 inhibitor).

Psychiatric side effects tend to have a sudden onset, within 1 – 2 weeks of starting treatment.

Pathophysiology

The mechanism leading to psychiatric symptoms is unclear, but theories include corticosteroid effects on dopaminergic and cholinergic systems, decreases in serotonin release and toxic effects on hippocampal neurons.

Risk Factors

There are no absolute risk factors apart from having treatment with corticosteroids.

- Past history of steroid induced psychiatric disorders gives a 32% increase of future psychiatric effects with steroid treatment. Prior risk of primary psychiatric disorder does not appear to increase risk.
- Dubovsky et al (2012) found no significant correlation between dosage and onset, specific psychiatric reaction or duration of symptoms. However, more recent research has found a dose response. Higher doses appear to give a higher risk of developing psychiatric problems however there are reports at doses as low as 2.5mg of prednisolone daily.
- There are age dependent reactions - older people are more likely to develop a delirium (over 70 years old there is a 10-fold increase in delirium)
- Women may be more likely to develop depression and men more likely to develop mania.

Prognosis

Increasing doses or resumption of corticosteroids have been found to have the strongest influence on the psychiatric course.

Delirium settles more quickly than other psychiatric presentations – mean duration 5.4 days versus mania, depression and psychosis mean duration 19.3 days.

Treatment

A variety of pharmacological strategies for treatment and prevention have been proposed. Psychoeducation and support of patients and families is critical to reassure and reduce risk of relapse with future use and are perhaps neglected, aspects of management.

Treatment is based on the most predominant symptom and weaning steroids as soon as possible. However as many effective mood stabilisers take weeks to work, most patients will benefit from low dose second generation antipsychotics for the immediate effect on arousal and agitation.

Consideration should be taken regarding any role for ECT in this situation. Lithium and antidepressants, like SSRIs, are useful in treating depressive symptoms and therefore are preferred options.

Interventions for psychosocial stressors and management of co-morbidities (other drug effects, metabolic abnormalities, infections) would be the responsibility of the treating physician.

Risk

Suicidal Behaviour and Severe Neuropsychiatric Disorders Following Glucocorticoid Therapy in Primary Care, Laurence Fardet, Irene Petersen, and Irwin Nazareth American Journal of Psychiatry 2012 169:5, 491-497

An epidemiological study by Fardet et al. of British general practice patients who received oral glucocorticoids showed that patients who received these drugs **were seven times as likely to attempt suicide as were patients** with the same illness who did not receive steroids. The increase was most prominent in younger people. Mania and delirium were also significantly more common, particularly in older men. Neuropsychiatric effects were more common in patients receiving higher doses and those with previous mental disorders. Brown (p. 447) notes in an editorial that this is the first large-scale study of the effects of steroids, with over 300,000 patients exposed to the drugs.

Suicidal ideation, intent and plans are an integral part of an assessment.

Risk to others – specifically the wife and doctor whom he believes are trying to euthanise him.

The medical risk of deterioration without correct treatment.

A psychiatrist should be able to provide advice for managing the environment in the hospital, including making decisions about the best site to continue treatment; psychiatric or medical ward.

Consideration of the role of compulsory treatment and any value of recommending a nursing special.

There are other risks that are less integral to this situation including risk to reputation, children or vulnerable adults as he is an inpatient.

Diagnosis

DSM-V Diagnostic Criteria for Substance / Medication-Induced Depressive Disorder

A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterised by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.

and

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
2. The involved substance / medication is capable of producing the symptoms in Criterion A.

and

C. The disturbance is not better explained by a depressive disorder that is not substance / medication-induced. Such evidence of an independent depressive disorder could include the following:

The symptoms preceded the onset of the substance / medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance / medication-induced depressive disorder (e.g., a history of recurrent non-substance / medication-related episodes).

and

D. The disturbance does not occur exclusively during the course of a delirium.

and

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Substances that do not fit into the classes of substances like steroids, should be coded as 'other substance intoxication' and the specific substance indicated (F19.929). ICD-10 substance-related codes combine the substance use disorder with the substance-induced aspect of the clinical picture – which complicates the diagnosis in a setting where the substance is appropriately prescribed.

Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder (F19.94)

F1x.0 Acute intoxication A transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses.

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 Mr Harold Rainbow, a 56-year-old man who has been married to Gypsy for 30 years.

You were admitted to hospital last Sunday because you had developed pneumonia, and then your asthma got really bad. You are an inpatient in a respiratory medical ward, and have been told by your Respiratory doctor, Dr Johnson, that he has asked a psychiatrist to see you today.

Your experience over past few days:
Your physical health is really getting you down, and you have been feeling very low in mood since coming to hospital.

If asked you tell the candidate that you have become concerned over the past few days that your wife is conspiring with Dr Johnson to kill you as they are in love. You believe that the oral antibiotic he has prescribed is actually a poison. You're not angry with your wife and Dr Johnson as you know you are such a terrible person, and that everyone would be better off without you here - but you are just scared that being poisoned will hurt.

History of your asthma and pneumonia:

- You have been on the medical ward being treated with intravenous antibiotics for pneumonia that developed following a skiing holiday in Queenstown. It started with a head cold while there which made your asthma worse, so you increased the use of your inhaled preventers, and started prednisolone tablets last Saturday which initially had reasonable effect.
- Once you had been home a day you developed a fever, and increasing shortness of breath. Your wife, Gypsy Rainbow, called an ambulance and you recall having injections and treatment in the emergency department.
- (*If asked, the symptoms you had at the time of admission were: a cough which produced a green sputum, pain in your chest, really bad shortness of breath and wheezing, fever, chills, and feeling weak*).
- You do not need to remember the names of the antibiotics prescribed as they are provided to the candidate.
- You are a non-smoker who has had mild persistent asthma since childhood - this means you have wheezing symptoms more than twice a week, but no more than once in a single day.
- You have needed medication for many years, starting in your adolescence with regular use an inhaler to open your airways – initially *Ventolin*™ and now *Serevent*™ inhaler.
- From your early adulthood you also needed to start using an inhaled corticosteroid – called *Pulmicort.*
- You have not previously been admitted to hospital as a child or adult.
- You have not previously had such a severe attack but have taken short courses of oral steroids (prednisolone 50milligrams) in the past when your asthma has been worse.
- You do not have any allergies to medication.

Mental health symptoms:

If asked any of the following please provide this information -

Depression: Your mood has recently been low and you feel sad, but have not been tearful.
You have recently been wondering if life is worth living, and you are tired of having to live with your asthma. You have felt like you are a terrible person, and think that you have never achieved anything in your life. Your thoughts are slow and sluggish.

The thought of deliberately harming yourself has never entered your mind. While you have not had active thoughts of a suicide plan you have thought about dying. You don't feel your life should continue. You feel you should die but don't want to kill yourself.

You would have liked to live a long and peaceful life with Gypsy, and can recall that you were feeling fine before you got pneumonia.

Interest: You admit that you may have lost interest in the footy, and reading the newspaper over the last week. You aren't too sure why your interest has waned but think it may be due to your physical health, saying: 'I can't be bothered with it all'. Prior to getting unwell you had been living a relatively active life.

Motivation: You don't really feel like doing anything at the moment. When Gypsy comes to visit, you have started putting her off by saying: 'I don't feel like talking today, maybe tomorrow.'

Sleep & Wakefulness: You have trouble getting off to sleep, and awaken several times during the night due to your breathing and coughing. You have been waking up feeling a bit groggy, and have been napping during the day. You do not experience nightmares or strange behaviours in your sleep. You do not have restless legs or stop breathing during the night (sleep apnoea).

Concentration: You're not sure how to judge that, but maybe it's 'not so good'. Your mind does wander a bit like when you are reading, and you have just lost interest.

Appetite: You don't look forward to meals, saying: 'Food's lost its taste, maybe that's steroids?'

Weight loss: You don't think you have lost weight.

Energy: You do get tired easily.

Psychosis: You think that your wife and the Respiratory doctor are colluding to kill you with medication as a form of euthanasia due to your complete worthlessness. You have seen them very close to each other, whispering and talking conspiratorially together. You are sure they are plotting to poison you, so you don't feel you can trust the oral medication that he prescribed yesterday.

You believe that the oral antibiotic will cause a painful death typified by fits (convulsions) and bleeding gums. If you have to die, you wonder if the candidate might organise a neater death. You will take medication once it's provided, and you know it won't make a mess.

You do not feel that things have a special meaning for you, that media reports refer to you (TV talking about you), or that other can read or influence your thoughts or feelings.

You adamantly deny hearing voices / having visions, having unusual experiences.

Anxiety: You do feel 'a bit edgy' especially when your breathing is difficult, but this settles within minutes after taking medication. In general, you do not worry about things, and you have never been a nervous, highly-strung or worrying person. You do not have any particular fears or phobia, and have never had a panic attack.

Your personal history:

- You work as a CEO of a large private import logistics company.
- You have no children.
- There is no mental illness in your family.
- You have had no diagnosis or treatment of mental illness in your life.
- You saw a leadership coach for counselling about how to be a more effective executive when you completed your MBA in your thirties (30's).

4.2 How to play the role:

Casually dressed in a track suit (or similar) wearing slippers or Ugg boots.

Slightly dishevelled look like you cannot sleep well so you have been tossing and turning.

You look worried and depressed, and when talking about your wife you appear somewhat paranoid and upset.

4.3 Opening statement:

'Doctor, why do you need to talk to me?'

4.4 What to expect from the candidate:

The candidate should try to talk with you about how you are feeling, should ask specific questions about the last few days - feelings and thinking. They are then required to explain to you what they believe is happening for you.

The candidate will then turn to the examiner, and provide them with a treatment plan.

4.5 Responses you MUST make:

'It's really no use going on.'

'I know what a terrible person I am.'

4.6 Responses you MIGHT make:

See specific descriptions above.

4.7 Medication and dosage that you need to remember:

Predisolone 50 milligrams a day for the last eight days (you started taking it at home last Saturday).

Ventolin™ and now *Serevent*™ inhaler - to open airways.

Pulmicort inhaler.

STATION 8 – MARKING DOMAINS

The main assessment aims are:

- Obtain a focussed history from an asthmatic patient of symptoms and treatment since being in hospital in order to identify steroid induced mood disorder.
- Synthesise the findings and appropriately communicate the diagnostic explanation to the patient.
- Explain the management plan for steroid induced mood disorder including management of suicide risk associated with this patient.

Level of Observed Competence:

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication in technique.

Achieves the Standard by:
conducting a detailed but targeted assessment; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; integrating key psychosocial issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features; assessing for typical and atypical features; effectively eliciting symptoms despite depressed mood and negative cognitions.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Elicit the paranoid belief about his wife and the doctor planning euthanasia.

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; there are no psychotic symptoms elicited.

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.9 Did candidate formulate and describe a steroid induced neuropsychiatric disorder? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to make the diagnosis; appropriately considers possible alternative explanations.

Achieves the Standard by:
demonstrating capacity to integrate available information in order to formulate a diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis; adequately prioritising options relevant to the obtained history and findings; identifying relevant predisposing, precipitating perpetuating and protective factors; communicating in appropriate language and detail.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain the direct link between initiation of oral steroid and the development of the mood disorder.

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

Below the Standard (scores 2):
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; there is no link made between the patient having steroids and the emergence of the mood disorder.

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:
provides a sophisticated link between the plan and key issues identified; identifying that drug interaction risk between the oral antibiotic and prednisolone; clearly addresses difficulties in the application of the plan.

Achieves the Standard by:
demonstrating the ability to prioritise and implement evidence based interventions; planning for risk management; considering compulsory status; selecting the treatment environment; recommending specific options to manage safety; skilfully engaging appropriate treatment resources / support; explaining that the symptoms should settle quickly with treatment; outlining safe, realistic time frames for reviews; ensuring record keeping and communication to necessary others; recognising their role in effective treatment; identification of potential barriers.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Recommend tapering of prednisolone and prescription of an antipsychotic.

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; significant omissions affecting quality scores 1.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; does not discuss the prednisolone dose at all and fails to treat with an antipsychotic as this would 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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

3.0 COLLABORATOR

3.2 Did the candidate appropriately involve the treatment team in developing a management plan? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
takes a liaison role in treatment planning; effectively negotiates complex aspects of care; works to ensure clear communication and treatment partnerships; aims to provide succinct and professional advice.

Achieves the Standard by:
communicating proposed plans clearly and with good judgment to involve others; suitably engaging necessary other health professionals; expressing views and expectations candidly and respectfully; taking appropriate and effective leadership to ensure positive patient outcomes; considering the sensitivity of involving the wife in care planning and support; adapting communication style to the setting; carefully approaching the feedback to the physician regarding psychotic beliefs.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Prioritise the monitoring of suicide risk until the mood disorder settles.

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) or (b) 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; there is no plan to monitor suicide risk.

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

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