

# Committee for Examinations Objective Structured Clinical Examination

Station 1  
Brisbane September 2016



## 1.0 Descriptive summary of station:

In this station the candidate is working in general adult psychiatry and has been asked to assess a 34-year-old man in the Emergency Department (ED). A relative had brought John, an Aboriginal man, to the ED because he threatened suicide in the context of alcohol intoxication. The candidate is to develop rapport with this Indigenous man, who is a lawyer, and is intellectually, academically and professionally similar to himself or herself, and who is able to move effectively within both world views - that of the Indigenous and Western worlds.

## 1.1 The main assessment aims are:

- To demonstrate the capacity to engage an Indigenous patient, to put him at ease, display respect and an understanding of cultural differences.
- To take a history that encompasses the cultural aspects of the presentation and present the formulation to the examiner.

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

- Effectively engage an Indigenous patient.
- Elicit that the suicidal gesture was impulsive and confirm that there is no underlying mood disorder requiring treatment.
- Identify that the patient is willing to make changes to his drinking.
- Explore the cultural context of this man within the presentation and incorporate it into the formulation.
- Elicit the link between John's commitment to community work and its impact on personal relationships.
- Arrive at the conclusion this patient is comfortable moving within both Western and Indigenous cultures.

## 1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (Indigenous), Substance Use Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Process; Data Gathering Content; Formulation), Communicator (Patient Communication – To Patient, Cultural Diversity)

### **References:**

#### Aboriginal and Torres Strait Islander References:

- Ungunmerr-Baumann, Miriam-Rose, *Dadirri Inner Deep Listening*. 2002 Emmaus Productions
- Balaratnasingan, S. Anderson, L. Janca, A. Lee, J. *Towards culturally appropriate assessment of Aboriginal and Torres Strait Islander social and emotional wellbeing*. Australasian Psychiatry. October 2015.
- Gee, G. Dudgeon, P. Schultz, C. Hart, A. Kelly, K. (2014) *Aboriginal and Torres Strait Islander Social and Emotional Wellbeing*. In: Dudgeon, P. Milroy, H. and Walker, R. (eds.) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Commonwealth of Australia, 2014. p. 55-68.

#### Māori References:

- Medical Council of New Zealand. *Statement on cultural competence*. 10 August 2006.
- Durie, MH, Kingi, TKR. *A Framework for measuring Māori mental health outcomes*. 1997, Te Pūmanawa Hauora, Department of Māori Studies, Massey University, Wellington.
- The National Centre of Mental Health Research, Information and Workforce Development. *He rongoākei te korero. Talking therapies for Māori: Wise practice guide for mental health and addiction services*. Auckland: Te Pou o Te Whakaaro Nui. October 2010.

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## Cultural Assessment and Formulation:

- Edited by R. Lewis-Fernández, N.K. Aggarwal, L. Hinton, D.E. Hinton, L.J. Kirmayer. *DSM-5® Handbook on the Cultural Formulation Interview*. APA Publishing.
- Mental Health Commission. *Cultural Assessment Processes for Māori: Guidance for Mainstream Mental Health Services*. September 2001. New Zealand.
- Sheldon, M, (2010) *Reviewing psychiatric assessment remote aboriginal communities*. In: Purdie, N, Dudgeon, P. and Walker, R. (eds.) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Commonwealth of Australia, 2010. p. 211-222.
- E-Learning Aboriginal and Torres Strait Islander mental health.  
<https://www.ranzcp.org/Publications/E-learning.aspx#ATSIMH>

## Suicide Statistics:

- National Centre of Mental Health Research, Information and Workforce Development. *He rongoākei te korero. Talking therapies for Māori: Wise practice guide for mental health and addiction services*. Auckland: Te Pou o Te Whakaaro Nui. October 2010.
- Commonwealth of Australia. *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. 2013.
- De Leo, D., J. Svetlicic and A. Milner (2011) 'Suicide in Indigenous People in Queensland, Australia: Trends and Methods, 1994–2007', *Australian and New Zealand Journal of Psychiatry* 45(7): 532-8.

## **1.4 Station Requirements:**

- Standard consulting room; a bed required.
- Five chairs (examiners x 2, roleplayer x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – Aboriginal man in late 20s/early 30s, dressed in crumpled clothing.
- 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 in general adult psychiatry and have been asked to see a man in the Emergency Department (ED). John is a 34-year-old Aboriginal man, who was brought to the ED last night by a relative after having threatened suicide at a family gathering. He was intoxicated at the time and had started thinking about his recently failed relationship.

From John's file you see that he presented 2 years ago in similar circumstances after his marriage to the mother of his children ended. He currently is employed by Legal Aid in Cairns as one of their lawyers, and has a busy role to which he is very committed.

### Your tasks are to:

- Take a history from John and the background that led to his presentation to the Emergency Department.
- Present your formulation incorporating in relevant depth important cultural findings **to the examiners**.

**You will receive a time prompt at eleven (11) minutes if you have not started presenting your findings to the examiners.**

## 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 e.g. investigation results.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient and co-examiner.

### During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:  
***'Your information is in front of you – you are to do the best you can'.***
- TAKE NOTE of the cue/time for the scripted prompt you are to give at **eleven (11) minutes** and say:  
***'Please proceed to the second task.'***
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

### At conclusion of examination:

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

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

- You are to state the following:  
***'Are you satisfied you have completed the tasks?  
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 other scripted introduction or specific prompts.

The role player opens with the following statement:

***'Hi doc. Look I'm feeling calmer; I want to go home.'***

There is a scripted prompt at **eleven (11) minutes** if the candidate has **not** commenced the second task. Please say:

***'Please proceed to the second task.'***

#### 3.2 Background information for examiners

##### Cultural Station:

The aim of this cultural station is to assess the interface between mental illness and culture, specifically the Indigenous cultures of Australia and New Zealand. The candidate is expected to demonstrate the skill of working with a patient in a culturally sensitive manner and consider the impact of culture on the patient's presentation. The candidate will present a formulation to the examiner demonstrating their ability to incorporate the cultural findings in their understanding of the case.

This long station uses an impulsive suicide attempt in the context of alcohol intoxication, as a platform to explore the broader complex nature of culture, in the presentation of mental illness. The station works on the premise of an Indigenous patient, in an Adult Psychiatry Area of Practice covering the fellowship competencies and learning outcomes of Medical Expert and Communicator.

The station is most concerned with the capacities of engagement and assessment. In respect of this, the Medical Expert examines the candidate's ability to perform a comprehensive, culturally appropriate psychiatric assessment, report a mental state examination and risk assessment, integrating all available information to accurately formulate this man's condition.

The Communicator examines the candidate's ability to listen to this Indigenous man's story and examines the candidate's interpersonal skills in effectively communicating with him. Specifically, this is in the context of an Indigenous man who has negotiated the western world paradigms working as a lawyer. This is a man who is active in his Aboriginal world, is aware of his people's history, with a strong connection to Country. He is remorseful and ashamed of his behaviour. He requests to be discharged into the care of his family.

In order to 'Achieve' in this station the candidate **must** demonstrate that they are able to:

- Effectively engage an Indigenous patient.
- Elicit that the suicidal gesture was impulsive and confirm that there is no underlying mood disorder requiring treatment.
- Identify that the patient is willing to make changes to his drinking.
- Explore the cultural context of this man within the presentation and incorporate it into the formulation.
- Elicit the link between John's commitment to community work and its impact on personal relationships.
- Arrive at the conclusion that this patient is comfortable with moving within both Western and Indigenous cultures.

### **Outline for Indigenous cultural cases:**

As part of the examination process across the two countries the Royal Australian and New Zealand College of Psychiatrists is able to assess the candidate's competency in engaging, interviewing and managing people of Indigenous culture. There are three Indigenous nations to consider who in themselves are complex from the perspective of cultural, biological, psychological, social, spiritual and religious parameters: the Nations are Aboriginal and Torres Strait Islander (ATSI) peoples and Māori peoples.

To examine culture is complicated, but there are some issues that could be seen to overlap between Aboriginal and Torres Strait Islander (ATSI) and Māori cultures, and could be used as contexts to examine candidates. Such contexts for example could be health (wellbeing and illness) or social determinants of wellbeing (access to Country, lands, waterways, cultural sites, rituals, histories, ancestral beliefs, and restoration of the negative impacts of colonisation, etc.). The main focus of this question is interview approach. A successful approach allows for an easing into the interview, this takes time, and therefore this cultural station is a long station in the OSCE.

The Indigenous nations of the two countries have different histories so cannot be conceptualised as the same. A useful consideration to keep in mind is the period of first contact with outside forces. The Aboriginal and Torres Strait Islander people who are an ancient people with histories dating back over 60,000 years, at first contact were highly sophisticated hunter gatherers and seafarers, so there was no impetus to macro-psychological change, as their lifestyle was effective. Māori histories in New Zealand date 1000 to 2000 years, and were agricultural and hunter-gatherer with a history of seafaring across the Pacific Ocean from an older period. Again there was no impetus to macro-psychological change. At first contact in the late 1770's England was in the industrial revolution with a drive to move their convicts offshore, as North America forcefully refused to accept them. As part of England's political expansionistic policies they not only sought territory but also somewhere to send their convicts. The impact of first contact on the Indigenous nations of both countries with England was catastrophic. There were extermination and assimilation policies, with little regard for the longevity of Indigenous nations, and expectation they would die out. However, this has not occurred but there remains deprivation of resource and equality. Some have been able to assimilate at the cost of cultural identity. Some have been able to build cultural identity and fluency in the western world, to build resilience. Colonisation continues to be less than kind to the Indigenous nations.

Of key importance in the Indigenous cultural station is the expectation candidates can maintain the patient's dignity and demonstrate respect, humility, and awareness of culture. The candidate should have some general awareness of the cultural issues relevant to Australia and New Zealand. Candidates need to demonstrate a willingness to listen to the story, modify their interview style depending on the way the patient presents, cope with uncertainty, and manage the differences between the candidate and the patient that may be significant.

As with all people, a further complexity is that not all Aboriginal & Torres Strait Islanders peoples or Māori peoples are the same; their cultural understandings differ depending on their connection to culture and its cultural norms, their life experiences, and impact of assimilation due to ongoing colonisation.

### **Specific cultural aspects of this station:**

John's father's father was a *Kanaka* and subject to *Blackbirding*. Blackbirding is described as the coercion of people through trickery and kidnapping to work as labourers. In the 1870s, the blackbirding trade focussed on supplying cheap labour from the Indigenous populations of northern Queensland and neighbouring Pacific Islands to plantations, initially cotton then particularly sugar cane, in Queensland and Fiji. The first documented practice of a major blackbirding industry for sugar cane labourers occurred between 1842 and 1904. Some historians liken blackbirding to the generally coercive recruitment methods once employed for press-gangs by the Royal Navy in England.

South Pacific islanders employed (coerced/kidnapped) in Queensland, on sugar plantations, cattle stations or as servants in towns were known collectively as *Kanakas* (Hawaiian for 'Person' or 'Man'). By 1900 more than 60,000 Islanders had been recruited in this manner. Because of the continuing heavy demand for labour in Queensland, despite attempts to stop blackbirding, the practice continued to flourish through the late 1800's. It eventually came to an end in 1904 as a result of a law, enacted in 1901 by the Australian Commonwealth. This law called for the deportation of all Island Kanakas after 1906.

The man in this station was born in Yarrabah, which is an Aboriginal community situated approximately 53 kilometres north from Cairns on Cape Grafton. It is much closer by direct-line distance but is separated from Cairns by the Murray Prior Range and an inlet of the Coral Sea. At the 2006 census, Yarrabah had a population of 2,371. The Gunggandji people originally inhabited the Yarrabah area.

The summary of John is that he is an initiated Gunggandji man from Yarrabah and then the family moved to Cairns. He has strong cultural and spiritual beliefs, and was raised in culture and language.

His personal history forms the basis of the cultural understandings of this man. Who he is and who his family are and their history are important to him.

John works hard as a lawyer, working for his people and his Country and has been visiting family in Brisbane.

John is feeling shame for being brought to ED by his brother-cousin from his Uncle's home. His impulsive suicide attempt was in the context of being intoxicated; on a background of a previous attempt two years ago under similar circumstances.

He typically avoids alcohol due to the effect it has on his mood when he drinks to excess.

John has a good relationship with his ex-wife and five children; and had recent contact with his ex-girlfriend.

John has no other symptoms of a major mental illness, including no symptoms of depression or significant grief issues and no current thoughts of harm to himself or others.

Exploring the family and personal history in relevant depth will enable development of a good understanding of this Indigenous man:

- To consider the current stressors this man is under that have resulted in his presentation
- To consider the biological, psychological, social, cultural and spiritual vulnerabilities and strengths
- To consider his current circumstances being a lawyer and a cultural man allows him to move with some ease in both worlds, he has validity in both worlds and is thus subject to the stresses and strains; highs and lows of both worlds.

## **ASSESSMENT AIMS:**

### **A. Rapport and approach:**

This man wants to be discharged to the care of his family now that he is no longer intoxicated. The candidate's role is to listen to this man's story and seek clarity regarding the suicidal risk, any triggers, and his connection to family and culture as a way to determine if he can be discharged safely into the care of his family. This is achieved by developing good rapport. It is helped by the fact that this man is academically and professionally similar to the candidate.

Often times Indigenous interviews need an approach different from non-Indigenous/western medical settings, especially when explaining roles. From a cultural perspective a candidate may be expected to give brief personal information about themselves enabling development of the cultural norms of connection, thereby validating the candidate's ability to ask very personal information. Typically, Indigenous peoples are interested in the person, how individual actions reflect a person's ethics and morals, rather than what a person's role is (doctor, specialist). In the station this is tested by the way the candidate manages the interaction.

It is helpful in developing rapport to establish family connections, and find out if the family is concerned about the patient's behaviour. Enquiring about cultural activities, family expectations of cultural involvement, where they were raised and their genealogy will give context to the presentation; as will explore explanations for illness, including spiritual beliefs.

An interrogating approach with multiple questions will not foster helpful answers and typically in a clinical setting, one would take time and allow time to consider and answer the questions being asked. Sometimes inadvertently interviews cause distress and feelings of shame. A person can feel negatively judged because they cannot answer the questions, have limited time to answer questions posed or not understand what is being asked of them. It is important to explain any jargon used so it is understandable by the person and their family. The interview is a careful balance between limiting closed-ended questions and avoid using open-ended questions too soon.

Appropriate use of language can help the person relax, encourage disclosure, and reduce shame. Equally, seeking clarity from the person about cultural and/or spiritual significance or language used is appropriate. Sometimes the use of storytelling about someone with similar symptoms can help the person to overcome feelings of shame or shyness. If using Indigenous language, ensure the proper pronunciation. It is important to be aware, more often than not, people just want the truth and to have a clear explanation.

With regard to non-verbal communication, a downward gaze may be more about respect than avoidance of eye contact or mental illness. It may be appropriate to shake hands or to engage in some other ritual, with guidance either from the person or a cultural mental health worker in an interview.

### **Deep Listening/Dadirri:**

Miriam-Rose Ungunmerr-Baumann articulated Dadirri as inner, deep listening and quiet, still awareness. She talked about the importance of listening to the story carefully, and allowing the person time to tell their story. It also encompasses the long silences that can occur when developing rapport or when issues are difficult to verbalise. It acknowledges there is no need for words; it requires the listener to listen deeply; to listen over and over again; to listen is to learn. As for Indigenous cultures around the world, one learnt by watching, following and listening, not by asking questions; it often involves waiting and then acting. The ability to observe is important. It is useful to have some comprehension of this way of being for Indigenous Australians. 'We don't mind waiting, because we want things to be done with care. We don't like to hurry. There is nothing more important than what we are attending to; there is nothing more urgent that we must hurry away for.'

In summary the candidates are to:

- Manage what could be challenging communication for some and put this man at ease by adapting communication and interview style, which will be notable by the man relaxing and maintaining eye contact and rapport
- Balance the man giving his story within the timeframe available; responding to concerns raised, maintaining open communication, gathering information.

### **B. Culture:**

It is not expected that the candidate will have an in-depth knowledge of the cultural ramifications. In the examination setting it may be difficult to demonstrate, but the formulation of a superior candidate may demonstrate an awareness of the history of colonisation, an understanding of impact of cultural violation, and disposition of values. The value of this understanding is the ability to explore other underlying cultural issues that may influence the presentation of mental illness.

Often there are expectations for Indigenous people to return 'to their families' because of the belief that all Indigenous people have intact communities and families. The impact of colonisation and westernisation has caused a breakdown in some of the traditional structures that could have absorbed people in need.

In summary the candidate is expected to:

- Demonstrate an ability to remain non-judgmental and be aware that limited views of wellbeing can result in distress being attributed to mental illness, and may cause suffering for the person and those who support them - fundamental in work with Indigenous people.

### **C. Formulation – including culture and risk:**

Indigenous spiritual and cultural understandings are important but often difficult to assess or make sense of in a traditional western clinical perspective. The formulation prioritises the information gathered into a sophisticated biopsychosociocultural spiritual formulation of his cultural complexity set in a period of distress, in a man who is highly educated culturally and in western terms of the modern world. The candidate is expected develop a formulation that works with the patient's expectations. They will achieve this by listening carefully to the man's history; developing understanding of his social, cultural, family and personal history; establishing clearly the causes for presentation.

In this man's case he wants to return to his family now that he is no longer intoxicated. He is no longer a risk of harm to himself or others and has a supportive family who responded appropriately to his level of distress. He is aware that alcohol excess impairs his reasoning and he then becomes overwhelmed by his losses. He accepts when he was intoxicated he ruminated on his relationship issues with his ex-girlfriend and he wanted to stop the feelings.



His suicidal gesture was impulsive. There are no symptoms or history to suggest he has a mood disorder. He is aware alcohol intoxication increases his vulnerability to ruminate on past and present problems, to feel overwhelmed and now on two occasions to feel suicidal. He needs to avoid alcohol intoxication. Impulsive suicidal gestures in Aboriginal and Torres Strait Islander people can sometimes be linked to episodes of high distress and intoxication. People can react with impulsive suicidal gestures when intoxicated and it is often in this unfortunate circumstance that suicide occurs. As in this situation, when sober the suicidal intent is absent.

In summary the candidate is expected to:

- Demonstrate a broad approach that allows for the complexity of both culture and biopsychosociospiritual models of illness to be employed in formulation and planning management
- Arrive at an understanding of this man's comfort in both western and Indigenous culture.

#### D. Diagnostic formulation:

The candidate will be expected to rule out alcohol dependence and common co-morbidities such as depression, impairment in social, cultural and occupational functioning. They could also consider psychosocial issues of grief and loss due to the relationship, or feelings of shame from the events of last night.

The traditional process of formulation and diagnosis are valid when culture is taken into account. The candidate's presentation of their diagnosis and formulation must highlight phenomenology or the absence of any, and cultural issues present. A robust formulation will allow for adequate choices in the next step in management of this man.

### 3.3 The Standard Required

In order to:

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

#### Reason for presentation:

You are John, a 34-year-old Aboriginal man. You are in the local hospital Emergency Department, having been brought in by your brother-cousin Fred. Last night you were at your Uncle George's home drinking beer with family after watching your Rugby League team (Cowboys) win. You have been down in Brisbane visiting with family for the week from Cairns and everyone was having a good time and being happy. However, it was a long day and you got drunk on beer.

You started thinking about your ex-girlfriend, May, who is an Aboriginal woman from Alice Springs. You had been with her for about 8 months and thought everything was going ok. Last night you were thinking hard about it all, and began to feel increasingly sad and angry. You admitted to your brother-cousin that May had cheated on you with your friend two months ago. She had contacted you earlier this week and said she wanted to get back with you but you are still hurting and too upset.

In your drunken state you said to Fred that you were going to hang yourself and then you left him sitting on the verandah. You managed to find a rope in the shed at your Uncle's house, but never got any further with your plan. Fred found you, the family all started getting upset and finally persuaded you to come to the hospital.

You have no thoughts of hanging yourself now and definitely do not want to hurt anyone. You have never wanted to hurt your girlfriend or your ex-friend. Your threat to hang yourself was impulsive, and not something you had been thinking about before last night. The thought just came to you as a way out of feeling so bad.

You are an easy-going man and happy with life in general. You are embarrassed by the situation that led to you coming into ED. You just want to get back to your Uncle's home and relax with your family.

You feel shame for being in the ED, and so want to keep a low profile. You would prefer that your confidentiality is held intact. Your main concern is that you would like to be discharged home to the care of your family. You do not feel suicidal now that you have slept and are no longer intoxicated. You know it was an impulsive act, and no longer have any thoughts of suicide.

You are upset with yourself for what you did. You know it is the result of drinking alcohol, which you have been trying to avoid, and will henceforth abstain from alcohol for a time. You might have a talk with the Aboriginal Grog Mob if you think you cannot manage. But this was very embarrassing and you feel ashamed of your behaviour.

#### Personal Background:

You were born in Yarrabah and are the youngest of six children – you have 3 brothers and 2 sisters. Your grandmother and grandfather helped raise you up North. They are your mother's people, and you lived just outside Cairns in an Aboriginal Shire (Yarrabah).

[Yarrabah is an Aboriginal community situated approximately 53km north of Cairns CBD on Cape Grafton. It is much closer by direct-line distance but is separated from Cairns by the Murray Prior Range and an inlet of the Coral Sea. At the 2006 census, Yarrabah had a population of 2,371. The Gunggandji people originally inhabited the Yarrabah area.]

Your father was sent to Yarrabah when he was young. He met and married your mother in Yarrabah. Your family moved into Cairns when you were young for work and schooling. You are close to your father's people too.

You grew up 'in culture'. You are an initiated man. You know your traditional practices and ceremonies. You have done men's business and you speak your mother's language. You are very comfortable in your culture. It informs your identity and your path in life. You attend the family and cultural business.

Your family history is important to you. Your father's father was a Kanaka, having been subject to blackbirding. He was kidnapped from the Solomon Islands to work on the sugar cane plantations in Queensland. Your father's mother was Aboriginal from Minjerrabah in Queensland, Stradbroke Island.

Your mother's father was an Aboriginal man from Yarrabah. He is a Gunggandji man. He was stolen generation having been removed to Fraser Island. He later returned to Yarrabah reconnecting with family and Country. Your mother's mother was white Australian, originally her people were from Ireland. She met your grandfather in Yarrabah where she worked as a teacher.

Your grandparents saw the impact of western life, so valued both culture and education. Your parents still live in Cairns and are involved in cultural business, and so your grandparents were actively involved in bringing you up.

As the youngest of six children, you gained the benefit from the move into Cairns. Your grandparents did the best they could for all their 'grannies'. Being the youngest you observed a lot. You were encouraged to study. You went to James Cook University to study law and you now work for Legal Aid in Cairns.

You chose Law because you wanted to improve the quality of life for your people. You have had to deal with quite significant issues pertaining to land and assets for your family with both the local and national government. On your Country there are precious minerals that the mining companies want access to. Along with local elders you are one of the legal people involved. This work means a lot to you, and you have devoted a lot of time and effort to it, which seemed to annoy your most recent partner.

You had your children in your early twenties; you are not with the mother and see your kids regularly in Cairns. You have 5 children who range from 14 years down to 8 years of age, the three eldest are boys and the youngest two are twin girls. They are all doing well and you have a good relationship with them. You have a reasonable relationship with your ex-partner Sue, but you do not live with her. You have a good relationship with your ex-partner's family. Your relationship ended two years ago – there was no single reason for this, but you just grew apart and decided to separate.

You believe your most recent ex-partner left because she could not come to terms with your commitment to your people and your work. You think that is why she took off with your friend Jimmy. But apparently he recently hit her so she wanted to come back to you, because you looked after her so well. You do not think you could trust her again. You have never cheated on her.

You socialise with friends and family back home in Cairns. You feel comfortable in Brisbane and have friends and family here too. You are fit and well and play NRL for the local club. Work is busy and stressful because you work mostly with your own people. You do your best. Your usual working environment is positive, and there is understanding about your cultural and family responsibilities.

#### Follow up options:

You are now sober and want to leave the Emergency Department. You would just like to go back to your Uncle's place with your brother-cousin. You accept that you drank more than you intended to last night. You know when you drink a lot of alcohol it makes you angry and sad, even though initially it can make you feel a bit better. Because of this you usually do not drink alcohol and you do not use illicit drugs or smoke cigarettes. You have seen what using drugs and smoking has done to the health and wellbeing of other members in your family.

You do not feel you have a medical or a spiritual or cultural problem. You do not think you need to see anyone for help, but if the candidate offers some follow up from the crisis/acute mental health team you reluctantly accept it. You are willing to see your General Practitioner (GP), Dr. Naidoo, when you get back to Cairns. Even though you have always been a spiritual person you see no point in talking to a traditional healer. You have no problem seeing a non-Indigenous doctor.

Because you know that excess alcohol is no good for you, if the candidate recommends it, you agree that you will watch your intake. You do not want to do alcohol counselling or go to any other similar service. If you need to in the future, you will look into it as you did before. You know where the services are as you have represented psychiatric patients in the past for the mental health act review tribunals.

You have never suffered with any of the following disorders:

- depression – feeling sad all the time, poor sleep and appetite, loss of interest in your activities.
- anxiety – worrying all the time, restless, feeling pain in your chest, difficulty breathing, butterflies in your stomach.
- psychosis – feeling afraid that someone is watching you or trying to harm you, thinking that the TV or radio sends you special messages, hearing voices other do not.
- mania or hypomania – very happy or irritable, increased energy, decreased need for sleep, believing you have special powers.

You are physically well and had a recent medical for insurance purposes and got a clean bill of health. You have no allergies and are not on any regular medication.

You are generally a happy person but when you drink too much alcohol you become morose and remember all the things in your life that did not go as you would have wished.

Two years ago you had a similar crisis in your relationship with the mother of your children. You were drinking too much alcohol and became very sad. You made an equally impulsive attempt to hang yourself with a rope but, like now, you were stopped from acting on it after having told a family member how you were feeling. You went into the local Indigenous/Aboriginal Medical Service and saw a doctor there. You liked that doctor principally because the doctor listened to you and told you the truth. You saw a counsellor briefly through the Employee Assistance Program. It helped you decide to get your priorities in order, and you got on with life successfully without the need for ongoing mental health input.

#### 4.2 How to play the role:

You are a 34-year-old Aboriginal man dressed in clothes that look like you slept in them, jeans and t-shirt. Because you feel shame for being in the ED again and telling someone your story again, you are somewhat reluctant to see a doctor. You just want to get out of there. You are hopeful the doctor will listen to your story and understand your situation. You are hopeful the doctor will let you go home to your family.

When the candidate asks you specific questions, provide the appropriate answer from the information listed. If the candidate asks you questions you have no scripted answers to, say '*I don't know*' or shrug your shoulders or look away. The candidate will ask you about your feelings regarding suicide and thoughts of harming others.

You want to feel that you are being heard and that the doctor is listening to your story, and you are willing to clarify things if the doctor asks for help understanding your situation.

If the candidate seems disbelieving of your story or dismissive of your cultural background, you become somewhat irritable.

It is not expected that the candidate will have an in-depth knowledge of the cultural issues, but the candidate is expected to demonstrate willingness to come to an understanding of your situation and complex cultural expectations.

You would prefer that they did not contact your GP, but understand it is procedure. You want to have consideration for your own way of coping with your situation, and you want to return to your family. You plan on heading back to Cairns after the weekend, in two days.

#### 4.3 Opening statement:

*'Hi doc, look I'm feeling calmer; I want to go home.'*

#### 4.4 What to expect from the candidate:

The candidate should start by asking about your reasons for being in ED, and how you came to be there.

They will ask about your presenting problem and your personal history, as well as a range of questions to look for other symptoms.

The candidate should ask you about your cultural beliefs and practices, and your role and the work you have been doing for your people. Give as much information as you can about your family history and your story.

If you feel the candidate is asking too many questions in an interrogative manner you may answer briefly.

If the candidate treats you in a sensitive manner and is respectful of your culture and beliefs, you feel able to elaborate on your answers. You are able to talk freely and give as much information as you can.

Then the candidate will talk with the examiner about what they think is happening. When they do just sit there relaxed.

**4.5 Responses you MUST make:**

Anticipated Question: Will likely ask you about ongoing thoughts of suicide, will want to know what happened and why you made the attempt

Scripted Response: ***'I was drunk; I drank too much...I know I shouldn't drink like that, it makes me feel down.'***

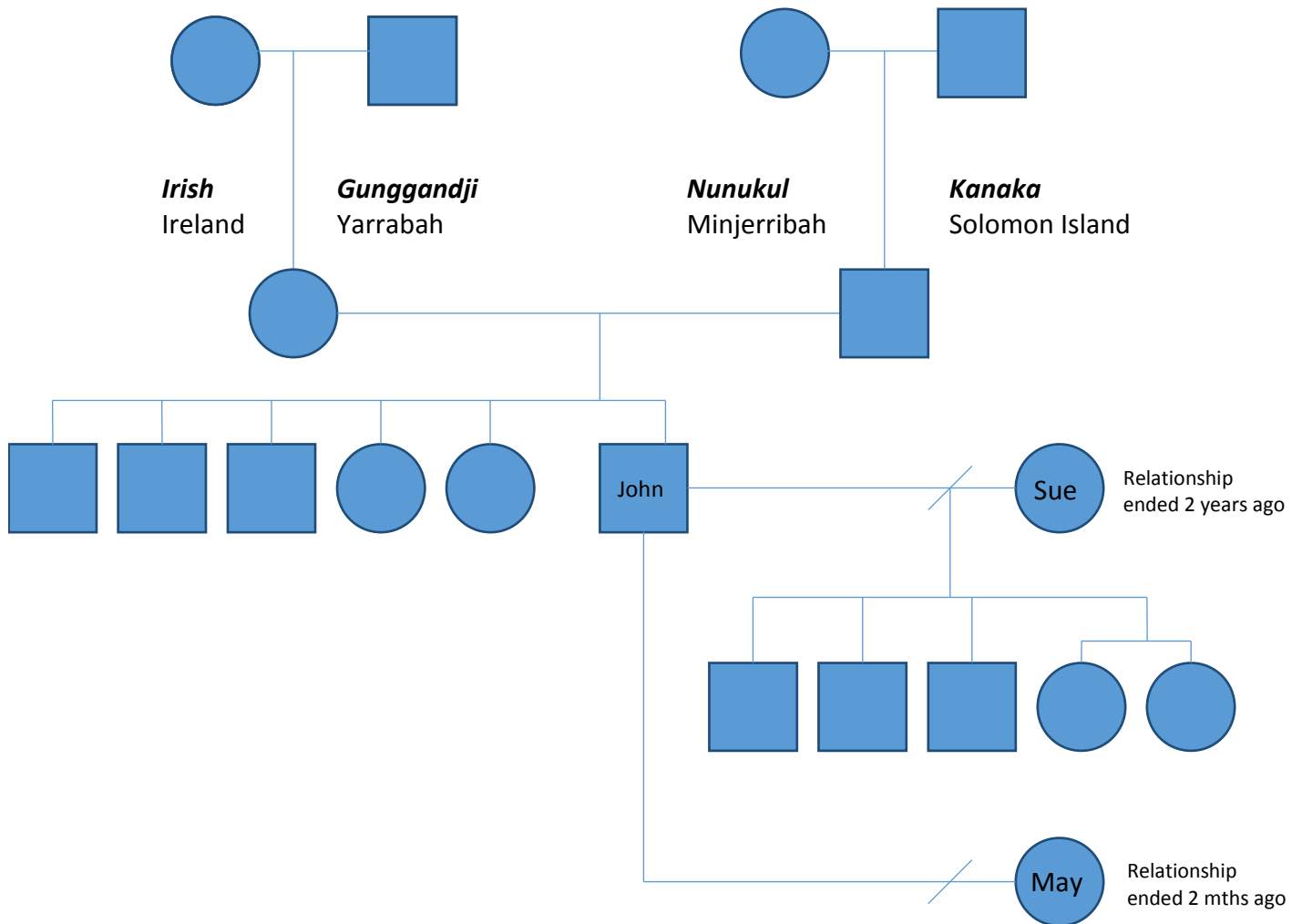
**4.6 Responses you MIGHT make:**

Anticipated Question: About your relationship with your girlfriend

Scripted Response: ***'I think maybe I might have spent too much time working.'***

**For Role-player in Station 1 September 2016 OSCE**

**John's Family Tree**



**Timeline**

- Yarrabah – raised up until school time; youngest of 6
- Cairns – moved with parents and maternal grandparents for work and schooling
- Raised in culture, initiated man, men's business, speak Gunggandji
- Studied Law and worked in Legal Aid in Cairns – your work is important to you
- Family and Sue – met Sue in late teens, started a family - 5 children; relationship ended 2 years ago
- End of relationship got drunk and suicidal – very upset, had help, recovered
- Land rights – minerals on your Country, issues with mining companies; local Elders
- May – 8 months with May, relationship ended 2 months ago
- Drunk and suicidal – very upset end of relationship, and the reason being seen by doctor in ED
- Now sober and calm, feel shame for being in ED again, hopeful doctor will let you go home

**Pronunciation guide:** Goo-gan-gee – Gunggandji

## STATION 1 – MARKING DOMAINS

### The Main Assessment Aims are:

- To demonstrate the capacity to engage an Indigenous patient, to put at ease, display respect and understanding of cultural differences.
- To take a history that encompasses the cultural aspects and present the formulation to the examiner.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.1 Did the candidate adequately conduct an assessment of this Indigenous man? (Proportionate value - 25%)

##### **Surpasses the Standard (scores 5) if:**

clearly presents an overall standard with a superior performance in a number of areas; competent overall management of the interview; superior technical competence in eliciting information.

##### **Achieves the Standard by:**

managing the interview environment; explaining purpose of the assessment and reassuring patient as to why they are seeing a psychiatrist; endeavouring to form a partnership using language and explanations tailored to this man, taking regard of his strong cultural history and connection to culture; enquiring about the patient's connection and identification with his culture; responding to any questions posed by the patient; attempting to understand issues within this man's cultural context; demonstrating flexibility to adapt the interview style to the patient; giving appropriate balance of open and closed questions; recognising emotional significance of the patient's material and responding empathically.

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

a. Effectively engage this Indigenous man.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

demonstrates significant deficiencies such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

1.1. Category: ASSESSMENT – Data Gathering Process	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 appropriately detailed and focussed history? (Proportionate value - 15%)

##### **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:**

obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; completing a risk assessment relevant to the individual case; integrating key sociocultural and spiritual issues relevant to the assessment; eliciting the key features to arise at a clinical decision; clarifying important positive and negative features.

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

a. Elicit that the suicidal gesture was impulsive and confirm that there is no underlying mood disorder requiring treatment

b. Identify that the patient is willing to make changes to his drinking.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard if:**

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history; neither (a) nor (b) demonstrated.

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

**1.11 Did the candidate generate an adequate formulation to make sense of this man's presentation? (Proportionate value - 25%)**

**Surpasses the Standard (scores 5) if:**

applies a sophisticated sociocultural formulation; cultural complexities were explored as pertains to this man's situation; the performance need not be flawless.

**Achieves the Standard by:**

identifying and succinctly summarising important aspects of the history; integrating medical, developmental, psychological, cultural and sociological information; developing hypotheses to make sense of the patient's predicament; accurately linking formulated elements to any diagnostic statement; analysing vulnerability and resilience factors.

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

a. Explore the cultural context of this man within the presentation and incorporate it into the 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 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

significant deficiencies including inability to synthesise information obtained; failure to question veracity where this is important; providing an inadequate formulation or diagnostic statement.

1.11. Category: FORMULATION	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 this Indigenous man? (Proportionate value - 15%)**

**Surpasses the Standard (scores 5) if:**

able to generate a 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; demonstrating respect and providing this man time to tell his story evidenced by relaxation of this man into the interview with establishing eye contact and able to obtain a reasonable history; forming a partnership using language and explanations tailored to the capacity of this man taking regard of culture, gender, ethnicity; communicating the history obtained.

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

a. Elicit the link between John's commitment to community work and its impact on personal relationships.

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

**Below the Standard (scores 2 or 1):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response. Significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

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

2.1. Category: PATIENT COMMUNICATION - To Patient	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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"/>



**2.4 Did the candidate demonstrate a culturally sensitive approach to patient? (Proportionate value - 20%)**

**Surpasses the Standard (scores 5) if:**

demonstrates a sophisticated and knowledgeable approach to cultural aspects of this man.

**Achieves the Standard by:**

recognising and incorporating cultural needs/expectations; adapting assessment and formulation to the specific cultural aspects presented.

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

- a. Arrive at the conclusion that this patient is comfortable with moving within both Western and Indigenous cultures.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

ignores sociocultural aspects of the scenario; insensitive approach to cultural needs of the patient.

2.4. Category: CULTURAL DIVERSITY	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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 defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

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

**1.1 The main assessment aims are:**

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

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

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

**1.3 Station covers the:**

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

**References:**

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

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, candidate x 1, role player x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – man in early 50s, casual and slightly dishevelled dress and demeanour.
- Pen for candidate.
- Timer and batteries for examiners.

## 2.0 Instructions to Candidate

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

You are a junior consultant psychiatrist working with a Community Acute Care Team of a mental health service, which is attached to a large teaching hospital. From time to time, private psychiatrists refer their patients to your service for crisis management and psychiatric admissions in the public sector.

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

*Dear colleague,*

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

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

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

*Regards,*

*Dr C Smith FRANZCP*

*Consultant Psychiatrist*

### Your tasks are to:

- Take a focussed history in keeping with treatment-resistant depression and associated polypharmacy from James.
- Outline and negotiate your recommended treatment plan with James.
- Reflect on the issues related to diagnosis and prescribing to be discussed with the private psychiatrist and present your communication strategy/goals **to the examiners**.

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

## Station 2 - Operation Summary

### Prior to examination:

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

### During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:  
***'Your information is in front of you – you are to do the best you can.'***
- TAKE NOTE of the cue/time for the scripted prompt you are to give at **twelve (12) minutes** and say  
***'Please proceed to the third task.'***
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

### At conclusion of examination:

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

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

- You are to state the following:  
***'Are you satisfied you have completed the tasks?  
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.

You have no opening statement.

The role player opens with:

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

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

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

#### 3.2 Background information for examiners

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

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

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

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

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

#### Defining Treatment-Resistant Depression

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

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

## Treatment for TRD

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

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

### According to the RANZCP CPG: Assessing and Managing TRD

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

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

#### First-line treatment

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

#### Second-line treatment

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

## **ECT and rTMS in TRD**

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

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

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

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

### **Review of polypharmacy**

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

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

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

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

A surpassing candidate may

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

### 3.3 The Standard Required

#### In order to:

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.



## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **4.2 How to play the role:**

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

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

#### **4.3 Opening statement:**

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

#### **4.4 What to expect from the candidate:**

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

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

#### **4.5 Responses you MUST make:**

*'Do I have more than depression?'*

*'Do you think I might get better?'*

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

#### **4.6 Responses you MIGHT make:**

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

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

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

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

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

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

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

#### **4.7 Medications:**

Current psychiatric medications:

- Clomipramine 225 milligrams at night (KLOM-IP-RA-MEEN)
- Mirtazapine 90 milligrams at night (MURT-AZ-A-PEEN)
- Lamotrigine 200 milligrams twice a day (LA-MOT-RI-GEEN)
- Chlorpromazine 100 milligrams at night (KLOR-PROM-AZEEN)
- Quetiapine 100 milligrams as required when you feel anxious or more depressed (KWET-I-A-PEEN)
- *Cilazapril one tablet daily for blood pressure (SIL-AZ-A-PRIL)*
- *Panadeine when needed for pain (PAN-A-DEEN)*

## STATION 2 – MARKING DOMAINS

### The Main Assessment Aims are:

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

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

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

##### **Surpasses the Standard (scores 5) if:**

clearly achieves the standard overall with a superior performance in a number of areas; sensitively investigates the ambiguity of diagnosis of treatment-resistant depression.

##### **Achieves the Standard by:**

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

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

- Seek to establish rapport.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

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

1.1. Category: ASSESSMENT – Data Gathering Process	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 appropriately detailed and focussed history? (Proportionate value - 25%)

##### **Surpasses the Standard (scores 5) if:**

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

##### **Achieves the Standard by:**

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

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

- Elicit key aspects to diagnose treatment-resistant depression.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 - 35%)**

**Surpasses the Standard (scores 5) if:**

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

**Achieves the Standard by:**

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

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

- Explain to the patient the alternative options for psychopharmacology.
- Demonstrate consideration of contemporary clinical practice guidelines for treatment-resistant depression.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

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

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**3.0 COLLABORATOR**

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

**Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard and recognises complexity of the liaison; manages potential conflicts of interest; recognises the delicacy of the situation.

**Achieves the Standard by:**

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

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

- Expect to identify rationale for treatment choices in consultation with the private psychiatrist.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

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

3.3. Category: EXTERNAL RELATIONSHIPS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 - 10%)**

**Surpasses the Standard (scores 5) if:**

above the standard of achieved and does not discuss and attribute blame or fault.

**Achieves the Standard by:**

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

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

- a. Be clear that current medication regimen is not typical and is high dose polypharmacy.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

does not address the ethical factors in this scenario.

7.1. Category: ETHICS	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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**1.0 Descriptive summary of station:**

To assess Will Schembri, a 69-year-old with a history of depression and concerns regarding decline in his cognition despite an improvement in his depressive symptoms. The aim is to undertake a series of bedside tests and incorporate available information to come to a preferred diagnosis of dementia.

**1.1 The main assessment aims are:**

- To evaluate the candidate's ability to accurately conduct a range of focussed bedside cognitive tests and discuss their implications.
- To evaluate the candidate's ability to synthesise and integrate information in order to formulate a likely diagnosis.
- To be able to differentiate the preferred diagnosis from differential diagnoses based on cognitive testing and MRI findings (dementia vs depressive pseudodementia).

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

- Accurately perform immediate recall and delayed recall (short term memory) with appropriate instructions.
- Accurately perform at least 2 out of a range of Frontal Lobe tests.
- Accommodate the patient's slowness in a polite and respectful manner.
- Identify cognitive deficits as more likely to be related to Alzheimer's dementia rather than depression.
- Identify the significance of abnormal MRI findings particularly medial Temporal Lobe atrophy.
- Recommend a multidisciplinary approach to management.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders, Neuropsychiatric Disorders
- **Area of Practice:** Old Age Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Physical - Technique; Diagnosis - Investigational Analysis), Communicator (Patient Communication – To Patient), Collaborator (Teamwork - Treatment Planning)

**References:**

- The Mental Status Examination in Neurology, Richard L Strub & F. William Black, Fourth Edition, F A Davis Company, 2000.
- Cognitive Assessment for Clinicians 2<sup>nd</sup> Edition, John R Hodges, Oxford University Press, 2007.
- Lishman's – Organic Psychiatry: A textbook of neuropsychiatry, 3rd edition, Blackwell Science Ltd 1997.

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Elderly appearing gentleman, mid 60s.
- 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 Memory Clinic. You are about to see Will Schembri, a 69-year-old man referred by his GP, Dr Morris. He has come to your clinic with this referral letter.

*Dear Colleague,*

*Thank you for seeing Will Schembri for a cognitive assessment. I have been treating him for depression and have trialled several antidepressants at adequate doses and for adequate periods of time with marginal effect.*

*Will is 69 years old and lives in rural Queensland with his wife, Betty. He has been a pretty healthy man otherwise and doesn't have significant cardiovascular risk factors. He had a colonic cancer resected 15 years ago. At a review with me a few days ago his wife reported ongoing concerns about his memory, as he continues to have progressive memory difficulties, and a decrease in initiative and spontaneity despite a subjective improvement in mood.*

*His current medication is:*

- Sertraline 150mg/day
- Melatonin 4mg nocte

*He has previously tried various antidepressants: Venlafaxine, Desvenlafaxine, Nortryptiline, Mirtazapine.*

*Other relevant history:*

- Two episodes of depression in his forties, which resolved spontaneously without treatment.
- No other relevant past psychiatric or medical history.
- No allergies.
- No relevant drug or alcohol history.
- No relevant family psychiatric history.

*Please find attached a copy of his recent MRI Brain Report.*

*Thank you for your opinion.*

*Dr Carl Morris.*

### **MRI Brain Report - June 2016:**

Diffuse cerebral atrophy with widened sulci and dilatation of the lateral ventricles can be observed. Disproportionate atrophy of the medial temporal lobes, particularly of the volume of the hippocampal formations can be seen. Dilatation of the peri-hippocampal fissure is noticed. The temporal horns of the lateral ventricles disproportionately enlarged. The midline structures have unremarkable appearance.

### **Your tasks are to:**

- To conduct relevant, focussed bedside cognitive testing with Mr Schembri, interpreting the results **to the examiners** as you do them.
- Based on your testing and the MRI findings, present your working diagnosis and a differential diagnosis **to the examiners.**
- Based on your formulation present a management plan **to the examiners.**

**You are only required to take history related to your cognitive assessment.**

**You will not receive any time prompts.**



### 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 e.g. investigation results.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient and co-examiner.

#### During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE there are no cues for any scripted prompt.
- 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.

You have no scripted introduction and no specific prompts in this station.

The role player opens with:

***'Hello doctor.'***

#### 3.2 Background information for examiners

In this station the candidate will be judged on whether they can accurately perform a range of relevant bedside cognitive tests and to interpret their findings. This is a critical requirement in order to 'achieve' in this station.

The candidate should then comment on these findings in order to be able to differentiate and consider a preferred diagnosis (dementia vs depressive pseudodementia) as a most likely diagnosis. The candidate needs to recognise that the presentation is most consistent with dementia, with impairments in memory, frontal executive functioning and apraxia. The candidate needs to be able to postulate as to which form of dementia is more likely; based on the MRI Alzheimer's disease is more likely. Better candidates might talk about possible front-temporal dementia, and why it is unlikely to be a subcortical or multi-infarct picture.

The candidate is not expected to do a physical examination or full neurological examination. They may clarify aspects of history and then perform a cognitive assessment that is relevant and accurate. The candidate is not expected to do a complete MMSE, but do relevant sections.

The candidate is then expected to discuss the important elements of a management plan relevant to this patient.

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

- Accurately perform immediate recall and delayed recall (short term) memory testing with appropriate instructions.
- Accurately perform at least 2 out of a range of Frontal Lobe tests. (e.g. similarities, differences, proverbs, Luria, set-shifting, Go-no-go, verbal fluency).
- Accommodate patient's slowness in a polite and respectful manner.
- Identify cognitive deficits as more likely to be related to Alzheimer's dementia rather than depression.
- Identify the significance of the abnormal MRI findings particularly medial Temporal Lobe atrophy.
- Recommend a multidisciplinary approach to management.

The approach to this task will vary, the candidate may perform tests for functions of frontal, parietal and temporal lobes with an adequate interpretation of these results. Overall expectation is that the candidate will perform sections from a basic MMSE, ACE or MOCA-type screen for orientation, registration, attention and concentration, short-term memory, construction or drawing, language, repetition, executive function and following simple commands. They may also assess tactile perception (tactile agnosias), and praxis. The patient's intelligence and general knowledge may be assessed.

#### **MEDICATIONS:**

Melatonin (N-acetyl-5-methoxytryptamine) is often taken to help relieve stress, tension and mild anxiety as well as assisting to relieve insomnia in usual doses between 0.1-6mg. If taken in the morning it is considered to provide stamina and endurance and some people use melatonin for Alzheimer's disease or memory loss (dementia). The most common melatonin side effects include daytime sleepiness, headaches and dizziness. Other, less common melatonin side effects might include abdominal discomfort, mild anxiety, irritability, confusion and short-lasting feelings of depression.

Less common side effects of Sertraline include confusion and drowsiness, and a lack of energy.


#### **COGNITIVE TESTING:**

The following is a summary of the common tests that may be undertaken by the candidate, but they are not expected to perform all of these tests and may include some bedside tests that are not a part of this list.

## Mini-Mental State Examination (MMSE)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

1

Source: [www.medicine.uiowa.edu/igec/tools/cognitive/MMSE.pdf](http://www.medicine.uiowa.edu/igec/tools/cognitive/MMSE.pdf)

Provided by NHCQF, 0106-410

### **Attention & Sustained Attention/Vigilance/Alertness:**

Ability to sustain attention and keep track of events is an important day-to-day function. A disturbance in attention or alertness can lead to vulnerability to interference and difficulty in inhibiting immediate, inappropriate responses. Disorientation to time and sometimes place may occur if attention is grossly impaired. Maintenance of attention requires integrated activity of the pre-frontal cortex, thalamus and brain-stem linked via the reticular activating system.

Alertness is commonly considered to be normal when the patient is awake and fully cooperative. All other tests are impacted if the person is not alert. The patient's basic level of attention can be readily assessed by using the Digit Repetition Test or Serial Sevens Subtraction Test (or months of year/days of week backwards) and his/her orientation (to time and place).

Tests like serial subtraction of 7s or spelling a familiar word backwards (WORLD – DLROW) examines sustained attention i.e. concentration.

**Serial Sevens:** The candidate should instruct the patient to '**subtract 7 from 100 and keep subtracting 7 from what is left**'. Once they have started, the patient should not be interrupted until they have completed five subtractions. If they stop before the five subtractions the instruction should be repeated.

In recitation of days of week/months of year many of these are familiar and so people have over-learned the sequence; therefore, capacity for fast and errorless reverse order recitation is a good measure of sustained attention.

### **Working memory:**

Working memory is short-term memory and is critical for cognitive abilities such as planning, problem solving and reasoning. Working memory requires the information to be available and then the ability to manipulate it.

The amount of information that is readily accessible for individuals varies (working memory capacity/span) and so has a relationship to cognitive ability/general intelligence. Distraction, trying to hold too much information at one time, or engaging in demanding tasks can all affect working memory function.

Various components of working memory are responsible for immediate repetition of words, numbers and melodies as well as for spatial information. It works independent of and parallel to long-term memory and its central component is frontal lobe function (phonological memory in peri-sylvian language areas in dominant hemisphere: visuo-spatial in non-dominant hemisphere). Patients are asked to recall immediately after.

Verbal - orally administered test in which respondent mentally re-orders strings of number and letters and repeats them to the examiner.

**Digit span**, especially reverse, depends on short-term (working) memory, which in turn depends on frontal executive and phonological processes. It is tested by asking the patient to repeat progressively longer strings of digits; usually starting with three. Two trials are given at each level if required, and the digit span is the highest level the person passes on either trial. The numbers should be read at a speed of one per second (like telling someone your phone number). Normal forward digit span is  $6 \pm 1$  depending on age and intellectual ability, and reverse is usually one less.

The bedside test is repetition and recall of a word list as described in the Folstein MMSE; or an address, after a short period of other cognitive activity.

### **Long-term memory:**

Includes learning new information, retaining newly learned information over time and recognising previously presented material and recalling it when needed. Tests measure declarative (explicit) memory which are available to conscious access and reflection. This memory is responsible for the laying down and recall of personally experienced, and highly temporally specific events or episodes (episodic memory), and knowledge of facts and concepts (semantic memory). They both form components of long-term memory.

### **Frontal Lobe Functions:**

**Verbal fluency:** refers to the ability to produce spontaneous speech fluently without undue word-finding pauses or failures in word searching. Fluency testing evaluates the patient's ability to scan memory traces rapidly in a specific semantic or phonemic category and to produce a series of responses in a given time frame. Verbal fluency is a test of frontal lobe function of initiation (to generate retrieval strategies) and temporal lobes (where basic information is stored).

Two easily administered evaluations are the Animal Naming Test and the FAS test (a controlled oral word association test).

*Semantic/semantic fluency:* e.g. names as many animals/vegetables/fruit in 1 minute. The patient should be advised to exclude names of people or places.

*Directions for Animal Naming:* the candidate is to instruct the patient to recall and name as many animals as possible in 60 seconds - any animal from zoo, farm, jungle, water, or house is acceptable.

Scoring: The normal individual should produce from 18-22 animal names during a 60 second period with expected variation being between 5 to 7. Impaired verbal fluency: less than 13 in person 70 years or under.

*Directions for FAS Test:* FAS test consists of three separate, timed word naming trials using the letters "F" "A" "S" respectively. Different forms of the same word (short, shorter) are counted as separate responses. No proper names count.

Scoring: Normal is 15 words per letter. Reduced Verbal fluency: less than 12 words per letter.

**Abstraction:** similarities and proverb interpretation: concrete interpretations or an ability to make analogies are common in frontal lobe dysfunction. Start with simple pairs and progress to more abstract (e.g. praise and punishment/poem and statue). People normally form an abstract category although they will generally be able to put forward 3-4 similarities to each pair. Proverbs are highly dependent on emotional level and cultural background.

**Go-no-go test:** Tests Response Inhibition: The candidate will ask the patient to place a hand on table and raise one finger in response to a single tap, while holding still to two taps - inhibitory control where the patient does not raise their finger to two taps.

**Luria 3-step test:** test of motor sequencing with set-shifting, which test complex motor movements, particularly associated with left frontal lesions. The examiner demonstrates 'fist-edge-palm' five times WITHOUT verbal clues, and then asks the patient to repeat the sequence. Patients with frontal deficits are unable to reproduce the movements, even if given specific verbal cues.

**Alternating hand movements:** the examiner holds arms outstretched with one hand open with fingers extended and other with clenched fist. The positions are reversed alternatively in a rhythmical sequence with alternately opening and closing each hand in a rhythmical sequence. The candidate will ask the patient to copy.

**Alternating sequences test:** examiner produces a short sequence of alternating triangular and square shapes. The patient is asked to copy the sequence and continue it to the end of the page. There should be no repeats of one shape.

May also include brief evaluation of **Frontal Lobe release reflexes** - Grasp reflex, Sucking (pout, snout, rooting) reflex, Palmo-mental reflex, Glabella tap.

The candidate may assess Parietal Lobe functions and the assessment may feature the following elements:

### **Bilateral**

- Astereognosis (tactile agnosia) – inability to recognise objects by palpation e.g. coins, keys placed in hand(s).
- Agraphesthesia – inability to name/recognise letters or numbers 'written' on the hand with eyes closed.
- Ideational apraxia – inability to conceptualise and complete multi-step tasks e.g. licking an envelope and putting a stamp on it.
- Ideomotor apraxia –inability to execute a request on command (they can do it automatically) e.g. asked to flip a coin, or do 3 step command.

### **Dominant hemisphere**

- Agraphia/dysgraphias – copying defect (dyspraxic), wide margin or mis-spelling of initial word (neglect), writing or spelling difficulties (general linguistic).
- Acalculia – disturbance in the ability to comprehend or write numbers properly.
- Left-right disorientation – disorder in demonstrating the correct hand (or other part of the body) to command.
- Finger agnosia – inability to name fingers to inability to move a finger when given its name.
- Aphasia – loss or impairment of language function; conductive - having difficulty with repetition and naming but comprehension relatively spared.

*(Gerstmann's syndrome: dysgraphia, dyscalculia, right-left disorientation, finger agnosia associated with lesions of angular gyrus)*

### **Non-dominant hemisphere**

- Asomatognosia – inability to recognise parts of the body e.g. “What part of the body is this?”
- Constructional apraxia (visuospatial agnosia) – inability to draw shapes, copy diagrams that require visual-spatial organisation e.g. drawing a clock, copying intersecting pentagons
- Dressing apraxia
- Neglect phenomena – personal, motor and sensory or extrapersonal
- Amusia – inability to recognise musical tunes

### **Constructional Ability**

A high level, non-verbal cognitive function, constructional ability is a very complex perceptual motor ability involving the integration of occipital, parietal, and frontal lobe functions. Both two and three-dimensional drawings are used. The instructions can be: **‘Please draw a picture of a clock with the numbers and hands on it’**; followed by asking the patient to **‘Set the time as 11:10 or 10:20’**. Others include asking the patient to draw a daisy in a flowerpot; or a house in perspective so that you can see two sides and the roof.

The candidate is expected to be able to differentiate dementia from a depressive pseudodementia.

	Dementia	Pseudodementia
Onset Course Distress	Insidious Progressive Usually none	Acute and recent May appear normal at times Depressed and distressed
Insight into memory loss Quality of responses Pattern of responses Principal deficit	Poor Attempts tests May point to specific areas or deficits Higher cortical function	Complains about this Often does not try Inconsistent responses Inattention, slow responses

### **MRI**

The most common cause of dementia is Alzheimer disease. Current diagnosis is made by clinical, neuropsychological, and neuroimaging assessments. Routine structural neuroimaging is based on nonspecific features like atrophy, a late feature in the progression of the disease. Neuropathologic changes underlying Alzheimer disease first occur in the medial temporal lobe. Structural neuroimaging is focussed on detection of medial temporal lobe atrophy (MTA), particularly of the hippocampus, parahippocampal gyrus (including the entorhinal cortex), and amygdala. In early Alzheimer’s disease, the medial temporal lobe shows specific volumetric reduction, and the accurate identification of atrophic changes requires detailed anatomic knowledge. A marker for Alzheimer disease is atrophy of the hippocampus and associated dilatation of the peri-hippocampal fissures.

### **Management**

Need to take a multi-disciplinary approach to management:

- Exclude any treatable symptoms of depression or other physical disorders that may be causing this picture.
- Gain collateral with regard to prior history that could indicate other forms of dementia like vascular dementia.
- Consider any role of medications, e.g. acetylcholinesterase inhibitors or antipsychotics.
- Understand the rationale for the current treatment including their duration and impact.
- Conduct more in-depth neuropsychology testing and consider other necessary investigations.
- Assess impact on function and capacity to manage independent living.
- Review the level of carer burden and explore possible options for support in the community.

### 3.3 The Standard Required

#### In order to:

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

You are Will Schembri and you have been referred by your General Practitioner Dr. Morris – your wife, Betty, told you that you needed to come to the appointment.

It is unlikely that the candidates will ask you about your personal details and your current wellbeing – the following information is provided in the event that they do:

You are a 69-year-old man, and have retired from your work in 2012 where you were involved in making doors at a factory. You live in your own home in Kingaroy, a small country town, with your 70-year-old wife Betty, to whom you have been married for 50 years. You have a happy relationship with your wife and describe her as a very good support. You have 2 sons, Roy 42 and Mark 41, both of whom are married and live in Brisbane. You have no grandchildren.

You were born in rural Victoria to parents who worked as cattle farmers. You were one of 9 children. Your parents were quite busy and at times money was tight but there was always enough food on the table, and your needs were adequately met. You were a generally average student and completed intermediate level at school.

Thereafter, you moved to Queensland, completed a building apprenticeship and built your current house during your apprenticeship. You worked in the same company for 30 years and were promoted to a foreman, and put in charge of major hospital works and other significant structures.

You were diagnosed with colonic cancer 15 years ago for which they removed part of your intestine. You do not have a bag attached to the outside of your body after the surgery, nor did you need chemotherapy or radiation therapy. You do not have any ongoing symptoms or problems from the cancer.

You are a non-smoker and drink a beer every evening. You have never had any problems with alcohol. You have never experimented with any drugs.

#### Past Psychiatric History:

You have had couple of periods of low mood and anxiety, which have resolved quickly without any medications in the past. This occurred when you were in your 40s and you do not remember much about it – you prefer not to think about those times as they are now behind you.

#### Current History:

- You began to lose confidence in yourself and started to get overwhelmed in work demands, and retired from work around 4 1/2 years ago. You felt sad at the time and lacked enthusiasm and energy.
- You have always been a bit of a loner and never had many interests besides being a good provider for your family, and so cannot comment if these have changed.
- Your sleep was not too bad, 5-6 hours every night and you did not lose your appetite.
- You never felt suicidal.
- You consulted your GP and he gave you some medicines – you do not remember the names but the GP told you he had sent a list in his referral letter. You have never had ‘shock treatments’ (ECT – electroconvulsive therapy).
- You have been feeling better in your mood, but Betty is worried about your memory and wants you to get checked out.

### 4.2 How to play the role:

You are adequately groomed man who responds in a polite and cooperative manner to the candidate. However, you do not show much emotion on your face, with limited smiling and you tend to stare at candidate rather blankly. You are slow in your movements and speech. You do not offer information spontaneously, but give accurate information as scripted. You will sit still and not make any abnormal/unusual movements.

You speak slowly, softly, and respond to questions asked. Your speech is mostly unspontaneous and you do not speak unless spoken to. You report your mood as OK. You have difficulty providing time frames for recent events. And so say “I think” or ‘approximately’ if asked to specify when recent events occurred.



You are willing to undertake the cognitive testing (of your brain function) as suggested by candidate – **please see specifics below under section 4.5**. If asked to complete a drawing (constructional) task you become quite anxious and overwhelmed, and are unable to do it accurately.

If asked you are also unable to do alternating hand sequences (will be explained to you at training). If asked to do 'remember and recall' three unrelated words, you are unable to complete this task accurately, even with cues.

**NB: Please practise all the likely tasks as a group so that your responses are similar to other role players.**

#### 4.3 Opening statement:

After the candidate introduces themselves say:

*'Hello doctor'*

#### 4.4 What to expect from the candidate:

The candidate should introduce themselves and commence testing various abilities related to the functioning of the brain by giving you detailed instructions and expecting you to follow the commands/directions. These tasks can involve testing memory about events in your life (based on the script provided); testing date, day, time, place, language, concentration, general knowledge; drawing/copying things, and possibly some physical tasks.

#### 4.5 Responses you MUST make - to memory and cognitive testing:

**Actions to be done INCORRECTLY:**

**Drawing:** You may be asked to draw interlocking pentagrams, a cube and/or a clock face (see diagrams)

- Clock face: unable to put numbers inside clock symmetrically.
- Pentagrams are slightly rotated so don't really look like the picture you will be shown.
- If asked to copy other diagrams, you have difficulty doing so.

**Concentration:** If asked to '**subtract 7 from 100 and keep subtracting 7 from what is left**' (serial 7's) you go wrong after 2<sup>nd</sup>. You say: 93...888...80. Then give up. If the candidate does not give the full instruction – start exactly as they tell you to.

You can repeat numbers up to 5 numbers forwards – but you are not able to do more than 2 numbers in reversed order.

You are slow on saying months of the year backwards - please leave one month out towards the end. You can, however, repeat days of the weeks backwards.

**Fluency:** If asked to say as many words as possible in one minute starting with a particular letter – say at least 5 words. If asked to name animals, supermarket items, or something similar in one minute – say at least 7 words.

**Similarities:** You can do easy but not hard similarities e.g. banana and orange: what you eat, bicycle and aeroplane – both have wheels as opposed to 'they are forms of transport'; East and West – 'East' there (pointing) and 'West' there (pointing).

**Proverb interpretation:** If not sure - say "I don't know", otherwise rephrase and repeat the proverb. For instance, "A stitch in time saves nine" - say 'if I do one stitch now I won't need to do nine stitches later'.

**Memory:** In the 'Three Unrelated Word' test, you will be able to repeat them immediately. After a few minutes you are unable to recall any at all, even if given cues.

**General knowledge:** For instance, if asked about issues in the distant past like politics etc., answer them as best you can. For more recent memory, e.g. recent general elections – you know they were held recently but you do not recall the name of PM.

**Physical tasks:** If asked to show how you would do simple imaginary actions, e.g. blow out a match, do it slowly. For more complex imaginary actions, e.g. pour liquid into a glass and stir it: do it slowly, with a bit of hesitancy as trying to work out what step comes next. Cannot do three stage commands.

**Luria (fist-palm-edge):** Follow the instruction but with slow response, persevere with the same edge and look a bit perplexed.

**Go-No-Go:** Imitate the examiner's movements – one tap one tap; two taps two taps.

**Calculation:** Do as well as you can.

**Orientation:** You should answer questions correctly in the following domains: You are oriented in time, place and person.

**Language:** You can repeat sentences back to the candidate as they said them; you can write a simple sentence, and you understand most questions and commands; you are able to solve simple problems; you can spell WORLD backwards - correctly but you are a bit slow.

#### 4.6 Responses you MIGHT make:

*'I'm not losing my marbles.'*

**Anticipated Question:** How is your mood?

**Scripted Response:** It's alright, I guess. It's just my energy is a bit down.

**Anticipated Question:** Do you have problems with your memory?

**Scripted Response:** I don't think so. Betty seems to think there is a problem.

If the candidate attempts to explore other symptoms not described or take more information about your past history respond with:

*'Dr Morris asked all this stuff and said I was just coming here for a memory check.'*

#### 4.7 Medication and dosage that you need to remember:

- Sertraline tablets 150milligrams each day
- Melatonin tablets 4milligrams at night

Previously you have tried various antidepressants but you do not remember the names.

## STATION 3 – MARKING DOMAINS

### The Main Assessment Aims are:

- To evaluate the candidate's ability to accurately conduct a range of focussed bedside cognitive tests and discuss their implications.
- To evaluate candidate's ability to synthesise and integrate information in order to formulate a likely diagnosis.
- To be able to differentiate preferred diagnosis from differential diagnoses based on cognitive testing and MRI findings (dementia vs depressive pseudodementia).

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.5 Did the candidate demonstrate adequate and accurate technique and appropriate range in the selected bedside testing? (Proportionate value – 30%)

**Surpasses the Standard (scores 5) if:**

performs bedside testing without any flaws/errors in any test; is able to complete tests in a well organised and efficient manner covering a variety of domains of cognitive assessment.

**Achieves the Standard by:**

choosing relevant cognitive tests; applying selected tests in a generally accurate manner; using tests that would assess attention, concentration, memory; providing correct verbal instructions; testing for functions for various lobes of the brain; performing the Clock Drawing Test.

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

- Accurately perform immediate recall and delayed recall (short term memory) testing with appropriate instructions.
- Accurately perform at least 2 out of a range of Frontal Lobe tests.

**A score of 4** may be awarded depending on the depth and breadth of additional tests covered; the candidate includes a variety of tests and administers them accurately.

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

demonstrates incorrect technique for most of the bedside testing utilised.

1.5 Category: ASSESSMENT Physical - Technique	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 patient? (Proportionate value - 10%)

**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 while taking into account the patient's cognitive limitations.

**Achieves the Standard if:**

demonstrates empathy and an ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the patient; managing challenging communications; containing behavioural abnormalities; using clear instructions tailored to the functional capacity of the patient.

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

- Accommodate patient's slowness in a polite and respectful manner.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

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

2.1. Category: PATIENT COMMUNICATION – To Patient	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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**

**1.10 Did the candidate interpret bedside cognitive testing and the MRI report correctly in formulating a diagnosis and differential diagnosis? (Proportionate value - 30%)**

**Surpasses the Standard (scores 5) if:**

demonstrates a superior performance linking relevant investigations with the MRI report; considers possible causal factors for dementia; clearly justifies why this is more likely to be dementia rather than pseudodementia.

**Achieves the Standard by:**

accurately interpreting the results and incorporating them into a relevant diagnostic profile - any errors are minor and do not materially adversely affect outcomes; using appropriate phenomenological terms to interpret findings; preferring dementia over pseudodementia; commenting on the type of likely dementia (Alzheimer's); indicating that depression has responded to treatment. Identify MRI findings viz: ventricular enlargement, grey matter atrophy, medial temporal lobe atrophy.

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

- a. Identify cognitive deficits as more likely to be related to dementia rather than depression.
- b. Identify the significance of the abnormal MRI findings particularly medial Temporal lobe atrophy.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

inaccurate or inadequate interpretation of findings; focusses on depression as the primary diagnosis; errors or omissions do materially adversely effect conclusions.

<b>1.10. Category: DIAGNOSIS - Investigation Analysis</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**3.0 COLLABORATOR**

**3.2 Did the candidate appropriately involve the treatment team in developing a management plan? (Proportionate value - 30%)**

**Surpasses the Standard (scores 5) if:**

takes a leadership role in treatment planning; effectively negotiates complex aspects of care; considers impact on the carer and respite and support for wife; considers involvement of a neurologist for ongoing management.

**Achieves the Standard by:**

proposing a plan to confirm the dementing illness; collecting collateral information from the wife; taking a biopsychosocial approach to treatment planning; including further neuropsychological testing and brain scanning; rationalising medications; engaging other health professionals including the GP and community support services; taking appropriate and effective leadership to ensure positive patient outcomes.

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

- a. Recommend a multidisciplinary approach to management.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

utilises only pharmacotherapeutic approach in further management; prescribes ECT without any further investigations as treatment of choice; errors or omissions impact adversely on the finalised plan.

<b>3.2. Category: TEAMWORK - Treatment Planning</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	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 defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

In this station the candidate will discuss an approach to undertaking an audit of how metabolic syndrome is monitored in patients with schizophrenia in a community mental health centre. The candidate is expected to identify the importance of feedback in any continuous quality improvement activity and consider some of the barriers of assessing how well health professionals are performing against accepted standards and guidelines. The candidate is also expected to describe their role in conducting an audit within a multidisciplinary team environment.

**1.1 The main assessment aims are:**

- To describe the metabolic syndrome and outline the parameters for metabolic syndrome monitoring.
- To describe the audit cycle and how to apply it to the scenario.
- To discuss the role of the psychiatrist in conducting clinical audits in a multidisciplinary environment.

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

- Include at least four core measures for monitoring metabolic syndrome (e.g. weight, waist circumference, blood pressure, fasting blood glucose, fasting lipids).
- Explain that monitoring is more frequent (e.g. 3-monthly) in the first year of treatment with a new antipsychotic medication.
- Accurately describe the key components of an audit cycle.
- Recognise the importance of colleague participation when conducting an audit.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Governance Skills, Psychotic Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS domains of:** Medical Expert, Manager
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management - Long-term, Preventative), Manager (Governance; Workload & Resource & Change Management)

**References:**

- Waterreus A, Laugharne J. Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm. *MJA*. 2009;190:185-189
- Lambert T. Managing the metabolic adverse effects of antipsychotic drugs in patients with psychosis. *Australian Prescriber*. 2011;34:97-99
- Laugharne J, Waterreus A, Castle D, Dragovic M. Screening for the metabolic syndrome in Australia: a national survey of psychiatrists' attitudes and reported practice in patients prescribed antipsychotic drugs. *Australasian Psychiatry*. 2015. DOI: 10.1177/1039856215618521
- Benjamin A. Audit: how to do it in practice. *BMJ*. 2008; 336:1241-1245

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- 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.

**This is a VIVA station. There is no role player in this station.**

You are working as a junior consultant psychiatrist and are approached by your Clinical Director to audit how metabolic syndrome is currently being monitored in patients with schizophrenia by the psychiatrists in your community mental health centre.

**Your tasks are to:**

- Describe your approach to auditing this aspect of clinical practice within the mental health community centre including your choice of key criteria/measures.
- Discuss how to implement the audit including your role in conducting an audit in a multidisciplinary team environment.

**If you have not commenced the second task by six (6) minutes you will receive a prompt to move to the second task.**

## 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 e.g. investigation results.
  - Pens.
  - Water and tissues are 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 and say:  
***'Please proceed to address the first task.'***
- 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.'***
- TAKE NOTE of the cue/time for the scripted prompt you are to give at **six (6) minutes** if the candidate has not commenced the second task. Please say:  
***'Please proceed to address the second task.'***
- 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 tasks?  
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.

This is a VIVA station. Your role is to keep to time and to mark the candidate. Specifically, the tasks are described below:

When the candidate enters the room briefly check ID and say:

***‘Please proceed to address the first task.’***

At **six (6) minutes**, if the candidate has not commenced the second task, the examiner says:

***‘Please proceed to address the second task.’***

#### 3.2 Background information for examiners

In this station the candidate is expected to describe the key aspects of monitoring for metabolic syndrome that could be included in an audit and then to outline their understanding of and approach to audit in patients with schizophrenia engaged with a community mental health centre.

The second part of the scenario focusses on discussing the role of a psychiatrist in conducting an audit in a multidisciplinary team environment.

In order to ‘Achieve’ this station the candidate **must**:

- Include at least four core measures for monitoring metabolic syndrome (e.g. weight, waist circumference, blood pressure, fasting blood glucose, fasting lipids).
- Explain that monitoring is more frequent (e.g. 3-monthly) in the first year of treatment with a new antipsychotic medication.
- Accurately describe the key components of an audit cycle.
- Recognise the importance of colleague participation when conducting an audit.

#### **The Metabolic Syndrome**

The metabolic syndrome (MetS) is a well-described cluster of inter-related risk factors for developing cardiovascular disease and type 2 diabetes. The core components of MetS are central obesity, hypertension, hyperglycaemia and dyslipidaemia. A person with MetS is two to three times more likely to have a heart attack or stroke and five times more likely to develop type 2 diabetes than someone who does not.

The relationship between psychotic illness and metabolic dysregulation is complex but we know that patients with psychotic illness are at a higher risk of developing MetS, and antipsychotic medications can increase this risk, probably through obesity-related mechanisms. Other risk factors such as socio-economic status, high rates of smoking, alcohol and other drug use, reduced physical activity and poor nutrition are also relevant in patients with psychotic illness developing MetS. Current evidence suggests clozapine and olanzapine are associated with greater weight gain than other antipsychotic medications, as well as increased risk of diabetes and lipid dysregulation.

The need for screening, monitoring and prevention of MetS has been acknowledged in the psychiatric literature and more recent treatment guidelines. The intervals of monitoring vary in different guidelines but it is important to start monitoring patients immediately after they have started antipsychotics, then every three months during the first year and every six months after that (Lambert 2011). However, a recent survey of Australian psychiatrists found that routine screening for MetS in patients on antipsychotic medications is inadequate (Laugharne et al. 2015). For example, 55% of the respondents in this survey indicated that there was no established metabolic monitoring protocol or guideline in their work place, and 13% indicated that they did not know what to monitor or detect MetS.



The candidate could identify any of the following as specific aspects to measure in a MetS monitoring protocol:

- Medical history
- Lifestyle history (e.g. diet, smoking, physical activity)
- Blood pressure\*
- Fasting blood glucose\*
- Fasting lipids\*
- Weight\*
- Waist circumference\*
- Hip to waist ratio
- Body Mass Index (BMI)
- HbA1c
- CRP, Troponin
- ECG
- Echocardiogram
- Baseline measurements followed by 3-monthly in the first year and 6-monthly after that\*  
(NB: some guidelines suggest baseline measurements, then in 6 weeks, 12 weeks and then annually)
- Intervention plan/algorithm (e.g. lifestyle interventions, switching antipsychotics, medications for MetS)

(\* indicates what are usually considered as minimal monitoring criteria).

The current International Diabetes Federation Definition of Metabolic Syndrome ([www.idf.org](http://www.idf.org)) includes:

- Central Obesity - waist circumference (94cm for European men, 80cm for European women; South Asian men 90cm, South Asian women 80cm)  
**AND** any two of the following:
- Raised triglycerides - (1.7mmol/L) OR specific treatment for this lipid abnormality
- Reduced high-density lipoprotein cholesterol (<1.03mmol/L in males and <1.29mmol/L in females) OR specific treatment for this lipid abnormality
- Raised blood pressure (systolic BP 130mmHg or diastolic 85mmHg) OR treatment of previously diagnosed hypertension
- Raised fasting plasma glucose (5.6mmol/L) OR previously diagnosed Type 2 diabetes

A surpassing candidate may demonstrate their familiarity with monitoring requirements for metabolic syndrome, including any specific criteria like those above.

### Clinical audit

Clinical governance is a systematic approach to maintaining and improving the quality of patient care within a health system and originates from within the United Kingdom NHS, with its most widely cited formal definition describes it as: *A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish* (G. Scally and L. J. Donaldson, *Clinical governance and the drive for quality improvement in the new NHS in England* BMJ (4 July 1998): 61-65).

As services become more focussed on patient-centred care and improved outcomes there is a need for clinical professionals to develop knowledge and skills to monitor and develop quality. Quality assurance is any systematic process of checking to see if a service is meeting specific requirements and clinical audit is one of the key tools applied in the coordinated approach to the assessment of the quality of services delivered.

Clinical audit is considered to be a continuous quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The aim of clinical audit is to improve care by improving professional practice and the general quality of patient care delivered.

This is achieved by healthcare professionals reviewing patient care against agreed standards/criteria and making changes to meet those standards then repeating the audit to see if the changes have been implemented and the quality of patient care improved. Therefore, standards-based audit is a cycle which involves defining standards, collecting data to measure current practice against those standards, and implementing any changes deemed necessary.

Clinical audit is considered an integral part of clinical governance within the health service. In addition to measuring quality, there must be a commitment to change practice where the results of the audit show that improvements should be made. The key component of clinical audit is that performance is reviewed (audited) to ensure that what should be done is being done; assesses the gap between what we know and what we do exists, and it then provides a framework to enable improvements to be made.

A clinical audit may ask one or more of the following questions:

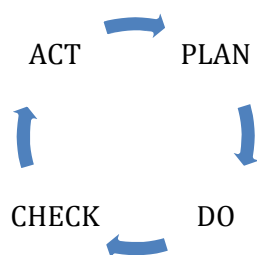
1. Is what should have happened actually happened?
2. What is the standard?
3. Does what is actually happening meet or exceed agreed standards?
4. Is current practice following published guidelines?
5. Is current clinical practice applying up to date knowledge?
6. Is current evidence is being applied in the particular situation under review?

In clinical governance the most commonly known audit process is the PDSA/PDCA Cycle. In 1924 Walter A. Shewhart introduced a Plan, Do, and See method for quality control to which W. Edwards Deming then applied a statistical process control method which led to the development of the well-known Plan, Do, Check, Act Cycle. The **Deming Cycle, or PDSA/PDCA Cycle** consists of a sequence of four repetitive steps for continuous improvement and learning: Plan, Do, Check (Study) and Act. It is also known as the Deming wheel of continuous improvement spiral.

PDCA cycle is made up of four key activities:

<b>PLAN:</b>	plan ahead for change. Analyse and predict the results.
<b>DO:</b>	execute the plan, taking small steps in controlled circumstances.
<b>CHECK:</b>	check, study the results.
<b>ACT:</b>	take action to standardise or improve the process.

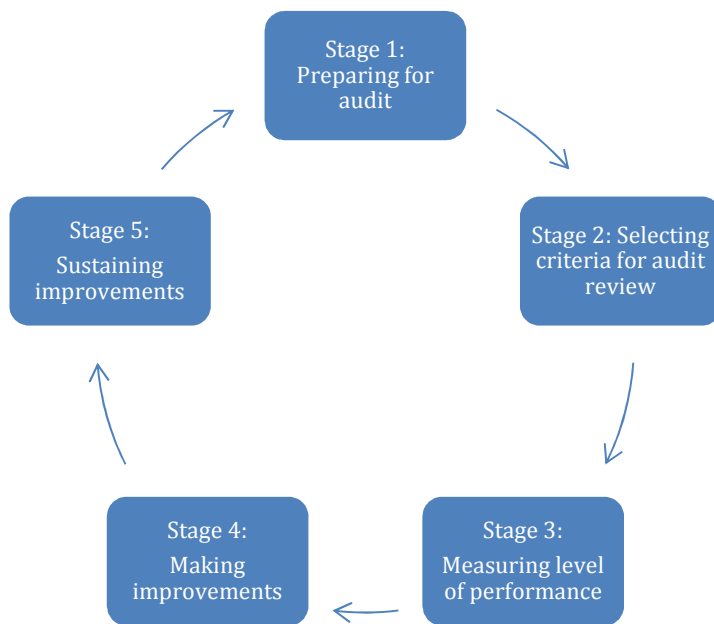
The PDCA cycle should be repeated again and again for continuous improvement.



The PDCA cycle is a useful procedure when:

- An opportunity is recognised and a plan for change made - **Plan**.
- A change is trialled/tested. Usually carried out as a small-scale study - **Do**.
- The trial/test is reviewed, results/outcomes are analysed and new learnings are identified – **Check**.
- Action is taken based on what is learned in the check/study step – **Act**.

In general **audit cycles** build on the PDCA cycle as is summarised in the following diagram. It involves a cycle of assessment, implementing a change and reviewing the impact of the change (i.e. re-auditing to close the audit cycle).



- Stage 1: Preparing for audit** - Identify the area/topic i.e. consider the need for change in an area/topic and where you suspect that standard could be improved and/or where the change you expect to recommend is possible.
- Stage 2: Selecting criteria for audit review** - Find the standard, ask the question and find the evidence. May need to do a literature search for the standard in the area/topic chosen. Write a plan for how to do the audit: This should include the rationale for doing the audit, the standard you have chosen, the population to be surveyed, the time frame for collecting the data and the data intend to measure.
- Stage 3: Measuring level of performance** - Collate data and compare the results against the selected audit standard. Then write a summary of the findings, discussing how the differences compare to the standard, possible explanations and remedies.
- Stage 4: Making improvements** - Identify the changes that need to make to achieve the standard and how they will be implemented. Put in place the actions and plans to correct any gap between the actual activity and the selected standard.
- Stage 5: Sustaining improvements** - This stage is critical to the successful outcome of an audit: It measures whether the changes implemented have had an effect and determines whether further improvements are needed to achieve the standard identified in Stage 2.

Audit can also provide information to show others the effectiveness of the service, the efficient use of resources and to ensure its development. It can measure the gap between what we know and what we do, and look for any unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the patient. It also allows for training and education opportunities as well as improving communication and liaison.

In order to meet the standards of this station a candidate should therefore present an outline of a practical plan. They should also recognise the importance of feedback as a critical part of the audit process. Barriers to audit are often lack of resources, lack of expertise or advice in design and analysis, and organisational obstructions. Aspects that will need to be taken into consideration include having access to resources (e.g. time, data, and quality managers/statisticians), any opportunity costs, the need for ethical approval (if required) and utilisation/dissemination of the findings.

Audit differs from research. It aims to evaluate how close practice is to best practice and standards and to identify ways to improve quality of health care, whereas research aims to establish what that best practice is. So research generates new knowledge or increases the current knowledge, while audits focusses more on improving services and is practice based as an ongoing process. Patients are not allocated randomly in audit and it never involves a placebo treatment or a completely new treatment.

Better candidates will be able to recognise that audit is a continuous quality improvement activity assessing whether minimum standards/expected performance are being met and then maintained, and making changes to practice when necessary; and so there needs to be a program that sets regular times for repetition. They may also recognise that clinical care is more complex than just focussing on a set of key criteria that are audited, and that audit and feedback alone only provide moderate effects, whereas if combined with a broader strategy of education and quality improvement audit is more beneficial.

### **The role of the psychiatrist in clinical audit**

It is important for doctors to participate in activities that review and evaluate the quality of their individual practice or the work done by their team. This drive for continuous improvement in healthcare delivery is part of what defines medical professionalism. There is a growing emphasis on medical participation and includes reflection beyond descriptive observation, as any changes that clinicians can make to service delivery should directly improve patient outcomes.

All RANZCP Trainees are expected to undertake a scholarly project as part of their training requirements. One option for Trainees to consider is the undertaking of a clinical audit. As part of the Continuing Professional Development (CPD) program of the RANZCP, the section on Practice Improvement Activities recommends *Practice Development and Review* and *Continuous Quality Improvement* activities like formal clinical audit and quality improvement activities which have furthered the participant's CPD goals. Possible activities could include practice audits, participation in root cause analysis, structured quality improvement and risk management projects.

Despite these expectations there are some perceived disadvantages of audit amongst clinicians; namely of reduced clinical ownership, suspicion of the reviewers, fear of reprisal or litigation, and professional isolation.

When discussing the psychiatrist's role in conducting clinical audit in a multidisciplinary team environment, the candidate is expected to identify the role that psychiatrists play in implementing clinical governance. As the clinical leader of this project they should consider their collegial relationship with other psychiatrists in the service and how to engage them. As part of the preparation, the other psychiatrists should be consulted on how to set up the audit cycle and confirm the key criteria, as well as participating in the feedback on performance and deciding on the actions for any performance improvement. The candidate would be expected to consider ways in which feedback will be given within a no blame environment. When comparing audit results among colleagues, it is important to be sensitive to variations, so candidates may consider the value of anonymising the data presented in group settings.

A better candidate will clearly demonstrate the role of psychiatrists in clinical governance, leadership, managing team dynamics and change management. They may also identify that someone will need to undertake the audit and who will be involved in the review. A better candidate may also consider the value of benchmarking with other services and learning from exemplar teams.

## **3.3 The Standard Required**

**In order to:**

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## STATION 4 – MARKING DOMAINS

### The Main Assessment Aims are:

- To outline the parameters of metabolic syndrome monitoring.
- To describe the audit cycle and how to apply it to this scenario.
- To discuss the role of a psychiatrist in conducting an audit in a multidisciplinary team environment.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.16 Did the candidate outline the parameters for an appropriate longer term preventative metabolic monitoring program? (Proportionate value – 30%)

##### **Surpasses the Standard (scores 5) if:**

demonstrates sophisticated knowledge of the metabolic syndrome such as its epidemiology related to psychotic illness; formulates a local monitoring protocol based on existing national/international guidelines; appropriate inclusion of reference to long-term outcomes.

##### **Achieves the Standard by:**

describing the metabolic syndrome; demonstrating awareness of possible psychiatric/physical complications of illness or treatment and available interventions/monitoring; acknowledging there is some variation in terms of the monitoring intervals in different guidelines; including existing guidelines that incorporate medical and lifestyle history and intervention algorithms; prioritising evidence based monitoring criteria; proposing to critically review the literature on this topic if a knowledge gap is identified.

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

- Include at least four core measures for monitoring metabolic syndrome (e.g. weight, waist circumference, blood pressure, fasting blood glucose, fasting lipids).
- Explain that monitoring is more frequent (e.g. 3-monthly) in the first year of treatment with a new antipsychotic medication.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

provides an incorrect definition of the metabolic syndrome; has difficulty with most of the skills above; demonstrates a lack of capacity to reflect when a knowledge gap on this topic is identified.

1.16. Category: MANAGEMENT - Long-term, Preventative	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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

#### 4.1 Did the candidate demonstrate a capacity to apply principles of clinical governance in the undertaking of clinical audit? (Proportionate value – 40 %)

##### **Surpasses the Standard (scores 5) if:**

demonstrates a sophisticated level of competence in conducting clinical audit; provides solutions to address identified barriers; incorporates this audit as part of an organisational audit framework; recognises the importance of feedback as part of a broader strategy of education and quality improvement.

##### **Achieves the Standard by:**

identifying principles of clinical governance and the role of audit as a continuous quality improvement activity; incorporating feedback of the findings as part of audit; considering the need to repeat the audit; recognising audit as contributing to changing practice; considering possible barriers to implementation.

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

- Accurately describe the key components of an audit cycle.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

The candidate lacks clarity about clinical audit strategies; lacks clarity about clinical governance and standards.

4.1. Category: GOVERNANCE	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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"/>	

**4.4 Did the candidate outline their role in conducting an audit and demonstrate effective allocation of tasks and resources in order to complete the audit process within a multidisciplinary team? (Proportionate value - 30 %)**

**Surpasses the Standard (scores 5) if:**

demonstrates a sophisticated approach to clinical and administrative resource allocation; robust approach to cost/risk/benefit analysis and considering any opportunity costs associated with task completion; describes the critical role of psychiatrists in clinical governance, leadership, managing team dynamics and change management; addresses perceived disadvantages to audit.

**Achieves the Standard by:**

demonstrated ability to make decisions based on workload and patient needs; taking into consideration practical aspects like access to resources (time, data, and quality managers/statisticians); recognising perceived disadvantages to participating in audit; considering a literature review and seeking advice; organising and delegating tasks within a clinical setting; taking responsibility for the allocation and management of tasks and resources; applying governance within organisational structures.

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

- a. Recognise the importance of colleague participation when conducting an audit.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

does not underpin decisions on a clinical evidence base; does not prioritise decisions on efficient allocation of resources; poorly defines own scope of practice and responsibilities; does not consider audit activities as part of a psychiatrist's role.

4.4. Category: WORKLOAD & RESOURCE & CHANGE MANAGEMENT	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

The task is to assess Harold, a 69-year-old man with Parkinson's Disease. His wife and GP are concerned about him due to his progressively increasing lack of enthusiasm despite good control of his illness. The candidate is expected to identify a range of differential diagnoses and specifically consider depressive disorders and apathy.

**1.1 The main assessment aims are:**

- To assess the ability to explore the medical condition of Parkinson's Disease and identify the psychological and psychiatric symptoms.
- To evaluate ability to explore a range of psychiatric complications of Parkinson's Disease.
- To assess competence in interpreting depressive and apathy symptoms.
- To evaluate ability to generate and present a broad differential diagnostic statement.

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

- Clarify the impact of Parkinson's Disease on the patient's functioning (physical, psychological and social).
- Explore at least three of the psychological, cognitive and psychiatric symptom complexes.
- Ask about both psychological and biological symptoms of depression.
- Explore the phenomenon of apathy.
- Explain at least one depressive disorder as a possible differential diagnosis.
- Offer at least two other diagnoses of non-depressive illnesses.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Old Age Psychiatry
- **CanMEDS domains of:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis)

**References:**

- Rao, SS, Hofmann LA, Shakil A (2006) Parkinson's Disease: Diagnosis and Treatment, American Family Physician, 16 Dec 2006
- Weintraub D, Stern MB (2009) Recognizing psychiatric and cognitive complications in Parkinson's Disease. Medscape Neurology: Parkinson's Disease Expert Column
- Slaughter JR, Slaughter KA, Nichols D, Holmes SE, Martens MP (2001) Prevalence, clinical manifestations, aetiology and treatment of depression in Parkinson's Disease. J Neuropsych Clin Neurosc 13:2, Spring 2001 187-196
- Shulman LM, Taback RL, Rabinstein AAQ, Weiner WJ (2007) Non-recognition of depression and other non-motor symptoms in Parkinson's disease, J Neurol Neurosurg Psychiatry 78: 36-42
- Starkstein SE, Leentjens AFG (2008) The nosological position of apathy in clinical practice, J Neurol Neurosurg Psychiatry 79: 1088-1092
- Ferreri F, Agbokou C, Gauthier S (2006) Recognition and management of neuropsychiatric complications in Parkinson's disease, CMAJ, 175 (12), 1545-1552
- Marsh L, McDonald WM, Cummings J Ravina B (2006) Provisional diagnostic criteria for depression in Parkinson's disease: Report of an NINDS/NIMH Work Group, Movement Disorders, 21 (2), 148-158.

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, roleplayer x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – male, late 60s, casual rather untidy dress.
- 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 working in the outpatient setting. You are about to see Harold, a 69-year-old retired schoolteacher, referred by his GP for your opinion.

Harold was diagnosed as suffering from Parkinson's Disease six months ago and his movement disorder responded well to medication. However, his wife, Marg, now reports, '*He's not the man he used to be*' and his GP agrees, saying Harold doesn't seem depressed but has '*lost his sparkle*'.

A Geriatrician could find no cognitive impairments and no physical problems other than the movement disorder associated with Parkinson's Disease.

### Your tasks are to:

- Obtain a relevant focussed history from Harold about his illness and presenting symptoms.
- Outline the most likely diagnosis plus important differential diagnoses with Harold.

You are **not required** to examine Harold physically, to test his cognition or to discuss management.

You will not receive any time prompts.



## 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 e.g. investigation results.
  - 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.
- DO NOT redirect or prompt the candidate – 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 tasks?  
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 tasks.

### 3.0 Instructions to Examiner

#### 3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

You have no opening statement or specific prompts in this station.

The role player opens with the following statement:

***'I'm not sure why Marg wanted me to see you. Everything is going OK with me.'***

#### 3.2 Background Information for Examiners

In this station the examiner is to assess the candidates' ability to understand the background of the diagnosis of Parkinson's Disease. They are to explore a range of psychological, cognitive and psychiatric complications of Parkinson's Disease: the patient presents with decreased activity, energy and interest following the diagnosis and management of Parkinson's Disease.

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

- Clarify the impact of Parkinson's Disease on the patient's functioning (physical, psychological and social).
- Explore at least three of the psychological, cognitive and psychiatric symptom complexes.
- Ask about both psychological and biological symptoms of depression.
- Explore the phenomenon of apathy.
- Explain at least one depressive disorder as a possible differential diagnosis.
- Offer at least two other diagnoses of non-depressive illnesses.

The candidate should try to assess the range of other psychological, cognitive and psychiatric symptom complexes evident in Parkinson's Disease:

1. **Cognitive** symptoms (apathy and decreased initiative, impaired memory and concentration, indecision);
2. **Psychotic** phenomena (hallucinations, illusions, paranoia, persecutory ideas, thoughts);
3. **Anxiety** disorders (panic, generalised anxiety, social phobia, obsessive compulsive);
4. **Impulse Control** disorders (gambling, sexual, buying, eating behaviours, stereotyped movements);
5. **Sleep and Wakefulness** disorders (insomnia, hypersomnia, sleep fragmentation, sleep terror nightmares, nocturnal movements, REM behaviour disorders);
6. **Emotional Expression** disorder (pseudobulbar affect, affective lability, uncontrolled crying or laughter).

The candidate is expected to elicit symptoms best described as of 'indifference' or 'flattening of affect' (decreased range and reactivity), together with deficits in activity and interest, in a passive and hard to engage historian. As part of understanding the presentation the candidate is expected to enquire about depressive symptoms specifically mood, affect, motivation, interest, energy, suicidal thoughts and biological features (sleep, appetite, weight, diurnal variation, concentration) as well as to specifically assess for apathy.

The examiner is to then judge the adequacy of diagnosis and differential diagnoses presented. The candidate should demonstrate competence in interpreting depressive and apathy symptoms and in presenting a broad differential diagnostic statement. Harold, the patient in this station, has been scripted to provide a range of deficit-type symptoms that can occur in either Parkinson's Disease or Major Depression (see table on next page).

The key knowledge for the candidate to display is awareness that the intrinsic manifestations of Parkinson's Disease often include a range of symptoms that can mimic depressive disorders. This overlap in symptoms makes the diagnosis of a Depressive Disorder problematic in patients with Parkinson's Disease. In light of this the candidate must consider at least one likely primary diagnosis to be an affective/mood disorder (minor or major). Each of the disorders listed below could count as a separate differential diagnosis:

1. Adjustment disorder with depressed mood.
2. Depressive disorder due to Parkinson's Disease.
3. Primary depressive disorder (major depressive disorder).
4. Depressive disorder due to another medical disorder, substance or medication.
5. Dysthymic disorder.
6. Apathy.

Non-depressive differential diagnoses may include:

1. Bipolar disorder.
2. Frontal lobe impairment.
3. Early cognitive decline (mild neuro-cognitive disorder in DSM-5) – possibly due to cerebral ischemia.
4. Organic personality syndrome.
5. Undetected substance abuse or other anxiety disorders.
6. Occult malignancy.

### Symptoms common to Parkinson's Disease and Major Depression

Symptom category	Parkinson's Disease	Major Depression
Motor	Bradykinesia	Psychomotor retardation
	Masked facies	Restricted/depressed affect
	Dyskinesia	Agitation
Cognitive	Apathy & decreased initiative	Decreased interest & enjoyment
	Impaired memory & concentration	Impaired memory & concentration
	Indecisiveness	Indecisiveness
Vegetative	Fatigue & decreased energy	Fatigue & decreased energy
	Impaired sleep	Impaired sleep
	Weight & appetite changes	Weight & appetite changes
Somatic	Physical discomforts	Physical complaints

### Depression in Parkinson's Disease

Despite this difficulty and symptom overlap, clinically significant depression is one of the most common psychiatric disturbances reported by patients with Parkinson's Disease. A review of 44 studies involving almost 6,000 patients with Parkinson's Disease found that 31% were diagnosed with a depressive disorder (Slaughter, Slaughter et al 2001). Applying the DSM criteria of the time revealed that 24.8% suffered from Major Depression and a total of 42.4% experienced a DSM Depressive Disorder (Dysthymia plus Major or Minor Depression).

However, depression is often not recognised and under-diagnosed. One study found that less than half of the patients with clinically diagnosed depression were recognised by their treating neurologists as depressed (Shulman, Taback et al 2007).

Depression can be particularly difficult to diagnose in patients with Parkinson's Disease because of the overlap between the two illnesses. Psychomotor slowing, concentration and sleep difficulties occur frequently in Parkinson's Disease, as do diminished appetite and sexual desire. Social withdrawal is common in Parkinson's Disease as patients become less able to participate or more uncomfortable with their appearance, tremor or dyskinesia.

Varying authorities present different characterisations of the symptoms suffered by patients with Parkinson's Disease. Some claim that Parkinson's patients experience more anxiety, brooding, irritability, cognitive deficits, pessimism and suicidal ideation without suicidal behaviour, although lower rates of guilt and self-blame (Shiffer, Kurlan et al, 1988). Symptoms favouring depression that may help in the differential diagnosis include early morning awakening, pervasive (more than two weeks) low mood, diurnal mood variation, and pessimistic thoughts about oneself, the world and the future (Rickards, 2005).

### Apathy in Parkinson's Disease

It has become increasingly recognised that 'apathy' is a distinct psychiatric syndrome (Starkstein, Leentjens, 2008) and one that is frequently found in patients with Parkinson's Disease. There is a significant overlap in the symptoms attributed to apathy and those of a depressive disorder. Several authors have proposed diagnostic criteria for apathy as shown below from Starkstein (2000).

- A. Lack of motivation relative to the patient's previous level of functioning
- B. Presence during most of the day of at least one symptom from the following domains
  - i Diminished goal directed behaviour
    - Lack of effort or energy to perform everyday activities
    - Dependency on prompts from others to structure everyday activities

- ii. Diminished goal directed cognition
  - Lack of interest in learning new things or in new experiences
  - Lack of concern about one's personal problems
- iii. Diminished concomitants of goal directed behaviour
  - Unchanging or flat affect
  - Lack of emotional responsivity to positive or negative events

C. Causing distress or impairment

D. Not due to substances or diminished consciousness

It can readily be seen that the 'Apathy' diagnosis has much in common with the Depressive Disorders we most commonly see in psychiatric practice. In the current station, the patient Harold has been scripted and counselled to present as more apathetic than depressed. This does not mean that a Depressive Disorder should not be considered by the candidates. In point of fact, a joint working group of the American National Institute of Neurological Disorders and Stroke, and National Institute of Mental Health has reported on the Diagnosis of Depression in Parkinson's Disease (2003). They recommended a broad, inclusive diagnostic approach be taken when confronted with depressive symptoms in Parkinson's patients. It was the consensus that the clinician should count every symptom, rather than try to determine whether a symptom is due to depression or due to some other aspect of Parkinson's Disease. For example, patients with problems sleeping would get points on the rating scales or diagnostic criteria for sleep disturbances, regardless of whether their insomnia was perceived to be due to worrying or tremor.

That is, rather than attempting to tease out the underlying cause of the symptom (e.g. depression or Parkinson's), it may be more prudent to consider all symptoms at face value when applying DSM IV-TR or 5 Depression criteria. Such an inclusive approach will ensure that depression is not missed or under-diagnosed in patients with Parkinson's Disease.

#### **Other psychiatric conditions that could be considered**

Parkinson's Disease is primarily a movement disorder characterised by rest tremor, bradykinesia, rigidity and postural instability. However, the high prevalence of psychiatric complications suggests that it is more accurately conceptualised as a neuropsychiatric disease (Ferreri, Agbokou Gauthier, 2006). Neuropsychiatric disturbances include not only depression, apathy and cognitive impairment but also psychosis, anxiety, sleep and weight disturbances, fatigue, addictions and affective lability. These may result from complex interactions between the progressive pathological changes of the disease, emotional reactions and treatment side effects. Neuropsychiatric complications are estimated to occur in more than 60% of patients with Parkinson's Disease at some time during their illness.

The candidates in this station are expected to enquire about the presence of the some of the more common neuro-psychiatric complications.

#### **Psychotic phenomena**

These can be mild and relatively benign or complex and disturbing. The milder form includes illusions, 'passage' and 'sense of presence' phenomena or stereotyped visual hallucinations of human figures or animals. Patients often have insight into the hallucinations and do not find these 'benign hallucinations' troubling. The more severe psychosis involves vivid hallucinations, elaborated persecutory delusions and little insight. In this station, the patient denies all psychotic phenomena.

#### **Cognitive impairment**

Cognitive deficits tend to be of a 'sub-cortical' nature characterised by poor memory retrieval, psychomotor slowing, amotivation and slowed thinking (bradyphrenia). Executive impairment may be more pronounced and language deficits less prominent compared to early Alzheimer's Disease. In this station a Geriatrician has found no cognitive impairment and the candidates are instructed not to examine cognition.

#### **Anxiety**

Anxiety symptoms can be more upsetting and disabling than depressive symptoms and occur in up to 40% of patients with Parkinson's Disease. Discrete episodes of anxiety are sometimes related to motor symptom 'off' periods. Disorders include Generalised Anxiety Disorder, Panic Attacks, Obsessive-Compulsive symptoms/ Disorder and Social Phobia.

In this station, the patient has not suffered any specific anxiety disorder but does experience anxiety at the time of medication troughs.

#### **Sleep and Wakefulness disturbances**

Disturbances of sleep are common in Parkinson's Disease and include insomnia, hypersomnia, sleep fragmentation, sleep terrors, nightmares and nocturnal movements (restless leg syndrome) and REM Behaviour Disorder. Excessive daytime sleepiness and fatigue are common. The patient in this station reports initial insomnia, broken sleep and drowsiness on awakening.

### **Impulse control and related disorders**

Behaviour addictions including compulsive gambling, buying, sexual behaviour and eating have been reported associated with dopamine agonist medication. Patient may under-report these problems due to ambivalence or embarrassment. The patient in this station does not report any impulse control behaviours.

### **Involuntary emotional expressions**

Pseudobulbar affect with episodes of involuntary crying or laughing can occur in patients with Parkinson's Disease. The expressed emotion may be excessive and incongruent with the patient's underlying mood. This is not reported by the patient in this station.

## **3.3 The Standard Required**

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

#### Personal Circumstances

You are Harold, a 69-year-old man. You have been happily married to Marg for the past 44 years. You have two grown children; Mary aged 40, who is also a schoolteacher, lives interstate and John aged 38 who works as a building inspector lives in a nearby suburb. Both Mary and John are married and both have two children.

You retired 9 years ago from teaching Year 7 at a local public school. You just felt you'd had enough and had adequate superannuation to live comfortably. You did not have any difficulties teaching but just felt it was time to retire.

You have had a full life in retirement. You used to play golf twice weekly and volunteer at the local Meals on Wheels kitchen three times a week. In retirement, you and Marg have gone on caravan holidays for up to a month, two to three times each year. You used to take a keen interest in rugby league (Brisbane Broncos' supporter), gardening and current affairs, through newspaper reading and viewing ABC television. Your daughter Mary phones Marg all the time and they talk for hours. Your son phones every week and visits **'when he can'**. You do not belong to any clubs or go out socially on a regular basis.

#### Past Medical History

You have always been fit and healthy. You have never had any medical illness or allergies. You did not take any medication until the diagnosis of Parkinson's Disease. You don't like to take tablets, but do take the Parkinson's medication **'to keep Marg happy'**.

Specifically, you do not have high blood pressure, diabetes, heart trouble, or arthritis. You have never had an operation or hospital admission.

There are no illnesses that run in your family. Your mother died at age 89 years of **'old age'** and your father died of stomach cancer at age 81 years.

No one in your family has ever suffered Parkinson's Disease, dementia or any psychiatric condition.

You have never smoked cigarettes. You don't like the effects of alcohol and have never been intoxicated. The last drink you had was at New Year's Eve and then only to keep company with the others. You have never used any illicit drugs.

#### Parkinson's Disease

You first noticed a shake of your right hand when drinking tea about a year ago. This gradually worsened but you thought nothing of it. Marg told your GP about the shake last year and he sent you to see an 'old age doctor' who diagnosed Parkinson's Disease. Your GP has prescribed a medication called Sinemet that you take three times a day. At first, you felt a bit of nausea, but that settled in a few weeks. Sinemet worked well to decrease the shake so that it is now barely noticeable. You feel **'right as rain now'**.

On reflection, you may have had some stiffness and stumbles when walking, and some trouble arising from a chair, but these symptoms have improved on the tablets.

If the candidate specifically asks, you have noticed the following:

- Small handwriting (**'But that's better now'**)
- Trouble sleeping (trouble getting off to sleep, waking through the night, feeling groggy first thing in the morning - see below)
- Soft voice (**'Marg kept asking me to stop mumbling, but not recently'**)
- Change in your facial expression (**'Marg used to say I looked sad, but I didn't feel sad'**)
- Constipation (see below: **'I thought it was the Parkinson's or the tablets'**)

If asked any other physical symptoms (faints, falls, dizziness, stooping posture, loss of smell) either answer in the negative or say **'I don't think so'**.

You were never worried about the shake or about the diagnosis of Parkinson's Disease because you know it can be treated. You don't recall being particularly upset with having to take these tablets. You have friends who have Parkinson's and they seem all right to you. You don't think the diagnosis has had any impact on you at all. Say **'It's no problem to me'**.

If the candidate asks about your leisure activities, reluctantly admit that you don't go to golf much any longer. To further specific enquires, admit you stopped helping out at Meals on Wheels and you rarely leave the house these days.

Now that you are on medication, you feel your movements are **'back to normal'** and say, **'I don't know what the fuss is all about'**. You think Marg worries too much, but you have gone to the doctors to put her mind at ease.

## **PSYCHOLOGICAL SYMPTOMS – responses to be provided only on direct questioning**

### **Depression**

You do not think you are depressed, and do not feel sad, downcast or tearful. You have never wondered if life is worth living. The thought of suicide or self-harm has never entered your mind. (If asked, you do not have any weapons). You look forward to a long and peaceful life with Marg. If asked, you do not feel hopeless or negative about anything. You feel 'OK' about the future, but say this with little conviction.

If asked, you don't go out as often as you used to do. You have only played golf **'about once a month this year'** and stopped going to Meals on Wheels about eight months ago **'because I was embarrassed about that shake in my hands'**.

Interest: You admit that you may have lost interest in the footie, garden and reading the newspaper. You still watch ABC television but often forget what you've just watched. You aren't sure why your interest has waned, but you just say:

**'I can't be bothered with all that anymore'**.

You have noticed that when the grandchildren visit, you feel irritated by their noise and questions and say:

**'I do love them but I can hardly wait for them to leave.'**

Motivation: You spend most days just sitting in the living room, listening to talkback radio. You don't really feel like doing anything anymore. When Marg suggests outings or activities, you put her off by saying:

**'I don't feel like doing that today, maybe tomorrow.'**

Memory: You have not noticed any problems with your memory or thinking ability. You could say any or all of the following:

**'I can still do cross word puzzles, when I feel like it.'** (but admit you haven't done one this year)

**'I can remember the names of most of the kids I taught years ago.'**

**'I've got Parkinson's not Alzheimer's.'**

If the candidate asks or starts to test your memory or any other mental abilities (drawing, making hand movements, naming animals in sixty seconds), say:

**'I did that with that old age doctor. He said my memory's fine.'**

If the candidate asks or starts to examine you physically, similarly say:

**'My GP and the other doctor have done all that.'**

Concentration: You're not sure how to judge that, but maybe it's 'not so good'.

**'My mind does wander a bit .... like when I'm watching television.'**

**'I don't read books anymore. Don't know why. Just lost interest, I guess.'**

The candidate may ask questions about the physical effects of depression.

Sleep: You have trouble getting off to sleep and awoken several times during the night. **'Marg says I thrash about in the bed at night.'**

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

Weight loss: You may have lost weight in the past year **'now you mention it, my pants do seem a bit loose.'**

Constipation: You have noticed that, but **'I thought it was the Parkinson's or the tablets.'**

Energy: You do get tired easily **'I only spend ten minutes in the garden before I want to go inside and lie down.'**

## Anxiety

- Just before taking your Parkinson's medication you do feel '**a bit edgy**' but this settles thirty minutes after taking the noon and night tablets.
- In general, you do not worry about things.
- 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.

## Psychosis

- You do not hear voices, have visions, experienced illusions or suffer from any other form of hallucinations.
- You do not feel paranoid, watched, spied upon or under surveillance.
- 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.

## Sleep & Wakefulness

As noted above: You have trouble getting off to sleep and awaken several times during the night.

***'Marg says I thrash about in the bed at night.'***

You do awaken feeling a bit groggy and sometimes have an afternoon nap of half an hour.

However, you do not feel particularly drowsy during the day or fall asleep without warning.

You do not experience nightmares, sleep walking or strange behaviours in your sleep.

You do not have restless legs or stop breathing during the night (sleep apnoea).

## Impulse Control

You do not suffer compulsive gambling, buying, eating or sexual behaviour.

## Emotional Expression

You have never experienced episodes of uncontrolled crying or laughing.

### **4.2 How to play the role:**

Your clothing is casual leisurewear with little attention to cleanliness or matching. You are generally unconcerned about your condition and slightly resistant to questioning. You offer only sparse spontaneous conversation of your own, and only answer questions with brief responses.

Your mood is best described as 'flat' with little emotional reaction, either positive or negative; and you are self-contained, showing minimal interest in what the candidate is asking.

You have come along to please Marg, your wife, and can barely wait to end the interview.

### **4.3 Opening statement:**

***'I'm not sure why Marg wanted me to see you. Everything is going ok with me.'***

### **4.4 What to expect from the candidate:**

The candidate should clarify your personal circumstances and then enquire about the diagnosis of Parkinson's Disease and its impact on you.

The candidate may ask you questions about your general health (medications, other illnesses) before focussing on psychological symptoms. They may ask a range of questions about depression including your energy, concentration, interest, appetite, sleep, activities, etc. They should also enquire about anxiety, memory, psychotic symptoms (hallucinations, delusions, disordered thoughts).

### **4.5 Responses you MUST make:**

***'Don't know why, but I just can't be bothered anymore.'***

***'Have I answered all your questions? Can I go home now?'***

### **4.6 Responses you MIGHT make:**

***'You sure ask a lot of questions.'***



## STATION 5 – MARKING DOMAINS

### The Main Assessment Aims are:

- To assess the ability to explore the medical condition of Parkinson's Disease and identify associated psychological and psychiatric symptoms.
- To evaluate ability to explore a range of psychiatric complications of Parkinson's Disease.
- To assess competence in interpreting depressive and apathy symptoms.
- To evaluate ability to generate and present a broad differential diagnostic statement.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take a focussed history of the symptoms, diagnosis and impact of Parkinson's Disease? (Proportionate value - 10%)

##### **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:**

obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; using a tailored biopsychosocial approach; eliciting longitudinal history of Parkinson symptoms (onset and how symptoms developed over time) and current symptoms; clarifying how diagnosis was made, patient's attitude to illness, medication and side effects; checking for medical illnesses (past and current); exploring the concerns of patient's wife; clarifying important positive and negative features; assessing for typical and atypical features.

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

- Clarify the impact of Parkinson's disease on the patient's functioning (physical, psychological and social).

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 a history of other psychological, cognitive and psychiatric symptoms found in patients with Parkinson Disease? (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 including ability to explore at least five (5) psychological, cognitive and psychiatric symptom complexes.

##### **Achieves the Standard by:**

obtaining a history relevant to the patient's problems and presentation; integrating key sociocultural issues relevant to the assessment; considering risks associated with the presentation; demonstrating the ability to prioritise and elicit key issues related to the psychological, cognitive and psychiatric symptoms of Parkinson's Disease.

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

- Explore at least three of the psychological, cognitive and psychiatric symptom complexes.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

omissions adversely impact on the obtained content; no psychiatric complications of Parkinson's Disease other than depression/apathy are explored; other significant deficiencies in the history taking.

1.2 Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 an appropriately focussed history of depressive spectrum and apathy symptoms? (Proportionate value - 25%)**

**Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard and attempts to differentiate apathy from depressive symptoms, particularly anhedonia; demonstrates prioritisation and sophistication.

**Achieves the Standard by:**

conducting a detailed but targeted assessment; including brief assessment of recent stresses, family context, past/family psychiatric history, medication and general medical history; history taking is hypothesis-driven; assessing for important positive and negative features; checking for typical and atypical features.

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

- Ask about both psychological and biological symptoms of depression.
- Explore the phenomenon of apathy.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

does not enquire about suicide; omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2 Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 explain the relevant diagnosis and differential diagnoses to the patient? (Proportionate value - 40%)**

**Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard and attempts to differentiate apathy from depressive symptoms; presents more than four diagnostic possibilities with well-reasoned explanations; identifies any limitations of the diagnoses prioritised.

**Achieves the Standard by:**

integrating available information in order to formulate a diagnosis/differential diagnoses; presenting the patient with a broad range of possible diagnoses or explanations for his symptoms; adequately prioritising possible diagnoses relevant to the obtained history and findings; utilising a biopsychosocial approach; communicating in an appropriate language and detail; checking the patient's understanding.

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

- Explain at least one depressive disorder as a possible differential diagnosis.
- Offer at least two other diagnoses of non-depressive illnesses.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

inaccurate diagnostic formulation; does not provide any diagnostic possibilities or provides only names of conditions without any explanation of the reasoning behind this; errors or omissions are significant and do materially affect conclusions.

1.9 Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

In this station the candidate is expected to elicit the normal versus abnormal mood states of bipolar disorder from Jane, a 34-year-old female who has had a history of severe manic episodes. Her husband is convinced she is relapsing and there is high expressed emotion at home. The assessment is undertaken in an outpatient clinic.

**1.1 The main assessment aims are:**

- To evaluate the ability to distinguish normal range of mood versus abnormal mood states in bipolar disorder.
- To assess the ability to explore the presence of a high expressed emotion environment.
- To assess the capacity to manage an individual's concern regarding possible relapse.

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

- Assess for both elevation and depressive symptoms of bipolar disorder.
- Consider that Jane is unlikely to be presenting with a bipolar relapse.
- Explain features of high expressed emotion (EE) to the patient without using jargon.
- Convey the importance of obtaining collateral information from the husband to confirm the findings.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - Data Gathering Content; Management – Initial Plan), Communicator (Synthesis)

**References:**

- David J. Miklowitz, Michael J. Goldstein, Keith H. Nuechterlein, Karen S. Snyder, Jim Mintz; Family Factors and the Course of Bipolar Affective Disorder, *Arch Gen Psychiatry*. 1988;45(3):225-231.
- Gin S Malhi, Darryl Bassett, Philip Boyce, Richard Bryant, Paul B Fitzgerald, Kristina Fritz, Malcolm Hopwood, Bill Lyndon, Roger Mulder, Greg Murray, Richard Porter and Ajeet B Singh; Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders, *Australian and New Zealand Journal of Psychiatry* 2015, Vol. 49(12) 1087–1206
- Ronald L. Butzlaff, Jill M. Hooley, Expressed Emotion and Psychiatric Relapse A Meta-analysis *Arch Gen Psychiatry*. 1998;55(6):547-552. Hooley, JM. Expressed Emotion and Relapse of Psychopathology. Annual Review of Clinical Psychology. Vol. 3: 329-352 (Volume publication date April 2007) DOI: 10.1146/annurev.clinpsy.2.022305.095236

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, roleplayer x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – woman in her early to mid-30s, casually but neatly dressed.
- 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 psychiatrist in an outpatient service. You are about to see Jane, a 34-year-old mother of two who has bipolar disorder. She has a history dating back to her late teens, with the last two severe manic episodes occurring post-partum in the last 6 years.

Her husband Paul made the appointment for her because he believes she is relapsing and your administrative officer noted he said 'she needs sorting'.

### Your tasks are to:

- Take a history from Jane to elicit her current symptom status.
- Discuss your findings with Jane.
- Outline a plan to address her husband's concerns to Jane.

**You will not receive any time prompt.**

## 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 e.g. investigation results.
  - 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 – there are no cues or time prompts for you to give.
- DO NOT redirect or prompt the candidate – 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 tasks?'***  
***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.

You have no opening statement or prompts.

When the candidate enters the room briefly check ID number.

The roleplayer opens with:

***'Hello Doctor. Paul thinks I am getting unwell again.'***

#### 3.2 Background information for examiners

The aim of this station is for the candidate to elicit the difference between normal variations in emotion versus abnormal mood states in a woman with bipolar disorder. The candidates are expected to identify that Jane's husband is convinced she is relapsing but that there is high expressed emotion at home which impacts on their relationship. The candidates are expected to come to the conclusion that Jane is not experiencing a relapse but is responding to stressors within the home.

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

- assess for both elevation and depressive symptoms of bipolar disorder.
- consider that Jane is unlikely to be presenting with a bipolar relapse.
- explain features of high expressed emotion (EE) to a patient without using jargon.
- convey the importance of obtaining collateral information from the husband to confirm the findings.

A surpassing candidate may:

- investigate in what way the high EE has developed and how these background factors can be addressed
- consider the psychodynamic features of high EE in Jane's parents and what psychotherapeutic options may address this
- clearly address barriers to the application of the plan such as difficulty engaging husband and how to focus on this or whether to involve other family members.

Expressed Emotion (EE) has been described since the 1970s as a qualitative measure of the 'amount' of emotion displayed, mainly in the family setting, and usually by a family member or carer. EE measures hostility, warmth, and positive remarks and was developed as a measure for the assessment of expressed emotion in relatives of adult patients with mental disorders like schizophrenia, bipolar disorder, depression, and eating disorders. It has been found to be a useful tool to predict relapse in these patients (Vaughn and Leff, 1976; Eisenberg, Thompson, Fabes, Shepard, Cumberland, Losoya et al., 2001; Hooley and Parker, 2006). Research supports that families that express emotion in an inadequate and excessive way toward the patient produce increased levels of stress that in turn do not favour readjustment and the recovery.

Critical comments, hostility and emotional over-involvement were found to be the most predictive areas on the semi-structured Camberwell Family Interview (CFI; Leff and Vaughn, 1985). 'Criticism' was defined as unfavourable comments about a family member; 'hostility' was defined as generalisation of criticism or hostility; and 'emotional over-involvement' consists of over-protective behaviour, devoted behaviour and exaggerated emotional response. Following the CFI, came the Five-Minute Speech Sample (FMSS; Magana, Goldstein, Karno, and Miklowitz, 1986). The FMSS is a brief method that is designed to assess the respondent's expressed emotional (EE) status toward a family member and is derived from statements made by a patient's relative during a 5-minute monologue. Low EE is demonstrated by a low level of expressed emotion, characterised by a well-modulated and balanced level of communicated emotion as opposed to High EE which is more often characterised by an excessive presence or intensity of the emotions, often beyond the control of the family member who has difficulty modulating their responses. Within each major sub-scale there can be high or low ratings; for instance, High Criticism can be scored when a) the first statement is negative, b) the family member/carers describes a negative relationship with the patient, or c) they criticise the patient.

The concept is used as a measure of the family environment that predicts poorer clinical outcomes for patients with a range of disorders. There is evidence that links high EE to clinical relapse in patients.

Evidence suggests that EE may play a causal role in the relapse process, and the possibility that high levels of EE may stress patients by disturbing activity in neural circuits that underlie psychopathology.

## Management

Apart from general interventions like undertaking a more thorough history and mental state examination, and obtaining collateral there are specific interventions that can be considered:

Lithium is effective for the treatment of mania and for the longer term maintenance of bipolar disorder. Lithium levels are important in the longer term maintenance of bipolar disorder and with optimum levels for this being 0.6 – 0.75mmol/L (Severus et al 2008, Malhi et al 2015). It prevents the recurrence of mania and is associated with an increased risk of relapse if stopped suddenly (Young and Newham, 2006), hence the need for adherence to a medication regime.

There is a known relationship between the sleep-wake cycle and bipolar disorder (Levenson, Nusslock, Frank, 2013). Sleep disturbance can be one of the first 'symptoms' to occur in manic relapse and predicts the onset of mood symptoms (Bauer, 2008). Increasing wakefulness and decreased need for sleep are the key characteristics of such sleep disturbance during these episodes of elevation but should be distinguished from other causes of, and reasons for insomnia. However prolonged periods of sleep disruption from other causes such as social disruptions after life events (Frank, 2005), or transmeridian travel (Inder, Crowe, Porter, 2015) can themselves lead to mood dysregulation. Attention to regulating sleep is therefore an important component of the management of bipolar disorder (Frank, 2005).

Involvement of the partner is critical to resolving whether the patient has relapsed, and to address the problems within the relationship and any specific intervention that the partner may benefit from. Getting collateral without undermining the patient is an important part of the intervention plan.

### 3.3 The Standard Required

In order to:

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

**Achieve 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 medico-legal 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.

**Standard Not Achieved** – 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 Jane, aged 34 years. You live with your husband, Paul, and your two children, Robbie (6) and Angus (18 months). You have not worked since you had Robbie and you were a bank teller for 8 years before this, a job which you thoroughly enjoyed.

You have known Paul for 10 years and have been married for 7 years. He is a persuasive, rather charismatic and confident person. He is usually a nice man but he has become more *'difficult and hostile'* over the past 4 or 5 years since you had children, and there is more conflict in the relationship. The impact of the manic episodes you had in the past took him by surprise even though you had been honest with him about your bipolar disorder when you decided to marry.

He has always told you he was traumatised and embarrassed by your manic episodes, and does not want you to relapse. He is concerned about any signs of possible relapse and constantly watches you in a controlling and critical fashion. He is very quick to be critical and comment negatively on things you do around the house if they are not up to 'standard' and makes you feel that you are ineffective. He appears to be becoming overinvolved with your daily activities and checks your phone, Facebook page, internet use and banking, and wants justification for your spending. You are not happy in the relationship but you still love him and *'forgive him'* as *'he must be stressed being a busy IT consultant and the only wage earner'*.

Lately you have been thinking about your role as a mother and a woman, and would like to return to work so you have been looking at banking related jobs on the internet. Your husband has twice come home late in the last week and criticised you for what he describes as *'internet overuse and unrealistic plans about work because the children are still young'*. When you repeatedly try to engage him in animated discussions about how you feel about going to work, you only get so far and then he tells you he thinks your mood is overly high, so you back down and tend to withdraw for a bit to let things settle.

Despite the increasing tension at home you have good support from close friends who have told you they think Paul is a critical controlling man, and that he is not helpful for you. They think your plans to work part-time are perfectly reasonable and have had no concerns about you. You also have a very good relationship with your boys and they are developing normally; Robbie is at school and Angus has just started attending a toddler playgroup two mornings per week. They are sociable and happy though lately Robbie has become *'a bit feisty and stubborn'*, and last week your husband came home to you raising your voice at him. You then had an argument with your husband as he criticised you for this, and were upset enough that you could not get to sleep that night so got up out of bed (as per your sleep hygiene rules) and played a game of cards.

Without even trying to discuss it with you, this week Paul phoned your parents to tell them he thinks you may be relapsing, which caused further conflict with him. This action has just again reminded you of your upbringing with a critical controlling father, and a very un-nurturing angry mother who probably had her own *'issues'*. Your parents live 50km away in the country and told him to *'sort you out'*.

You have come to the appointment reluctantly *'to keep the peace'* even though you (and your friends) do not believe you are relapsing. You have been in conflict with your husband but you feel it is him who has been the difficult one.

Since your last manic episode about 18 months ago you have been stable on your medication, which is 1000 milligrams of lithium (500 mg twice a day) to stabilise your mood. You don't have any concerns about taking lithium and know that this medication needs regular blood tests to check the levels of medication. The levels were last measured at '0.6' about 10 days ago. This level is very similar to others taken over the years when you are well.

#### Past Psychiatric History:

You have had two clear depressive episodes in your late teens/early twenties, the first in the context of conflict with your parents and the second in the context of conflict with your then boyfriend. You did not require inpatient treatment for either. You then had one manic episode overseas while travelling and were admitted to a mental health unit in the UK for about a week. More recently, after the birth of both your sons you had severe manic episodes requiring involuntary admission and treatment for three months each. After your last episode you were discharged from hospital to the outpatient services, and have been under their care for the past year and are in a discharge planning phase to the GP.



When you were depressed, you were sad and teary on most days for a few weeks, slept poorly, did not want to do anything and stayed in bed a lot. You were never suicidal, and did not try to hurt yourself or anyone else.

During the last manic episode your mood was high and you felt you were invincible, making plans to open several online businesses and spending lots of money on clothes for your children and yourself. You also posted multiple rambling messages on Facebook which your husband was embarrassed about. You did not sleep and lost weight, and you had more conflict with your husband when he intervened, which led to you telling him you were leaving him. You were admitted because you were not feeding your baby enough as you were so distracted and busy, and he lost weight. You were not sexually disinhibited and did not show dangerous behaviours like driving fast or recklessly.

Your doctor has also prescribed an 'as required' medication called lorazepam (which is like Valium and is to help calm you down when you are upset). But have only needed to take this twice earlier this year when you still hadn't fallen asleep by 11.30pm. You accept that you have bipolar disorder and always try to take your medication, and have learned to pay particular attention to your sleep-wake cycle. You have had antidepressants in the past (citalopram and Prozac) and an antipsychotic that made you put on weight after you were admitted with mania in the UK - you cannot recall the name.

You keep regular appointments with the mental health team and have really benefited from the support the mental health clinicians have provided you. Unfortunately, your husband Paul has not been in too many appointments and the community team has not provided any input to him; he therefore does not fully understand bipolar disorder or how it presents for you.

You have never had psychotic symptoms like hearing voices or seeing things that others do not, believing that people were out to harm you or believing that the TV and radio refer to you.

You do not drink alcohol or use drugs – you have never done so. You are a non-smoker.

You have never had any problems or charges by the police.

#### **4.2 How to play the role:**

You present within a normal range of mood. You have no mood symptoms at the moment, though you are upset and worried about your relationship and this is the primary focus of the station. In light of this you are happy to consider couple counselling if offered.

You have not been elevated in mood and have not had significantly increased anxiety levels. Your ability to concentrate, your energy levels and libido are all normal. You had that one night last week when you could not sleep after an argument with Paul, and it was too late to take your lorazepam so you got up and played patience (cards) and had a hot milk.

You have no unusual ideas or grand plans and haven't been overspending. You have been on the internet a lot recently looking for jobs (but at times when the boys are in bed or at school) and are excited about the possibility of obtaining a part-time position in a bank as you feel this would give you some better sense of identity and a source of social contact.

#### **4.3 Opening statement:**

*'Hello Doctor, Paul thinks I am getting unwell again.'*

#### **4.4 What to expect from the candidate:**

The candidate may ask how the last 2-4 weeks have been going, and will ask about your past history and about the home environment. They should also ask why Paul is concerned about you.

The candidate may suggest obtaining information from Paul or your parents or friends about how you have been and you are ok with this. The candidate may also suggest Paul comes in for an appointment, you are happy with this.

The candidate may suggest that Paul could be depressed or anxious – you hadn't thought of this but accept suggestions the candidate may make.

**4.5 Responses you MUST make:**

*'Why is Paul so critical of me?'*

*'Do you think I might get unwell?'*

**4.6 Responses you MIGHT make:**

*'I am happy to accept any suggestions you make.'*

*'I am worried about my relationship.'*

**4.7 Medications:**

Lithium 1000 milligram (you take two 250 milligram tablets twice a day) – you haven't missed any doses and do not get any side effects.

Lorazepam (half a tablet) as required to help with sleep/anxiety – you have taken it twice in the past year – not sure how many milligrams it is.

## STATION 6 – MARKING DOMAINS

### The Main Assessment Aims are:

- To evaluate the ability to distinguish normal range of mood versus abnormal mood states in bipolar disorder.
- To assess the ability to explore the presence of a high expressed emotion (EE) environment.
- To assess the capacity to manage an individual's concern regarding possible relapse.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value – 35%)

##### **Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard with a superior performance in a range of areas; elicits the intergenerational component of high expressed emotion; elicits why the husband may be overly concerned about relapse; explores her understanding of Paul's experience and his knowledge of her disorder.

##### **Achieves the Standard by:**

demonstrating use of a tailored biopsychosocial approach; conducting a targeted assessment for any current symptoms of bipolar; obtaining a history of how is Jane functioning and whether this is validated by others; eliciting evidence in keeping with high levels of EE in the home; history taking is hypothesis-driven considering what are the concerns of the husband/what factors are influencing this; integrating key sociocultural issues in particular the high EE at home; eliciting the key issues of a normal relationship with children, and realistic ideas regarding work; completing a risk assessment relevant to the individual case.

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

- Assess for both elevation and depressive symptoms of bipolar disorder.

**A score of 4** may be awarded depending on the depth and breadth of additional factors covered such as other factors that could affect relapse – adherence to meds, knowledge of lithium levels, understanding and acceptance of diagnosis.

##### **Below the Standard (scores 2 or 1) if:**

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

##### **Does Not Achieve the Standard (scores 0) if:**

omissions adversely impact on the obtained content such that the candidate ignores the possibility that Jane may be well; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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

#### 2.5 Did the candidate demonstrate effective communication skills appropriate to the context? (Proportionate value – 30%)

##### **Surpasses the Standard (scores 5) if:**

integrates information in a sophisticated manner that can effectively be utilised by Jane; provides succinct and professional information about EE in bipolar disorder and/or psychiatric illness in general; describes in detail the research in high EE; does not appear to blame Jane's husband for his responses.

##### **Achieves the Standard by:**

providing an accurate and structured description of how the family environment is impacting on presentation; mentioning the research component in relation to EE; acknowledging Jane's opinion of her illness status; recognising that the presence of high EE may lead to relapse in the future; adapting communication style to Jane's responses and to the setting; demonstrating discernment in selection and delivery of content particularly in relation to Jane's husband's behaviour.

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

- Consider that Jane is unlikely to be presenting with a bipolar relapse.
- Explain features of high EE to a patient without using jargon.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

talks over Jane or utilises a dictatorial style; does not take into account concerns about home situation; places blame for the situation on the husband; focusses on this being a relapse; does not accept her view that she is well.

2.5. Category: SYNTHESIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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**

**1.13 Did the candidate formulate and describe a relevant initial plan on how to address the husband’s concerns? (Proportionate value – 35 %)**

**Surpasses the Standard (scores 5) if:**

provides a sophisticated link between the plan and key issues identified; explores potential barriers to engaging the husband; respectfully considers the role Jane plays in the conflict at home e.g. dependency, lack of confidence, own poor communication.

**Achieves the Standard by:**

obtaining collateral information from a range of sources; demonstrating the ability to prioritise and implement evidence based care which includes targeting the stressors (home environment and relationship); planning for risk management with Jane in case her condition deteriorates; confirming recent/current lithium levels; strengthening Jane’s coping skills and communication with Paul; suggesting psychological interventions like couples counselling; recommending specific interventions of value e.g. Interpersonal and Social Rhythm Therapy that may assist; setting realistic timeframes and recognition of the need for review.

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

- a. Convey the importance of obtaining collateral information from the husband to confirm the findings.

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

**Below the Standard (scores 2 or 1):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response e.g. no plan for review or follow up; significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

plan includes changes to medication because candidate considers the patient is unwell; plan lacks structure or is inaccurate; plan not tailored to patient’s immediate needs or circumstances.

<b>1.13. Category: MANAGEMENT - Initial Plan</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	<b>5</b> <input type="checkbox"/>	<b>4</b> <input type="checkbox"/>	<b>3</b> <input type="checkbox"/>	<b>2</b> <input type="checkbox"/>	<b>1</b> <input type="checkbox"/>	<b>0</b> <input type="checkbox"/>

**GLOBAL PROFICIENCY RATING**

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

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

In this viva station the candidate is expected to demonstrate their knowledge of the negative symptoms of schizophrenia, including historical factors, identification, differential diagnosis and their management.

**1.1 The main assessment aims are:**

- To demonstrate knowledge of the historical descriptions associated with negative symptoms in schizophrenia from classical psychiatric literature.
- To demonstrate the ability to identify negative symptoms of schizophrenia through the process of excluding other possible explanations like depression, response to severe positive symptoms and extrapyramidal side effects as part of the differential diagnosis.
- To demonstrate an awareness of the treatment of negative symptoms of schizophrenia.

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

- Identify at least one historical figure associated with the description of negative symptoms.
- Describe alternative causes for negative symptoms of schizophrenia that includes depression, extrapyramidal side effects and positive symptoms.
- Incorporate a BioPsychoSocial approach to treatment.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS domains:** Scholar, Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Scholar (Literature Knowledge), Medical Expert (Diagnosis; Management – Initial Plan)

**References:**

- Buchanan, R. (2007) Persistent Negative Symptoms in Schizophrenia: An Overview *Schizophrenia Bulletin*. **33**: 1013–1022
- Tanden R, Gaebel W, et al. Definition and description of schizophrenia in the DSM-5. *Schiz Res* 2013 [http://dx.doi.org/ 10.1016/j.schres.2013.05.028](http://dx.doi.org/10.1016/j.schres.2013.05.028)
- Andreasen NC: Scale for the Assessment of Negative Symptoms (SANS). Iowa City, University of Iowa, 1984
- Vella, S. Cynthia. and Pai, N. B. (2015). Negative symptoms of schizophrenia: a historical, contemporary, and futuristic view. *Archives of Medicine and Health Sciences*, 3 (2), 329-334
- Castle, D., Copolov D., Wykes T., Mueser K. Pharmacological and psychosocial treatments in schizophrenia, Informa 2008

**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'.
- 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.

**This is a VIVA station. There is no role player in this station.**

You are working as a junior consultant in a community psychiatry clinic. One of your patients, Jason, is a 27-year-old man with a diagnosis of schizophrenia. He lives with his mother. During a routine review, his mother tells you that she is concerned that her son is spending his day sitting on the couch doing nothing.

You think he may have negative symptoms of schizophrenia.

**Your tasks are to present:**

- The historical aspects of the concept of negative symptoms in schizophrenia.
- Describe the differential diagnoses for negative symptoms of schizophrenia.
- Outline management options for negative symptoms of schizophrenia.

**You will not receive any time prompts.**

## 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 e.g. investigation results.
  - Pens.
  - Water and tissues are 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.
- Your scripted introduction is:  
***'Please proceed to complete your tasks.'***
- TAKE NOTE – there are no cues or time prompts for you to give.
- 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 **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 tasks?'***  
***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.

Your scripted introduction is:

***“Please proceed to complete your tasks.”***

There are no specific prompts.

#### 3.2 Background information for examiners

This station aims to assess the candidates' ability to understand, identify and manage the negative symptoms of schizophrenia. The candidate is expected to demonstrate their theoretical knowledge of negative symptoms on which they can base their assessment, diagnosis and treatment. This includes formulating a differential diagnosis that incorporates severe positive symptoms, extrapyramidal symptoms and depressive symptoms.

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

- Identify at least one historical figure associated with the description of negative symptoms.
- Describe alternative causes for negative symptoms of schizophrenia that includes depression, extrapyramidal side effects and positive symptoms.
- Incorporate a BioPsychoSocial approach to treatment.

#### History

The negative symptoms of schizophrenia, defined as the absence or diminution of normal behaviours and functions, have been recognised since Kraepelin and Bleuler. Kraepelin's description of the 'avolitional syndrome' manifested as a 'weakening of those emotional activities which permanently form the mainsprings of volition' and resulting in 'emotional dullness, failure of mental activities, loss of mastery over volition, of endeavour, and of ability for independent action' represents one of the most elegant descriptions of negative symptoms.

Following Kraepelin, Bleuler further theorised about the condition known as dementia praecox, which he renamed as schizophrenia in 1911. Bleuler ascertained that schizophrenia was a disturbance of association, affectivity, attention, and volition. This view of schizophrenia remained the prominent view until the 1960's when the emphasis shifted toward symptoms reflective of a disturbance of reality such as delusions and hallucinations. Positive symptoms reflective of a reality disturbance are much more easily identifiable being either present or absent, as oppose to the diminution of functioning apparent in the negative symptomatology described by Kraepelin and Bleuler.

A few theorists continued to identify the importance of negative symptoms with Andreasen recognising that although positive symptoms are readily identifiable, it is not the most fundamental characteristic of schizophrenia; hence, she developed the first scale for measuring negative symptomatology in schizophrenia in 1983; the scale for the assessment of negative symptoms (SANS). This instrument offered the first operational definition of the negative symptomatology construct. The SANS measures the following negative symptoms: alogia, affective blunting, avolition, apathy, anhedonia, asociality, and attentional impairment. Crow defined two types of schizophrenia; Type I being associated with positive symptoms and Type II being associated with negative symptoms, the latter being unchangeable by treatment and associated with poor long-term outcomes.

#### Negative Symptoms

Negative symptoms are identified as one of the core criteria of schizophrenia in both the DMS-5 and ICD-10. They include blunted affect or decline in emotional response, alogia, apathy, amotivation, avolition, asociality and anhedonia:

- Affective flattening or blunted affect
- Anhedonia relates to a lack of enjoyment
- Asociality refers to a tendency to isolate oneself
- Alogia is a lack of speech
- Apathy and avolition pertains to a lack of interest, enthusiasm or concern.



These symptoms tend to persist longer than positive symptoms and are more difficult to treat, and account for much of the long-term morbidity and poor functional outcome of patients with schizophrenia. Improvements in negative symptoms are associated with a variety of improved functional outcomes, including independent living skills, social functioning, and role functioning. Targeting these symptoms in the treatment of schizophrenia may have significant functional benefits.

In DSM-5, negative symptoms are classified under criterion A (Characteristic symptoms).

According to DSM-5, avolition and diminished emotional expression have been found to describe two distinguishable aspects of negative symptoms in schizophrenia, and diminished emotional expression better describes the nature of affective abnormality in schizophrenia than affective flattening.

Persistent negative symptoms include the negative symptoms of schizophrenia that:

1. are primary to the illness
2. interfere with the ability of the patient to perform normal role functions
3. persist during periods of clinical stability
4. represent an unmet therapeutic need

### Prevalence

In clinical samples, patients with the deficit form of schizophrenia or primary negative symptoms represent about 20%–30% of patients, whereas in population-based samples approximating incidence samples, patients with the negative symptoms of schizophrenia comprise 14%–17% of patients with schizophrenia.

### Assessment

The clinical assessment of persistent negative symptoms is based on cross-sectional and longitudinal evaluation of negative symptoms, in conjunction with the use of other symptom criteria designed to minimise the inclusion of secondary negative symptoms (such as medication side effects). Restricted affect, diminished emotional range, and poverty of speech are mainly evaluated by observation, while curbing of interest, diminished sense of purpose, and diminished social drive by interview.

The Scale for the Assessment of Negative Symptoms (SANS) or Positive and Negative Symptom Scale (PANSS) are currently the standard scales used to assess negative symptoms, but they have a number of limitations including insufficient number of items to assess the full range of negative symptoms, inclusion of nonspecific items that can be found in other psychiatric disorders, inadequately defined anchors, lack of standardised scoring methods or lack of sensitivity to change over brief periods of time.

Items included in SANS are:

<p><b>Affective Flattening or Blunting</b> (a diminution of emotional expression).</p> <ul style="list-style-type: none"> <li>• Unchanging Facial Expression</li> <li>• Decreased Spontaneous Movements</li> <li>• Paucity of Expressive Gestures</li> <li>• Poor Eye Contact</li> <li>• Affective Non-responsivity</li> <li>• Lack of Vocal Inflections</li> <li>• Inappropriate Affect</li> <li>• Global Rating of Affective Flattening</li> </ul>	<p><b>Anhedonia</b> (inability to experience pleasure) - <b>Asociality</b> (general lack of interest in social relationships)</p> <ul style="list-style-type: none"> <li>• Recreational Interests and Activities</li> <li>• Sexual Interest and Activity</li> <li>• Ability to Feel Intimacy and Closeness</li> <li>• Relationships with Friends and Peers</li> <li>• Global Rating of Anhedonia-Asociality</li> </ul>
<p><b>Alogia</b> (defined as a poverty of speech either in frequency or content)</p> <ul style="list-style-type: none"> <li>• Poverty of Speech</li> <li>• Poverty of Content of Speech</li> <li>• Blocking</li> <li>• Increased Latency of Response</li> <li>• Global Rating of Alogia</li> </ul>	<p><b>Avolition</b> (defined as a general lack of motivation) - <b>Apathy</b> (lack of interest in general)</p> <ul style="list-style-type: none"> <li>• Grooming and Hygiene</li> <li>• Impersistence at Work or School</li> <li>• Physical Anergia</li> <li>• Global Rating of Avolition-Apathy</li> </ul>
<p><b>Attention</b></p> <ul style="list-style-type: none"> <li>• Social Inattentiveness</li> <li>• Inattentiveness During Mental Status Testing</li> <li>• Global Rating of Attention</li> </ul>	

## Differential Diagnosis:

The negative symptoms of schizophrenia can closely resemble the symptoms of a depressive episode (these include apathy, extreme emotional withdrawal, lack of affect, low energy and social isolation).

Negative symptoms may be medication related effects (secondary negative symptoms due to sedation and extrapyramidal symptoms - EPSE). These are known as the neuroleptic induced deficit syndrome. The bradykinesia, limb stiffness, and mask-like facies seen in Parkinsonism are a social and functional handicap. The development of symptoms is dose dependent and emerges in about 20 to 40 percent of patients. With continuation of medication, the Parkinsonian symptoms may gradually subside and tolerance may develop.

While cognitive symptoms of schizophrenia have been accepted for many years they are not specifically included in the diagnostic criteria for schizophrenia in DSM-5 because of the lack of specificity to the disorder.

Severe positive symptoms can cause reduced mobility and withdrawal secondary to preoccupation with auditory hallucinations or as a reaction to persecutory delusions. Hallucinations and delusions may lead to emotional and social withdrawal both as a response to the often threatening content of these psychotic phenomena, and to the attempt to reduce external stimuli in the face of being overwhelmed by emotional experiences. During acute psychotic episodes it may be impossible to distinguish between secondary negative symptoms originating from this cause and primary negative symptoms – such a distinction may be possible only in retrospect. Catatonia, although rare, needs to be kept in mind due to the psychomotor inhibition associated with this state.

Social isolation resulting from a chronic illness may in itself produce social withdrawal similar to primary negative symptoms and must be considered in each patient.

## Management of Negative Symptoms

Negative symptoms are generally viewed as being resistant to treatment, but evidence suggests that they do respond to pharmacologic and social interventions. Most responsive to treatment are negative symptoms that occur in association with positive symptoms (psychotic-phase) and secondary negative symptoms caused by neuroleptic medication, depression, or lack of stimulation.

The most effective treatment for secondary symptoms is to target the underlying cause. Neuroleptic-induced akinesia may respond to anticholinergic agents, reduction in antipsychotic dose, or a change in antipsychotic. Using one of the newer-generation antipsychotics (clozapine, risperidone, olanzapine, quetiapine, or ziprasidone) may prevent EPS. Medication must be used in the lowest effective dose.

## Psychosocial Treatments for Negative Symptoms

A psychosocial approach to schizophrenia builds on relationships between the patient and others and may involve social skills training, vocational rehabilitation, and psychotherapy. Activity-oriented therapies appear to be significantly more effective than verbal/talking therapies. This is in part due to their effect in reducing the environmental under-stimulation experienced by chronically unwell people due to their social isolation and lack of employment. The role of NGOs in this area is invaluable. An assessment by an occupational therapist to identify areas of strength and using a recovery-based approach can ensure a better outcome.

### Goals of psychosocial therapy:

- set realistic expectations for the patient
- stay active in treatment in the face of a protracted illness
- create a benign and supportive environment for the patient and caregivers.

**Social skills training** designed to help the patient correctly perceive and respond to social situations, is the most widely studied and applied psychosocial intervention. The training is similar to that used in educational settings but focusses on remedying social rather than academic deficits. In schizophrenia, skills training programs address living skills, communication, conflict resolution, vocational skills, etc.

In early studies of social skills training, patients and their families described enhanced social adjustment, and hospitalisation rates improved. More recent studies have confirmed improved social adjustment and relapse rates but suggest that overall symptom improvement is modest.

**Cognitive remediation** involves using computer based training tasks with graduated levels of difficulty that challenges compromised cognitive abilities like attention, concentration and executive function. These exercises vary from those that target specific cognitive processes like facial recognition to others that use many integrated brain processes. They typically begin with simple tasks and build to more complex ones.

**Cognitive behaviour therapy** for negative symptoms aims to harness motivation, and promote social and emotional re-engagement by techniques like behaviour self-monitoring, activity scheduling and graded task assignments.

Psychoeducation should be aimed at helping family members, who are often more distressed by negative symptoms than the patients, to understand that these symptoms are not under the patient's control. An explanation of the blunted affect, psychomotor retardation and social withdrawal as being part of the illness would help them manage these situations better, and may aid in reducing high levels of expressed emotions.

### **Medication for Negative Symptoms**

Comorbid depression may require adding an antidepressant, or it may respond directly to an antipsychotic. Lack of stimulation is best handled by placing the patient in a more appropriately stimulating (but not overstimulating) and supportive environment. Non-enduring primary or psychotic-phase negative symptoms respond to effective antipsychotic treatment of the positive symptoms.

Conventional first generation antipsychotics (e.g. haloperidol, chlorpromazine) clearly offer some benefit in treating positive symptoms. However, using higher-than-appropriate doses may result in severe EPS.

Two-thirds of the approximately 35 studies comparing conventional and second generation antipsychotics (SGAs) in treating negative symptoms have found SGAs to be significantly more effective (regardless of which atypical was used). In general, SGAs improve negative symptoms by about 25%, compared with 10 to 15% improvement with conventional agents.

Much of the greater benefit with SGAs appears to be related to their at least equivalent ability to improve positive symptoms without causing EPS. Consequently, the key to improved patient outcomes is appropriate dosing of SGAs that reduces positive symptoms optimally without EPS and without the need for an anticholinergic.

The significance of clozapine lies in its ability to provide clinical improvement in treatment resistant patients, resulting in an overall improvement in the quality of life, with effects on both positive and negative symptoms.

## **3.3 The Standard Required**

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## STATION 7 – MARKING DOMAINS

### The Main Assessment Aims are:

- To demonstrate knowledge of the historical descriptions associated with negative symptoms in schizophrenia from classical psychiatric literature.
- To demonstrate the ability to identify negative symptoms of schizophrenia through the process of excluding other possible explanations like depression, response to severe positive symptoms and extrapyramidal side effects as part of the differential diagnosis.
- To demonstrate an awareness of the treatment of negative symptoms of schizophrenia.

### Level of Observed Competence:

#### 6.0 SCHOLAR

#### 6.4 Did the candidate demonstrate knowledge of relevant history relating to the development of the concepts associated with negative symptoms of schizophrenia? (Proportionate value - 20%)

##### **Surpasses the Standard (scores 5) if:**

clearly achieves the standard overall with a superior knowledge presented systematically; supports presentation with references from the literature.

##### **Achieves the Standard by:**

displaying knowledge of the evolution of the historical concept of negative symptoms from Kraepelin to current times; describing the theories about negative symptoms; recognising contributions recorded by individuals in the literature; including development of techniques to assess negative symptoms; outlining the symptom descriptions that make up negative symptoms.

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

- Identify at least one historical figure associated with the description of negative symptoms.

**A score of 4** may be awarded if the candidate includes a number of historical and current figures involved in the evolution of this concept.

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

unaware of any of the historical aspects of negative symptoms; insufficient support from the literature.

6.4. Category: SCHOLAR – Literature Knowledge	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 relevant differential diagnoses for negative symptoms of schizophrenia? (Proportionate value - 40%)

##### **Surpasses the Standard (scores 5) if:**

clearly achieves the standard overall with a superior performance in a number of areas; is aware of the significance of social isolation and cognitive impairment in addition to depression, EPSE and severe positive symptoms; recognises the difficulties of differentiating these conditions.

##### **Achieves the Standard by:**

providing most of the likely differential diagnoses for this condition; demonstrating detailed understanding of the diagnostic criteria; adequate prioritising of conditions relevant to making the diagnosis; providing features that differentiate alternatives with details regarding the features of each which help in the diagnostic process; explaining how negative symptoms mimic other symptoms.

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

- Describe alternative causes for negative symptoms of schizophrenia that includes depression, extrapyramidal side effects and positive symptoms.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

significant deficiencies such as giving irrelevant options or offers no differential diagnosis.

1.9. Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 adequately discuss a management plan for the negative symptoms of schizophrenia? (Proportionate value - 40%)**

**Surpasses the Standard (scores 5) if:**

clearly achieves the standard overall with a superior performance in a number of areas; provides a broad, well-constructed biopsychosocial approach; recognising the roles of the MDT and NGOs in a recovery based framework; identifying limitations of treatments.

**Achieves the Standard by:**

demonstrating an understanding details of specific treatments; setting realistic goals and a supportive environment; prioritising a switch from first generation antipsychotics if prescribed; describing the role of medication to relieve extrapyramidal symptoms and change to antipsychotics that minimise these; considering the unique role of clozapine; providing details of psychosocial treatments such as social skills training, vocational rehabilitation, and psychotherapy; involving the family and applying psychoeducation.

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

- a. Incorporate a BioPsychoSocial approach to treatment.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

significant deficiencies such as having a disorganised approach; no relevant management options provided.

1.13. Category: MANAGEMENT – Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

The candidate will interview a parent in relation to his concerns about his 8-year-old son who has Autism spectrum disorder (ASD) and is being bullied at school. The candidate should be able to demonstrate that they are familiar with interventions available for consideration.

**1.1 The main assessment aims are:**

- To test the candidate's knowledge regarding the common mental health issues caused by bullying through an interview situation that requires the candidate to elicit and establish the range and severity of parental concerns in relation to an ASD child who is being bullied.
- To test the candidate's capacity to advise and suggest options for action to the parent that includes addressing the care needs of the child and the school context in which the bullying occurs.

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

- Elicit the history of recent changes in the emotional and behavioural state of the child, Alex.
- Specifically assess for symptoms of possible depression and anxiety and possible recent self-harm.
- Prioritise individual care needs that include referral for more specialised assessment with a child and adolescent specialist.
- Consider the school environment and the importance of action by the school to address the issues.
- Be accurate in relation to the potential seriousness of bullying of Alex.
- Demonstrate sensitivity to the dilemma for the parent that Alex is positively engaged with the school which may not be consistent or proactive in its approach to complaints of bullying.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Child and Adolescent Disorders
- **Area of Practice:** Child and Adolescent Psychiatry
- **CanMEDS domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment-Data Gathering Content; Management-Initial Plan), Communicator (Synthesis)

**References:**

- Rutter, M. et al (2008) *Rutter's Child and Adolescent Psychiatry*, 5<sup>th</sup> Edition, Wiley-Blackwell
- Augustyn, M. (2015) 'Autism spectrum disorder: Diagnosis', *UpToDate*, [www.uptodate.com](http://www.uptodate.com)
- Carter, S. (2009) 'Bullying of students with Asperger Syndrome', *Issues in Comprehensive Pediatric Nursing*, 32:145-154
- Queensland Government: <https://www.qld.gov.au/disability/children-young-people/bullying-disability-mental-health>
- Bullying prevention and response: a guide for schools (2015): [www.education.govt.nz/bullying/prevention](http://www.education.govt.nz/bullying/prevention)

**1.4 Station Requirements:**

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, roleplayer x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – male; 30s-40s. Must be credible parent of young child.
- 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 in a community mental health centre. John has been a patient of yours for some time. This section of the interview occurs after you have completed your routine clinical review of his bipolar affective disorder and determined that John is clinically stable. There are no current concerns with his mental state or treatment.

You have asked him if there is anything further that he would like to discuss and he has raised with you concerns in relation to his 8-year-old child, Alex, being bullied. You are aware from previous discussion that Alex has Autism spectrum disorder and is attending main-stream school.

### **Your tasks are to:**

- Discuss with the parent his concerns in relation to his child.
- Discuss with the parent his options for responding to his child's issues.

**John is clinically stable and you should not spend time in exploration of his illness.**

**Do NOT focus on assessment of John's parenting capacities.**

**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 e.g. investigation results.
  - 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 – there are no cues or time prompts for you to give.
- DO NOT redirect or prompt the candidate – 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 tasks?'***  
***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.

You have no opening statement or prompts.

The role player opens with the following statement:

***'I would like to spend some time talking about some worries that I have about my son, Alex.'***

#### 3.2 Background information for examiners

In this station the candidate is expected to interview a parent, John, in relation to his concerns about his 8-year-old son, Alex, who has Autism spectrum disorder (ASD) and is being bullied at school. The candidate must demonstrate their knowledge of the common mental health issues caused by bullying, and advise the parent on options for action.

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

- Elicit the history of recent changes in the emotional and behavioural state of the child, Alex.
- Specifically assess for symptoms of possible depression and anxiety, and possible recent self-harm.
- Prioritise individual care needs that include referral for more specialised assessment with a child and adolescent specialist.
- Consider the school environment and the importance of action by the school to address the issues.
- Be accurate in relation to the potential seriousness of bullying of Alex.
- Demonstrate sensitivity to the dilemma for the parent that Alex is positively engaged with the school which may not be consistent or proactive in its approach to complaints of bullying.

Literature suggests that 'being targeted by bullies appears to lead to wide-ranging maladjustment in children, and should be a clinical concern' (Rutter, pg. 547). Surveys indicate that nearly 50% of children are involved in bullying at some time in childhood, although chronic involvement as a victim is less common.

Bullying is the repeated intimidation or oppression of a person by another more powerful individual or group. It is repetitive and is intended to cause pain and discomfort.

Bullying can take different forms including verbal aggression; social exclusion or isolation (e.g. spreading lies and rumours; conditional friendship with alternating friendship and bullying); physical aggression (e.g. threatening behaviour or coercion; assault); sexual. Bullying may occur via social media and the Internet.

Verbal bullying is more common. Physical bullying is less common and declines with age. Bullying by individuals is more common than bullying by groups.

Bullies may focus on any aspect that sets an individual apart from others.

Children who get bullied are more likely:

- To be good at academics/sport/performing arts;
- To have a learning disability;
- To look and act differently (for example: obesity, clumsiness, disruptive off-task behaviour, speech impairment);
- To have emotional problems, low self-regard and poor social skills (for example: lack friends, socially ineffective, emotional immaturity - like to play by themselves, quiet, try to be good, cannot defend themselves).

Australian estimates:

- Approximately once a week for one in six children aged between 7 and 17 years of age (Rigby, 1997).
- General bullying (no specified type) is the highest (32%) among Year 5 students and (29%) among Year 8 students (A.C.B.P.S., 2009).
- Males typically report being bullied more than females.
- Covert bullying is the highest among Year 4 and Year 8 students with hurtful teasing the most prevalent. Covert bullying tends to start in late primary school for girls and early secondary school for boys. Girls more so than boys, tend to engage in covert bullying. Covert bullying tends to occur usually between same genders (A.C.B.P.S., 2009).
- Cyber bullying occurs more through social networking sites than mobile phones. Older students engage in more cyber bullying than younger students. Students from non-government schools tend to engage more in cyber bullying than government school students (A.C.B.P.S., 2009).

Several studies have been conducted into the prevalence of bullying in New Zealand and further studies are recommended (2015).

Studies into the impact of bullying are confounded by the risk factors that pre-exist bullying. A longitudinal study that controlled for pre-existing risk factors at age 5 school entry demonstrated that at age 7 years, children who had experienced bullying had more emotional problems, more disruptive behavioural problems, fewer prosocial behaviours and were less happy at school (see Rutter, pg. 547).

General impacts of bullying for victims may include:

- Absenteeism and school refusal
- Social and emotional problems: loneliness, low self-esteem, poor social concept
- Physical ill-health
- Decline in academic performance
- Depression and anxiety (Hawker and Bolton, 2000: meta-analysis of 20 years of research; Rutter et al)
- Persistent effects into adulthood.

Bullying is identified as a risk factor for:

- Suicide

Children and young people with Autistic spectrum disorder (ASD) appear to be at high risk of bullying. They may be especially vulnerable to being bullied because of their social and behavioural difficulties. Factors that place children at particular risk of isolation include disparity between social and intellectual development.

Trends towards inclusive schooling in main-stream settings may increase the potential for bullying as many children with disabilities can struggle to belong to their peer group in these settings. Australian studies indicate that more than 50% of children with autism are placed in the main-stream school environment.

Children and young people with disabilities may be under-diagnosed, and treated for depression and anxiety. There is some evidence that they may also be less likely to be recognised as victims of bullying. The impact of bullying can be profound, debilitating and have long-term mental health consequences.

One study of bullying in children with Asperger's syndrome reported:

- 65% of parents reported their children had been victimised by their peers within the past year
- Approx. 50% reported being scared by their peers with 9% reporting being attacked by a gang or hurt in their genitals
- 12% had never been invited to a birthday party
- 6% were almost always picked last for teams
- 3% ate alone at lunch every day

(Carter, S. (2009) Bullying of Students with Asperger Syndrome, Issues in Comprehensive Paediatric Nursing, 32:145-154).

Other studies have reported higher rates (for example, Little 2002, reported that 94% of parents reported that their child with Asperger's Syndrome had been bullied in the previous year).

Evidence-based interventions for school emphasise the creation of positive school environments that promote positive interactions and self-advocacy; wellbeing and social and emotional learning programs that support building resilience as a multi-faceted school-wide approach through promotion of self-awareness, self-management, social awareness, relationship skills and decision-making; anti-bullying policies; active parent involvement.

In addition there are specialised programs for children with ASD.

ASD is a neurodevelopmental disorder characterised by impairments in two major domains: deficits in social communication and social interaction; and restricted repetitive patterns of behaviour, interests and activities (Augustyn, 2015). ASD includes disorders previously known as: autistic disorder, pervasive developmental disorder and Asperger disorder. ASD has a strong genetic component, and a comprehensive family history over 3 generations may elicit: ASD, language delay, learning and attentional disorders, anxiety, OCD, extreme shyness, mood disorders, schizophrenia, tic disorders, for example.

It is not expected that the candidates will attempt to further specify the diagnosis according to severity levels or other specifiers. The focus of the station is not the candidate's knowledge of the diagnosis of ASD.

An achieving candidate would therefore be expected to:

- Elicit and establish the range and severity of concerns as a result of bullying experienced by a child with ASD: change in emotional and behavioural status with possible depression and anxiety symptoms, and possible self-harming behaviours.
- Advise and suggest options for the parent to address the concerns: recognise the potential severity and propose a RANGE of options including the parent taking their concerns to the school AND specialised assessment of Alex.

A surpassing candidate may deal with the issues at greater depth and with greater sophistication. They may mention specific anti-bullying programs for children with ASD.

### 3.3 The Standard Required

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

You are John, a mature adult, 38 years old, with bipolar affective disorder that has been stable for many years. You are married to Susan and together you are the parents of Kate who is 12, Alex who is 8 and Josh who is 5 years old. You work as an engineer in a position that involves some travel but generally maintain regular hours. Susan works as a retail assistant. You live in your own home and fortunately live close to both your and Susan's parents who are ready and willing to assist with child minding duties. There are no issues with the 12 and 5-year-old children.

Your illness is stable. Neither you nor Susan have any current concerns in relation to your illness and treatment. In fact you have had no issues in relation to your illness for some time. You are seeing your psychiatrist today for a routine clinical review and after you have discussed your current mental health and treatment, your doctor has asked you if there is anything further that you want to raise. You have discussed with your doctor in the past, concerns in relation to your second child, Alex, who has autism. You use the opportunity to raise RECENT concerns in relation to Alex being bullied at school.

You are well informed about the diagnosis of autism and the issues for children with autism. The diagnosis is not the focus of your concern today. Today you are concerned with the impact of bullying on your child who already has a mental health condition and who may well be developing additional mental health problems as a result of the bullying. As such you will remind your doctor of how Alex is affected by autism and tell him/her about the recent changes in Alex's behaviour.

Alex is aged 8 years. He has been assessed as, of at least high average IQ. He has fluent verbal language – so can express himself - and has not ever suffered from, for example, meaningless repetition of sounds/words. You were happy to accept advice from developmental (child) paediatric and educational experts that because of Alex's intelligence and good language skills, he would benefit from main-stream schooling with special education support and you remain happy with that decision. You think that he has benefited, for example, he has been able to develop his conversational skills to a limited but still pleasing extent – certainly he has made more progress in this regard than other children you are aware of who have approximately the same level of disability but are not attending main-stream school. You would be reluctant to consider changing Alex's school, especially as it is clear that in this school he likes to learn, and has previously told you and Susan that he LOVES (!! ) his school.

The main impact of Alex's autism is demonstrated in the following ways of behaving:

1. How people think, process, store, and apply information about other people and social situations (called social cognitions). Alex simply won't have a conversation without raising his interest in reptiles and resists all attempts to divert him from the topic.
2. A range of behaviours;
  - a. Poor eye contact in social situations and under-developed social cognitions (he just can't participate in back and forwards conversation, and misinterprets non-verbal (e.g. body language) communication; but he also listens best to conversations when he doesn't make eye contact).
  - b. Repetitive behaviours that are of moderate frequency and moderate intensity and are obvious in the school setting; for example:
    - i. He insists on always sitting on the same section of the same mat in the same place during story-telling sessions;
    - ii. He refuses to link hands when his class mates are walking in file to cross the road but insists on marching at least 10 paces behind the group;
    - iii. During recess, he leaves and returns to the classroom whilst running his fingers along the same section of wall and walking on his toes, and gets quite upset if he cannot do this;
    - iv. If there is tension or conflict (either at school or at home) he starts rocking back and forth;
    - v. During class he often moves his fingers in ways that attract attention (it is like he is double jointed).
    - vi. At home, he always has to shower for the same length of time and washes parts of his body in the same order every time.
  - c. Poor motor skills which are obvious in the school setting in relation to sports, and you think he will never learn to ride a bike or swing on the monkey bars in spite of all the help he has had from you and other children.
  - d. Moderate difficulty sleeping - this pre-exists the recent change but has become worse (please see below re: detail).

You are concerned because for the last month, Alex has been coming home from school with his clothing torn, and cuts and bruises that he cannot explain. His treasured book on reptiles came home torn beyond repair. He is increasingly reluctant to go to school and seems very anxious on school days, often asking to stay home. He is a bit more defiant too when you or Susan ask him to do something. He has also been a bit aggressive with his siblings (not too aggressive and you are not concerned, particularly, about the welfare of the 5-year-old). His sleep

has also deteriorated with no particular pattern that you can discern – he just is sleeping more poorly than usual with nightmares, and a couple of episodes of bed wetting which is extremely unusual for him.

You are worried that he is getting depressed and he certainly seems very anxious. In addition to wanting to stay home from school, you have noticed an increase in the repetitive behaviours which is generally a sign that Alex is stressed. You have actually started to worry in the last few days that Alex might be hitting himself in the head – something he only does when he is extremely stressed.

You are not aware of previous issues with bullying. You have approached the class teacher who tends to be a bit dismissive of your concerns. Whilst noting that one particular child, Sam, has been calling Alex hurtful names like 'spastic', 'retard', 'idiot', 'jerk' and doing things like putting Alex's lunch in the bin, laughing at him and screaming if he happens to be touched by Alex, the teacher said that the class is just a difficult group and such behaviour is just a fact of life. You have heard from other parents that the school can be a bit reluctant to get involved when there are complaints of bullying, and someone told you about their experience of the school being inconsistent with applying their own bullying policy.

You are aware that Alex has a friend called Peter at school. You think they are both a 'bit like two outcasts'. He has shown little interest in developing further friendships.

If you are asked, you are aware that Alex has been comprehensively evaluated, including:

- the diagnosis of autism has been definitely established;
- his growth is within normal limits and he is neither over nor underweight;
- he does not have an unusual physical appearance (called dysmorphic);
- he does not have floppy muscle tone (hypotonic);
- all examinations checking his vision, hearing and touch sensations (sensory) have been normal.

#### 4.2 How to play the role:

You are a concerned and sensible parent, well-educated in regard to autism. You are well read and knowledgeable about your son's condition.

You are interested in what the candidate has to say and want to get some useful advice from the candidate.

#### 4.3 Opening statement:

*'I would like to spend some time talking about some worries that I have about my son, Alex.'*

#### 4.4 What to expect from the candidate:

The context of the interview is that you have spoken to your doctor before about Alex and the doctor is aware that he has mild autism.

The candidate should start with focussing their discussion on your concerns about your son, offer the description of how Alex is affected by autism readily with minimal prompting.

You should expect to be asked in detail about the changes in Alex's behaviour and emotional state, and specifically you should be asked about depression and anxiety. Provide information as prompted by the candidate's questions.

#### 4.5 Responses you MUST make:

There are no specific responses you must make during the interview.

#### 4.6 Responses you MIGHT make:

The candidate may not engage in your concerns.

1. They may suggest that this is not a legitimate issue for discussion with your treating doctor.

Response:

*'Being a good parent is really important to me and I would like to discuss it with you because you know me well.'*

2. They may seek to refer you to the school or others involved in Alex's care.

Response:

Remind the candidate that the teacher said that the class is just a difficult group and such behaviour is just a fact of life. You have heard from other parents that the school can be a bit reluctant to get involved when there are complaints of bullying and someone told you about their experience of the school being inconsistent with applying their own bullying policy.

## STATION 8 – MARKING DOMAINS

### The Main Assessment Aims are:

- To test the candidate's knowledge regarding the common mental health issues caused by bullying through an interview situation that requires the candidate to elicit and establish the range and severity of parental concerns in relation to an ASD child who is being bullied.
- To test the candidate's capacity to advise and suggest options for action to the parent that includes addressing the care needs of the child and the school context in which the bullying occurs.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 40%)

##### **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 to obtain a baseline of Alex's usual behaviour and emotional state, and his risk factors for being a target of bullying; conducting a detailed but targeted assessment that clearly relates the recent changes to Alex's usual baseline state; completing a risk assessment; demonstrating phenomenology; eliciting the key contextual issues, including, for example, the attitude of the school and the teacher; clarifying important positive and negative features.

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

- Elicit the history of recent changes in the emotional and behavioural state of Alex.
- Specifically assess for symptoms of possible depression and anxiety and possible recent self-harm.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 - 40%)

##### **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; may mention specialised programs for children with ASD who are being bullied; identifies the complexities/appropriateness of notification to child protection services.

##### **Achieves the Standard by:**

elaborating on the candidate's role in effective treatment (provides a rationale for either remaining involved or not); identification of potential barriers; considering specific treatments for Alex if a diagnosis of depression or anxiety is confirmed; planning for risk management of possible recent self-harm; skilful engagement of appropriate treatment resources/support.

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

- Prioritise individual care needs that includes referral for more specialised assessment with a child and adolescent specialist.
- Consider the school environment and the importance of action by the school to address the issues.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

adamant that a referral to child protection services is necessary at this time.

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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**

**2.5 Did the candidate appropriately and adequately manage the communication? (Proportionate value - 20%)**

**Surpasses the Standard (scores 5) if:**

demonstrates sustained sophistication throughout the interview.

**Achieves the Standard by:**

providing accurate and structured verbal feedback in suitable language; prioritising and synthesising information with appropriate detail and sensitivity; adapting communication style to the setting; reflecting realistic limitations to understanding of the issues.

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

- a. Be accurate in relation to the potential seriousness of bullying of Alex.
- b. Demonstrate sensitivity to the dilemma that Alex is positively engaged with the school which may not be consistent or proactive in its approach to complaints of bullying.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

dismissive of parent's concerns or adamant that changing Alex's school is indicated at this stage.

2.5. Category: SYNTHESIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

The candidate has a meeting with the sister of a patient who has been admitted to a medical ward with complications related to anorexia nervosa. The candidate's tasks are to convey information about anorexia nervosa, provide information about the medical complications of this disorder and answer any questions.

**1.1 The main assessment aims are:**

- To demonstrate how to empathically interact with an anxious relative of a patient who is seriously ill.
- To convey DSM-5/ICD-10 diagnostic criteria of anorexia nervosa to a lay person.
- To demonstrate knowledge of the physical complications of anorexia nervosa and convey medical information to a lay person.
- To support the family member by providing relevant information and advocate for the least intrusive treatment.

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

- Describe disturbance in the way which one's body weight or shape is experienced.
- Refer to intense fear of gaining weight or of becoming fat.
- Accurately discuss the significance of the low potassium.
- Sensitively respond to the concern that Olivia may die.
- Carefully balance the concept of least restrictive practice with risk of poor medical outcomes.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders – Eating Disorders
- **Area of Practice:** Consultation Liaison
- **CanMEDS domains:** Medical Expert, Communicator, Health Advocate
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Diagnosis; Diagnosis - Investigation Analysis), Communicator (Synthesis), Health Advocate (Addressing Stigma)

**References:**

- Hay P, Chinn D et al: Royal Australian New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. ANZJP 2014, Vol. 48(11) 1-62
- Mehler SM and Brown C: Anorexia nervosa – medical complications. Journal of Eating Disorders 2015, 3:11. DOI 10.1186/s40337-015-0040-8
- Sanders B: Notes on Eating Disorders. [www.askdoctorclarke.com](http://www.askdoctorclarke.com). Pg. 1-5
- APA Practice Guidelines for eating disorders. [www.psychiatryonline.org](http://www.psychiatryonline.org)
- A guide to admission and inpatient treatment for people with eating disorders in Queensland. Mental Health. Eating Disorders Outreach Service (EDOS), Metro North Mental Health, QLD

**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 - woman in her 20's who is mildly anxious/apprehensive about her younger sister, who is ill in hospital.
- 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 in the consultation liaison team at a local tertiary hospital. Olivia is a 19-year-old patient with anorexia nervosa, binge-eating/purging type. She is engaged in treatment with the local Eating Disorders Unit and your consultation with Olivia has been limited to when she has required hospital treatment for complications related to anorexia nervosa.

Olivia has been re-admitted to the medical ward the previous evening after she collapsed at home. Olivia has a BMI of 14 at this time and you have not yet seen her since she was admitted last night. She apparently had a series of blood tests and now has gone to another part of the hospital for an echocardiogram.

You are seeing Jane, Olivia's older sister. Jane has asked to see a doctor involved in her sister's treatment. Jane is anxious and worried about Olivia, who has given her consent to disclose all information to Jane.

### Your tasks are to:

- Briefly explain the key features of anorexia nervosa to Jane.
- Describe the common medical complications of this condition.
- Answer any questions Jane may have about treatment options.

**You will not receive any time prompts.**

## 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 e.g. investigation results.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated family member.

### 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 or time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated family member 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.

You have no opening statement or prompts.

The role player opens with the following statement:

***'Thank you for seeing me doctor. I am keen to know what is happening with my sister.'***

#### 3.2 Background information for examiners

In this station the candidate is in a Consultation Liaison (CL) setting. They are expected to demonstrate skills to empathically engage a close relative of a patient who is anxious about her sister. They are to briefly explain the key features of the diagnosis of anorexia nervosa and outline the expected common medical sequelae to a lay person using non-complex terminology.

The candidate will be expected to answer a question posed by the sister related to the role of compulsory treatment and forced feeding (nasogastric feeding). The candidate must convey the aim of least intrusive multidisciplinary treatment but, at the same time, outline the rationale for admitting patients to hospital to treat life-threatening states.

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

- Describe disturbance in the way which one's body weight or shape is experienced.
- Refer to intense fear of gaining weight or of becoming fat.
- Accurately discuss the significance of the low potassium.
- Sensitively respond to the concern that Olivia may die.
- Carefully balance the concept of least restrictive practice with risk of poor medical outcomes.

A surpassing candidate will be able to clearly delineate their role in the patient's care, be able to easily engage the sister and contain her anxiety. They will advocate that they would be available to answer questions at a later date and refer to a family support agency as well as provide written information.

#### **Diagnosis of anorexia nervosa**

According to the DSM-5 criteria, to be diagnosed as having anorexia nervosa a person must display:

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

**There are two main subtypes identified in DSM-5:** Restricting type, and binge-eating/purging type.

The ICD-10 defines anorexia nervosa as a disorder characterised by deliberate weight loss, induced and sustained by the patient, which occurs most commonly in adolescent girls and young women, but adolescent boys and young men may also be affected, as may children approaching puberty and older women up to the menopause. It is associated with a specific dread of fatness and flabbiness of body contour which persists as an intrusive overvalued idea. Patients impose a low weight threshold on themselves and there is usually undernutrition of varying severity with secondary endocrine and metabolic changes and disturbances of bodily function. Symptoms include restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics.

For a definite diagnosis of anorexia nervosa the following are required:

- Body weight maintained at least 15% below that expected (either lost or never achieved), or Body Mass Index (BMI) of 17.5 or less. Pre-pubertal patients may show failure to make the expected weight gain during the period of growth.
- Weight loss is self-induced by avoidance of 'fattening foods' and one or more of the following: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and/or diuretics.
- Body-image distortion in the form of a specific dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on themselves.
- Endocrine complications manifesting as amenorrhoea or loss of sexual interest and potency in men.
- If onset is pre-pubertal, the sequence of pubertal events is delayed or even arrested (in girls there is no breasts development and the menarche is delayed; in boys, genitals remain juvenile). With recovery, puberty is often completed normally, but the menarche is late.

Usually the key information explored in history would include:

- pattern of dietary restriction, details of main meals and if any snacks consumed and feelings of early satiety
- disturbed eating behaviours - eating alone
- ritual patterns - like long meals, food division into small pieces
- weight loss/inability to restore weight
- body image disturbance and fears about weight gain
- bingeing and purging behaviours
- excessive exercising
- constipation
- use of laxatives, diuretics, medications to decrease weight
- any history of fainting, light headedness, palpitations, chest pain, SOB, ankle swelling, weakness, tiredness and amenorrhoea.
- cognitive changes such as slowed thought processing, impaired short-term memory, reduced cognitive flexibility, and attention and concentration difficulties.
- suicidal ideation or active self-harm

### **Physical complications of anorexia nervosa**

The candidate should provide a systematic explanation of physical complications of anorexia nervosa.

Indications for admission to hospital for adults are usually:

- BMI <12 (psychiatric admission may be indicated at BMI <14 - better candidates identify this point).
- 1kg weight loss per week or grossly inadequate nutritional intake – rapid weight loss or grossly inadequate intake
- Hypotension especially systolic <80mmHg, and postural hypotension noted by >20mmHg drop with standing
- Blood Sugar Level <2.5-3mmol/l
- Hypothermia - temperature <35°C with or without cold/blue extremities; or hyperthermia >38°C
- Metabolic alkalosis or acidosis
- Hyponatraemia - <125mmol/l
- Hypokalaemia - <3.0mmol/l
- Lowered Magnesium/lowered Phosphate
- Lowering renal function as noted by decreasing eGFR
- Hypoalbuminaemia - <30g/L
- Elevated liver enzymes - elevated aspartate aminotransferase (AST) and alanine aminotransferase (ALT) - >500
- Albumin <30g/L
- Any arrhythmia including QTc prolongation, or non-specific ST or T-wave changes including inversion or biphasic waves
- Starvation induced bone marrow suppression causing neutropenia (<0.7 x 10<sup>9</sup>/L)

## Medical treatment

Inpatient treatment should focus on medical stabilisation as the first priority followed by prevention and treatment of re-feeding syndrome, weight restoration and reversal of cognitive effects of starvation prior to outpatient psychotherapy. Continued treatment in specialist Eating Disorder Unit (EDU) if available, either inpatient or outpatient after liaison with usual clinical team.

- It is important for the candidate to convey the need for gradual medical stabilisation and to specify which part of treatment takes place where.
- The candidate should convey the role of the CL Services – involvement in clinical care while the patient is in hospital until they are medically stable. At this stage the patient's care is then transferred to another psychiatric unit/team or an EDU for ongoing nutritional rehabilitation and psychiatric treatment. The CL service can ensure two-way communication, and influence management decisions as to whether to proceed as a psychiatric inpatient or out patient.
- Medical treatment prioritises management of:
  - Electrolytes
  - Bone marrow suppression
  - Glucose
  - BP
  - Weight
- The candidate should convey the need to aim for oral food and fluids instead of nasogastric or IV as a preference: done gradually with no glucose-based food/fluids initially to prevent 'refeeding syndrome.' A candidate may briefly explain this as a potentially fatal complication of aggressive re-feeding especially in someone who has been starving over a long period – with a better candidate presenting this information in a sensitive manner so as not to increase levels of anxiety, particularly as this is not the issue with this patient who does not need forceful refeeding.

Refeeding Syndrome – is understood to be a clinical state reached due to switch from fasting state glucose production to carbohydrate induced insulin release, leading to rapid intracellular intake of potassium, phosphate and magnesium to metabolise the carbohydrate. This then aggravates the already existing low electrolyte state. The first two weeks of refeeding pose the greatest risk with potential biochemical abnormalities including hypokalaemia, hypophosphataemia, hypomagnesaemia and hypocalcaemia. The risk of heart failure in refeeding syndrome is reduced by gradual refeeding.

The cascade is further complicated by already existing low glucose that is aggravated by a background of poor glycogen stores. It is mitigated by controlling weight gain to 500 to 1400g/week in an in-patient setting. With dietician input, patients gain weight faster.

- Since medical complications are the consequence of starvation, effective treatment means that regular food intake with supervision is supported when the patient returns to the community. In this case Olivia's sister may be willing to play a part to assist with this.
- Candidates should convey clearly that nutritional counselling is not the sole treatment. Family therapy is crucial part of treatment in an adolescent. In this scenario, given that the patient is living in her parents' home with older sister recently returned, it will be critical to look at family therapy as an option: a better candidate may recommend this.

## Nasogastric feeding and compulsory treatment

If the patient is unable or unwilling to maintain oral intake the question should be asked, 'Is it ethical to watch someone die from a reversible disorder?' based on starvation of the brain.

The ethical issues of treatment that need to be considered are the autonomy of the patient who has been offered choices, beneficence in taking the best action for patient, within the context of patient capacity – starvation and low body weight lead to impaired capacity to make decisions about nutrition, which is reversible through nutrition to the brain. The Minnesota Semi-starvation Study conducted (Ancel Keys - [http://en.wikipedia.org/wiki/Minnesota\\_Starvation\\_Experiment](http://en.wikipedia.org/wiki/Minnesota_Starvation_Experiment)) demonstrated that loss of 25% of body weight led to profound cognitive changes in all subjects. Such starvation-induced changes include obsessive preoccupation with food and eating, and loss of perspective and insight. These changes were found to only be reversed when weight was restored.

24hr continuous nasogastric (NG) feeding using a low fibre, energy dense enteral feed should not be delayed. This can be commenced whilst awaiting dietitian consultation. The decision to move to more invasive treatment should be based on medical risk as well as BMI. If a patient is unwell enough to need to be admitted to a medical ward the illness needs to be treated; for instance, if bradycardia, postural hypotension and an inability to eat are present.

It could actually be that it is safer to use NG feeding on a medical ward as it can prevent rebound hypoglycaemia because of slow continuous feeding, and there may be better management because of difficulty of monitoring eating regularly on a busy medical ward.

Anorexia nervosa is a mental illness that can be life-threatening – it has the highest mortality rate (20%) of any psychiatric illness: deaths are due to malnutrition and suicide. It is associated with impaired capacity due to the mental illness itself as well as the effects of starvation on the brain. The use of compulsory treatment can be appropriate in a situation where the patient's impaired capacity is putting them at risk. Either guardianship or mental health legislation can be considered, although in many jurisdictions mental health acts provide the patient and staff a clearer legal framework with closer oversight. The decision can depend on the team.

Decisions for compulsory treatment should be based on the fact that the patient has a mental illness and requires immediate treatment (that is available through an authorised service). Because of the patient's illness there is an imminent risk that the person may cause harm to themselves (or someone else) and they are likely to suffer serious mental or physical deterioration. The patient lacks the capacity to consent to be treated for the illness, or they have unreasonably refused proposed treatment for the illness.

### 3.3 The Standard Required

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

Your name is Jane, and you are 21 years old and single. You are the older sister of Olivia, who is 19 years old. You have just moved home with your parents and Olivia as it is situated close to the University of Queensland where you plan to be a Master's student from next year. You have just returned one week ago from a year-long overseas trip. You and a friend travelled around UK, Europe and USA after completing your Bachelor's degree. The last week has been hectic with you catching up with old friends, looking into your university registration and generally settling back into home. You have not spent too much time with the family, but had been looking forward to seeing them all this weekend.

Jane was fine when you went away – she had been plump in her late teens but had lost some weight before you went away and you were glad that she was doing so because she was worried about being fat. In the year that you have been away she has lost a lot of weight and you were surprised to see her when you returned a week ago. She has refused to tell you how much she weighs.

You are both university students – Olivia is a first year Fine Arts student and you are to start your Master's in English Literature. You are the only children to your parents – Roger and Mary. Your parents are very busy. Your father is a General Surgeon and has a busy private practice while your mother has a fashion boutique in a local mall. Mom had mentioned Jane's weight loss to you a couple of times when you spoke in the past year, but you did not pay much attention to it. You had no idea she was under treatment for anything. You suppose your family did not want to worry you.

Roger and Mary are both at work at the moment and they have conveyed their concerns but are unable to be present at this time given the unscheduled admission of Olivia the preceding evening. They plan to come to see Olivia this evening. You are at the hospital and you would appreciate a chance to talk to the doctor.

You are keen to know exactly what is wrong with Olivia and what her diagnosis actually is. You are anxious and worried as you were the one who witnessed her collapse and called the ambulance.

Events of the preceding day – you had noticed your sister going for a run: she runs for over one hour most days. She fainted just after coming home from her run. Fortunately, you were home, witnessed her collapsing and called the ambulance. You are sure Olivia had passed out for a few seconds. Olivia soon woke up but was very dizzy when trying to stand up. You kept her on the ground until the paramedics came.

The paramedics took her blood pressure which they said was low, her pulse was slow even though she had just returned from a run. They said her heart was not right after they attached electrical leads to her chest and did an ECG. They then brought her into hospital and she was admitted overnight.

It was a very anxious time for you. You had never experienced anything like this before and you were very scared. You rang your mother at work who thanked you for your quick action – she was relieved that Olivia was getting care at the hospital. Your parents eventually came home from work later last night; Fridays are usually a busy day for both of them.

Today you have been informed that Olivia has been getting a drip since coming in last evening. She has gone to have a special ultrasound to examine her heart. You did manage to talk with her briefly and you are surprised that she is completely unconcerned by what happened and her thin appearance - she seems to want to lose weight even though she is so thin. You get the feeling that she is scared of gaining weight despite being so thin.

Last night your parents told you that over the last six months she has stopped going out with friends and is focussing on her body. This is what they have heard from Olivia's friends. Come to think of it, you think you have heard her vomiting but Olivia completely denies this.

She has no known allergies, and this is her first ever hospitalisation. You do not believe Olivia has any alcohol or drug issues and you know she does not smoke.

The rest of your family are healthy. If expressly asked about inherited or other conditions in your wider family, you can disclose that your father's first cousin died unexpectedly at age 20. He just dropped dead. He was a university student. He was said to have had a *'dilated heart, something like that'*.

The nurse advised you that Olivia has been diagnosed with anorexia nervosa. You are shocked, you knew about girls in high school and at university with eating disorders, but didn't ever think someone in your family would get this. You are distressed by her physical ill health – especially when all she seemed to do was exercise! You don't have first-hand knowledge of severe cases and never paid much attention as only Hollywood actresses and super models get really bad.

It was that same nurse you overheard talking to the other staff about force feeding Olivia (see section 4.5 below).

You have never met anyone with anorexia before and you are unsure of details of Olivia's eating patterns, other daily routines and beliefs as you have been away while she has been unwell.

#### **4.2 How to play the role:**

You are neatly dressed in casual attire, much like any other more senior university student. You come across as generally anxious but trying to be friendly and co-operative. Your speech is initially quite fast because of your anxiety, but dependent on how the candidate speaks to you this can settle.

#### **4.3 Opening statement:**

*'Thank you for seeing me doctor. I am keen to know what is happening with my sister.'*

#### **4.4 What to expect from the candidate:**

The candidate should try to reassure you and give you a chance to ask all the questions you want to ask. They should briefly explain what anorexia nervosa is and offer any additional information you need. They should then talk about some of the physical complications that can arise in patients with anorexia nervosa without causing you to feel highly anxious. The candidate should also carefully explain when people are 'force fed.'

If the candidate keeps asking you questions about Olivia's illness, inform them that you are unaware of any details as you have just returned home. You wish to learn about the illness today.

The candidate may offer you some written information, to see you again to make sure the family understands. They may also explain their role in the facilitation of referral to correct services before Olivia is discharged from hospital.

#### **4.5 Responses you MUST make:**

*'A nurse said that because Olivia's "K is 1.9" she is critically ill – what does this mean?*

*'Is she going to die?'*

*'The nurses are saying that they are going to force feed Olivia – could they do that?'*

#### **4.6 Responses you MIGHT make:**

**Anticipated Question:** *How much does Olivia eat?*

**Scripted Response:** *She has been eating less in last six months. Dinner might be just a banana while in the past she would have had steak and chips.*

**Anticipated Question:** *Is she afraid of weight gain?*

**Scripted Response:** *Yes, she seems to be. Perplexing when she is eating so little and is thin.*

**Anticipated Question:** *What does she think about her body shape?*

**Scripted Response:** *I do not know.*

**Anticipated Question:** *Does she ever say she feels fat/big/overweight/too big for her size?*

**Scripted Response:** *She has never said this to me.*

**Anticipated Question:** *Does Olivia seem unconcerned by her low weight?*

**Scripted Response:** *Yes – she will not believe me that she should be worried!*



**Anticipated Question:** Do you know anything about Eating Disorders? In particular anorexia?

**Scripted Response:** There were girls at school who had eating disorders, but none of them were as bad as Olivia.

**Anticipated Question:** Do you have good supports?

**Scripted Response:** Yes, my classmates and friends.

**Anticipated Question:** Have I answered all your questions?

**Scripted Response:** Yes, I think so. (as long as they have adequately responded to the MUST say questions (section 4.5))

**Anticipated Question:** Would you like to be referred to a support service?

**Scripted Response:** What does that involve?

#### **4.7 Medication and dosage that you need to remember:**

None.

## STATION 9 – MARKING DOMAINS

### The Main Assessment Aims are:

- To demonstrate how to empathically interact with an anxious relative of a patient who is seriously ill.
- To convey DSM-5/ICD-10 diagnostic criteria of anorexia nervosa to a lay person.
- To demonstrate knowledge of the physical complications of anorexia nervosa and convey medical information to a lay person.
- To support the family member by providing relevant information and advocate for the least intrusive treatment.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.9 Did candidate formulate and describe the relevant diagnosis of anorexia nervosa? (Proportionate value - 25%)

##### **Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard and demonstrates a superior performance that prioritises information without overloading the sister with excessive detail; appropriately identifies any limitations of diagnostic classification systems to guide treatment.

##### **Achieves the Standard by:**

integrating available information in order to describe the diagnosis; utilising a biopsychosocial approach; adequately prioritising information relevant to the situation and findings; clearly explaining the core features of anorexia nervosa, including communicating in appropriate language and detail and according to good judgment.

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

- Describe disturbance in the way which one's body weight or shape is experienced.
- Refer to intense fear of gaining weight or of becoming fat.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

provides inaccurate or inadequate diagnostic formulation; errors or omissions are significant, and do materially adversely affect conclusions.

1.9. Category: DIAGNOSIS	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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 history/tests/investigations correctly when describing the complications of anorexia nervosa? (Proportionate value - 40%)

##### **Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard and demonstrates a superior performance linking relevant history, investigations with other diagnostic procedures to explain medical complications.

##### **Achieves the Standard by:**

accurately interpreting the history and results and incorporating them into the explanation of complications; any errors are minor and do not materially adversely affect outcomes; utilising information to prioritise significance and interpretation for the sister; referring to the most likely cardiac complications; describing importance of acute treatment and follow up based on available information.

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

- Accurately discuss the significance of the low potassium.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

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

1.10. Category: DIAGNOSIS - Investigation Analysis	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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**

**2.5 Did the candidate demonstrate effective communication skills appropriate to the audience and context? (Proportionate value – 20 %)**

**Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard and integrates information in a manner that can effectively be utilised by the audience; provides succinct and professional information.

**Achieves the Standard by:**

providing accurate and structured verbal report and feedback to questions; prioritising and synthesising information; adapting communication style to the situation; demonstrating discernment in selection of content; considering the impact of information provided and adapting style; demonstrating capacity to listen to and respond sensitively to those areas of specific concern raised by her sister.

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

- a. Sensitively respond to the concern that Olivia may die.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

any errors or omissions impact on the accuracy of information provided; inadequately adapts to responses; unable to maintain rapport.

2.5. Category: SYNTHESIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 possible discriminatory practice from the nursing staff? (Proportionate value - 15%)**

**Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard and recognises the important role of psychiatrists in addressing stigma; balances the impact of stigma and the need for treatment; considers interventions with staff and family to reframe compulsory or forced feeding.

**Achieves the Standard by:**

identifying the impact of alternative beliefs and stigma of mental illness on patients and families; recognising the role of staff in the generation and maintenance of stigma; applying principles of prevention, promotion, early intervention and recovery to clinical practice; taking into account the ethical principles that underlie application of appropriate clinical interventions; constructively address competing attitudes towards mental health; promoting positive aspects of non-intrusive, non-invasive interventions where possible; giving a brief context of any potential role for or boundaries of legal options i.e. mental health legislation, doctrine of necessity.

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

- a. Carefully balance the concept of least restrictive practice with risk of poor medical outcomes.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

limited capacity to identify impact of possible stigma on decision making for people with mental illness; does not consider addressing perceived stigma.

5.2. Category: ADDRESSING STIGMA	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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**1.0 Descriptive summary of station:**

The candidate is required to take a focussed drug and alcohol history from Lisa, a 25-year-old woman who took an accidental overdose of over the counter opioids, in order to establish codeine dependence. The candidate is then expected to outline options for the management of codeine dependence. The history should be comprehensive and include enquiring about the use of substances other than codeine.

**1.1 The main assessment aims are:**

- To evaluate the candidate's ability to take a focussed drug and alcohol history, and establish opioid dependence (codeine) based on the findings.
- To evaluate the candidate's ability to outline management options for opioid dependence.

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

- Elicit sufficient criteria to clearly establish an opioid use disorder.
- Explain the diagnosis of an opioid misuse disorder in a non-judgemental manner.
- Highlight the importance of involvement of the partner in treatment planning.
- Include the benefits of opioid substitution.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Substance Used Disorders
- **Area of Practice:** Addictions
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Formulation – Communication; Management – Initial Plan, Management – Long-term, Preventative)

**References:**

- 'Policy for maintenance pharmacotherapy for opioid dependence' Victorian government department of health 2013. (PDF on the internet <http://www.health.vic.gov.au/dpcs/pharm.htm>)
- 'National clinical guidelines and procedures for the use of buprenorphine in the maintenance treatment of opioid dependence' Commonwealth of Australia 2006.
- 'Clinical guidelines and procedures for the use of Methadone in the maintenance treatment of opioid dependence' Commonwealth of Australia 2003.

**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: female in her mid-twenties, slightly dishevelled.
- 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.

As a junior consultant psychiatrist in the emergency department (ED) you have been asked to see Lisa, a 25-year-old woman, brought in the previous night. Her partner found Lisa drowsy and barely responsive and called an ambulance. ED staff diagnosed opiate intoxication and she is now medically cleared.

The on-call psychiatry registrar had assessed Lisa and documented:

- *Lives in a rental house with Jake (her partner for the past 7 years); in a loving relationship but no children.*
- *No relevant medical history or regular prescribed medications.*
- *No history of developmental trauma; grew up in a loving, supportive family.*
- *Works full time as an events company promoter for the past 5 years and loves her job.*
- *Denied any psychiatric history - first presentation to the ED. Overdose was unintentional - accidentally took too much medication to help her sleep.*
- *Mental state examination: denied symptoms of depression, mania and psychosis. Did admit to anxiety relating to insomnia but none at other times. She was cognitively intact.*

Lisa refused to answer questions about her drug and alcohol history until she sees you.

### **Your tasks are to:**

- To take a focussed drug and alcohol history.
- To explain the diagnosis to the patient.
- To explain management options to the patient.

**You will not receive any time prompts.**

## 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 e.g. investigation results.
  - 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 - there are no cues or time prompts for you to give.
- DO NOT redirect or prompt the candidate – 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.

You have no opening statement or any prompts.

The role player opens with the following statement:

***'Thanks for seeing me, this is a bit embarrassing.'***

#### 3.2 Background information for examiners

The aims of this station are to test the candidate's ability to take a focussed drug and alcohol history, establish a diagnosis of opioid dependence/opioid use disorder and establish dependence on codeine. The history should be comprehensive and include enquiring about the use of substances other than codeine, including alcohol, prescription medication and illicit drugs. The candidate must explain the diagnosis to the patient and outline initial and longer-term management options which must include substitution therapies, detoxification, antagonist treatments, residential treatments and 'medication free' options.

In this scenario the candidate is expected to discuss the risks and benefits of different options in the management of opiate dependence - this must include a discussion of different options that include abstinence and substitution therapy. They may prefer a short course of buprenorphine through the withdrawal period.

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

- Elicit sufficient criteria to clearly establish an opioid use disorder.
- Explain the diagnosis of an opioid misuse disorder in a non-judgemental manner.
- Highlight the importance of involvement of the partner in treatment planning.
- Include the benefits of opioid substitution.

A better candidate may:

- not only take a comprehensive drug and alcohol history but may enquire about gambling as well. They will clearly establish criteria for both physiological and psychological dependence on codeine, and identify that this case is severe.
- describe the severity of the dependence when explaining the diagnosis to the patient.
- also discuss the pros and cons of the different treatment options to the patient.

#### Substance Misuse Screening

1. Conduct a simple initial screening by asking about tobacco, alcohol, and drug use during the patient interview. Use a non-judgmental approach when asking these questions.
2. Should start with open-ended questions. May use statements like 'Tell me about your alcohol use?' instead of 'Do you drink alcohol?' assuming that all patients consume some alcohol may yield more forthright answers. Confirm responses by asking about frequency (how many days per week on average) and quantity (how many drinks on a typical day).
3. Alternatively, incorporate a short substance abuse screening instrument, like the 4-item CAGE or CAGE-AID (adapted version that also includes drug misuse). When substance abuse is indicated, follow-up with additional interview questions to learn more.
4. Patients may be less honest about drug use, but many signs and symptoms of drug use can be identified through the physical exam, laboratory, or toxicological testing. In this scenario the patient has been screened physically.

Identifying substance use may be made based on self-report data, objective analysis of specimens of urine, blood, etc. or other evidence (drug in the patient's possession, clinical signs and symptoms, or reports from informed third parties). It is always advisable to get corroboration from more than one source of evidence relating to substance use.

## Diagnosis of Opioid Use Disorder:

According to the DSM-5 a minimum of 2 criteria are required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (APA, 2013). Opioid Use Disorder is specified if opioids are the drug of abuse, with a problematic pattern of use leading to clinically significant impairment or distress occurring in the last 12 months:

1. Taking the opioid in larger amounts or for longer than intended
2. Persistent desire or attempts to cut down or quit but not being able to do it
3. Spending a lot of time obtaining, using or recovering from the opioid and its effects
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. \*Tolerance as defined by *either* a need for markedly increased amounts to achieve intoxication or desired effect *or* markedly diminished effect with continued use of the same amount
11. \*Withdrawal manifesting as *either* the characteristic withdrawal syndrome *or* opioids or something similar is used to avoid withdrawal.

*\*These criteria are not considered to be met for those individuals taking opioids solely under appropriate medical supervision.*

**Dependence Syndrome (ICD-10)** is similarly defined as a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

According to the ICD-10, an essential part of the dependence syndrome is the presence of either psychoactive substance taking or a desire to take a particular substance and that the subjective awareness of compulsion to use drugs is most commonly seen during attempts to stop or control substance use. This diagnostic requirement is therefore expected to exclude situations like surgical patients who are given opioids for pain relief who may show signs of an opioid withdrawal state when drugs are not given but who have no desire to continue taking drugs.

**Opioid Intoxication** in the context of recent use, leads to clinically significant problematic behavioural or psychological changes (e.g. initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgement). It is manifested by the following transient signs and symptoms:

- Drowsiness or coma; slurred speech; impairment in attention or memory that are not attributable to other causes. In rare instances perceptual disturbances like hallucinations with intact reality testing or auditory, visual or tactile illusions in the absence of delirium can occur.

**Opioid Withdrawal** can manifest after cessation or reduction of opioids after heavy prolonged use, or when an opioid antagonist is administered after a period of opioid use. Withdrawal is a time limited set of symptoms that develop within minutes to days. The person can experience dysphoric mood, nausea/vomiting, muscle aches, lacrimation or rhinorrhoea, pupillary dilatation/piloerection or sweating, diarrhoea, yawning, fever and insomnia. These symptoms occur at a level that causes significant distress or impairment in functioning and no other cause can be found.

## Management of Opioid Dependence/Opioid Use Disorder

- **This exert was taken from** 'Policy for maintenance pharmacotherapy for opioid dependence' Victorian government department of health 2013. (PDF on the internet <http://www.health.vic.gov.au/dpcs/pharm.htm>)

The candidate must outline management options. The views of the patient regarding treatment should include their motivation to enter treatment, clarity on the trigger for seeking treatment, what their goals are for the treatment episode and an opinion of their stage of change.



As in other areas of chronic disease management, addiction treatment planning should:

- be a continuous process;
- involve the patient and reflect the patient's circumstances and case complexity;
- be based on coordinated care across service providers to address multiple domains;
- be documented so as to be meaningful to the patient, their carers and other service providers.

People presenting in crisis often seek short-term treatment, without necessarily having considered all their treatment options. All types of available treatment for opioid dependence should be considered in consultation with the patient, taking into account the patient's treatment preferences, and be based upon the evidence of effectiveness and safety of available options. The principles of informed consent should be observed in selecting and referring patients to treatment services.

The use of buprenorphine for several days following a crisis generally alleviates withdrawal symptoms without significant sedation, thereby allowing patients and clinicians to examine post-withdrawal issues relatively early on in the withdrawal episode. Patients who are not interested in ongoing pharmacotherapy treatment can stop a short course of buprenorphine with minimal rebound discomfort. However, if a patient wants to extend the duration of their withdrawal program, or decide on maintenance treatment they can continue buprenorphine treatment over a longer period of time (and switch to methadone if necessary).

The table below lists key factors for the different treatment approaches that are relevant to selection of the type of treatment, but is not an exhaustive summary of evidence for the effectiveness of the different approaches.

TYPE OF TREATMENT	ADVANTAGES	DISADVANTAGES
Substitution treatment	<ul style="list-style-type: none"> <li>• Strong evidence of capacity to reduce opioid use, decrease mortality and improve quality of life</li> <li>• Avoids withdrawal in people who are ill or unstable</li> <li>• Capacity to retain patients in treatment</li> <li>• Widespread availability</li> </ul>	<ul style="list-style-type: none"> <li>• Expense to patient (daily travel dispensing fees)</li> <li>• Side effects</li> <li>• Stigma</li> <li>• Restrictions of supervised dosing (lifestyle travel etc.)</li> <li>• Prolonged withdrawal on cessation</li> </ul>
Detoxification	<ul style="list-style-type: none"> <li>• Short-term commitment</li> <li>• Attractive to consumer</li> <li>• Low threshold easy access</li> <li>• Entry point to treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Poor long-term outcomes if stand-alone treatment</li> <li>• Increased overdose risk following withdrawal (loss of tolerance)</li> <li>• Can lead to destabilisation of other health conditions (chronic pain, mental health)</li> </ul>
Antagonist treatment (naltrexone)	<ul style="list-style-type: none"> <li>• Effective in decreasing opioid use in highly motivated well-supported people</li> <li>• 'Opioid-free' medication</li> </ul>	<ul style="list-style-type: none"> <li>• Poor retention for most people</li> <li>• Limited acceptance</li> <li>• Side effects</li> <li>• Complicates pain management</li> <li>• Cost to patient</li> <li>• Requires detoxification before initiating naltrexone</li> <li>• Increased overdose risk following cessation due to loss of tolerance</li> </ul>

## Residential Treatment and Rehabilitation

- Effective for those with complex social problems and poor living skills
- Usually 'medication-free'
- Requires commitment of time and separation from home and community
- Long-term outcomes depend on aftercare
- Completion of detoxification usually a requirement for entry
- Expensive to provide
- Often waiting lists
- High variability in quality of counselling services

## Outpatient Counselling (no medication)

Some effectiveness in substance misuse problems of lesser severity and early stages.

A stepped care approach to treatment delivery suggests using less restrictive treatment approaches for those with low severity dependence (e.g. detoxification, counselling), increasing to more intensive treatment options (substitution treatment, residential) for those with more severe and entrenched problems.

Factors that indicate particular treatment directions:

- certain medical and psychiatric conditions (e.g. chronic pain, psychotic disorders, acute medical conditions such as infective endocarditis, HIV) can be destabilised during detoxification and attempts at sustaining an opioid-free lifestyle; such patients are often better directed to opioid substitution treatment.
- women who are opioid-dependent and pregnant should usually be directed to opioid substitution treatment due to the risk of antenatal complications associated with detoxification, and high rates of relapse to heroin or other opioid use with other treatment approaches.
- people with a preference for abstinence-based interventions who are well supported and well-motivated are more likely to respond to counselling with or without naltrexone.
- people with poor living skills and unstable social circumstances may benefit from residential treatment.

## Opioid Substitution Treatment

Substitution treatment has specific requirements that need to be addressed in the treatment plan, including jurisdictional approval to prescribe methadone or buprenorphine, and dispensing arrangements.

Once diagnosis, consent to treatment and choice of modality is established, treatment should be commenced without delay. If there are concerns about initiating treatment safely and effectively, specialist referral is recommended.

At commencement of treatment a plan should be developed, and should then be actively reviewed over the course of the treatment episode. The treatment plan should involve appropriate referral to relevant services where the selected treatment approach cannot be delivered by the assessing service.

Evidence indicates poor outcomes in more severely dependent populations in substitution treatment.

**Methadone** is generally prescribed for opioid dependent patients 18 years or older. It is contraindicated in people with severe hepatic impairment or respiratory insufficiency, or those with a hypersensitivity to methadone or other ingredients in the formulation. Caution is needed when assessing individuals with high risk polysubstance use, co-occurring alcohol dependence, a history of naltrexone use, comorbid psychiatric illness, chronic pain or relevant concomitant medical problems.

A starting dose of below 20mg for a 70kg patient can be presumed to be safe, as this is the lowest dose at which toxicity has been observed. Patients should be observed daily prior to dosing and an assessment made of intoxication. In the first two weeks, with daily dispensing, any concerns should be referred to a doctor before a dose is administered. Because of the pharmacology of methadone, it is preferable that patients are reviewed at least once, and preferably twice by an experienced clinician (doctor or nurse) in the first week with a view to assessing intoxication from methadone. It is recommended that the methadone dose is not increased for at least the first 3 days of treatment unless there are clear signs of withdrawal at the time of peak effect, i.e. 3-4 hours after dose. Dose increments should be of 5-10mg every 3 days, subject to assessment with a total weekly increase not exceeding 20mg. Effective doses should be determined for individual patients but in general are 60-100mg per day.

**Buprenorphine** is an increasingly popular alternative to methadone. Until recently the only buprenorphine preparation available in Australia for the treatment of opioid dependence was Subutex®, a sublingual tablet containing only buprenorphine. Buprenorphine is a partial opioid agonist at the mu ( $\mu$ ) opioid receptors. Methadone is a full opioid agonist, and its effect is primarily due to the induction of cross-tolerance, which is dose dependent. In contrast buprenorphine achieves its effect primarily by prolonged occupancy of a high proportion of opioid receptors, blocking the action of the illicit or uncontrolled drug.

The sublingual tablet contains buprenorphine hydrochloride in 0.4, 2, and 8mg strengths and is safer than full agonists at higher doses. It has similar indications, contraindications and precautions to methadone, but can be prescribed for age 16 years and up. The other product, sublingual Suboxone® contains a 4:1 ratio of buprenorphine/naloxone. As naloxone is an opiate antagonist that reverses the effects of opiates it is expected to reduce the likelihood of intravenous abuse of the drug.

Methadone and buprenorphine are more likely to be successful if they are part of a comprehensive treatment program, addressing the physical, psychological and social/environment issues. For example, treatment may include a combination of medication, counselling and the development of a positive support network of peers, friends and a support group.

### 3.3 The Standard Required

**In order to:**

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

You are Lisa, a 25-year-old woman, currently living with your boyfriend, Jake, in a rental property about 5km from the hospital. You have been in this relationship for 7 years and are planning on getting married next year and starting a family. You have not had children before. You have been working as a promoter for an events management company for the past 5 years and love your job.

You cannot remember much about the previous night; you do remember being worried you may not be able to sleep and taking 'Nurofen plus' as the codeine in it helps to make you drowsy. You think you probably took more than usual and that was why Jake found you very drowsy and called an ambulance. If asked by the candidate, you are adamant you did not intend to overdose and have never felt suicidal. You now feel very remorseful about what happened and would like to get some help. You were a little better by the time the ambulance arrived and they did not need any injection or medication at the time, but they decided to bring you in to make sure you were ok.

You have had problems with your sleep for as long as you can remember. Your sleep pattern has varied a bit over the years but you often would take 2 - 4 hours to get to sleep and you struggle to get up in the mornings. While it did have some impact on you when you were at school it really only caused significant problems when you started work. You found that you were constantly late for work and would often feel exhausted when you got there. When you started your current job you were fearful that you could lose it if this continued.

You had realised that when taking any medication for pain (like period pain or a headache), you would feel drowsy after taking medications that contained CODEINE and so started taking these to help with your sleep. Initially you found this helped with your sleep but after a few months, they didn't seem to be as effective. You were not sure why, maybe you were just more stressed and so you decided you would need to take more tablets to get to sleep. You have used these for years, unsure exactly how long.

In the beginning you would only take codeine containing medications on days before you had something important on at work, but for the past 2 years it has been every night in increasing amounts. Currently you need to take 30 to 40 tablets of codeine containing medications to get to sleep every night, and even then you sometimes struggle to get to sleep.

You have not been aware of any physical complications from taking the codeine, although if asked, you have noticed that you are very constipated. You actually hadn't really thought it was directly linked to taking codeine but put it down to poor diet and lack of exercise. You have had blood tests and physical examinations with your GP which have been normal, and the staff at the emergency department have told you that your blood tests are all normal.

With regard to the pattern of your codeine use, if you do not take codeine you now cannot sleep at all and you start to feel anxious. You also notice some physical symptoms including nausea, sweating, yawning, abdominal and leg cramps if you don't take codeine. You know that if you can just get some tablets you will be fine. If asked, you could consider that these ideas of getting medications could be cravings for codeine.

You are frightened that you may lose your job if you experience all these symptoms on days of work and have tried not to miss work for more than a day. You are aware that the increasing doses of codeine have started to affect your performance at work, especially when you decide to try to take less; you feel achy all over and like you might be coming down with a cold on these occasions, and need to take codeine during the day to get rid of the pain. However, this means you are often drowsy and find it hard to concentrate, resulting in your co-workers and boss making comments.

In order to get codeine containing medications you tend to visit several pharmacies on your way home from work, this can take you a few hours. Your preference is for *Nurofen plus* as you know how it works for you. You are not sure how much it all costs you but think it would be at about \$100 a week. Your boyfriend, Jake, is not aware of the amounts you are taking but is concerned as he has noticed you don't seem to be yourself. The other day, at a family function your mother also commented on the change in you and your best friend, Judy, asked you whether you are OK as you seem more tired and distracted. You have started to avoid going out and have to admit this all seems to be impacting on multiple areas of your life.

Despite all this, you and Jake are still on track to get married in January and start a family. After what happened last night you realise that you have to do something about this before it gets out of control and before you start trying for a baby.

If the candidate asks, you are a social drinker, you are not a big fan of alcohol, you only drink when out with friends usually on Friday and Saturday nights, when you would only have 2 to 3 glasses of white wine. You have never had a problem with alcohol in the past. When you were between the ages of 18 and 22, you did take illicit drugs mostly on weekends at parties: you used ecstasy, speed, cocaine and marijuana, you have never used these drugs daily and are certain you never became dependant on them. You are uncertain about the exact amounts used. You have not used these drugs at all for over 3 years. You have never injected any drugs and you have never used any other prescribed drugs (particularly drugs called benzodiazepines like Valium).

You have never had any drug or alcohol counselling or treatment of any kind – you would never previously have even thought that you might need this, although you have felt very embarrassed by what you have been doing and are reluctant to tell anyone including your GP and Jake. You are keen to know what your treatment options are, you are frightened that if you go 'cold turkey' you won't cope and you may lose your job. Thus you not only would like to know about how to 'detox' but also if the codeine could be replaced with something else to make sure you can sleep.

With regard to past history, you have no past psychiatric history; you are fit and well and don't take any regular medications. You have never been allergic to a prescribed medication.

If asked about your early life, you come from a close and loving family. There is no history of developmental trauma. You did fine at school. You have always been able to make and keep friends. There is no history of you having behavioural problems or getting into trouble with police or driving offences. You have a wide circle of friends, and over the years you have lost contact with the friends whom you used to use drugs with.

#### **4.2 How to play the role:**

Casually attired, you were brought into hospital the previous night so will probably be a bit dishevelled and look tired. You are initially a little reluctant to talk about your codeine use as you have been keeping it a secret and are ashamed of what happened last night.

During the discussion you accept that you are addicted to codeine, and that is the only issue you have. You are keen to hear what can be done to manage your addiction.

On occasion you will yawn and also be restless in your chair and may act as if you are feeling a bit nauseous.

#### **4.3 Opening statement:**

*'Thanks for seeing me, this is a bit embarrassing.'*

#### **4.4 What to expect from the candidate:**

The candidate is likely to start by introducing themselves and asking about the reasons for you not wanting to give a drug and alcohol history to the assessing registrar the night before. You will explain you felt embarrassed about talking about it then, but have now thought about it and you want help to deal with the problem. You will answer the questions asked of you freely but will not elaborate too much. You will accept the candidate's diagnosis without question and listen to the treatment options outlined without interrupting except to clarify anything you do not understand. At the conclusion you will thank the candidate and will ask to be given some time to think about it.

#### **4.5 Responses you MUST make:**

When the candidate advises you of the diagnosis of opioid dependence/codeine dependence/opioid use disorder:

*'Are you saying that I am a drug addict?'*

#### 4.6 Responses you MIGHT make:

*'I am really worried if I stop the codeine, I won't cope, I won't sleep.'*

If asked: Your mood is 'OK', your appetite, concentration, memory, energy levels and motivation are normal. You have never had periods of having an elevated mood or feeling high.

You get anxious about not being able to sleep but otherwise deny anxiety.

You are able to enjoy usual activities and have hope for the future. You deny suicidal thoughts or thoughts of self-harm.

You have never had any unusual experiences or psychotic symptoms like hearing voices that others do not hear or feeling like you are being watched or monitored.

#### 4.7 Medication and dosage that you need to remember:

**Nurofen plus:** contains 200milligrams of ibuprofen and 12.5milligrams of codeine.

Recommended dosage is 2 tablets followed by 1-2 tablets every 4-6 hours (with a recommendation not to take more than 6 tablets in 24 hours).

You have not been given any medication since coming into hospital.

## STATION 10 – MARKING DOMAINS

### The Main Assessment Aims are:

- To evaluate the candidate's ability to take a focussed drug and alcohol history, and establish opioid dependence (codeine) based on the findings.
- To evaluate the candidate's ability to outline management options for opioid dependence.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take appropriately detailed and focussed history of the patient's drug and alcohol history? (Proportionate value – 35%)

##### **Surpasses the Standard (scores 5) if:**

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; excludes other addictions like gambling; elicits the severity of the condition from the history taken.

##### **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 substance use with appropriate depth and breadth; history taking is hypothesis-driven; clarifying important positive and negative features; enquiring about other substances of abuse including alcohol, prescription medication and illicit drugs.

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

- Elicit sufficient criteria to clearly establish an opioid use 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 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history including a failure to enquire about criteria for a codeine use disorder; failure to enquire about other substance misuse.

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

#### 1.12 Did the candidate communicate their findings to the patient sensitively, appropriately and accurately? (Proportionate value - 15%)

##### **Surpasses the Standard (scores 5) if:**

communicates findings in a sophisticated manner; explains the severity of the opioid use disorder.

##### **Achieves the Standard by:**

correctly communicating findings of an opioid misuse disorder in suitable language, with appropriate detail and sensitivity; reflecting on limitations of the ED setting; being responsive to the patient's embarrassment.

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

- Explain the diagnosis of an opioid misuse disorder in a non-judgemental manner.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

unable to synthesise information in a cohesive manner; fails to explain a diagnosis of an opioid use disorder to the patient; incorrectly interprets the information provided by the patient.

1.12. FORMULATION - Communication	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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 - 25%)**

**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; succinctly covers generally accepted treatment options; provides the pros and cons of the different treatment options to the patient.

**Achieves the Standard by:**

demonstrating the ability to prioritise and implement evidence based treatment for an opioid use disorder; explaining initial management options including detoxification with and without medication aids, antagonist treatments, counselling.

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

- a. Highlight the importance of involvement of the partner in treatment planning.

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 mentions all 4 of the treatment options in some detail.

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

Errors or omissions adversely impact on patient care; only mentions one or none of the treatment options outlined above.

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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"/>

**1.16 Did the candidate formulate an appropriate longer term management plan, including preventative treatment? (Proportionate value – 25 %)**

**Surpasses the Standard (scores 5) if:**

overall plan is sophisticated, tailored yet comprehensive; incorporates a sophisticated psychosocial approach into plan; succinctly covers generally accepted treatment options including some psychological and social therapies promulgated in the literature; provides the pros and cons of the different treatment options to the patient. May address the issue of the sleep problem.

**Achieves the Standard by:**

demonstrating the ability to prioritise and implement evidence based care; explaining options including substitution therapies, residential treatments and 'medication free' options; giving priority to continuity of care; demonstrating awareness of possible complications of treatment and available interventions/monitoring; acknowledging appropriately realistic possibility of treatment failure; considering interface between medication vs no medication; counselling vs no counselling, community vs residential.

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

- a. Include the benefits of opioid substitution.

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

**Below the Standard (scores 2 or 1):**

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

**Does Not Achieve the Standard (scores 0) if:**

errors or omissions adversely affect outcomes; candidate has difficulty with most of the skills above.

1.16. Category: MANAGEMENT - Long-term, Preventative	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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**1.0 Descriptive summary of station:**

Jenny, a 40-year-old single, community care worker, is attending her first appointment for Cognitive Behavioural Therapy (CBT). She suffers from generalised anxiety disorder. The candidate is to review her symptoms and then explain the process of CBT.

**1.1 The main assessment aims are:**

- To evaluate the candidate's ability to take a focussed history exploring the patient's mood and anxiety symptoms, and cognitions that would be relevant when considering CBT.
- To assess the candidate's ability to explain the process of CBT specifically tailored for this patient.

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

- Elicit the generalised anxiety disorder symptoms of excessive worries for multiple events over more than 6 months, and feeling on edge.
- Identify at least 2 biological symptoms (poor concentration, disturbed sleep, muscle tension, headaches).
- Explain at least 4 core features of CBT.
- Demonstrate that they have listened to the patient by using any of the patient's terms for anxious cognitions during the explanation of the process of CBT.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders
- **Area of Practice:** Psychotherapy
- **CANMEDS domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Management – Therapy); Communicator (Patient Communication – To Patient)

**References:**

- Beck JS. Cognitive Behavioural Therapy: Basics and Beyond. 2nd Edition The Guildford Press 2011
- Hawton K, Salkovskis PM, Kirk J et al Cognitive Behaviour Therapy for Psychiatric Problems: A practical Guide. Oxford Medical Publications 1989
- Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (5th Edition) American Psychiatric Association (2013)

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, roleplayer x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – female, 35-45, timid demeanour, neatly but casually dressed.
- 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 in a psychotherapy clinic. Your patient, Jenny, is attending her initial assessment session prior to commencing Cognitive Behavioural Therapy with you.

Jenny is a 40-year-old single community care worker. She is not taking any medication. There is no relevant medical history and there is no history of substance abuse.

### Your tasks are to:

- Take a focussed history examining mood symptoms, behaviour and cognitions.
- Explain to the patient the application of Cognitive Behavioural Therapy for anxiety specific to her needs.

**You will not receive any time prompts.**

## 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 e.g. investigation results.
  - 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 – there are no cues or 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 **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 tasks?  
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.

You have no opening statement or time prompts.

The role player opens with:

***'I was worried I was going to be late and didn't want to upset you.'***

#### 3.2 Background Information for Examiners

In this station the candidate is to interview a woman who is attending her first appointment for Cognitive Behavioural Therapy (CBT). She suffers from generalised anxiety disorder and the candidate must take a focussed history exploring the patient's mood and anxiety symptoms, and cognitions that would be relevant when considering CBT. The candidate is then required to explain the process of CBT in a manner that clearly demonstrates that it is tailored to this specific patient.

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

- Elicit the generalised anxiety disorder symptoms of excessive worries about multiple events for more than 6 months, and feeling on edge.
- Identify at least 2 biological symptoms (poor concentration, disturbed sleep, muscle tension, headaches).
- Explain at least 4 core features of CBT. (i.e. *therapy is structured/time limited; therapy identifies and modifies core negative assumptions; therapy requires active participation and collaboration of the patient both in therapy and out of therapy (homework); homework would include self-monitoring and behavioural experiments; using psychoeducation; assisting the patient to develop skills of socratic thinking to question their assumptions; challenging the patient's assumptions and seeking alternatives explanations*).
- Demonstrate that they have listened to the patient by using any of the patient's terms for anxious cognitions during the explanation of the process of CBT.

#### Diagnosis of generalised anxiety disorder

According to the DSM-5 generalised anxiety disorder is characterised by excessive anxiety and worry (apprehensive expectation) occurring more days than not for at least 6 months, about a number of events/activities. The worries are difficult to control. There should be three or more of the following associated symptoms: restlessness/feeling on edge, easily fatigued, poor concentration/mind going blank, irritability, muscle tension, sleep disturbance. There is a disturbance in function and the disorder is not better explained by another mental or physical disorder.

In ICD-10 generalised anxiety disorder is defined as 'anxiety that is generalised and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances (i.e. it is 'free-floating'). The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, light headedness, palpitations, dizziness, and epigastric discomfort. Fears that the patient or a relative will shortly become ill or have an accident are often expressed'.

#### Cognitive and Behavioural Therapies

Cognitive therapy was developed by Beck in the 1960s. This was a structured, short-term, present-oriented psychotherapy for depression that was later developed for many other disorders. The aim of the therapy was to develop solutions to current problems and modify dysfunctional thinking and behaviour. The treatment is based on a conceptualisation of an individual's specific beliefs and patterns of behaviours. The therapist's goal is to seek ways to induce cognitive change (modification of thinking and beliefs) to ensure longstanding emotional and behavioural change in the patient. CBT is a structured time limited therapy.

The rationale of CBT is to control the patient's anxiety, to imagine and gain mastery over thoughts/situations that provoke anxiety while in a controlled and comfortable environment. In exploring the patient's cognitive model of the world the therapist will identify negative automatic thoughts that underpin recurring dysfunctional behaviours and negative emotions. Identifying and then modifying such thoughts leads to enduring change. Behavioural analysis is an early component in the process of therapy where cues and precipitating factors are sought, and identified, for

the recurrence of the negative thoughts and dysfunctional behaviours/mood. Developmental events are identified that led to the genesis of these thoughts and their propagation through life.

Therapy goals for patients with anxiety disorders include: improvement of the risk assessment of feared situations, consideration of their internal and external resources, decreasing the avoidance of feared situations and confronting such situations to test their negative predictions behaviourally.

The development of a therapeutic alliance is vital in all psychotherapeutic relationships. Active participation and collaboration are important components of CBT. Therapy homework (such as self-monitoring, diaries and behavioural experiments) devised in collaboration between patient and therapist, is essential for the progress of sessions.

The sessions should be goal-oriented, problem-focussed and initial emphasis should be on the 'here and now'. Through the course of therapy, the patient would learn to identify and evaluate thoughts, emotions and behaviours and be able to instigate plans and strategies to tackle these situations and become 'their own therapist'. Patients learn to use socratic thinking to question their assumptions, challenging them and seeking alternatives, whilst developing behavioural experiments to test the reality of their thinking.

Cognitive models for generalised anxiety disorder identify that individuals perceive a wide range of situations as threatening leading to heightened anxiety. The assumptions can relate to acceptance (I have to please others), competence (I have to do everything perfect, if I make a mistake I will fail), responsibility (I am responsible for others enjoyment when they are with me), control (I have to be in control all of the time), and anxiety (I must be calm all of the time). Selective attention to situational factors that appear dangerous contribute to the maintenance of anxiety.

Avoidance of the feared subject or procrastination are classic features of anxious behaviours which are reinforcing. Exposure therapy through self-control desensitisation, worry exposure or other strategies would form a key component of CBT in an anxiety disorder. Stimulus control intervention minimises worrying by limiting/postponing worrying to specific times or locations.

Other techniques that would be used during therapy include: education, distraction, activity schedules and relaxation techniques. The patient can be taught relaxation training that can be paired to anxiety provoking situations for instance, 'Progressive Muscle Relaxation' and 'Applied Relaxation' techniques which the candidate should be able to describe. The slow breathing technique may be identified by the candidate, and recommendation that these are all practised regularly, and it is important to instruct the patient to practise at home.

The candidate may describe that the patient would be expected to attend regular sessions, each session taking about 40-50 minutes. Sessions are structured and generally commence review of the previous session and homework.

A better candidate may identify possible problems that can arise during the therapy. They may include lack of anxiety or too much anxiety with situations. Other problems include reduced participation by the patient, particularly the homework.

### 3.3 The Standard Required

#### In order to:

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

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

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

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

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

You are Jenny, a 40-year-old community care worker - providing support services to assist aged, frail, vulnerable or disabled clients to live independently in their own homes in the community. You live alone in your own home and have no children.

When you were young, home could be an unpredictable place. Your father would drink alcohol heavily and there would be frequent arguments and threats between your parents. There was never any physical violence. Discipline could be harsh at home and you would spend much of your time in your room or out in the yard. Even when you were little you remember being unsure of yourself and your surroundings when away from home. You were anxious at times when at school especially when doing new things, changing classes, talking to teachers or moving to new places. On 2 occasions you changed school when your family moved home (when 8 and 13). Both of these times were difficult for you as you always struggled to make new friends. You did have one spell when you were bullied at school because you were quiet. This stopped when you moved school at the age of 13.

Your parents separated when you were about 15. You have had limited contact with your father since then as he moved to Western Australia. After leaving school you started to train as a nurse but ceased this to become a carer for your mother. She was involved in a car accident and was paraplegic (both of her legs were paralysed) as a result of her injuries. You spent many years as a carer for your mother: this could be difficult for you at times but you also found it rewarding and you felt that your relationship strengthened over the years.

Your mother developed breast cancer and deteriorated rapidly and died about 5 years ago despite treatment. Your GP gave you treatment for depression following her death – you were sad, easily upset and lacked motivation. However, support from your small circle of friends seemed to be more effective and so you stopped taking the medication after about 6 weeks. You cannot remember what the medication was called and you had no ill effects from stopping the treatment.

You have 2 brothers that left home in their early teens. You have had no contact with either since your mother's death. You are not aware of any family psychiatric history. You do not have any major medical problems.

After your mother's death you thought it was an obvious choice to get formal training and qualifications in community care so that you could then gain employment doing similar work to that which you were accustomed. You have enjoyed this work especially as you had a set group of clients that you visited regularly. You had got to know them well and you could feel safe and comfortable with them.

Unfortunately matters have worsened over the last year or two. The local council re-tendered the contract for services and a large company from out of state is now running the care service. All of the staff had to reapply for their jobs and there was an overall increase in workload and demands from senior management. You feel that your new manager is harsh and frequently demanding, although you do not think that you are being singled out by your supervisor. There is pressure to take less time with clients so that more people can be seen.

You have been feeling more anxious than normal since that change at work two years ago. You feel 'on edge' and find it hard to relax. You have been worrying and feel preoccupied about a lot of problems. Your thoughts all seem to tangle at times as your worries move from one thing to next. You have felt even more unsure of yourself and have been questioning your ability to do your job well and your decision making. At work you can worry about missing tasks or even missing clients on your day's list. You worry about upsetting your clients or their families and you fear the wrath of your manager even though she has never lost her temper with you before. You often tend to wonder if you have done the right thing or made the right choices. This will sometimes lead to you delaying decisions indefinitely. You have even delayed seeing your manager on occasions even though this was requested as part of your required 'annual review'.

You have also noticed physical changes over this period. Your sleep has become restless and you frequently have difficulty getting off to sleep as your mind 'won't switch off'. There is often a tightness in your stomach and your appetite has reduced. You have had problems with going to the toilet repeatedly as you need to urinate far more frequently than in the past. You get headaches and muscle aches occur far more frequently than in the past (a few times per week). The headache feels like a tight band around your head and often sets in when you are feeling pressured at work. You do not see flashing lights or suffer any visual changes at the time, nor do you experience nausea or vomiting with the headaches. Your concentration is not so good and you have been making silly mistakes or forgetting simple things at times. This has not been so serious as to cause any major problems but you do then worry that you may forget something important and that would have serious consequences.

Although these matters have caused you problems you do not feel depressed and can still spend time on other things at times. You enjoy playing the piano and sewing and find these a good distraction. You also continue to socialise with your group of friends. You have no major problems with motivation. You have no problems with going to the supermarket or other busy places. Your mood has never been unduly elevated. You have not experienced sudden intense anxiety attacks with feelings of impending doom (panic attacks). You are not unduly preoccupied with tidiness or order and do not have recurring irrational thoughts or any rituals (compulsions) that neutralise your worries.

You do not have a major history of substance misuse. You have always been wary of alcohol because of the experience with your father, although you do notice that after only a couple of drinks you feel more relaxed and are more sociable. You never 'need' more than that if you have a meal out with friends and only drink about once per month.

You went to your doctor after becoming more worried about all your physical symptoms. You have a very good relationship with your GP after years of frequent contact through your mother's various health problems. Your GP diagnosed you as having anxiety and did offer psychotherapy and medication. You now realise you have had long standing problems with anxiety. You were keen to remain medication free and so a referral was made for you to see the psychiatrist for something called cognitive therapy.

#### **4.2 How to play the role:**

You are to be casually dressed. You are mildly anxious and feel a bit tense, and have an underlying fear of authority. You will want to keep the candidate happy and pleased. You have a tendency to absolutes: e.g. *'I am always/never..., Everyone thinks ...'*. You have a tendency to think the worst outcome will occur (catastrophise).

#### **4.3 Opening statement:**

***'I was worried I was going to be late and didn't want to upset you.'***

#### **4.4 What to expect from the candidate:**

The candidate will focus on asking you questions about your worries. If you are asked a question that does not have the answer in the script the response should be negative. The candidate will then explain the process of future therapy with you.

#### **4.5 Responses you MUST make:**

Nil

#### **4.6 Responses you MIGHT make:**

If asked, you have never seen or heard things that other people have not; and you do not feel paranoid, or that people are against you; you do not receive special messages from the TV or radio.

***'I'm always worried that I will make a mistake at work and be complained about.'***

***'I'm not confident in making the right decisions.'***

***'What if I get it wrong and I make them angry.'***

***'If I make a mistake I could lose my job and my career could be over.'***

***'If I upset my clients I will be reported and disciplined.'***

#### **4.7 Medication and dosage that you need to remember:**

You do not take any medication.



## STATION 11 – MARKING DOMAINS

### The Main Assessment Aims are:

- To evaluate the candidate's ability to take a focussed history exploring the patient's mood and anxiety symptoms and cognitions that would be relevant when considering CBT.
- To assess the candidate's ability to explain the process of CBT specifically tailored for this patient.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 40%)

##### **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 data gathering; elicits extensive detail regarding the anxiogenic cognitions.

##### **Achieves the Standard by:**

demonstrated 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; eliciting the key issues; demonstrating phenomenology; clarifying important positive and negative features.

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

- Elicit the generalised anxiety disorder symptoms of excessive worries about multiple events for more than 6 months, and feeling on edge.
- Identify at least 2 biological symptoms (poor concentration, disturbed sleep, muscle tension, headaches).

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 of Cognitive Behavioural Therapy? (Proportionate value - 35%)

##### **Surpasses the Standard (scores 5) if:**

demonstrates a sophisticated understanding of CBT and the process of therapy; includes a clear understanding of levels of evidence to support treatment options.

##### **Achieves the Standard by:**

demonstrating a general understanding of CBT; using psychoeducation; explaining choice and rationale for specific psychotherapy; demonstrating sensitive consideration of barriers to implementation; assisting the patient to develop skills of socratic thinking to question their assumptions, challenging them and seeking alternatives explanations.

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

- Explain at least 4 core features of CBT.

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

##### **Below the Standard (scores 2 or 1):**

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

##### **Does Not Achieve the Standard (scores 0) if:**

errors or omissions impact adversely on patient care; plan lacks structure and/or is inaccurate.

1.14. Category: MANAGEMENT - Therapy	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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 appropriately and adequately tailored treatment for this patient? (Proportionate value - 25%)**

**Surpasses the Standard (scores 5) if:**

the candidate uses many of the patient’s terms that signify underlying anxious cognitions; effectively tailors interactions to maintain rapport within the therapeutic environment.

**Achieves the Standard by:**

providing a clear and appropriate explanation; demonstrating empathy and ability to establish rapport; using language and explanations tailored to the functional capacity of the client taking regard of culture, gender, ethnicity; communicating the CBT process and discussing acceptability.

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

- a. Demonstrate that they have listened to the patient by using any of the patient’s terms for anxious cognitions during the explanation of the process of CBT.

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

**Below the Standard (scores 2 or 1):**

scores 2 if the candidate does not meet (a) above by failing to use any of the terms used by the patient or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

errors or omissions materially adversely impact on alliance; inadequately reflects on relevance of information obtained; plan not tailored to patient’s needs or circumstances.

<b>2.1. Category: PATIENT COMMUNICATION - To Patient</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	<b>5</b> <input type="checkbox"/>	<b>4</b> <input type="checkbox"/>	<b>3</b> <input type="checkbox"/>	<b>2</b> <input type="checkbox"/>	<b>1</b> <input type="checkbox"/>	<b>0</b> <input type="checkbox"/>

**GLOBAL PROFICIENCY RATING**

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

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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