

DO NOT REMOVE FROM ROOM

BYE STATION 1 NOTES

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

You may make notations on your notepad and on the 'hospital seclusion rates' document provided, which you will take with you into Station 1.

After you have completed Station 1, all station material are to be left inside Station 1.

This bye station has five (5) tasks:

- You have **twenty (20) minutes** to prepare the tasks while in this active bye station.
- After you leave the bye station you have a further **five (5) minutes outside the examination room** to prepare your response to the five (5) tasks.

Instructions to Candidate

This is a **VIVA** station. In this **VIVA**, there is no roleplayer.

You are working as a junior consultant psychiatrist in an inpatient unit of a large city hospital, and have been asked by your clinical director to analyse the seclusion figures for the last year for the hospitals in your district. She has asked you to examine the raw data she has provided, and prepare a presentation for the next medical meeting. If any of the hospitals are found to be outliers in terms of their seclusion rates, she has also asked you to consider and propose possible reasons why this may be so.

Your tasks are to:

- Review data and provide a basic graphical representation that is suitable to identify trends, and will support a discussion around these.
- Explain how the seclusion figures are trending across the hospitals.
- Explain the hospitals' overall performance throughout the year.
- Provide possible reasons for these trends and any unexpected results.
- Identify interventions or strategies that could reduce the rates of seclusion within this hospital.

At ten (10) minutes, you will be given the final task by the examiner.

You will not receive any time prompts.

CANDIDATE: PLEASE DO NOT REMOVE THIS MATERIAL FROM THE STATION

The following information is provided for you. You may make notations on your notepad and on this document, which you will take with you into the station.

HOSPITAL SECLUSION RATES 2017

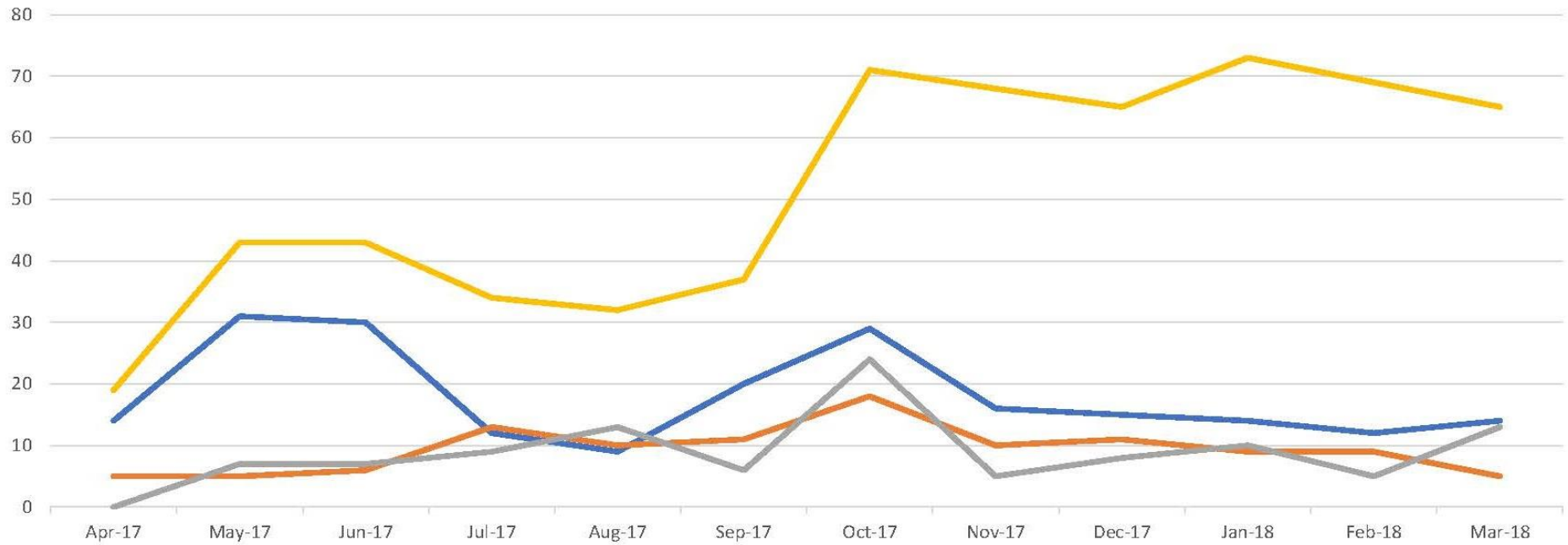
Northern Hospital - Rate of seclusion per 1000 patients days (acute setting, adult and older persons target populations)												
Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Numerator	14	31	30	12	9	20	29	16	15	14	12	14

Eastern Hospital - Rate of seclusion per 1000 patients days (acute setting, adult and older persons target populations)												
Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Numerator	5	5	6	13	10	11	18	10	11	9	9	5

Southern Hospital - Rate of seclusion per 1000 patients days (acute setting, adult and older persons target populations)												
Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Numerator	0	7	7	9	13	6	24	5	8	10	5	13

Western Hospital - Rate of seclusion per 1000 patients days (acute setting, adult and older persons target populations)												
Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Numerator	19	43	43	34	32	37	71	68	65	73	69	65

Basic Graph the Candidates May Draw



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Northern Hospital	14	31	30	12	9	20	29	16	15	14	12	14
Eastern Hospital	5	5	6	13	10	11	18	10	11	9	9	5
Southern Hospital	0	7	7	9	13	6	24	5	8	10	5	13
Western Hospital	19	43	43	34	32	37	71	68	65	73	69	65

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1.0 Descriptive summary of station:

This is a station that tests the candidate's ability to analyse clinical performance data on seclusion in four local hospitals, identify that there are variations in the numbers of people being secluded across the hospitals, and provide explanations as to why this may have occurred. The candidate is then provided with more specific information on which to provide an opinion.

1.1 The main assessment aims are to:

- Review and interpret the clinical performance data that has been provided.
- Identify that there has been an increase in the seclusion figures in one of the local hospitals.
- Outline the factors that may explain the variation in seclusion rates both between sites and throughout the year.
- Identify strategies to reduce seclusion rates.
- Provide opinion on specific data related to individuals.

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

- Provide a basic graphical representation that identifies a trend towards the increasing / higher level of use of seclusion in one of the hospitals.
- Outline at least three (3) factors to explain the variation between sites.
- Propose at least three (3) appropriate explanations for the trend throughout the year.
- Provide at least three (3) evidence-based strategies to reduce seclusion rates.
- Provide at least three (3) explanations why these multiple seclusions may be happening.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Governance Skills, Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Health Advocate, Scholar.
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Therapy), Health Advocate (Addressing Disparity), Scholar (Teaching & Presenting; Application of Knowledge), Manager (Governance)

References:

- Gaskin, C.J, Elsom S.J and Happell B. (2007) Interventions for reducing the use of seclusion in psychiatric facilities. *British Journal of Psychiatry* 191: 298-303.
- Oster C. et al. (2015) Seclusion and restraint use in adult inpatient mental health care: An Australian perspective. *Collegian* 23: 183-190.
- The Royal Australian and New Zealand College of Psychiatrists Position Statement 61: Minimising the use of seclusion and restraint in people with mental illness.

1.4 Station requirements:

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

2.0 Instructions to Candidate

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

This is a **VIVA** station. In this **VIVA**, there is no role player.

You are working as a junior consultant psychiatrist in an inpatient unit of a large city hospital, and have been asked by your clinical director to analyse the seclusion figures for the last year for the hospitals in your district. She has asked you to examine the raw data she has provided, and prepare a presentation for the next medical meeting. If any of the hospitals are found to be outliers in terms of their seclusion rates, she has also asked you to consider and propose possible reasons why this may be so.

Your tasks are to:

- Review data and provide a basic graphical representation that is suitable to identify trends and will support a discussion around these.
- Explain how the seclusion figures are trending across the hospitals.
- Explain the hospitals' overall performance throughout the year.
- Provide possible reasons for these trends and any unexpected results.
- Identify interventions or strategies that could reduce the rates of seclusion within this hospital.

At ten (10) minutes, you will be given the final task by the examiner.

Station 1 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - Pens.
 - Water and tissues 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.
- TAKE NOTE that there are no cues / times for any scripted prompt.
- 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 ten (10) minutes, you are to give the final task to the candidate.**
- 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.

This is a VIVA station so there is no role-player. Your role is to keep to time and to mark the candidate.

At ten (10) minutes, you are to give the final task to the candidate. The final task is:

You are the consultant of this acute 20 bed psychiatric unit.

The following are last month's data.

Two patients, Mr AB & Ms SR, have both been secluded multiple times over the month.

Based on likely causes of the seclusion patterns, please outline your approach to the management of reducing these seclusions.

August 2018

Patient	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion	Time secluded & time entered seclusion
Mr AB	4 hours 3.05pm	3 hours 1.55pm	2 hours 3.50pm	1.5 hours 2.00pm	4.5 hours 3.12pm	1.5 hours 2.10pm
Ms SR	3 hours 6.30am	1.5 hours 6.00am	1.5 hours 5.42am	1.0 hours 5.15am	1.5 hours 6.00am	1.5 hours 2.15pm

3.2 Background information for examiners

In this station the candidate is expected to demonstrate skills at analysing clinical data on seclusion rates, including presenting their analysis in a simple graphical form from which they can then identify an increase in seclusion figures in Western Hospital. The candidate is then expected to postulate on factors that may explain the variation between sites as well as the trend over the year. Finally, the candidate is expected to present strategies that will assist in reducing seclusion rates.

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

- Provide a basic graphical representation that identifies a trend towards the increasing / higher level of use of seclusion in one of the hospitals.
- Outline at least three (3) factors to explain the variation between sites.
- Propose at least three (3) appropriate explanations for the trend throughout the year.
- Provide at least three (3) evidence-based strategies to reduce seclusion rates.
- Provide at least three (3) explanations why these multiple seclusions may be happening.

Royal Australian and New Zealand College of Psychiatrists Position Statement 61:

The RANZCP is committed to achieving the aim of reducing, and where possible eliminating, the use of seclusion and restraint in a way that supports good clinical practice and provides safe and improved care for consumers. Reducing the use of seclusion and restraint requires commitment and leadership to changing practices and continued investment in delivering high quality care.

Background

In recent years, there have been a number of Australian reviews in relation to seclusion and restraint, including:

- *In 2005, Australian Health Ministers endorsed the National Safety Priorities in Mental Health: a National plan for reducing harm. The Plan identified four priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion' (National Mental Health Working Group, 2005).*

- The National Mental Health Seclusion and Restraint Project (2007 – 2009), also known as the Beacon Project, was developed as a collaborative initiative to establish demonstration sites as centres of excellence aimed towards reducing seclusion and restraint in public mental health facilities. The Beacon Project published a suite of national documentation in September 2009 (Mental Health Standing Committee, 2009), which was endorsed by the Mental Health Standing Committee (MHSC) for use by Australian mental health services.
- The National Mental Health Consumer and Carer Forum's 2009 position statement on Ending Seclusion and Restraint in Australian Mental Health Services (National Mental Health Consumer and Carer Forum, 2009).
- In its 2012 Report Card on Mental Health and Suicide Prevention, the National Mental Health Commission recommended that action must be taken to eliminate the use of seclusion and restraint in mental health services. In order to carry out this recommendation, the Commission called on all states and territories 'to contribute to a national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013' (National Mental Health Commission, 2013).
- In 2015, the National Mental Health Commission published A Case for Change: Position Paper on seclusion, restraint and restrictive practice in mental health services to help identify best practice as well as the barriers to reducing or eliminating seclusion and restraint in mental health settings (National Mental Health Commission, 2015).
- All Australian jurisdictions have introduced laws, policies or guidelines, focussing on reducing seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint.

In New Zealand, Te Pou o Te Whakaaro Nui (Te Pou) released a report in 2008, Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change (O'Hagan et al., 2008).

The standards governing the use of seclusion and restraint in the Health and disability services (restraint minimisation and safe practice) standards were also revised in 2008 (Standards New Zealand, 2008). The intent of the standards is to 'reduce the use of restraint in all its forms and to encourage the use of least restrictive practices'.

In 2010, the New Zealand Ministry of Health developed guidelines to identify best practice methods for using seclusion in mental health acute inpatient units in alignment with the specifications set out in the Health and Disability Services Standards to, over time, limit the use of seclusion and restraint on mental health patients. In addition, reducing (and eventually eliminating) seclusion is one of the goals of the Ministry's service development plan 'Rising to the Challenge' (Ministry of Health, 2012).

Subsequently, Te Pou has developed an evidence - based Six Core Strategies Checklist for reducing the use of seclusion and restraint practices. As research also shows that Tangata whai i te ora are over - represented in reporting of seclusion and restraint events, Te Pou has also developed recommendations to support better outcomes when working with Māori people using services. The work is drawn from Te Pou's work with services and from the study Strategies to reduce seclusion and restraint for tangata whai i t e ora (Wharawera - Mika et al., 2013).

Over the past decade, Trauma - Informed Care has emerged and encompasses strategies aimed at reducing coercive practices, including restraint and seclusion as a way of creating therapeutic environments that prevent retraumatising or traumatising consumers. The majority of consumers in inpatient settings have had past trauma experiences and as such 'universal trauma precautions' and nursing practices that are growth - promoting and recovery - focussed are recommended to prevent further harm. Restraint and seclusion are experienced by consumers as emotionally unsafe and disempowering practices and, therefore, can be re-traumatising (Muskett, 2014).

Recent data shows that the seclusion and restraint rate in mental health services in both Australia and New Zealand is declining. In Australia, there were eight seclusion events per 1 000 bed days in 2013 – 14, an average annual reduction of 12.2% since 2009 – 10. The highest rate of seclusion was for child and adolescent and general services with 9.6 and 9.5 seclusion events per 1000 bed days respectively. Older person services had the lowest rate of seclusion events (0.5), a reduction of 34.4 % in five years (Australian Institute of Health and Welfare, 2014). In New Zealand, the use of seclusion in adult inpatient units is also in decline, with the number of people secluded decreasing by 29% since 2009 and the total number of hours spent in seclusion reducing by 50% since 2009. However, Māori people remain over - represented in the seclusion figures. In 2013, Māori people were 3.7 times more likely to be secluded than non - Māori in an adult inpatient setting (per 100,000 population; Ministry of Health, 2014).

Definition

Both seclusion and restraint have long been used as an emergency measure to manage violent behaviour or agitation in mental health settings. The primary aim is to reduce risk of traumatic experience and / or injury for both consumers and staff involved.

- **Seclusion** is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.

- **Restraint** is the restriction of an individual's freedom of movement by physical, chemical or mechanical means. Here, 'physical' means bodily force that controls a person's freedom of movement, 'chemical' means medication given primarily to restrict a person's movement not to treat a mental illness or physical condition and 'mechanical' means a device that controls a person's freedom of movement.

While this position statement applies to the use of seclusion and restraint in mental health settings, it should also be used to inform policy in all other health, welfare or disability settings. This includes the use of seclusion and restraint on individuals with intellectual disability and in aged care settings and those presenting in emergency departments.

Evidence

Seclusion and restraint are generally used in the hope of preventing injury and reducing agitation, but studies have reported substantial deleterious physical and more often psychological effects on both patients and staff (Fisher, 1994).

It is acknowledged that there are situations where it is appropriate to use restraint and / or seclusion but only as a safety measure of last resort where all other interventions have been tried or considered and excluded. Under these circumstances, seclusion and restraint should be used within approved protocols by properly trained professional staff in an appropriate environment for safe management of the consumer. Seclusion and restraint are not a substitute for inadequate resources (such as lack of trained nursing staff). They should never be used as a method of punishment.

There is considerable variation in the clinical standards governing the use of seclusion and restraint in mental health services and guiding the appropriate use of the interventions or the use of alternative strategies. The aim is to reduce the use of these interventions and the adverse events that accompany them. Reduction of seclusion and restraint is possible, as demonstrated in studies such as those in the United States which have reduced use considerably without additional resources (Huckshorn, 2005). Evidence also shows that de-escalation and debriefing strategies can help minimise the use of seclusion and restraint. It requires leadership, commitment and motivation, and a change culture underpinned by recovery with a focus on workforce and training, prevention and early intervention, good clinical care, and supporting practice change.

The main barriers to reducing seclusion and restraint are:

- lack of identified good practice / agreed clinical standards for the use of seclusion and restraint.
- lack of quality improvement activity and clinical review – i.e. poor governance.
- inappropriate use of interventions and variation in practice – e.g. using threat of restraint or seclusion to coerce particular behaviour.
- lack of staff knowledge or skills to prevent, identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations.
- lack of staff knowledge or skills regarding appropriate triaging of mental health presentations.
- lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint.
- lack of staff education and training, particularly in non-mental health care settings.
- lack of resources and poor facilities.

Many of the barriers above are being addressed through the MHSC initiatives in Australia and the recent updates by Te Pou and Standards New Zealand. Common themes developed in all strategies for the reduction of seclusion and restraint include:

- national direction and appropriate funding.
- leadership towards organisational, clinical and cultural change.
- use of data to inform practice.
- improved governance and review.
- workforce development, including de-escalation and debriefing strategies.
- use of practical and evidence - based seclusion and restraint prevention tools.
- service user development and participation.
- better care planning.
- consumer roles in inpatient settings.
- debriefing techniques.
- review of relevant mental health legislation.

The RANZCP supports the development of these strategies and believes that an increased focus on developing good clinical care, governance, research and education will help reduce the use of seclusion and restraint in practice.

The RANZCP also supports measures to improve the environment and physical layout of mental health services to help consumers to feel as safe and secure as possible. These measures can, in turn, help services to reduce the need to utilise seclusion and / or restraint practices. Potential examples include having natural light and spaces specifically designed to provide comfort to people who are in crisis or distressed and enabling doors to the to the main wards to be unlocked (National Mental Health Commission, 2015).

Issues which could specifically explain why sites within the same district could have different seclusion utilisation include disparity in staffing numbers and stability; different levels of comfort on assertive medication management for aggression; allocation of resources (including access to security staff or lack thereof; size of the site / grounds; locked facility or not; ward culture; demographics of the hospital catchment area (population size, density and stability, metropolitan vs regional setting).

Increasing trends could occur for a range of reasons, for instance, changes in staff expertise such as registrar term change or recruitment of new nursing graduates; commencement of a new consultant who has different training / opinion around seclusion; tendencies to under medicate leading to episodes of seclusion.

The candidate may elaborate on the role and attitudes of the Nurse-in-Charge / Nurse Unit Manager (NUM), and other shift leaders and their impact on the culture of the ward. They could postulate on issues related to the training and attitude of all members of the MDT; the specific leadership of consultants; the availability of medical staff to de-escalate prior to seclusion; that there may be training gaps – both on policies and procedures (and whether they are being followed) and of de-escalation strategies and training in the management of occupational violence.

In the station the candidate will be given a set of data at ten (10) minutes to consider about their own ward. This is to test their ability to consider the role of a consultant to be a manager of unusual trends of seclusion. They are expected to be able to consider the multiple stakeholders to be consulted before developing a quality improvement plan. Explanations for the multiple seclusion incidents could be broken down to considering specific patient factors that could explain each of the patient's patterns of seclusion: whether this is early in the admission or throughout the admission; whether the patient is known to the staff or new to the service; diagnoses, treatment plans, adequate medication management, extenuating psychosocial factors confounding the inpatient management (*for example, does the patient have a diagnosis of a personality disorder leading to later use of effective sedating medications*); impact of personality structure and interactions with staff; transference and countertransference factors and cognitive biases.

The candidate should provide a range of actions to address the change in their hospital. This could include plans to meet with all stakeholders (nursing staff, medical staff, patient advocates), and prepare a strategy to aim to reduce seclusion rates for each patient. They should effectively consult around complex governance issues of occupational violence and aggression versus Human Rights versus the goal of seclusion; lead change management. There may be mention of a review of the timing of medications; or making transparent the role of cognitive bias to a particular patient. The candidate could focus on the role that shift change and handover takes in this process – are the nurses finding it difficult to manage highly aroused patients when there is a handover process being prepared and / or occurring.

The better candidate may:

- consider a quality project for their ward around better implementing the hospital de-escalation policy, and trying to actively reduce seclusion rates.
- want to investigate whether there are person specific factors, for instance, the same shift leader each time.
- recommend an external review.
- include consumer and carers in any review.
- consider local culture and interventions that include the entire ward.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

STATION 1 – MARKING DOMAINS

The main assessment aims are:

- Review and interpret the clinical performance data that has been provided.
- Identify that there has been an increase in the seclusion figures in one of the local hospitals.
- Outline the factors that may explain the variation in seclusion rates both between sites and throughout the year.
- Identify strategies to reduce seclusion rates.
- Provide opinion on specific data related to individuals.

Level of Observed Competence:

6.0 SCHOLAR

6.3 Did the candidate demonstrate an appropriately skilled approach to applying principles of presenting? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

provides a well-structured and clear visual representation; recognises the opportunity that presenting offers; prioritises the learning needs of peers; provides carefully tailored feedback strategies.

Achieves the Standard by:

demonstrating the capacity to: identify requirements to portray the main points for the presentation; organising the data in a simple manner; appropriately labelling key aspects of the graph to ensure a successful outcome; accurately interpreting data at a level relevant to the consultant audience; clearly seeing their role in the delivery of findings; identifying additional information that may be required.

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

- Provide a basic graphical representation that identifies a trend towards the increasing / higher level of use of seclusion in one of the hospitals.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not apply any structure to their graphical representation; does not demonstrate an increasing trend; does not see presenting as part of their role.

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

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

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature / research / clinical experience? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

candidate acknowledges that information provided is not comprehensive but is the subject of debate; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:

commenting on the voracity of the available evidence; discussing major strengths and limitations of information provided and their visual interpretation; specifying the key proponents of current knowledge base; describing the relevant applicability of theory to the scenario.

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

- Outline at least three (3) factors to explain the variation between sites.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; unable to demonstrate ability to analyse data; inadequate knowledge of the literature or evidence relevant to the scenario; inaccurately identifies or applies evidence provided.

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

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

5.0 HEALTH ADVOCATE

5.1 Did the candidate appropriately attempt to address disparity in the seclusion rates over time? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

actively seeks to evaluate local hospital data; considers impact of differences of local settings.

Achieves the Standard by:

demonstrating the capacity to: describe strategies to reduce inequalities and disparities in the clinical setting; use expertise and influence to advocate on behalf of patients; promote primary and secondary prevention strategies within individuals / communities; engage with minority groups to enhance delivery of care; actively link with relevant advocacy groups; mobilise additional resources when needed.

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

a. Propose at least three (3) appropriate explanations for the trend throughout the year.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; limited recognition of health inequalities and disparities; unable to explain or advocate for rational explanations across time; unsophisticated approach to explaining differences.

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

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

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological and / or psychological / social intervention strategies? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support treatment options; clarifies the role of other health professionals; considers sensitively barriers to implementation; identifies most strategies.

Achieves the Standard by:

demonstrating the following: the understanding of evidence-based least restrictive interventions; identification of specific options; appropriate selection of and rationale for specific strategies; including benefits / risks, application and monitoring.

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

a. Provide at least three (3) evidence-based strategies to reduce seclusion rates.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; errors or omissions impact adversely on patient care and seclusion outcomes; options lack evidence base and / or are inaccurate; plan not tailored to reducing seclusion or circumstances relating to seclusion.

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

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

4.0 MANAGER

4.1 Did the candidate demonstrate a capacity to apply principles of clinical governance? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

presents a considered systems approach to their answer including demonstrating willingness take responsibility for their role in this situation and in leading change; considers effectiveness of audit, review and feedback processes; incorporates significance of upholding human rights in the context of risk mitigation.

Achieves the Standard by:

identifying principles of clinical governance and standards, applying governance within organisational structures; demonstrating capacity to distinguish between leadership and management; contributing to principles of change management and change processes; considering a suitable range of options that explain the data; presenting a range of relevant and practical approaches to reducing seclusion rates in the two patients.

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

a. Provide at least three (3) explanations why these multiple seclusions may be happening.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; lacks clarity about clinical governance and standards; poorly defines own scope of practice and responsibilities.

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

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

GLOBAL PROFICIENCY RATING

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

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

The candidate is required to engage and educate a medical student who is a novice in electroconvulsive therapy (ECT), and demonstrate knowledge of technical administration and clinical aspects of ECT. This is done using a clinical vignette involving a patient with severe psychotic depression. He has previously responded well to ECT but tends to relapse when managed only with pharmacotherapy.

1.1 The main assessment aims are to:

- Address stigma related to ECT.
- Demonstrate knowledge of the technical administration of ECT.
- Outline the benefits and side effects of ECT along with measures to reduce cognitive deficits associated with ECT.
- Apply evidence-based knowledge of ECT to the individual patient.

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

- Explain at least two (2) measures taken to reduce stigma and negative impact of ECT.
- Consider continuation or maintenance ECT for this patient.
- Justify recommendation of high dose right unilateral ECT as the appropriate treatment for this patient.
- Recommend a stimulus dose 5-6 times the threshold dose which has been determined by further RUL RCT sessions.
- Accurately demonstrate bitemporal, right unilateral and bifrontal electrode placements.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Health Advocate, and Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Therapy; Assessment - Physical - Technique), Communicator (Synthesis), Health Advocate (Addressing Stigma), Scholar (Application of Knowledge)

References:

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1.4 Station requirements:

- Model styrofoam head.
- 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: Young male / female neatly dressed, articulate.
- 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 an adult inpatient unit. You are supervising Nic Jones, a fifth-year medical student attached to your team. This is Nic's first week in psychiatry, and Nic has requested a tutorial on the use of ECT for your patient, Mr Michael Middleton.

Michael Middleton is a 34-year-old man with bipolar disorder. He has been admitted with severe depression with psychotic features. Since admission his disorder has not responded well to an adequate trial of mood stabilisers, antidepressants and antipsychotic medications but continues to deteriorate.

His clinical history documents that he has had six episodes in the past, of both mania and depression. Most of the episodes have got better with 6 – 8 treatments of bitemporal ECT to achieve episode remission. He experienced cognitive difficulties especially retrograde amnesia for a few days post ECT, but when well he acknowledged that ECT was effective for him.

Mr Middleton's symptoms recurred despite maintenance mood stabilisers and antipsychotic medications even though he was unfailingly compliant with medications. Mr Middleton and his family are keen for you to make suggestions on ways to ensure that his illness does not keep relapsing. You have decided to again commence ECT for Mr. Middleton.

Nic Jones has gathered knowledge about ECT mainly from the movies and media. Nic is concerned about your decision to use ECT, and has asked if you can discuss ECT.

Your tasks are to:

- Address the medical student's concerns about the use of ECT.
- Outline your clinical decision to use ECT for Mr. Middleton to the medical student, including how side effects can be reduced.
- Explain how you would determine the dose of ECT for Mr. Middleton to the medical student.
- Using the model head, demonstrate where electrode are placed in ECT to the medical student.

You will not be given any time prompts.

Station 2 - Operation Summary

Prior to examination:

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

During examination:

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

- 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.

The role player opens with the following statement:

'I have heard some bad stories about ECT. Are they true?'

3.2 Background information for examiners

In this station, the candidate is expected to engage and educate a medical student, Nic Jones, who is a novice in electroconvulsive therapy (ECT), and has negative opinions about its use. They are to justify their decision to prescribe ECT in a patient with severe and recurrent episodes of bipolar disorder, and to demonstrate knowledge of technical administration and clinical aspects of ECT. The candidate will be assessed on their ability to address stigma related to ECT, and outline the benefits and side effects of ECT, including measures to reduce associated cognitive deficits.

In this station, the medical student believes that ECT is an antiquated treatment. Nic's knowledge is based on media reports of ECT which are largely negative. Nic is concerned that ECT can produce severe memory deficits (which has an evidence base), and even wondering if ECT could damage the brain. The candidate must address the student's concerns in several of ways: which may include acknowledging the abuse of ECT in the past; providing an outline of the changes that have taken place in the delivery of ECT (e.g. introduction of anaesthesia); emphasising the safety record of ECT (*Torrington, et al 2017*); describing modern techniques that reduce cognitive impairment (*Sackeim, et al 2008; Torrington, et al 2016*); explaining the stringent legal regulations in place for the practice of ECT; and promoting ECT psychoeducation opportunities that focus on patients, families and community.

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

- Explain at least two (2) measures taken to be reduce stigma and negative impact of ECT.
- Consider continuation or maintenance ECT for this patient.
- Justify recommendation of high dose right unilateral ECT as the appropriate treatment for this patient.
- Recommend a stimulus dose 5-6 times the threshold dose which has been determined by further RUL RCT sessions.
- Accurately demonstrate bitemporal, right unilateral and bifrontal electrode placements.

A surpassing candidate will demonstrate skills in engaging and educating the medical student in a sensitive manner that effectively addresses the stigma attached to ECT.

Detailed assessment aims

Electroconvulsive Therapy (ECT) is the most effective treatment for mood disorders (*UK ECT review group 2003*). In spite of its remarkable efficacy and exemplary safety records there is strong opposition to ECT, much of which arises from misconceptions derived from movies and media (*Payne and Prudic 2009*). Fear about ECT is common among patients and professionals. Unfounded fear contributes to stigma attached to ECT, and this acts as a major obstacle to its successful implementation. Therefore, engaging patients, families, professionals and trainees in ECT education is critical. Psychiatrists also have a duty to educate junior doctors and students to close the gap between reality and myths.

The exact mechanism of ECT is not precisely known. Few theories have been proposed and among them anti-convulsive property of ECT has gained attention (*Sackeim, et al 2004*). It is argued that ECT is a brain stimulating treatment in the sense that it stimulates the seizure shutdown mechanism of the brain. This hypothesis is supported by the observation that remission of depression is correlated with raising seizure threshold over the course of treatment.

Strategies reducing negative impact and stigma associated with ECT

Since its inception 80 years ago, ECT has undergone successive changes.

- ECT anaesthesia came to use in late 1960s.
- Abandonment of sine wave, and use of brief pulse and ultrabrief pulse: Sine waves were earlier used to produce seizure, but they were later replaced by pulse waves that are associated with fewer cognitive deficits. This progress culminated in the use of ultrabrief pulse which has favourable outcomes on cognitive functions post ECT.
- Other measures to reduce cognitive deficits (see below).
- Legislative regulation has been put in place, particularly when used in people with reduced capacity to consent, and tight regulation measures ensure appropriate use of ECT.
- Increased research into application, safety and outcomes of ECT to guide practice change.
- Training and education of staff and patients / family / carers, credentialing processes for psychiatrists regularly include ECT. ECT education activities focus on patients / family brochures and DVDs; being available to answer specific questions; visits to the ECT suite; family attendance at ECT.
- Media Education about ECT.

Indications for ECT

ECT is typically indicated for major depressive disorder complicated by reduced fluid and nutritional intake, high risk of suicide or catatonia. Depressive symptoms that are refractory to pharmacotherapy, and major depressive disorder complicated by psychotic symptoms can be treated by ECT. Other indications of ECT include manic syndrome and psychosis that do not respond to pharmacotherapy.

ECT has some use in severe behavioural and psychological symptoms of dementia, self-injurious behaviour associated with autistic spectrum disorders, Parkinson's disease and intractable epilepsy, but these conditions are not common or well researched indications for ECT (*van den Berg, et al 2017; Watchtel, et al 2018*), and so are not required to meet the standard in this station.

Better candidates may articulate details of ECT research, and use of evidence-based treatment guidelines including RANZCP guidelines (*American psychiatric Association 2001; Mahli, et al 2015. See RANZCP guideline*), specialised ECT journals and recent practice of family attendance at ECT may qualify for surpassing the standard.

Side effects of ECT

The common side effects of ECT are generalised body pain, headache and confusion usually on the day of the treatment. The most troublesome adverse effect of ECT is cognitive deficits particularly retrograde amnesia which can be permanent in approximately 12% of patients receiving bilateral ECT and sine wave stimulation, but has not been reported for persons receiving unilateral ECT (*Sackeim 2007*). The candidate should articulate contraindications for ECT, and precautions that must be undertaken in high risk conditions.

Cochlear implant is an important contraindication for ECT, and a number of conditions warrant precautions and careful considerations of risk-benefit ratio. Severe cardiac failure (ejection fraction below 30%), recent myocardial infarction, raised intracranial tension, current deep vein thrombosis, arterial aneurysm, arterio-venous malformation, bone fracture, uncontrolled hypertension and lower respiratory infections are some of the relative contra-indications for ECT. The treatment under these circumstances is given when it is determined that ECT is lifesaving, and no alternate treatment is effective or available.

Electrode placement

The candidate must demonstrate commonly used electrode placements: bifrontotemporal (or widely known as 'bitemporal'), bifrontal and right unilateral (RUL) placements.

- For bitemporal ECT the anatomical location is 2.5-3 cm above the midpoint on a line drawn from the tragus of ear to the outer angle of eye on either side (*Prudic and Duan 2017*).
- The original placements for bifrontal ECT were two inches apart symmetrically on either side of the midline extending superiorly from the nasion (*Abrams and Taylor 1973*). This was later modified to 4–5 cm above the outer canthus of the eye along a vertical line perpendicular to a line connecting the pupils (either response from the candidate is acceptable).
- The anatomic locations for RUL ECT include right frontotemporal position as in bitemporal placement, and the other will be just to the right of the vertex (d'Elia position).

The placements in ECT vary across centres and the profile of individual patients.

Prevention of cognitive deficits

Cognitive deficits particularly autobiographical memory loss is the most troublesome adverse effect of ECT. Furthermore, memory loss heavily contributes to stigma and historical opposition to ECT hindering its practice.

The candidate is expected to identify significant cognitive impairment associated with bitemporal ECT, specifically retrograde amnesia which can be permanent in some patients (*Sackeim 2007*). Although the exact figure is not required the candidate should demonstrate awareness of permanent nature of retrograde amnesia at least in some patients receiving bitemporal ECT.

The candidate is expected to elaborate on techniques to reduce cognitive side effects of ECT. These include:

- RUL electrode placement instead of bitemporal placement;
- reducing the frequency of ECT from three to two times a week;
- using ultrabrief pulse in place of brief pulse (*Sackeim, et al 2008; Tor, et al 2015*).

To the best evidence, RUL is as efficacious as BT ECT at higher dose (six times threshold) with better cognitive outcomes compared with BT ECT (*Kolshus, et al 2017*). For these reasons RUL is preferred over BT ECT for the patient in this station.

There is some evidence that the antidepressant effect of ECT may be related to suppression of prefrontal systems, and that amnesic effects may be related to medial temporal structures. The site of stimulation and direction of current flow may be more important than seizure propagation. Focal electrically administered seizure therapy (FEAST) is a relatively new approach to ECT designed to reduce adverse cognitive effects. It differs from ultrabrief pulse RUL ECT because it uses unidirectional rather than bidirectional current, and a novel nonsymmetric electrode placement (a large posterior electrode in front of the right motor cortex and a small anterior electrode above the centre of the right eyebrow, over the right orbitofrontal cortex) (*Sahlem GL et al 2016*).

As retrograde amnesia for autobiographical information is the most significant adverse effect of ECT, more recent research tends to suggest testing for long-term autobiographical amnesia. Tools like the Columbia University Autobiographical Memory Interview (CUAMI) or the short form of this scale (CUAMI-SF) have been studied.

Calculating the dose

There are two methods to determine dose in ECT: dose titration and age-based dosing (*American Psychiatric Association 2002*).

Although these methods are still debatable, stimulus dose titration has gained considerable impetus across the globe and is widely practised in Australasia. Elaboration of stepwise dose increment alone is not sufficient to meet the requirement of this domain. The candidate must mention the principle of titration: individualise the threshold dose. There is huge variation, up to 200-times, in the threshold dose. Therefore, determining threshold dose is critical in ensuring efficacy and safety particularly for right unilateral ECT (elaboration of titration protocol or differences in the doses between women and men is NOT required for achieving standard). For bitemporal ECT 1.5 times threshold is recommended, and for RUL six times (500% times above threshold) threshold is necessary for optimal outcome (*Sackeim, et al 2000*). Some centres follow five times threshold which is slightly under dosed, but this is acceptable for this station. A response of three times threshold is grossly inadequate, and against the evidence-base. The adequate dose for bifrontal ECT is currently the same as bitemporal ECT, but this is under investigation.

Role of continuation or maintenance treatment

Continuation ECT (C-ECT) and maintenance ECT (M-ECT) may be required for many patients with severe and recurrent forms of mood disorders. There is modest efficacy from these treatment modalities in preventing relapse and recurrence in patients who have responded to an index course of ECT. Multiple relapses soon after remission from acute ECT even with adequate pharmacotherapy is a clear indication for continuation or maintenance ECT.

Based on the evidence of efficacy and side effects, the candidate should arrive at a conclusion that C-ECT (up to six months after remission of index episode) or M-ECT (beyond six months with no predetermined end point) are options for this patient.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Nic Jones, a fifth-year medical student at the University of Auckland. The training for your medical degree lasts a total of six years. This is the first week of a six-week placement in psychiatry. You have had no real exposure to people with mental illness prior to this, and you are really enjoying your time in the ward talking to patients, and also learning all kinds of interesting facts and skills.

Today you are meeting your psychiatrist supervisor (the candidate) to discuss electroconvulsive therapy (ECT) in a tutorial. You plan to become a GP after you graduate, and are aware that your work will require you to care for persons with mental illnesses. Consequently, you wish to make the most of your time here. However, you are embarrassed to acknowledge that prior to this you did have a somewhat biased image of psychiatry, and of people with mental illnesses. You always thought that were probably scary and dangerous. Your experiences over the past week are beginning to show you otherwise.

As a part of your training you are expected to observe a few ECT sessions. You want to understand why ECT is still continued as a treatment in psychiatry. The candidate is expected to listen to your concerns and teach you things about ECT.

You do not have medical knowledge of ECT but have read about it in the media, and watched some movies that depicted ECT in a rather frightening manner ('Snake Pit', 'One Flew Over Cuckoo's Nest'). In these, you have seen the treatment produce violent shakes of hands, legs and the entire body with clenching of teeth. Patients seemed to be dazed and 'confused' after ECT. At the beginning of your training you recall one of your friends had told you that his father had been treated with ECT, and that he had subsequently suffered problems with memory loss. You therefore think that ECT is an outdated procedure, and cannot understand why it continues to be given these days. You also believe ECT may cause brain damage.

If the candidate asks you why you think it is outdated or encourages you to talk more about ECT, then freely talk about your lack of knowledge and what you have seen in the movies (you may demonstrate the violent movements and clenching of teeth in a manner that you saw in the movie). You also express the concern of memory loss as reported to you by your friend. He had said that his father's brain 'was fried' with ECT, but you wonder whether that was just his way of describing things. However, based on the experience of your friend's father, you know that ECT is associated with memory loss. Therefore, you are keen to know if there are any ways to reduce this side effect of ECT if it has to be used.

Your request for the tutorial has arisen because the psychiatrist has decided to administer ECT for Mr Michael Middleton, and you have a series of questions for the psychiatrist.

About the patient

Michael Middleton is a 34-year-old man admitted to the ward with bipolar disorder, which is also known as manic depression where people's moods can become very elevated or depressed. He is currently severely depressed with psychotic symptoms whereby he believes that his gut is rotting. Consequently, he has been refusing food for the last 2 – 3 days, and drinks only small amounts of fluids. The treating team has obtained consent to give him electroconvulsive therapy which is due to begin on Monday.

Background information to assist you to understand the case – but it is not required for you to provide to the candidate unless specifically asked:

In the past, Mr Middleton has had a total of six episodes of severe mania and depression which have required ECT to produce an improvement in his wellbeing. He gets well after a few treatments, but his illness tends to relapse quite rapidly after ECT is discontinued despite adequate medications which he takes regularly (he has been on a combination of medications called mood stabilisers, antipsychotics and when required, antidepressants). He does experience problems with his thinking especially for the times just before having ECT, and for a few days after ECT. When he is well he acknowledges that this is an effective treatment for him. Mr Middleton and his family are keen for the doctor to suggest alternative longer-term treatments to ensure that his illness does not keep relapsing.

In response to your interest in '**Why have you chosen to give Mr. Middleton ECT?**' the candidate may describe various psychiatric disorders for which ECT is indicated. '**What other side effects could he have?**' will allow the candidate to illustrate common side effects of ECT. You can then become curious to know whether there are conditions when it is risky to give ECT or when ECT is not safe to be used. Based on your concerns about memory loss you ask: '**How will you reduce memory loss for this man?**'

As the tutorial progresses, you become more and more interested in ECT. You started with a negative view of ECT, but with sufficient explanations from the candidate you are now keen to know **how ECT works**. This question leads to proposed mechanism of ECT. The candidate may offer you one or more theories of ECT.

Technical administration of ECT

At some stage you want to know how ECT is administered. The candidate is provided a styrofoam head for demonstration of electrode placements. If the candidate does not show you clearly, you ask the candidate for demonstrate exactly **where ECT electrodes are placed**. After the candidate has explained placements, you are curious about how the candidate will calculate the dose required for the patient.

You are aware that Mr. Middleton had relapses soon after a successful course of ECT, and that he has been wondering whether something can be done to maintain his wellness, thus the question: ***'How long should ECT be continued for Mr. Middleton?'***

4.2 How to play the role:

Overall you appear ambivalent about ECT, but start off with quite a negative attitude, based on what you know about it. However, being a student who is keen to learn, you are not against it but reserved. You have some concerns about it, but are open to accept an expert opinion. You will settle down if you feel that you are heard and understood.

If the candidate adequately addresses the stigma, you can show positive interest in learning about ECT.

4.3 Opening statement:

'I have heard some bad stories about ECT. Are they true?'

4.4 What to expect from the candidate:

The candidate is expected to address your concerns in a respectful manner accommodating your inexperience as a medical student. Then the candidate must describe different types of electrode placements (these will be shown to you at the training): called bitemporal, bifrontal and right unilateral (RUL) placements. The candidates should specify the anatomical landmarks for each placement and name them.

The use of ECT is an area of mental health that is stigmatised, and sometimes strongly opposed as a treatment. The candidate is expected to identify that ECT is a heavily stigmatised treatment, and acknowledge that ECT was misused in the past. The candidate may address your concerns, and respond by sharing knowledge of the historical changes that occurred in the field of ECT, which include the introduction of anaesthesia during ECT that transformed the crude form of treatment to modified ECT with transient muscle paralysis, measures to reduce memory loss, stringent legislative regulations that have been put in place under the mental health act for the administering of ECT; and ECT research and quality improvement activities.

The candidate must also take the time to demonstrate how ECT is done using the styrofoam head provided to show you where clinicians place the electrodes with illustration of anatomical landmarks.

4.5 Questions you MUST ask:

'Why have you chosen to give Mr. Middleton ECT?'

'How will you reduce memory loss for this man?'

'What other side effects could he have?'

'How long should ECT be continued for Mr. Middleton?'

4.6 Responses you MIGHT make:

'When shouldn't ECT be used?'

'How does ECT work?'

'What electrode placement is appropriate for Mr Middleton and why?'

'Do other things help reduce memory loss?'

4.7 Medication and dosage that you need to remember:

Mr Middleton is on medications, but you do not know what they are.

STATION 2 – MARKING DOMAINS

The main assessment aims are to:

- Address stigma related to ECT.
- Demonstrate knowledge of the technical administration of ECT.
- Outline the benefits and side effects of ECT along with measures to reduce cognitive deficits associated with ECT.
- Apply evidence-based knowledge of ECT to the individual patient.

Level of Observed Competence:

5.0 HEALTH ADVOCATE

5.2 Did the candidate appropriately seek to address stigma associated with ECT? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; mentions anti-ECT movements and high-profile media portrayal of ECT; makes reference to positive accounts of ECT experience by celebrities, Journal of ECT; acknowledges that stigma persists and ECT education has a long way to go.

Achieves the Standard by:

demonstrating knowledge about historical changes to ECT; identifying impact of society beliefs and stigma; acknowledging past abuse of ECT and unmodified ECT with severe complications (e.g. joint dislocation); emphasising the safety record of ECT; offering opportunity for family attendance at ECT to promote better understanding.

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

- Explain at least two (2) measures taken to reduce stigma and negative impact of ECT.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; omissions adversely impact on engagement and education; limited capacity to identify impact of stigma on use of ECT; significant deficiencies in providing historical changes in ECT; being dismissive, argumentative or critical of the medical student.

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

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

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge of indications and side effects of ECT based on available literature? (Proportionate value - 20 %)

Surpasses the Standard (scores 5) if:

acknowledges the limited scientific information about mechanism of ECT prevents clear explanations of best indications and expected side effects; aligns proposed, but debatable theories of mechanisms of ECT to possible indications and side effects; outlines actions to reduce risks like specific logistics of maintenance ECT (e.g. presence of a caretaker for 24 hours after ECT).

Achieves the Standard by:

demonstrating the understanding of common indications of ECT as well as other indications; enumerating contraindications for ECT and conditions that need precautions; accurately identifying substantial relapse rate following termination of acute ECT; explaining side effects of the treatment and those related to the use of anaesthesia.

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

- Consider continuation or maintenance ECT for this patient.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not cover these areas in their interaction with the student; errors or omissions impact adversely on patient care; inappropriate indications (e.g. anxiety disorders); does not identify high risk situations for ECT.

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

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

1.0. MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge of application of specific strategies to minimise ECT related cognitive impairment for this patient? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support treatment options; mentions newer techniques (e.g. FEAST); refers to sophisticated instruments to screen cognitive deficits specific to ECT (Columbia Autobiographical Inventory to detect autobiographical memory); makes reference to meta-analysis of randomised trials comparing brief pulse against ultrabrief pulse ECT.

Achieves the Standard by:

demonstrating awareness of common techniques to reduce cognitive impairment in routine clinical practice like use of right unilateral ECT instead of bitemporal ECT, use of ultrabrief pulse in place of brief pulse, increased interval between treatments (three times a week ECT vs. twice a week ECT), use of cholinesterase inhibitor (donepezil) in improving cognitive function; acknowledging possible, but mild reduction in efficacy with ultrabrief ECT; suggesting future switch into bitemporal ECT if RUL ECT fails after 6-8 treatments; considering continuation or maintenance for this patient.

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

- a. Justify recommendation of high dose right unilateral ECT as the appropriate treatment for this patient.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not provide an accurate account of strategies to reduce cognitive impairment; missing major aspects of treatment recommendations; dismissive of cognitive side effects of ECT.

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

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

2.0 COMMUNICATOR

2.5 Did the candidate effectively communicate the titration procedures in an appropriate manner to the medical student? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

integrates information in a manner that can effectively be utilised by the medical student; provides succinct and professional information; mentions controversy about dose titration; discusses advantages and disadvantages of titration against age-based method.

Achieves the Standard by:

providing accurate and structured verbal report; prioritising and synthesising information; demonstrating discernment in selection of content; explicitly stating the principle of titration; identifying the dose above threshold as critical in determining efficacy and side effects; describing optimal dose for electrode placement.

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

- a. Recommend a stimulus dose 5-6 times the threshold dose which has been determined by further RUL RCT sessions.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; any errors or omissions impact on the accuracy of information provided; inaccurate or inadequate information provided; recommends three-time threshold dose for right unilateral ECT or more than two times threshold for bitemporal ECT.

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

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

1.0 MEDICAL EXPERT

1.5 Did the candidate demonstrate adequate technique application of ECT? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

overall application technique is accurate and well explained; performs a detailed and thorough teaching procedure; refers to studies that compare different electrode placements; demonstrates a sophisticated understanding of brain stimulation; describes how an ECT suite functions.

Achieves the Standard by:

competently describing the electrode placements on the styrofoam head while explaining the sites; accurately and adequately describing anatomical landmarks; describing the process of choosing and planning electrode placement.

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

- a. Accurately demonstrate bitemporal, right unilateral and bifrontal electrode placements.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; incorrect technique is utilised; incorrect explanation is given.

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
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1.0 Descriptive summary of station:

In this station, the candidate is meeting with Marley, an 18-year-old woman, who presents for a first appointment with a psychiatrist around anxiety symptoms, and questions about gender identity. Marley has had difficulty in social situations, feels worried and stressed, and the school counsellor has been concerned and suggested a psychiatry review. The candidate's tasks are to talk to Marley about Marley's anxiety, provide a diagnosis and management plan as well as explore some of Marley's gender questions, and consider whether further assistance with gender identity is needed.

1.1 The main assessment aims are to:

- Demonstrate how to diagnose a social anxiety disorder in an adolescent.
- Empathically explore gender identity questions and concerns with an adolescent including acknowledging stigma.
- Show awareness of a range of gender identity descriptors and their definitions.
- Provide a treatment plan for social anxiety and gender dysphoria, and convey this to a patient.

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

- Explore Marley's gender identity concerns.
- Acknowledge the distress she is experiencing as a consequence of the behaviour of her peers.
- Include both social anxiety and gender dysphoria in their discussion with Marley.
- Accurately describe the meaning of the term transgender.
- Discuss psychological treatments for social anxiety OR offer to include her family in the management plan.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders, Child & Adolescent Disorders
- **Area of Practice:** Child & Adolescent Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator, Health Advocate, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Process; Diagnosis), Communicator (Treatment Planning – Engagement), Health Advocate (Addressing Stigma), Scholar (Medical Terminology).

References:

- Budge, S.L, Adelson J.L., Howard K.A.S (2013) Anxiety and Depression in transgender Individuals: The Roles of Transition Status, Loss, Social Support, and Coping. *Journal of Consulting and Clinical Psychology*. 81; 3, 545 - 557
- Bergero-Miguel, T; Garcia-Encinas MA, Villena-Jimena A, Guzman-Parra J. (2016) Gender dysphoria and social anxiety; an exploratory study in Spain. June
- Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition. American Psychiatric Association. 2013
- Excerpted from DSM-5. Note: The term gender dysphoria replaced the term gender identity disorder used in an earlier version of DSM
- Human Rights Campaign, survey
- What is Gender Dysphoria, American Psychiatric Association, <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>
- Millet, N; Longworth J, Arcelus J, (2016) Prevalence of anxiety symptoms and disorders in the transgender population; A systematic review of the literature. *International Journal of Transgenderism*; Vol 18, 1 pg 27 – 38
- Olson, K. Durwood, L. DeMeules, M. McLaughlin, K.A.
- PFLAG Glossary

Committee for Examinations
Objective Structured Clinical Examination
Station 3
Auckland September 2018



- Sherer, I, et al. (2015). Affirming gender: Caring for gender-atypical children and adolescents. Contemporary Pediatrics
- Steensma, TD, et al. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. J Am Acad Child Adolesc Psychiatry, 52(6):582-90
- World Professional Association of Transgender Health (WPATH)

1.4 Station requirements:

- Standard consulting room.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Female appearing 18 years of age.
- 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 youth community public mental health position. You see young people from age 15 to 20 in your service. You have received a referral letter from a school counsellor with regard to Marley, an 18-year-old student who attends the local co-educational high school. Marley is in Year 12, and has not been seen by your service previously.

The letter from the school counsellor reads:

Dear Doctor,

Thank you for seeing Marley who has been a student at our school for the last four years, starting in Year 9 after a transfer from an all-girls school. Marley was referred to me earlier this year when her classroom teacher became concerned about Marley's lack of involvement with other students, and her panic attacks when public speaking. Marley was previously well-engaged in a range of sports, and has had no academic problems.

She was very nervous about camp last year and didn't attend; she has been reluctant to come to sports and swimming. She has spoken to me about a request to wear her sports uniform every day (shorts and polo shirt) instead of the usual uniform which is a dress. She also wants to be exempt from the school photos which are in two weeks. She seems to be reluctant to mix with her previous friends, and tells me that a short relationship with a boy earlier this year did not go well. Staff haven't witnessed any bullying at school.

Marley has asked that she comes to see you on her own today.

*Regards
Deb Murray
School counsellor
St Angelos College*

Your tasks are to:

- Take a focussed history from Marley about her concerns.
- Develop a differential diagnosis and explain this to Marley.
- Outline treatment options and discuss these with Marley.

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.
 - 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 is no cue / scripted prompt for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'Hello doctor, I think I need help with how I am feeling.'

3.2 Background information for examiners

In this station the candidate is expected to take a history from an adolescent who presents with social anxiety in the context of confusion around gender identity. The 18-year-old is an articulate and intellectually bright female who has developed anxiety over the last 12 months which is now being noticed at school.

The candidate is to take a history pertaining to her symptoms as well as explore the cause behind some of her social avoidance. The candidate is expected to identify and discuss her concerns about gender identity and social anxiety as well as suggest a suitable treatment program for her social anxiety disorder.

The candidate should be able to demonstrate some knowledge of this topic, and be able to answer this question in general, but be aware that Marley is not wanting this treatment at this stage.

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

- Explore Marley's gender identity concerns.
- Acknowledge the distress she is experiencing as a consequence of the behaviour of her peers.
- Include both social anxiety and gender dysphoria in their discussion with Marley.
- Accurately describe the meaning of the term transgender.
- Discuss psychological treatments for social anxiety OR offer to include her family in the management plan.

A surpassing candidate may:

- ask about Marley's involvement of her parents, and sisters in her thoughts and plans with regard to her gender identity.
- make options available for Marley to talk in future about gender affirming treatment if she wishes to do so
- identify that Marley is unsure of her gender identity at present, and recognise that she may identify as gender fluid; pansexual or another gender description outside of assigned gender and transgender.
- delineate a treatment plan for both her gender dysphoria and social anxiety, and clearly identify the link between the two, and the requirement for Marley to have assistance with both for clinical symptom improvement.

Information for examiners

A. Gender Dysphoria

The **Diagnostic and Statistical Manual of Mental Disorders (DSM-5)** provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children, and for adolescents and adults.

In adolescents and adults, gender dysphoria diagnosis involves a difference between one's experienced / expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one's experienced / expressed gender, and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and / or secondary sex characteristics
3. A strong desire for the primary and / or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

International Classification of Disease ICD-10, Gender Identity Disorder, Unspecified / Gender-Role Disorder NOS F64.9

It is also known as Gender Dysphoria, and presents clinically as a disorder characterised by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery).

World Professional Association of Transgender Health (WPATH)

The Standards of care for transgender health are written and regularly reviewed by the WPATH (currently working on version 8). Version 7 guidelines are available free internationally for patients and health care workers, and are used in NZ and Australia. The Association offers a range of information and recommendations.

Overview of Therapeutic Approaches for Gender Dysphoria

Treatment options for gender dysphoria include counselling, cross-sex hormones, puberty suppression and gender reassignment surgery. Some adults may have a strong desire to be of a different gender, and to be treated as a different gender without seeking medical treatment or altering their body. They may only want support to feel comfortable in their gender identity. Others may want more extensive treatment including hormone treatment, and gender reassignment surgery leading to a transition to the opposite sex. Some may choose hormone treatment or surgery alone.

Advancements in the Knowledge and Treatment of Gender Dysphoria: Hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (*American Medical Association 2008; Anton, 2009; The World Professional Association for Transgender Health 2008*). As the girls mature, health professionals recognised that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (*Bockting, and Goldberg 2006; Bockting 2008; Lev, 2004*).

Individual psychotherapy can help a person understand and explore his / her / their feelings, and cope with the distress and conflict. Couples therapy or family therapy may be helpful to improve understanding, and to create a supportive environment. Parents of children with gender dysphoria may also benefit from counselling. Peer support groups for adolescents and adults, and parent / family support groups can also be helpful.

Options for Psychological and Medical Treatment of Gender Dysphoria

The number and type of interventions applied, and the order in which these take place may differ from person to person (e.g., *Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010*).

Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminise or masculinise the body; surgery to change primary and / or secondary sex characteristics (e.g., breasts / chest, external and / or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalised transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organisations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood. Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (*Cohen-Kettenis, 2001; Zucker & Bradley, 1995*). Boys in these studies were more likely to identify as gay in adulthood than as transgender (*Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984*). Newer studies, also including girls, showed a 12- 27% persistence rate of gender dysphoria into adulthood (*Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008*).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminising / masculinising hormone therapy (*de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010*).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents, and their secondary sex characteristics develop (*Cohen-Kettenis, 2001; Cohen-Kettenis & Pf. fflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995*). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (*Wallien & Cohen- Kettenis, 2008*). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviours (*Docter, 1988; Land.n, W.linder, & Lundstr.m, 1998*). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and / or secondary sex characteristics, and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (*Cohen-Kettenis & Pf. fflin, 2003*).

Transition Treatment for Adolescents

The decision to pause puberty using puberty blocking treatment in general needs to be made prior to Tanner stage 2 of pubertal development for there to be a ceasing of maturation of secondary sexual characteristics. Tanner stage 2 changes are the initial stages of puberty where secondary sexual characteristics are noted including enlargement of scrotum and testes in males, and breast bud development in females. These puberty blockers are prescribed and administered by a paediatric endocrinologist.

The puberty blocking agents are given intramuscularly, and must be given continuously (every 3 months) to pause pubertal changes.

This is Phase 1 treatment of a potential 3 stage treatment of gender transitioning:

Stage 1: pubertal blockade.

Stage 2: affirming hormone treatment i.e. treatment with testosterone for female to male change and oestrogen for male to female change.

Stage 3: surgical intervention – i.e. tracheal shaving, breast removal.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).
2. Provide family counselling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.
3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.
4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions.
5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organisations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (*Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005*), putting them at risk for social isolation, depression, and other negative sequelae (*Nuttbrock et al., 2010*).
6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (*Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002*).

Challenges / Complications

Gender dysphoria is associated with high levels of stigmatisation, discrimination and victimisation, contributing to negative self-image and increased rates of other mental disorders.

Transgender individuals are at higher risk of victimisation, and hate crimes than the general public. Adolescents and adults with gender dysphoria are at increased risk for suicide.

In adolescents and adults, preoccupation with cross-gender issues can interfere with daily activities and cause problems in relationships or in functioning at school or work. Transgender individuals may also face challenges in accessing appropriate health care, and insurance coverage of related services.

Definitions

Gender	<i>denotes the public (and usually legally recognised) lived role as boy or girl, man or woman. Biological factors combined with social and psychological factors contribute to gender development.</i>
Assigned gender	<i>refers to a person's initial assignment as male or female at birth. It is based on the child's genitalia and other visible physical sex characteristics.</i>
Gender-atypical	<i>refers to physical features or behaviours that are not typical of individuals of the same assigned gender in a given society.</i>
Gender-nonconforming	<i>refers to behaviours that are not typical of individuals with the same assigned gender in a given society.</i>
Gender reassignment	<i>denotes an official (and usually legal) change of gender.</i>
Gender identity	<i>is a category of social identity and refers to an individual's identification as male, female or, occasionally, some category other than male or female. It is one's deeply held core sense of being male, female, some of both or neither, and does not always correspond to biological sex.</i>
Gender dysphoria	<i>as a general descriptive term refers to an individual's discontent with the assigned gender. It is more specifically defined when used as a diagnosis.</i>
Transgender	<i>refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their gender at birth. (Note: the term transgendered is not generally used.)</i>
Transsexual	<i>refers to an individual who seeks, or has undergone, a social transition from male to female or female to male. In many, but not all, cases this also involves a physical transition through cross-sex hormone treatment and genital surgery (sex reassignment surgery).</i>
Genderqueer	<i>blurring the lines around gender identity and sexual orientation. Genderqueer individuals typically embrace a fluidity of gender identity and sometimes sexual orientation.</i>
Gender fluidity	<i>having different gender identities at different times.</i>
Agendered	<i>'without gender,' individuals identifying as having no gender identity.</i>
Cisgender	<i>describes individuals whose gender identity or expression aligns with the sex assigned to them at birth.</i>
Gender expansiveness	<i>conveys a wider, more flexible range of gender identity and / or expression than typically associated with the binary gender system.</i>
Gender expression	<i>the manner in which a person communicates about gender to others through external means such as clothing, appearance, or mannerisms. This communication may be conscious or subconscious, and may or may not reflect their gender identity or sexual orientation.</i>

Preferred Gender Pronouns

Some transgender and gender-nonconforming people may prefer gender-neutral or gender-inclusive pronouns when talking to or about them. 'They' and 'their' are sometimes used as gender-neutral singular pronouns. Singular gender-neutral pronouns also include 'ze' (or 'zie') and 'hir'.

B. Social Anxiety Disorder

ICD-10 Social Phobia F40.1

According to the ICD-10 Social Anxiety Disorder is also known as Social Phobia.

Approximate Synonyms:

- Avoidance disorder
- Avoidance disorder, childhood
- Avoidant disorder of childhood
- Fear of eating in public
- Performance anxiety
- Phobia, social
- Shyness disorder of childhood
- Social anxiety disorder (social phobia)
- Social anxiety disorder (social phobia), performance only
- Social phobia
- Specific phobia, eating in public

Clinical Information

- An anxiety disorder characterised by an intense, irrational fear of one or more social or performance situations in which the individual believes that he or she will be scrutinised by others. Exposure to social situations immediately provokes an anxiety response. In adults, the social phobia is recognised as excessive or unreasonable.
- Extreme apprehension or fear of social interaction or social situations in general.

The fear occurs in one or more social situations causing considerable distress and impaired ability to function in at least some aspects of daily life.

According to the **DSM-5**, (Diagnostic and Statistical Manual of Mental Disorders, fifth edition), there are a total of ten diagnostic criteria for Social Anxiety disorder:

1. fear or anxiety specific to social settings, in which a person feels noticed, observed, or scrutinised. In an adult, this could include a first date, a job interview, meeting someone for the first time, delivering an oral presentation, or speaking in a class or meeting. In children, the phobic / avoidant behaviours must occur in settings with peers, rather than adult interactions, and will be expressed in terms of age appropriate distress, such as cringing, crying, or otherwise displaying obvious fear or discomfort.
2. typically the individual will fear that they will display their anxiety and experience social rejection.
3. social interaction will consistently provoke distress.
4. social interactions are either avoided, or painfully and reluctantly endured.
5. the fear and anxiety will be grossly disproportionate to the actual situation.
6. the fear, anxiety or other distress around social situations will persist for six months or longer and
7. cause personal distress and impairment of functioning in one or more domains, such as interpersonal or occupational functioning.
8. the fear or anxiety cannot be attributed to a medical disorder, substance use, or adverse medication effects or
9. another mental disorder, and
10. if another medical condition is present which may cause the individual to be excessively self-conscious- e.g., prominent facial scar, the fear and anxiety are either unrelated, or disproportionate. The clinician may also include the specifier that the social anxiety is performance situation specific - e.g. oral presentations (*American Psychiatric Association, 2013*).

Onset

According to the DSM-5, the median age of onset of social anxiety disorder in the US is age 13, with 75% of those with social anxiety disorder experiencing the onset at a range of ages 8-15. The onset can either be insidious, or sudden onset triggered by a specific event. (*American Psychiatric Association, 2013*).

Prevalence

The DSM-5 cites the annual prevalence of social anxiety disorder between 7-12%, in both children and adults in the United States (*American Psychiatric Association, 2013*). It is thought to be the most common anxiety disorder and one of the most common psychiatric disorders.

Risk Factors

The DSM-5 notes that temperamental qualities of fear of poor social evaluation and inhibition are risk factors for the development of social phobia. Child maltreatment, including peer abuse is a correlational risk factor for social phobia, but causality cannot be verified. There appears to be a genetic basis, though it could be speculated that social anxiety is also a learned behaviour. (*American Psychiatric Association, 2013*). Obesity has been identified as a risk factor in teens, (*ADAA, 2013*) as teens who are obese may experience peer rejection and develop social anxiety as a learned behaviour.

Anxiety and Gender Dysphoria

Anxiety as a disorder has been found to be more common among the gender dysphoric and transgender population and in particular social phobia, specific phobias, OCD and panic disorders are more common (*Millet Longworth, Arcelus 2016*). Recent studies have shown that depressive symptoms occur in 51% of transgender women and 48% in transgender men, and anxiety symptoms occur in 40% of transgender women and 40% transgender men (*Budge, Adelson and Howard 2013*), 31.4% of patients with gender dysphoria were also diagnosed with social anxiety in the Bergero-Miguel study in 2016. These high levels of anxiety and mood disorders have been associated with an increased level of self-harm and suicide in this population, and therefore identification and support around gender identity is important.

Socially transitioned children (to their affirming gender) in a supportive environment have been shown to return to age norm levels of depressive and anxiety symptoms indicating that the psychopathology in this population is not inevitable (*Olsen et al 2016*)

When meeting a patient who identifies as having gender dysphoria or asks about gender identity, it is important to consider the presentation of major mood and anxiety disorder symptoms. The same can be said for patients, in particular adolescents who present with a new onset of anxiety and depressive symptoms without clear precipitants, to ask about gender identity in a sensitive way.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

About you and your family

You are Marley Canon, an 18-year-old female. You have been referred to this psychiatrist because Mrs Murray, your senior school counsellor, is worried about you, in particular your increasing anxiety that is seen at school and your social withdrawal from friends at school. You are currently a Year 12 student.

You live with your 45-year-old parents (Geoff and Bree) who run a company that renovates houses, and your two older sisters (Ella – 20, and Lisa – 21) who are both studying economics at university. Your parents have been together since they were 20, and you have always lived in the same house. You were a healthy baby, and born at term without any problems. Your family always said that you were funny and talkative, and you liked being with your extended family, cousins, and aunts and uncles whom you are close to.

This station is about your feelings of anxiety, and your feelings towards your gender.

About your anxiety

You began to feel anxious when you were in early high school (approximately at age 13), and found it harder to be relaxed around other adolescents. In particular your anxiety peaked when they were planning 'boy / girl parties', and started talking about sex, and partners occurred in your small group of acquaintances at school.

Your first '*panic attack*' occurred when you were giving a presentation at a science club in the middle of Year 7 at school, four and a half years ago. For the presentation night your parents had asked you to dress nicely, and there had been an argument beforehand about what you wore. You wanted to wear jeans and a shirt, but they wanted you and your sisters to wear dresses. In the end you wore a skirt that your eldest sister picked out for you. You were nervous about how you looked, and also just in general having to be in front of a crowd. You weren't sure what to do so you sat in the car holding your sister's hand up until it was time to go inside, and do the presentation.

You hadn't had a panic attack before, but you found the crowd, people looking at you and the sound of your voice in the room scary. You felt your heart race, and that you couldn't catch your breath. You didn't want to be around people as there was the feeling that you were going to make a fool of yourself, and that everyone would laugh at you. You can't remember the speech but recall leaving the stage, and asking to go home as you felt distressed. Since then you have had a sensation of nervousness when talking in class, and so avoid doing so as far as possible.

Due to this and your gender identity concerns (see below), you have begun to avoid groups at the cinema or going shopping, and in general tried to stay away from anyone at school. Your handful of friends by early Year 12 had dropped to two, and they left school and chose to work instead. You now have no friends, speak very little to others, and often sit at the back of the class. You have panic feelings most days when around others, you try to avoid others, as you would rather be alone. You actually do like people, and want to be with them but struggle to manage with the anxiety symptoms when around them.

About your gender identity

You were born female, but you are unsure of your gender identity: it has been on your mind for a few years, but you don't think you are gay or bisexual.

You feel that perhaps you are male, but your sisters and mum are really feminine, and you aren't sure if it is just because you aren't like them. You are unsure if you are comfortable with your body, and you have bought a chest binder online to see if you can flatten your breasts. You haven't worn it yet.

This year, you have had one brief relationship with a boy called Max that lasted a few weeks, and you kissed him twice, but it didn't '*feel right*'. You were not '*in love*' with him, and do not think that breaking up with him has anything to do with the way you feel. But since then you have been confused and anxious, and have found that retreating from everyone is easier than having to feel so unsure and anxious around others. You have read a lot on the web, and wonder if you might be '*transgender*'. You are looking for help to understand your anxiety, and questions about your gender identity.

You have no desire at this point to have hormone or surgical treatment to transition from female to male. You have read about it online on a few sites that are about being transgender, but you definitely are not considering that yet.

You haven't harmed your body in any way to change its shape or size or to look more masculine.

You have cut your hair short, you prefer clothes from the male section of the shop, and mostly like t-shirts, jumpers and jeans.

If asked:

- You don't have a partner, you are unsure if you like males or females but think perhaps both.
- You don't hate your body as such, but you are '*really uncomfortable in your own skin*', and in particular you find wearing a bra distressing.
- You don't feel anxious about other things like heights, spiders, small spaces, etc.
- You have had periods of low mood but no self-harm – you have thought of cutting when you are alone at night in your room, and worried about school the next day, but you haven't actually hurt yourself.
- You haven't contemplated suicide.
- You have never been physically or sexually abused or assaulted.
- You don't hear or see things that other people can't (auditory or visual hallucinations) or have strange thoughts about being watched, followed or people trying to harm you, or thinking there is something very special about you.
- You haven't used drugs.
- You don't drink alcohol.
- You have no medical conditions.

Your history

In primary school you had a good group of friends, mostly boys, and enjoyed playing sport. You were in competitive softball and swimming, and did well in both sports. Many of your friends have been boys, and your best friend, David, has been your friend since you were 8 years of age. You preferred male clothing, and often resisted wearing a dress although you agreed to do so at school. The fact that you wore the same uniform as your sisters was helpful in accepting this.

You were not invited to play with many girls, and this did not worry you much. You were happy at home playing with Lego, and you would build scenes and compare them to the ones that David made. You enjoyed playing Minecraft, and your parents would at times let you play online and dial in with other friends, Matt and Jason. This was a past time for some years, and Minecraft was a central interest of yours. The other girls at school were not very interested in your interests, and at school you kept to yourself unless you were playing sport. You had always exceeded academically, and you were keen to go to university and study. You were very good at maths and science subjects, and you were interested in astronomy.

Shortly after the time your anxiety first started, David also talked about moving to an all-boys school some distance away for his final years in high school. You had not really pictured things changing when you were in Year 6, and were not aware that David might move to another school. This school was further away, and that meant that you would not be able to see him at all after school. Matt and Jason also went to that school, and you were acutely aware that as an all-boys school that you could not go.

In Year 9, David moved away to go to a boarding school and you asked your parents to move you to a co-ed school as you didn't enjoy being around all girls. You had few female friends by that point, and spent most of your time either with David, and his brother in the school holidays or at home alone. You liked gaming, astronomy and a science vlogger on YouTube by this point.

You asked to go to a school where you could do '*boys subjects*', and wear a sports uniform instead of a summer dress. Your parents sat down and spoke to you, and asked if you were gay, you felt confused and you said 'no', that you just wanted to go to a co-ed school. They found one and you were keen to attend. Some of the kids were friendly, and you had a small group of friends and academically did well.

However, you became more nervous around others, withdrew from social events with female friends including parties, birthdays and sleepovers. People at school began to call you 'dyke', and you found in Year 10 and 11 that people were calling you '*Markey*' instead of Marley, saying you were a '*boy-girl*' when you got your hair cut very short. You began to avoid catching the school bus with others early in Year 12, telling your parents that you were leaving early to study. You would experience anxiety about meeting people from school, so you began to walk the long way each day.

Family history of mental illness

No one in your family has mental illnesses other than your maternal aunt, Jodie, who has had depression for 10 years, and your mother who had 'anxiety' diagnosed by a psychologist 5 years ago, and then went to 'therapy' and got better. You don't know any other details.

4.2 How to play the role:

You are dressed in male-type casual clothing, no makeup, no nail polish and no jewellery. You make some eye contact, and appearing somewhat shy and reserved in your manner but overall you are happy to talk even though you appear a bit embarrassed. You may slightly fidget with sleeves or hands at the start of the interview.

You become calmer if / when the candidate identifies your questions about transgender. If the candidate asks you about boyfriends and heterosexual relationships you look uncomfortable. If the candidate is generally caring and empathic, look more relaxed.

4.3 Opening statement:

'Hello doctor, I think I need help with how I am feeling.'

4.4 What to expect from the candidate:

The candidate should, in a caring way, raise the concerns from the referral letter, and ask about your worries and panic at school. They should respond empathically and talk about social anxiety. They may want to explore your 'failed' relationship with a boy but insist that it was not significant, and only lasted 2 weeks.

From the prompts in the letter and their history taking from you, they should be able to identify that transgender / gender dysphoria is a topic they should explore as well as the anxiety you are experiencing. It should be done gently, and overall use this to describe why your anxiety around others is increasing.

They should be comfortable talking about what transgender is, how it presents and how it may be different from the gender people are born as.

4.5 Responses you MUST make:

'So do I have a nervous disease?'

'Why are my classmates so weird to me?'

'Do you think I'm transgender or is there another name for me not being sure?'

'Is there treatment for how anxious I feel?'

4.6 Responses you MIGHT make: (Additional statements that may assist the candidate)

If the candidate asks whether you think you are gay.

Scripted Response: ***'I don't know if I am gay.'***

If the candidate asks what you think your sexual / gender identity is.

Scripted Response: ***'I'm not really sure if I am a boy or girl.'***

4.7 Medication and dosage that you need to remember:

You do not take any medication, you are medically well.

STATION 3 – MARKING DOMAINS

The main assessment aims are to:

- Demonstrate how to diagnose a social anxiety disorder in an adolescent.
- Empathically explore gender identity questions and concerns with an adolescent including acknowledging stigma.
- Show awareness of a range of gender identity descriptors and their definitions.
- Provide a treatment plan for social anxiety and gender dysphoria, and convey this to a patient.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct an assessment of the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

clearly achieves the standard overall 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 with Marley despite her anxiety; integrating generalist and sub-specialist assessment skills including discussion of gender identity; engaging the patient and demonstrating flexibility to adapt the interview style to the patient, problem or special needs; being sensitive towards the patient; not using an interrogative or aggressive style; prioritising information to be gathered; using techniques that enable exploration of both anxiety and gender identity features; balancing open and closed questions appropriately; summarising; being attuned to patient disclosures, including non-verbal communication; recognising emotional significance of the patient's material in particular friendships and identity.

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

- Explore Marley's gender identity concerns.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; significant deficiencies such that the errors or omissions do materially adversely affect assessment process.

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

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

5.0 HEALTH ADVOCATE

5.2 Did the candidate appropriately seek to address stigma? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

recognises the stigma attached to gender dysphoria / transgenderism, and the impact that this has on the patient and their engagement in treatment; addresses the stigma by supporting the patient in their history giving, and helping the patient understand the spectrum of gender.

Achieves the Standard by:

demonstrating the capacity to identify the stigma of mental illness on patients, families and carers; applying principles of early intervention to clinical practice.

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

- Acknowledge the distress she is experiencing as a consequence of the behaviour of her peers.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not actively seek to address stigma.

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

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

1.0 MEDICAL EXPERT

1.9 Did candidate formulate and describe both anxiety and gender identity disorder in Marley’s assessment? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; identifies her anxiety as social anxiety and correctly identifies her gender dysphoria by using both descriptors in the discussion with Marley; has ability to incorporate the limitations of diagnostic classification systems to guide assessment.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; utilising a biopsychosocial approach which includes family and friendship history; considering option of generalised anxiety rather than social anxiety, but including gender dysphoria; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; communicating opinion in language that is understood by the patient.

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

- a. Include both social anxiety and gender dysphoria in their discussion with Marley.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

6.0 SCHOLAR

6.6 Did the candidate explain the relevant terminology correctly according to current evidence and critical understanding? (Proportionate value – 10%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance linking relevant terminology with the clinical presentation; provides explanations relevant to the scenario.

Achieves the Standard by:

accurately interpreting the clinical terminology relevant to anxiety; incorporating accurate explanations of terms relevant to the area of gender identity - any errors minor and do not materially adversely affect explanations; recognising the more significant terms to follow up on; not overwhelming the patient with irrelevant material.

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

- a. Accurately describe the meaning of the term transgender.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; provides inaccurate interpretation of terminology; errors or omissions are significant and do materially adversely affect conclusions.

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

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

2.0 COMMUNICATOR

2.6 Did the candidate adequately engage the patient in developing a relevant initial management plan? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

discusses the link between the plan and key issues identified in a sophisticated manner; comprehensively applies the principles of working closely with patient, and demonstrates the importance of ensuring respectful and open communication; sensitively explores any difficulties raised regarding the application of the recommended plan.

Achieves the Standard by:

offering clear and appropriate options for social anxiety and gender identity issues that are based on best available evidence; explaining treatment for social anxiety including both psychological and medication-based treatments; negotiating suitable treatment environments; checking on the level of understanding and acceptance; working through potential conflict or resistance; outlining significant others relevant to implementing a successful plan.

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

a. Discuss psychological treatments for social anxiety OR offer to include her family in the management plan.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; errors or omissions will impact adversely on patient care.

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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CONTENT	PAGE
Overview <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
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Instructions to Examiner <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	5 5-6 6
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1.0 Descriptive summary of station:

This is a station that tests the understanding of the candidate to manage an alleged sexual assault in an adult inpatient psychiatry unit. The candidate receives a call after hours from their registrar who reports that a patient with minor intellectual disability has had a sexual encounter with another patient on the unit. The station requires the candidate to present the immediate and longer-term management of this situation.

1.1 The main assessment aims are to:

- Demonstrate knowledge of the governance issues that must be addressed in sexual assault on an inpatient unit.
- Explain the procedures that need to be taken in this situation that includes addressing both patients' needs.
- Clearly outline the communication required for the staff and patients.

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

- Verify the legal status of both patients involved in the incident.
- Identify their role in informing Tamara's primary care giver / legal guardian of the incident.
- Address the safety and welfare of both patients following the incident.
- Acknowledge their role in participating in an incident review.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Governance Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator, Collaborator, Manager
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Initial Plan), Communicator (Patient Communication – To Carer), Collaborator (Teamwork – Treatment Planning), Manager (Governance)

References:

- Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units, Department of Health, October 2009 (updated June 2012), www.health.vic.gov.au/mentalhealth/cpg
- Sexual safety in inpatient settings – service response, Department of Health & Human Services, Health Victoria, <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/promoting-sexual-safety-in-inpatient-settings/sexual-safety-in-inpatient-settings-service-response>
- 'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities, Ashmore, Toni; Spangaro, Jo; McNamara, Lorna, International Journal of Mental Health Nursing. Vol.24(2), 2015, pp. 139-148
- Managing sexual behaviour on adult acute care inpatient psychiatric units, Ford, Elizabeth; Rosenberg, Michele; Holsten, Margarita; Boudreaux, Tyson, Psychiatric Services. Vol.54(3), 2003, pp. 346-350

1.4 Station requirements:

- Standard consulting room.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Pen for candidate.
- Timer and batteries for 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. In this **VIVA**, there is no role player.

You are working as a junior consultant psychiatrist in an adult inpatient unit, and are on call over the weekend.

The registrar on call rings you at 11pm on Saturday night to inform you that a new patient, Tamara, had been found by nursing staff in the female toilets with a young male inpatient, Brett. At the time, Brett's pants were pulled down and Tamara was upset. Brett has since absconded, and Tamara remains distressed.

Brett is not known to the ward staff, and had been admitted earlier in the day with first episode psychosis and disinhibited behaviour.

Tamara has mild intellectual disability, and was admitted on Friday after lacerating her wrist and threatening suicide. Tamara is begging the staff not to tell her mother because '*Mum will get cross and I'll be in trouble*'.

Your tasks are to:

- Explain **to the examiner** how you would proceed at this time.
- Outline **to the examiner** the management of this situation over the next few days.

You will not receive any time prompts.

Station 4 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - Pens.
 - Water and tissues 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.
- TAKE NOTE that there is no cue / time for any scripted prompt.
- 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 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.

This is a VIVA station. There is no opening statement and no prompts.

3.2 Background information for examiners

In this station, the candidate is expected to demonstrate their understanding of how to manage an alleged sexual assault in an adult inpatient psychiatry unit. The candidate receives a call after hours from their registrar who reports that a patient with minor intellectual disability has had a sexual encounter with a male patient on the unit. The station requires the candidate to present the immediate, and longer-term management of this situation that demonstrates their knowledge of the governance issues that must be addressed in an inpatient sexual assault, and explain the procedures that need to be taken in this situation. There is an expectation that the candidate addresses both patients' safety and needs.

There are both individual capacity / consent / welfare issues as well as broader governance issues, and both must be addressed. From an individual patient perspective, sexual behaviour between patients is not an uncommon event, however issues of consent and capacity have to be addressed. Issues of safety for individual patients at risk should always be identified, and proactively managed. This is a difficult situation as a sexual activity includes an intellectually disabled woman, and her capacity to consent is unclear, and will need to be investigated.

In addition, the perpetrator is described as psychotic, and behaviourally disinhibited. He has absconded, and is potentially at risk himself. Decisions will need to be made about his current risk level, irrespective of his legal status - voluntary versus involuntary (different states / territories and New Zealand have different mental health acts that need to be followed).

Systems issues are covered under local clinical governance procedures and policies as well as overarching principles of good clinical care. Candidates need to be aware of policies of the appropriate institution, and put them into place (so a range of answers will be acceptable).

The candidate should consider a number of ward issues that may arise which include working with a potentially distressed registrar and staff. Their focus needs to put in place a plan to reduce the distress of the female patient who may have been sexually assaulted:

- The welfare of the female patient - has she been physically harmed; does she need a rape assessment; what did nurses (or other patients) witness; how distressed is she, and what interventions have been made?
- Management decisions of the absconded male patient – risk assessment and urgency to return him to the unit (or elsewhere); wellbeing of the alleged perpetrator taking into account his first presentation of psychosis with behavioural disinhibition; levels of observation ordered prior to the incident.
- Ward management – care for the staff including the registrar to ensure ongoing continuity of care in the ward; debriefing of any staff or patients involved / witnessing the incident; documentation and recording of the incident by staff; access to supports for staff and patients.
- The broader governance issues - governance issues may vary from state to state but the issues that need to be addressed include: invoking of hospital protocols / procedures for management of sexual assault; clarification of legal status of both patients, and the implications for consent; consideration of calling the police; management of the potential crime scene; capacity of the two patients to fully participate in management of the incident; identification of legal guardians for both patients; managing disclosure to family members / carers / support persons for both patients (particularly as Tamara has asked that her mother not be advised); escalation and notification to relevant senior staff.

Admission status - voluntary or involuntary, as whichever implies some capacity for consent or non-consent.

Tamara's legal guardian - if not clearly documented, assumption is that Tamara's mother is the guardian. The mother or the legal guardian, if this is not the mother, needs to be informed, irrespective of the desires of the patient (in this case, an adult who is in the care of her mother and has an intellectual disability).

Police reporting - this is often decided at an institutional level. However, all sexual assaults should be reported to the police.

Longer term issues that might be considered include safe areas for female patients; how to provide safe spaces for all patients including those at risk from acting on disinhibited behaviour; difficulties that often arise after hours, and the need for a consultant to act decisively and respond promptly.

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

- Verify the legal status of both patients involved in the incident.
- Identify their role in informing Tamara's primary care giver / legal guardian of the incident.
- Address the safety and welfare of both patients following the incident.
- Acknowledge their role in participating in an incident review.

A surpassing candidate may:

- Be able to discuss consent vs non-consent in an intellectually disabled patient, and think about the issues including capacity.
- Explore issues of capacity and how that may be determined.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

STATION 4 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate knowledge of the governance issues that must be addressed in sexual assault on an inpatient unit.
- Explain the procedures that need to be taken in this situation that includes addressing both patients' needs.
- Clearly outline the communication required for the staff and patients.

Level of Observed Competence:

2.0 COMMUNICATOR

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

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of the complexity of this situation; effectively tailors interactions to maintain overall safety of the ward environment.

Achieves the Standard by:

demonstrating empathy and providing a safe environment for discussion; attempting to gain an understanding of the situation including the capacity to consent of both parties involved; checking on clinical status of both patients; ensuring the victim is not injured; clarifying the next of kin / guardianship status for both patients; recognising confidentiality needs for both patients; considering the welfare and safety of all patients, staff and the registrar involved in managing the situation; involving other staff members who were present at time of incident in the data gathering process.

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

- Verify the legal status of both patients involved in the incident.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not consider exploring of details of incident prior to describing steps involved in management.

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

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

3.0 COLLABORATOR

3.2 Did the candidate appropriately involve treatment team in developing management plans? (Proportionate value – 15%)

Surpasses the Standard (scores 5) if:

takes a leadership role in incident planning; effectively negotiates complex aspects of care; elaborates on the sensitivities related to informing Tamara's mother and the family of the alleged perpetrator.

Achieves the Standard by:

taking appropriate and effective leadership to ensure patient safety and positive patient outcomes; communicating proposed plans clearly and with good judgment to involve others; suitably engaging necessary other health professionals; expressing views and expectations candidly and respectfully; identifying tasks for staff members to undertake; dealing effectively with disagreement or concerns; considering their own emotional response to the situation, and taking steps to manage this.

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

- Identify their role in informing Tamara's primary care giver / legal guardian of the incident.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; errors or omissions impact adversely on the finalised approach and plan.

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

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

1.0 MEDICAL EXPERT

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

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; works to reduce conflict and risk of complaint from family members.

Achieves the Standard by:

being aware of policies / procedures of the appropriate institution and putting them in place; specifically outlining the need to invoke hospital protocol on the management of alleged sexual assault in the inpatient setting; considering the implications of capacity to consent in a developmentally disabled person who is possibly an involuntary patient; planning for risk management; recognising the need for consultation / supervision; considering report of incident to the police; informing the unit director and hospital management of the incident.

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

- a. Address the safety and welfare of both patients following the incident.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to immediate needs or circumstances.

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

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

4.0 MANAGER

4.1 Did the candidate demonstrate a capacity to apply principles of clinical governance? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

able to tolerate and manage uncertainty; effectively consults around complex governance issues; leads change management.

Achieves the Standard by:

identifying principles of clinical governance and standards; taking a broad view including patient safety, staff training in managing such situations, and possible medicolegal implication for the organisation; ensuring good clinical handover to colleagues responsible for patients' care; proposing options to address issues of female only wards or vulnerable patients' safe space areas.

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

- a. Acknowledge their role in participating in an incident review.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; lacks clarity about clinical governance and standards; poorly defines own scope of practice and responsibilities.

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

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

GLOBAL PROFICIENCY RATING

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

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

Justin, a 32-year-old man, has been referred by his GP to the community mental health clinic for assessment. Justin has not worked for 6 months due to back pain, and has asked his GP for a letter for his insurance company as he has income protection insurance if unable to work. The GP believes that he should be able to return to his job as an architectural draftsman and so has wondered if he is depressed. Justin does not believe he is depressed, and cannot understand why the GP cannot see that obviously his pain is preventing him from returning to work.

1.1 The main assessment aims are to:

- Evaluate the issues related to the presentation of chronic pain and its interface with functioning.
- Identify differential diagnoses and justify the preferred diagnosis of Somatic Symptom Disorder / Chronic Pain Syndrome.
- Sensitively outline advice which is directed towards a return to work.

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

- Specifically explore Justin's beliefs regarding the ongoing nature of his pain and disability.
- Suggest the diagnosis of Somatic Symptom Disorder OR Chronic Pain Syndrome.
- Prioritise an interdisciplinary graduated return to work plan OR a referral to a Pain Clinic.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders (e.g. sex, neuropsychiatric, sleep, somatoform, eating, etc.)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis; Management – Treatment Contract)

References:

- Comparison of patients diagnosed with 'complex pain' and 'somatoform pain' Peter la Cour Scandinavian Journal of Pain 17 (2017) 49–52
- Chronic Pain, Psychopathology, and DSM-5 Somatic Symptom Disorder. Joel Katz, PhD,¹ Brittany N Rosenbloom, MSc,² and Samantha Fashler, MA² Can J Psychiatry. 2015 Apr; 60(4): 160–167
- Your System Has Been Hijacked: The Neurobiology of Chronic Pain Erica B. Baller and David A. Ross Biological Psychiatry October 15, 2017; 82:e61–e63
- Is the search for a 'pain personality' of added value to the Fear-Avoidance-Model (FAM) of chronic pain? Katja Boersma*Scandinavian Journal of Pain 17 (2017) 226–227
- Low Back Pain and Sciatica in over 16's. Assessment and Management. Nice Guideline N59. Published Nov 2016. National Institute for Health and Care Excellence. www.nice.org.uk
- Musculoskeletal Pain Fact Sheet, Revised 2017. International Association for the Study of Pain. (IASP.)

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Male 30's 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 about to assess Justin who has been referred by his GP with this accompanying letter:

Thank you for seeing Justin Munroe who is a 32-year-old architectural draftsman. He has been unable to return to work because of pain after injuring his back 6 months ago, despite reassurances from orthopaedics that there is no serious enduring injury. Justin has asked me to support his application for income protection insurance to cover his mortgage in the event of illness preventing him from working. I am wondering if he has actually developed a depression or if there is some other problem.

Justin does not feel he is depressed and is a little angry about my referral to you. He has asked for a copy of your assessment and advice letter. I would be grateful for your diagnostic assessment and any help you can suggest to enable Justin to return to functioning.

*Dr Fred Masters
General Practitioner*

Your tasks are to:

- Explore the issues that may be affecting Justin's ability to return to work.
- Explain to Justin your preferred diagnoses and the advice you will provide to the GP.

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.
 - 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 any scripted prompt for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'I don't really understand how a psychiatrist can help with my back pain.'

3.2 Background information for examiners

In this station the candidate is expected to interview a 32-year-old man who has been referred by his GP to the community mental health clinic for assessment. Justin has not worked for 6 months due to back pain despite no obvious enduring injury. His GP believes that he should be able to return to his job as an architectural draftsman, and has referred him for an assessment for depression. The patient does not believe he is depressed, and the candidate is expected to elicit symptoms to support a diagnosis of Somatic Symptom Disorder-Pain Predominant (DSM-5) or Chronic Pain Syndrome (ICD 10).

Given the widespread prevalence of chronic pain, and its high global burden of disease, as well as its comorbidity with other mental illness it is important that psychiatrists are able to recognise this problem, and are aware of its presentation and factors which increase the likelihood of occurrence.

The candidate should discuss with the patient what the candidate would do, and explore the issues associated with the particular pain condition, and then make recommendations for the management of chronic pain in order to enable Justin to return to work.

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

- Specifically explore Justin's beliefs regarding the ongoing nature of his pain and disability
- Suggest the diagnosis of Somatic Symptom Disorder (SSD) OR Chronic Pain Syndrome
- Prioritise an interdisciplinary graduated return to work plan OR a referral to a Pain Clinic.

The distinction between a SSD (with predominant pain) and that of a Chronic Pain Syndrome is not clear in many cases, and may depend on diagnostic viewpoint. Therefore, in this question either of these diagnoses is acceptable whereas the diagnosis of a Major Depressive Episode or malingering is not.

Recommended interventions should include work specific actions like recommending a graduated return to work plan. The candidate may include taking into account the fact that he works in an office all day, and having an ergonomic review of his work area from an occupational health and safety officer. The candidate should also identify the benefits of a referral to a specialist pain clinic.

Other general interventions that a candidate could decide to include non-pharmacotherapy options like patient education and use of a pain diary; self-care activities (physical exercise, stress management, relaxations techniques); therapies (behaviour or cognitive therapy, cognitive-behaviour therapy, biofeedback, physical therapy, family therapy, mindfulness based therapies); complementary and alternative therapies (massage, manipulative methods, acupuncture); medications (analgesics, pain modifying medications like gabapentin, nortriptyline or venlafaxine); surgery and other invasive procedures (nerve blocks). However a number of these have limited evidence base for chronic pain; for instance, family therapy, manipulation, surgery and acupuncture.

Engaging family members / partners in the assessment and treatment process allows for the patient's functioning at home to be evaluated, and will also provide his partner and family members with the opportunity to better understand his problems and how to support him.

The surpassing candidate may demonstrate clear capacity to empathise with the patient and take his concerns seriously; maintain an optimistic and positive attitude and resist any temptation to recommend a series of further investigations that are unlikely to reveal anything new; answer any questions the patient may have as they will provide sufficient information of treatment options including the pros and cons of each option.

DSM-5: Somatic Symptom Disorder

- A** One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- B** Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
 2. Persistently high level of anxiety about health or symptoms.
 3. Excessive time and energy devoted to these symptoms.
- C** Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specifiers

- **With predominant pain** (for individuals whose somatic symptoms predominantly involve pain)
- **Persistent** (characterised by severe symptoms, marked impairment, and long duration)
- **Mild** (one symptom in Criterion B)
- **Moderate** (two symptoms in Criterion B)
- **Severe** (two criterion B symptoms and multiple somatic complaints or one very severe symptom)

ICD 10 F45.1 Undifferentiated Somatoform Disorder

When somatoform complaints are multiple, varying and persistent, but the complete and typical clinical picture of somatization disorder is not fulfilled, the diagnosis of undifferentiated somatoform disorder should be considered.

ICD10 G89.4 Chronic Pain Syndrome

Chronic pain associated with significant psychosocial dysfunction.

In ICD 11 there will be a new set of diagnostic codes for chronic pain, developed by the International Association for the Study of Pain (IASP) which it is hoped will apply to the most clinically relevant disorders and enable a more pragmatic and germane classification leading to more accurate epidemiological data and better development and implementation of new therapies.

Chronic Pain, Psychopathology, and DSM-5 Somatic Symptom Disorder (Joel Katz, PhD,¹ Brittany N Rosenbloom, MSc,² and Samantha Fashler, MA²)

The IASP defines pain in general as '*an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage*'.

In contrast, there is not a generally agreed on definition for chronic pain: it was traditionally defined by the length of time that pain persists, but a time-based approach ignores many other important features. Recent conceptualisations have introduced a more nuanced approach, and the IASP currently defines chronic pain variously as '*pain without apparent biological value*', '*pain that has persisted beyond the normal tissue healing time... as determined by common medical experience*', and (or) as '*a persistent pain that is not amenable, as a rule, to treatments based upon specific remedies*'. But even these refinements do not incorporate all the varieties of persistent pain. For example, some chronic pain conditions, such as rheumatoid arthritis, are unlikely to remit, and others, like migraine headaches run a recurring course. Despite these challenges, for research purposes, chronic nonmalignant pain is typically defined as pain that persists for longer than 6 months.

Neuropathic pain arising from a direct lesion or damage to somatosensory system is considered pathological. Neuropathic pain involves profound alterations in the normal peripheral and central neural processing of afferent input. Following injury or disease, nociceptive neurons change their response properties; they may display spontaneous activity, an increase in responsiveness, and a reduction in activation threshold to normal and subthreshold inputs. Pain of neuropathic origin is often described as burning, aching, and electric shock-like in quality. It is typically more severe and less responsive to conventional treatments than are nociceptive and inflammatory pain. Pathological pain with similar features also occurs in people who have not sustained an injury or who have no discernible disease, such as in fibromyalgia, irritable bowel syndrome, and tension headaches. Regardless of the presence or absence of an identifiable aetiological trigger, when in certain at-risk people changes in neuroplasticity the pain becomes classified as disease.

Chronic inflammation causes problems that acute inflammation does nonneuropathic pain does not. This includes cancer and diseases of gums, joints and blood vessels. The connection between chronic pain and chronic inflammation is not as clear as acute pain in acute inflammation, although it is known that neuroplasticity is involved in creating and maintaining chronic pain.

In chronic pain, sensory neurons become altered and produce chronic pain. Alterations in the spinal cord and brain (*central sensitisation*) occur, further increasing chronic pain. *Sensitisation* causes a wider range of pain experiences and also includes a relationship to emotional experiences. *Neuro inflammation* is the type of inflammation occurring in the brain and the periphery that is significant in chronic pain syndromes such as fibromyalgia.

Many different types of cells and mediators are involved in changing and maintaining the experience of chronic pain. These include monocytes, macrophages, T-cells, skin cells, glia, microglia, astrocytes, schwann cells, oligodendrytes, stem cells. Pain modulation and upregulation can also be caused by medications which includes opiates.

These factors result in physiological mechanisms such as a reduction in neural threshold, enlargement of neural receptive field and unmasking of previously non-functioning synaptic connections and give experiences such as spontaneous pain, pain in response to a stimulus that does not usually cause pain (allodynia), increased pain in response to a pain inducing stimulus (hyperalgesia), spread of pain to undamaged tissue including in remote body regions (secondary and remote hyperalgesia), ipsilateral injury-induced, contralateral peripheral neurite loss (mirror image pain).

There is significant overlap in patients presenting with pain symptoms between the diagnoses of Somatic Symptom Disorder (Pain Predominant) and a Chronic Pain Syndrome. There is a stronger emphasis on anxiety or worrying thoughts about the symptoms of pain in SSD however most definitions of a Chronic Pain Syndrome include psychological comorbidity and abnormal pain behaviours.

There is a school of thought that the use of the SSD pain predominant diagnosis rather than that of a chronic pain syndrome when the predominant symptom is pain is stigmatising and demoralising to the patient who is coping with the social and psychological consequences, such as job loss and social isolation of a severe and intractable problem caused by an interplay of peripheral and central neurophysiological mechanisms gone awry. However in the psychiatric setting the diagnosis of SSD (with predominant pain) is the more likely diagnosis to be made. There is also a significant co-morbidity between chronic pain, mood and anxiety disorders and substance dependence.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Justin Munroe, a 32-year-old architectural draftsman. You live with Kayla, your girlfriend of 3 years in your home.

You have been referred to a psychiatrist by your GP (Dr Fred Masters) because you have been suffering from back pain for six months, and have not been able to return to work. He is worried that you have depression, which you don't.

History of your back pain

You hurt your back, lifting a heavy pack of tiles while doing some house renovations 6 months ago, and each time you have tried to go back to work your back gets too painful after a few days. You were off work for 3 months at first, and have now had 3 failed attempts at returning to work but each time you have had to stop after less than a week. You have had physio, seen a chiropractor and an orthopaedic surgeon. No one has found anything seriously wrong and you have been told that you '*strained your lower back*', and that there is no surgical treatment or other mechanical intervention that will help you or is needed. Despite this you find both sitting and standing (leaning over) at work causes pain. You have to spend a lot of time drawing at a computer, and have tried a standing desk set up (because someone else at work uses one) but it still got painful. Your understanding of injury and pain is that pain means that there is an associated injury, and is a warning to stop doing what you are doing and rest. The pain is in the region of your middle and lower back, and is a dull constant pain that worsens if you try to ignore but gets better when you rest. You do really want to return to work – you do not want to be considered a burden on others or a 'bludger'.

You have stopped the renovations because of the pain, and you have run out of money and are now living off your girlfriend's salary. At home your girlfriend does most of the chores, but you can help out with things around the house if you can rest in between, and move around and change position. You tend to do a lot when you feel better and then it always causes pain, so you stop doing things again. You just want the pain to go away so you can get back to normal.

You are irritated by people who don't seem to understand that you really do want to get back to work, and by the doctors who can't seem to fix your back. You continue to worry that they could have missed something more serious, and believe that the ongoing pain is proof of that. You spend quite a lot of time on the internet researching back pain causes and treatments. You are currently taking pain killers (see section 4.7 below). Kayla is starting to get a bit fed up with things, but your relationship is okay.

You drink on weekends and more often in the week more recently, but this is limited by finances to 12 bottles of beer a week. You used to go to the pub with mates, but you can't afford that now. You don't use illegal drugs, and nothing seems to help much including the painkillers the doctor gives you. You have never used strong pain killers containing opiates or codeine or any other medications.

Other symptoms you may be asked about

If asked, your appetite is okay, you have good concentration and read, and watch movies and sport on TV, you have a normal sex drive, your sleep is sometimes disturbed by pain, and you tend to lie awake worrying about things for a while before getting to sleep. You often feel bored and a bit apathetic. You continue to enjoy seeing friends and family. You have never really been into exercise or engaging in sport.

You do not believe that you have a terrible illness that is going to kill you or that any part of your body is rotting. You do not hear voices or see things that other people do not.

No one is against you (including your doctor and employer).

You worry and think a lot about your pain and finances, but do not have any other thoughts that keep coming to your mind.

You have never been overly preoccupied with your body or looks.

Feel free to ask the candidate if they believe you are crazy if they persist with this line of questioning.

About your work

You have been in your job for 5 years, and are good at your job but were getting a bit bored. You had hoped to be promoted but it hasn't happened. You had hoped to be an architect, but you didn't get good enough grades. You feel that your true creative talent is being wasted. You don't like having to draw up other people's designs when you think you could do better yourself.

About your childhood

If asked about your childhood - you have one older brother, Mark. School was okay, but you didn't like it that much, but you were average academically. You were quite shy, and you had one or two friends. Your parents split up when you were 10, and you lived with your mum with occasional visits to your dad in the school holidays. You have no history of trauma or bullying but you remember feeling anxious when your parents argued.

Physical and mental health history

As a child you remember having problems with your stomach, and had one or two admissions to hospital with suspected appendicitis. Your appendix was removed but it didn't seem to help, and eventually it went away. Your only medical problem now is migraine which occurs every few weeks, and caused you to lose time off work, and had used up some of your sick leave even before the back problem.

You have never had a mental health problem. You believe your mum was depressed around the time of the marriage breakup, and you think she has always been over-anxious about things in general. She is worried about you.

4.2 How to play the role:

Casual dress, tidy, a bit frustrated but not angry or hostile. Not in obvious pain. Today is 'a good day' – you have been resting, not much pain.

4.3 Opening statement:

'I don't really understand how a psychiatrist can help with my back pain.'

4.4 What to expect from the candidate:

The candidate should ask you about your pain and your mood, daily activities, sleep, concentration, work, what treatment you have had, and what has happened when you have tried to go back to work. They may ask your understanding of what is wrong.

They should tell you that you are not depressed but you have developed a somatic symptom disorder or chronic pain syndrome, and your brain is misinterpreting signals from your back. They might give you advice about a gradual return to work or referral to a work rehabilitation service or a chronic pain service. They might discuss medications which could help.

4.5 Responses you MUST make:

'My GP is just making things difficult – it's obvious that I am in pain and I can't work.'
(early on, soon after candidate has given their explanation of why you are there)

'So what are you telling my doctor is wrong with me?'
(once the candidate has asked you a series of questions about what is happening to you)

'How will you get me better then?'
(interrupting the candidate's explanation of what they think is wrong)

4.6 Responses you MIGHT make:

If asked about medicines not mentioned above, i.e. anything other than paracetamol and ibuprofen, say you have not heard of them.

If asked, if you have tried any sort of graduated return to work program before, say no.

You have no understanding of the concepts of 'a chronic pain syndrome'. These are not terms you have ever heard.

4.7 Medication and dosage that you need to remember

You take both occasionally for a few days at a time when the pain is bad. You last took tablets last week:

- Ibuprofen (Nurofen) 2 tablets about 5 times a day with food.
- Paracetamol (Panadol) 2 tablets 4-6 times a day.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate the issues related to the presentation of chronic pain and its interface with occupational function.
- Identify differential diagnoses and justify the preferred diagnosis of Somatic Symptom Disorder / Chronic Pain Syndrome.
- Sensitively outline advice which is directed towards a return to work.

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 including asking about history of trauma, indicators of previous personality functioning, any history of prescription of pain modifying medications, history of previous pain experiences and responses; recognises the significance of history from supports.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; conducting a targeted assessment including screening for depression; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth including asking about daily activities, presence of pain and treatment undertaken; assessing for depression and substance use disorder; discussing prior attempts to return to work; integrating key sociocultural issues relevant to the assessment including alcohol and drug use; exploring what his job entails and how he feels about it, his boss and co-workers; gaining a picture of Justin's anxieties about his back pain, impact of current situation on relationship.

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

- Specifically explore Justin's beliefs regarding the ongoing nature of his pain and disability.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; collects a standard psychiatric history without nuanced content around chronic pain or somatic symptom disorders.

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

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

1.9 Did candidate formulate and describe relevant diagnosis / differential diagnosis? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; discusses neurobiological theories of chronic pain in a way that Justin can understand.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; prioritising conditions relevant to the obtained history and findings; utilising a biopsychosocial approach including communication in appropriate language and detail, and according to good judgment; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient's predicament; accurately describing recognised theories of a chronic pain disorder or somatic symptom disorder (pain dominant) in terminology understandable by Justin.

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

- Suggest the diagnosis of Somatic Symptom Disorder OR Chronic Pain Syndrome.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; makes a diagnosis of Major Depressive Disorder or malingering.

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

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

1.15 Did the candidate formulate and discuss with the patient the proposed advice to be given to the GP? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standards with presentation of a plan that is comprehensive and accurate; considers a variety of options and aims to incorporate the patient's goals, preferences and vulnerabilities.

Achieves the Standard by:

communicating findings and advice in a manner likely to be easily understood and accepted by Justin; explaining a range of appropriate biopsychosocial options and recommendations; working with the patient to reach better understanding and more accepted outcomes; reasonably establishing that the patient understands the advice to be given; discussing limitations of pharmacotherapy in managing the condition; making comment about the usefulness of other options.

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

- a. Prioritise an interdisciplinary graduated return to work plan OR a referral to a Pain Clinic.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; inability to synthesise information in a cohesive manner; does not communicate his advice to be written to the GP.

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
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<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-8</p> <p>9</p>
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1.0 Descriptive summary of station

In this station the candidate is working in an eating disorders unit. The patient is a 48-year-old widow who has a long history of Anorexia Nervosa, restrictive type. She is currently significantly underweight, and has had several admissions for weight restoration where she gains weight but loses it quickly after discharge. The candidate is to talk with the son of the patient who is very concerned about his mother, and is struggling to understand the treatment approach. The candidate is then to address the examiner in response to a viva question where the candidate is expected to outline medical monitoring for the patient.

1.1 The main assessment aims are to:

- Explain the concept of BMI and describe the appropriate use of inpatient treatment of Anorexia Nervosa.
- Address the son's concerns related to his mother.
- Demonstrate knowledge of appropriate management of Anorexia Nervosa.
- Outline medical monitoring of a patient with Anorexia Nervosa who is below normal weight range.

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

- Correctly interpret Megan's current BMI.
- Clearly outline that physical deterioration leads to admission.
- Refer to at least one guideline or admission criteria in explanation of treatment interventions.
- Explain the rationale, for at least three of the following, for serial monitoring: Phosphate levels, Vital signs FBC, magnesium, LFTs, ECG, BSL.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders (eating disorders)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Formulation – Communication; Management – Therapy; Management – Initial Plan; Assessment – Investigations, Selection).

References

- A guide to admission and inpatient treatment for people with eating disorders in Queensland 2017. www.metronorth.health.qld.gov.au/rbwh/healthcare-services/eating
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Association. Arlington, VA, APA 2013.
- Eating disorders: recognition and treatment. NICE guideline [NG69] Published date: May 2017. www.nice.org.uk/guidance/ng69
- Guidelines for the inpatient management of Adult Eating Disorders in General Medical and Psychiatric settings. NSW Health, 2014. www.health.nsw.gov.au
- Hay, Phillipa, et al. "Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders." *Australian & New Zealand Journal of Psychiatry* 48.11 (2014): 977-1008.
- World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (Vol. 1). World Health Organization.

1.4 Station requirements:

- Standard consulting room.
- Writing paper and pen.
- Four chairs (examiners x 1, candidate x 1, observer x 1, actor x 1).
- Role player: Male in early 20s.
- 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.

You are working as a junior consultant psychiatrist in an eating disorders service.

Megan is a 48-year-old mother with a 4-year history of Anorexia Nervosa, restrictive type, who has agreed to let you talk with her adult son Michael.

You are aware that Megan currently weighs about 44kg following an average loss of 100g per week (BMI = 16.1). She has told you and Michael that she struggles to eat three rice cakes a day. She walks at least 4 hours a day, and sucks ice chips for thirst. Megan complains of being cold, and has difficulty with concentration and memory. Routine blood tests only show consistently raised urea (approx. 30mg/dL (7-20mg/dL)), and intermittent neutropenia (currently $1.6 \times 10^9/l$ ($1.5 - 8.0 \times 10^9/l$)).

Megan has had several admissions to hospital for weight restoration, after which discharged herself against advice prior to achieving her target weight. The last admission was 5 months ago.

She is now being offered day patient treatment.

Michael is struggling to understand the treatment plan, why Megan is not being offered admission to hospital.

Your tasks are to:

- Justify the decision for outpatient care, and explain criteria for admission to Michael.
- Outline common treatment options for outpatient care to Michael.
- Outline the medical monitoring priorities you would choose **to the examiner**.

You will not receive any time prompts.

Station 6 - Operation Summary

Prior to examination:

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

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

At conclusion of examination:

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

If a candidate elects to finish early after the 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.

The role player opens with the following statement:

'Mum says she is ready to come into hospital to get well but her weight isn't low enough! What the heck is BMI?'

3.2 Background information for examiners

This station aims to assess the candidate's ability to engage with the son of a 48-year-old woman with Anorexia Nervosa, and address his concerns. The son is struggling to understand why his mother, who is obviously unwell, is not being offered inpatient treatment. The candidate is to explain the concept of BMI to the son, and then outline appropriate medical management, focussing on priorities for medical monitoring to the examiner.

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

- Correctly interpret Megan's current BMI.
- Clearly outline that physical deterioration leads to admission.
- Refer to at least one guideline or admission criteria in explanation of treatment interventions.
- Explain the rationale, for at least three of the following, for serial monitoring: Phosphate levels, Vital signs FBC, magnesium, LFTs, ECG, BSL.

Anorexia Nervosa (AN) is a psychiatric illness with a lifetime prevalence of 1%. Although the onset of AN is commonly in adolescence, all eating disorders can present at any age. Patients may present for treatment years after the onset of the disorder. Eating disorders impact on a person's personal and working life, and have significant comorbidity, particularly with anxiety and depression (up to 96% in adults).

The RANZCP has developed comprehensive treatment guidelines for eating disorders, which candidates should be familiar with (2014).

AN is a condition with significant medical complications which often requires collaboration and good communication between psychiatrists, GPs, physicians and family members. Patients at low weight look obviously unwell, and family members and GPs can struggle to understand why inpatient treatment is not offered. The RANZCP guidelines refer to a meta-analysis (2011) which identified the Standardised Mortality Ratio (SMR) to be 5.86. SMR compares mortality in a group with a specific illness to age and sex matched controls, and varies around the figure 1.00 to the degree to which it exceeds (higher mortality rate) or is under (lower rate): the resulting ratio is then multiplied by 100 to yield a percentage. With treatment good outcomes are possible, with 40% of adults making a good 5-year recovery, and 40% a partial recovery.

Medical complications require close monitoring during illness and recovery. Patients who are restricting food can suffer from electrolyte and metabolic problems, and patients can suffer significant metabolic problems when refeeding. Cognitive changes can occur in starvation states, and are associated with reduced grey matter volumes which may not resolve with weight restoration.

General principles of treatment for all eating disorders include:

- person-centred informed decision making
- involving family and significant others
- recovery-oriented practice
- least restrictive treatment context
- multidisciplinary approach
- stepped and seamless care
- a dimensional and culturally informed approach to diagnosis and treatment.

Treatment priorities for AN are as follows:

- engagement
- medical stabilisation
- reversal of cognitive effects of starvation
- provision of structured psychological treatment.

Engagement with treatment is essential. Patients are frequently pre-contemplative, or contemplative regarding actual change. Patients frequently present asking for help, but not actually prepared to gain weight or eat more. It is necessary to begin any treatment by ensuring the patient is motivated to change. Motivational interviewing can be used to help a patient find the motivation to change and become committed to change. (Treasure, 2011). Patient ambivalence to change can contribute to splitting in the team.

Treatment should be provided in the least restrictive setting. Consideration of risk and testamentary capacity could be relevant. It is considered best practice to have access to a range of treatment options including outpatient, intensive outpatient with meal support, day program, and inpatient treatment.

The candidate should refer to the treatment guidelines or other evidence to justify outpatient treatment. The patient, Megan, is compliant with outpatient treatment, in that she attends appointments and is engaged in therapy. She complies with medical monitoring. Consequently, based on the clinical presentation and history provided in the scenario, involuntary admission would not be appropriate at this time.

Outpatient treatment should involve a multidisciplinary approach including:

- Psychoeducation.
- Psychotherapy, which will include motivational interviewing and supportive approaches. Motivational techniques are necessary when the patient is not ready to engage in therapy. Manualised CBT approaches, such as CBT-E can be used when the patient has motivation for change.
- Meal support.
- Medical monitoring including regular weighing, checking of vital signs, ECG, blood tests.
- Dietician advice which may include a prescribed diet.

Criteria for psychiatric admission may include suicidality, active self-harm, moderate agitation or distress, and failure to improve in a less restrictive setting. Criteria for medical admission vary slightly across regions, the following table is provided as a resource for examiners to demonstrate variations across regions.

	RANZCP		NSW		QLD		SA
	psych ad	Med ad	psych ad	Med ad	psych ad	Med ad	ad
BMI	<14	<12	<16	<14	12-14	<12	<15
weight loss	1kg/wk several weeks, or intake <100kcal/day		1kg/wk		<1kg/wk		1-2kg/wk 2 weeks
BP	systolic <90 postural drop >10	systolic <80 drop >20					
temp	<35.5	<35 or blue extremities	<35			<35.5	<35.5
potassium	low	<3.0		<3.0			2.8-3.3
sodium	<130	<125	<130	<125	<130	<125	<125 or >150
magnesium		low		low	low		
phosphate		low				low	<0.05
neutrophils	<1.5	<1.0				<0.7	

	RANZCP		NSW		QLD		SA
	psych ad	Med ad	psych ad	Med ad	psych ad	Med ad	ad
eGFR			<60			<60	
ECG	any arrhythmia, QTc prolongation, non-specific ST or T wave changes						
heart rate		<40 bpm, >120 bpm postural tachy >20bpm					
BSL		< 2.5 mmol/l					

Body mass index (BMI)

BMI is a measure of body fat, and is commonly used to determine whether a person's weight is within a healthy range. BMI applies to both adult men and women, is a useful measurement for most people over 18 years old. But it is only an estimate, and it doesn't take into account age, ethnicity, gender and body composition, and is the calculation of body weight in relation to height.

The calculation for BMI is: $BMI = \text{weight (kg)} / \text{height (m)}^2$

Result between 18.5 and 24.9 is considered to be within the healthy weight range. However, there are some exceptions. For example, the healthy weight BMI range tends to be:

- Lower for people of Asian background
- Higher for those of Polynesian origin
- Higher for older people
- Higher for elite athletes with higher than normal levels of lean body tissue.

Underweight: < 18.5

Normal weight: 18.5 - 24.9

Overweight: 25 - 29.9

Obese: ≥ 30

Medical monitoring should include weekly:

- Vital signs including pulse, temperature, lying and standing blood pressure
- Weight and BMI calculation
- Electrolytes
- Liver function tests
- Calcium (bone)
- Magnesium and phosphate
- Full blood count
- ECG

After 6 months of amenorrhoea and every second year:

- Bone density

Re-feeding syndrome: is a serious medical complication which can lead to sudden death. Patients are particularly vulnerable in the first two weeks of initial re-feeding after a period of starvation, especially overnight during the fasting that occurs. It is understood to be due to the switch from glucose production to carbohydrate induced insulin release. This results in rapid intracellular uptake of phosphate, magnesium and potassium. Electrolyte imbalance results and heart failure is also a risk. Monitoring of phosphate, potassium and magnesium daily is essential if the candidate chooses to suggest re-feeding syndrome may be an issue if the patient commences after an extended period of fasting; refeeding syndrome can occur at low and higher BMI. This is unlikely in this scenario as she is still eating small amounts at home, the more important issue is focussed on general malnutrition.

DSM 5 Criteria for Anorexia Nervosa

1. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.
2. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify whether:

Restricting type: During the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e. self-induced vomiting, or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting and / or excessive exercise.

Binge-eating / purging type: During the last three months the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e. self-induced vomiting, or the misuse of laxatives, diuretics, or enemas).

Specify current severity: **Mild:** BMI more than 17 **Moderate:** BMI 16- 16.99 **Severe:** BMI 15-15.99 **Extreme:** BMI less than 15.

ICD-10 diagnostic criteria for anorexia nervosa (F 50.0) (2)

- Actual body weight at least 15% below expected weight, or body mass index 17.5 or less (in adults).
- Weight loss is caused by the avoidance of high-calorie foods and at least one of the following:
 - > Self-induced vomiting
 - > Self-induced purging
 - > Excessive exercise
 - > Use of appetite suppressants and / or diuretics
- Distorted body image as a specific psychological disorder.
- Endocrine disorder, manifest in the female as amenorrhoea and in the male as a loss of libido.
- If onset is pre-pubertal, the puberty in boys and girls may be delayed (growth ceases; in girls the breasts do not develop).

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Michael, the 26-year-old engineer son of Megan who was diagnosed with Anorexia Nervosa. With your mother's consent you have come to see your mother's psychiatrist today because you are very concerned about her continued weight loss.

About Megan, your mother's history

Megan is 48 years old. You live together in an apartment, and you can see your mother continuing to lose weight and rarely see her eat. Sometimes you can cajole her into eating a rice cake, or some lettuce, or a few almonds. She sucks ice chips when she is thirsty. You know that she spends hours of the day walking, and sometimes if she wakes up at night she can occasionally go out walking even into the early hours of the morning – which you get concerned about.

When you were growing up, Megan was '*a bit cuddly*' (slightly overweight), like the other mums. Your father was a demanding and controlling man who did not want her to lose weight. The whole family was frightened of him. He could be verbally aggressive, and was physically violent to your younger brother Paul. You suspect that he was violent to Megan behind closed doors, but not in front of you. He was a sports fanatic who valued fitness and strength. He did not allow Megan to lose weight, though, saying he liked her just as she was. Your mother had told you that she thought he didn't want her to lose weight in case someone else became interested in her. He had been '*the jealous type*' when they were young.

Your father was diagnosed with a terminal cancer of his colon 5 years ago, and died after a short illness (6 months). Despite the conflict in the marriage your mother cared for him with devotion. You look at your mother now, and have noted that she looks emaciated just as your father did before he died, which of course really worries you. Your mother has however, been at her current weight (about 42kg) and even less in the past, so you are not that afraid that she will die. Rather you are really frustrated at her failure to improve.

You all expected that your mother would come out of it herself after your father died. They weren't very close. She had seemed to grieve normally, but with encouragement she started to do the things that she had wanted to do before, that your father had not allowed. At first, she seemed to do well, joining a gym, losing weight, getting a part-time job in retail. But she became obsessed with diet and weight and shape, and just kept eating less and losing more weight. She spent more and more time walking.

Your mother got a job at the local supermarket, but after a few months, and at a pretty low weight the manager asked her to take leave '*to get well*'. She had made some mistakes on the cash register, and they were concerned that she was too weak for the exertion of stocking shelves.

Initially when family members expressed concern she fobbed them off, but as she lost even more weight she became really irritable, especially when anyone questioned her about it. Your mother seems to get a bit better and then a bit worse, and tends to blame the doctors for not doing what she thinks will help her. She seems to want you to advocate on her behalf, and you feel annoyed and a bit trapped by her.

The GP, Dr Phillips, had referred her to the local eating disorders service. Megan made little progress with outpatient treatment. She felt she didn't fit in with the groups in the day patient program as most of them were '*so young*'. She only went a few times. Eventually she was admitted to a medical ward for what you have come to understand as '*weight restoration*' which means the clinical staff work to increase her weight, and reduce all the strategies she uses to lose weight. She did well in hospital. Unfortunately, your mother has a pattern of increasing her weight, and then discharging herself before reaching her target weight, telling the staff that her children need her at home – which of course is untrue.

You know your mother had thought that she can '*do it by herself*', and get better. For several months after her first admission nearly 4 years ago, your mother had returned to work, and had maintained her weight but did not gain any. She continued to see the psychologist, whom you think did something called '*CBT*', which you understand to be a sort of talking therapy. You know that for a while she kept a diary where she wrote what she ate, and her thoughts about it. However you don't believe that she does that any more.

Over the next couple of years, your mother had a couple of shorter admissions for weight restoration. The last admission was 5 months ago. She had gained weight but lost it very soon after discharge, even so, she did see the GP regularly to be weighed, and had regular blood tests. You met with Dr Phillips a few months ago who was amazed that Megan's blood tests had always been good. Dr Phillips encouraged you to see your mother's psychiatrist, because the GP shared your disbelief that your mother wasn't in hospital. The GP had suggested Megan present herself to casualty to get admitted, but the doctors checked her out and said she didn't need admission.

Your mother now says she is unhappy. You don't think that she is depressed. You don't see her getting tearful. She is active in the daytime, she seems to enjoy seeing her few friends, as long as she doesn't have to eat. She says that she wants to get well and that she can do that in hospital. She says that she wants to have a normal life, and that she wants to go back to work. Your mother has always said she won't take tablets. She does tend to complain that the treating team don't help her because they do not support her to do what she wants to do. For example, she wants to go to hospital now, but when she was in hospital she said she couldn't stay because it was unreasonable to expect her to drink nourishing fluids as part of her meal plan, and that it wasn't fair that she should keep gaining weight when she had already gained several kilos. In the past she has wanted you to convince the doctors to let her stay in hospital but not gain weight. She has discharged herself against medical advice each time that she has been admitted. You feel a bit trapped.

Your mother has never had a problem with over-eating, especially high carbohydrate, high sugar foods (called bingeing), and you don't think she takes slimming or laxative tablets or make herself vomit (called purging). You know that if she does eat something more substantial, like a piece of birthday cake, if she is forced into it, then she becomes distressed and upset. But you haven't noticed her going to the bathroom after meals or anything like that.

Your mother does not have many friends whom she contacts infrequently. She won't go out with them to anything that involves food, e.g. coffee or lunch, or movies. You think that there are one or two women who try to stay in contact with your mother, but she pushes them away.

About you and your family

You are one of three children. Your sister Katrina is 24 years old, and your brother Paul is 22 years old. Your sister, Katrina, says she is worried but doesn't know what to do. She tends to stay away.

You are not often at home as you work in an office, and spend a lot of time with your girlfriend, Grace.



image of woman with BMI 16

4.2 How to play the role:

You are smartly dressed.

You are frustrated that your mother has made no real improvement with all the treatment she has had. You can get irritated with the candidate if you do not feel that your concerns are being heard. If you feel that your concerns are addressed, and that the Dr understands your dilemma you will calm down. Your dilemma is that you feel pretty trapped by your mother wanting you to advocate for her. You have to agree with her that your mother should be in hospital. But you can see that it hasn't helped before as she has discharged herself. You can't really see that anything has changed since that previous admission.

4.3 Opening statement: (delivered in a way that shows that you are really annoyed)

'Mum says she is ready to come into hospital to get well but her weight isn't low enough! What the heck is BMI?'

4.4 What to expect from the candidate:

The candidate is expected to explain what BMI is, and how it is used. They should be able to explain a range of treatment options including outpatient and day patient treatments, and talking treatments which may educate your mother about her illness, and the effects of starvation (psychoeducation) as well as to help her identify reasons to gain weight (motivational Interviewing may be mentioned), or Cognitive Behavioural Therapy (CBT) in which the patient is helped to identify and challenge distorted thinking patterns, and set specific challenges with her eating. A dietician should be involved to give an appropriate meal plan. Support at meal times should be suggested (meal support).

4.5 Responses you MUST make:

'I really think she needs to go to hospital.' (said emphatically)

'I think she is ready to change?' (said as a question)

'She says it's dangerous for her to eat at home. Is that right?' (said after explanation of inpatient and outpatient treatment options)

4.6 Responses you MIGHT make:

If the candidate does not explain what BMI is.

Standard Response: ***'So how do you work out this BMI?'*** (still annoyed)

If the candidate hasn't talked about outpatient therapies.

Standard Response: ***'What else can be done for my mother?'***

If the candidate does not explain why inpatient treatment is not offered.

Standard Response: ***'I still don't get why she isn't in hospital. She looks just like dad did when he was in palliative care!'***

If the candidate comments on how you must feel trapped by your mother's demands.

Standard Response: ***'That's right. That's how I feel.'*** (and the anger is relieved)

4.7 Medication and dosage that you need to remember:

Nil

STATION 6 – MARKING DOMAINS

The main assessment aims are to:

- Explain the concept of BMI and describe the appropriate use of inpatient treatment of Anorexia Nervosa.
- Address the son’s concerns related to his mother.
- Demonstrate knowledge of appropriate management of Anorexia Nervosa.
- Outline medical management of a patient with Anorexia Nervosa who is below normal weight range.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.12 Did the candidate interpret and communicate the BMI investigation to the son appropriately, sensitively and accurately? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

candidate explains BMI in a sophisticated manner; offers an appraisal of the significance of the BMI; provides alternatives to BMI with explanations.

Achieves the Standard by:

accurately describing the process of calculating the BMI; communicating an explanation of the concept of the BMI in suitable language, with appropriate detail and sensitivity; reflecting any limitations and value of BMI.

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

- Correctly interpret Megan’s current BMI.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; inaccurate or inadequate interpretation of investigations; incorrectly interprets even basics of the BMI.

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

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

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

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support treatment options; acknowledges that guidelines can vary and can be the subject of debate.

Achieves the Standard by:

identifying specific criteria that lead to admission; suggesting treatment outcomes and prognosis expected from admission; considering sensitively barriers to implementation; acknowledging the role of the son as advocate for his mother; planning for risk management.

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

- Clearly outline that physical deterioration leads to admission.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; errors or omissions impact adversely on patient care; plan lacks structure and / or is inaccurate.

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

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

1.13 Did the candidate describe community treatment strategies? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between community treatment options and Megan's presentation; clearly addresses difficulties and barriers to the application of community care.

Achieves the Standard by:

demonstrating the ability to prioritise and implement evidence-based care; identifying outpatient psychotherapies like motivational and CBT strategies; suggesting day patient treatment programmes; teaching skills like mindfulness; addressing motivation; considering involuntary versus voluntary community modes; recognising the need for consultation and referral with other health professionals.

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

- a. Refer to at least one guideline or admission criteria in explanation of treatment interventions.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; errors or omissions will impact adversely on patient care; treatment options are inaccurate; options not tailored to needs or patients with eating disorders.

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

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

1.8 Did the candidate make an appropriate choice of investigations for monitoring? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

sophistically considers the resource impact of choices; identifies any difficulties with access to investigations chosen; demonstrates consideration of cost-benefit reasoning.

Achieves the Standard by:

prioritising and selecting the optimal range of tests; justifying selection of tests and investigations; identifying potential limitations of investigations; including relevant weekly tests as well as annual bone density, and periodic vitamin and iron checks.

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

- a. Explain the rationale, for at least three of the following, for serial monitoring: Phosphate levels, Vital signs FBC, magnesium, LFTs, ECG, BSL.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; incorrectly chooses even routine / standard range of investigations; unable to prioritise relevant investigations.

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

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

GLOBAL PROFICIENCY RATING

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

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

Prior to seeing Mavis Davies, a 72-year-old woman, her community mental health nurse (called Rita) asks to speak with the candidate. Since discharge, Mrs. Davies has been frequently ringing the ward and the reception, wanting whomever answers to listen to her and to help her. This has been happening both day and night, with the staff becoming frustrated by her behaviour. This station explores how bereavement in an older person with a dependent personality affects her interaction with others. The candidate's tasks are to explore the concerns of the community mental health nurse, to make sense of the history obtained, and describe diagnoses of grief and dependent personality with relevant differential diagnoses.

1.1 The main assessment aims are to:

- Take a focussed history from the community mental health nurse in order to understand their concerns.
- Provide a psychological framework that explains the presentation.
- Describe relevant diagnoses and differential diagnoses to the examiner.

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

- Explore the possibility of major depression.
- Identify three (3) psychological factors influencing the presentation.
- Propose both diagnoses of grief / loss and Dependent Personality Structure / Disorder.

1.3 Station covers the:

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

References:

- International Statistical Classification of Diseases and Related Health Problems. 10th Revision (ICD-10)-WHO Version for;2016 – <http://apps.who.int/classifications/icd10/browse/2016/en> - Chapter V Mental and behavioural disorders (F00-F99): specifically, F30-39; F40-F48; F60-F69
- International Statistical Classification of Diseases and Related Health Problems. 10th Revision (ICD-10)-WHO Version for;2016 – <http://apps.who.int/classifications/icd10/browse/2016/en> - Chapter XXI Factors influencing health status and contact with health services (Z00-Z99): Z55-Z65 - Persons with potential health hazards related to socioeconomic and psychosocial circumstances – specifically, Z63 Other problems related to primary support group, including family circumstances
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – copy of DSM-5 – American Psychiatric Publishing, Washington, DC, 2013 - specifically, Depressive Disorders p160; Personality Disorders p675; Other Conditions That May Be a Focus of Clinical Attention p716
https://www.sciencetheearth.com/uploads/2/4/6/5/24658156/dsm-v-manual_pg490.pdf
- Gabbard, GO. Psychodynamic Psychiatry in Clinical Practice. Fourth Edition. American Psychiatric Publishing, Washington, DC, 2005 – Chapter 3 Psychodynamic Assessment of the Patient p63 & Chapter Cluster C Personality Disorders p565
- Iglewicz, A., Seay, K., Zetumer, S.D., Zisook, S. The removal of the bereavement exclusion in the DSM-5: Exploring the evidence. *Current Psychiatry* 2013 Nov;15(11):413
- Kaplan & Sadock's Comprehensive Textbook of Psychiatry 9th Edition – Lippincott Williams & Wilkins, Philadelphia, USA, 2009 – Chapter 6 Theories of Personality and Psychopathology p788; Chapter 13 Mood Disorders p1629; p1689; p1693. Chapter 23 Personality Disorders p2197; Chapter 25 Relational Problems p2469
- Pies, R. The Bereavement Exclusion and *DSM-5*: An Update and Commentary. *Innovations in Clinical Neuroscience* 2014 Jul-Aug; 11(7-8): 19–22
- Shear, M.K. et al. Complicated Grief and Related Bereavement Issues for DSM-5. *Depress Anxiety*. 2011 February; 28(2): 103–117. <https://www.ncbi.nlm.nih.gov/pubmed/21284063>

Committee for Examinations
Objective Structured Clinical Examination
Station 7
Auckland September 2018



1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Female 40-45 years of age, well dressed and relaxed.
- 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 the community mental health service. Rita Matthews, the community mental health nurse for Mrs. Mavis Davies, has asked to meet with you prior to your appointment with Mrs. Davies at the clinic today.

Mrs. Davies, a 72-year-old widow, had her first admission to the inpatient psychiatric unit five weeks ago. She was admitted in a tearful and distressed state, finding it difficult to cope without her husband, who had died after a long illness. Since discharge, she has been frequently ringing the ward and the clinic reception at all hours wanting help to make decisions.

Rita would like to understand why this is happening.

Your tasks are to:

- Explore the concerns of the community mental health nurse.
- Explain Mrs Davies' presentation from psychological perspectives to Rita.
- Justify your preferred diagnoses and relevant differential diagnoses **to the examiner**.

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.
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

During examination:

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

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'Hello Doctor, I want to talk to you about Mrs. Davies before you see her.'

3.2 Background information for examiners

In this station the candidate is to meet with a community mental health nurse to obtain an update about an elderly widow who has recently been admitted to an inpatient unit following the death of her husband. The candidate is to listen to the community mental health nurse, and take a focussed history from which they can generate a formulation, and describe relevant diagnoses and differential diagnoses.

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

- Explore the possibility of major depression.
- Identify three (3) psychological factors influencing the presentation.
- Propose both diagnoses of grief / loss and Dependent Personality Structure / Disorder.

The following information is provided to inform an understanding of this case.

BEREAVEMENT

(Bereavement and Grief - From Kaplan & Sadock's Comprehensive Textbook of Psychiatry)

Definitions:

The terms **bereavement** and grief refer to either the state of having lost someone to death or the response to such a loss. Researchers have suggested that the term bereavement be used to refer to the fact of the loss. The term **grief** is then used to describe emotional, cognitive, functional, and behavioural responses to the death. Manifestations of grief vary from person to person, from moment to moment, and involve all aspects of the bereaved individual's being.

Mourning usually refers more specifically to the behavioural manifestations of grief, which are influenced by social and cultural rituals such as funerals, visitations, or other rituals.

Complicated grief sometimes referred to as unresolved or traumatic grief is the current designation for a syndrome of prolonged and intense grief that is associated with substantial impairment in work, health, and social functioning.

An Attachment Theory Perspective

Grief can be understood using attachment theory. Attachment theory posits a basic human instinct to form strong, persistent affectionate relationships. Loss of such a relationship is always difficult. Thomas Bowlby and others have described attachment figures as people that we most want to be with and to whom we turn when under stress. Most adult relationships attachment is reciprocal so that those people who provide us with secure base and safe haven functions are also the ones for whom we provide this support. When a relationship with an attachment figure / caregiving recipient is disrupted, there is a loss of sense of well-being, increase in distress, and difficulty solving problems and fully engaging in other aspects of life.

Phenomenology of Grief

Grief includes intense feeling states, entails a variety of coping strategies, and leads to alterations in interpersonal relationships, biopsychosocial functioning, self-esteem, and world view that may last indefinitely. Manifestations of grief reflect the individual's personality, previous life experiences, and past psychological history; the significance of the loss; the nature of the bereaved individual's relationship with the deceased; the existing social network; intercurrent life events; health; and other resources. There is little evidence for systematic progression of grief. Instead, progress is typically erratic and recursive, occurring in explosive bursts plentifully interspersed with moratoria as information regarding the reality and meaning of the death is periodically engaged, evaluated, and set aside. Different aspects of the loss and their associated feelings may be repeatedly revisited, leading to an impression that the process is going nowhere, yet this is usually not true, and normal grief can have this recursive quality.

Duration of Grief

Most societies mandate modes of bereavement and time for grieving. Grief researchers have suggested that re-engagement in restoration-related activities is an important part of the early period of normal grief. While ample evidence indicates that the bereavement process does not end within a prescribed interval, the lasting form of grief (i.e., integrated grief) is much more private, less intense, and less preoccupying than the acute form. Aspects of grief often persist indefinitely for many otherwise high-functioning, normal individuals. Perhaps the most lasting manifestation of grief, especially after spousal bereavement, is loneliness.

Multidimensional Assessment of Bereavement and Grief

Because people we love invade our minds and every aspect of our lives, the loss of such a person results in a range of difficulties. A multidimensional approach to the assessment of bereaved people includes: (1) emotional and cognitive responses, (2) coping strategies, (3) continuing relationship with the deceased, (4) alterations in existing relationships and forming new ones, (5) changes in functioning and health, and (6) changes in identity. Assessing these features lends itself to rational management and treatment strategies.

Complicated Grief (CG)

Although the personality of the bereaved person may play a role, the same person may successfully grieve the loss of one person and not another, so the development of CG appears to be more specific to a given relationship than to a given personality type. It has been reported that, if recently bereaved individuals meet criteria for complicated grief by 6 months, they are at increased risk for changes in smoking, eating, depression, and high blood pressure by 13 months. By 25 months, these bereaved individuals may be at an increased risk to develop heart trouble, new cases of cancer, and more often expressed suicidal ideation.

Bereavement and Depression

Many clinicians are confused by the relationship between grief and depression. Bereavement is a major stressor that is one of the most likely to precipitate an episode of major depression. Studies show that approximately one-third of all widows or widowers manifest a full major depressive episode 1 month after the death of a spouse, approximately one-fourth at 7 months, and approximately 15 percent at 1 and 2 years. Up to 10 percent may meet criteria for major depressive episode for the entire year. In addition, bereaved persons are not only at a high risk for a major depressive episode, but they also are at risk for lingering subsyndromal depressive symptoms. Such symptoms, even in the absence of full depressive disorders, may be associated with prolonged personal suffering, role dysfunction, and disability.

Dependent personality and grief

Research has shown that people with certain personality traits are more likely to have long-lasting depression after a loss. People with dependent personality disorder who are dependent on their spouse are more likely to develop depression and have difficulty coping with the loss of their loved one.

Dependent personality and depression

Often those with dependent personality have low self-esteem and / or a sense that life cannot be controlled. Consequently, they are more likely to have a complicated grief response such as depression and physical problems.

Social Support

A lack of social support increases the chance of having problems coping with loss. Social supports include the person's family, friends, neighbours, and community members who give psychological, physical and financial help. After the death of a close family member, there are many related losses. The death of a spouse may cause a loss of income and changes in lifestyle and day-to-day living.

Psychological perspectives that the candidate may discuss in their presentation

The biopsychosocial theory perspective proposes that most disorders may be a direct or indirect result of biological, psychological, and social factors / dynamics. Mrs. Davies displays difficulty making decisions or meeting ordinary demands of life, feelings of devastation or helplessness when relationships end (death of husband, departure of daughter, and discharge from ward), being preoccupied with fears of being abandoned, and consistent attempts to avoid responsibility. She is thus more susceptible to a range of problems and illnesses, such as depression and anxiety.

From classical psychoanalytic theory perspective, dependency issues may stem from the oral stage of infant development. Infants who were either frustrated or overindulged in this stage may later develop dependency behaviours. The child becomes dependent on the interactions between themselves and their caregivers, which later becomes the self-concept of the individual. It is possible that past traumas may have been experienced and are now being repressed, to ensure maintenance of the caregiver relationship, and the meeting of their dependency needs. Insecure attachment to the parental figure through being overindulgent, unresponsive, inconsistent, or abusive may cause anger, anxiety, fear and dependency reactions in the child.

In respect of defence mechanisms employed by Mrs. Davies, she reacts to abandonment with increasing submissiveness and clinging behaviour as evidenced by her excessive contact with mental health services. The death of her husband, the departure of her daughter, and the discharge from the hospital are all perceived as varying degrees of abandonment. Given that the mental health services remain present, she has projected her need onto the service.

Another possibility psychodynamic is that she is defending against unconscious hostility, originally directed against possible overbearing parents, by submitting to others to unconsciously avoid anger. From the perspective of object relations theory, Mrs. Davies may have internalised images of persons who matter to her, especially her parents.

It is possible that Mrs. Davies had overprotective, authoritarian parenting, and that her husband could have been similar to her parents. She likely developed sensitivity to interpersonal cues especially regarding the need to maintain a dependency on others rather than develop independence and autonomy. In her presentation she clearly has a strong desire to obtain and maintain nurturing, supportive relationships.

In terms of attachment theory, there is biological need for comfort and support in the relationship between parents and young children. In secure attachment the child has comforting psychological images of reliable caretakers who provide a solid base from which to explore the world, and achieve a balance between independence and closeness to others. It is possible that her parents may have been unresponsive, inconsistent, or abusive. She may have consequently developed a fearful or insecure attachment to her parents. Thus, this internalised model is taken into future relationships. This might have led to Mrs. Davies' excessive demands for care and may explain her difficulty self-soothing and calming herself when sad, anxious, frustrated or angry.

From a behavioural and social learning theory, children learn through conditioning (automatic associations) and reinforcement (reward and punishment). Mrs. Davies may have been rewarded for making excessive demands for care. This can reinforce expectations for care and development of dependence. It is possible she has never been rewarded for independence. In insecure attachment parents are inconsistent, so children may learn that they cannot control their lives. In regard to Mrs. Davies she went from the care of her parents into the care of her husband, so has never had the opportunity to develop independence.

From the perspective of cognitive psychology Mrs. Davies' dependency developed as a result of how she and others thought about her. Somehow in growing up she received the idea that she is powerless, and others are powerful and effective. Possibly her parents may have conveyed to her that she would be abandoned and alone unless she submits.

Temperamentally, Mrs. Davies seemed to be a gentle, shy and easily frightened child and as such she may have evoked protective feelings in others. Her parents may have been overanxious and discouraged independence. A sibling may have bullied her, reinforcing her temperament and protective tendencies in others. As a result, Mavis became more sheltered, reinforcing her behaviour and that of others to protect her, intensifying her dependency on powerful others.

An example of a possible psychological explanation of Mrs. Davies

Mrs. Davies' presentation occurs most notably in the context of the death of her husband, to whom she had been married for over fifty years. It seems that her husband had managed most practical aspects of their daily life, and that his strong presence had acted to complement Mavis' dependant personality style. As a result, when he died she was unable to cope with many of the tasks which he had normally taken care of. It is also likely that Mavis' own intense grief at losing her husband created an anxiety which made it even more difficult for her to manage such tasks. From a systems perspective, Mrs. Davies' own anxiety seems to have caused discord between her and her children, who themselves are likely grieving for their father. Her behaviour is thereby isolating her from her children, which is likely to strengthen her feelings of emptiness and isolation.

Mrs. Davies' presentation can also be understood from a developmental perspective. There is a sense that she has depended upon attachment figures for excessive care and reassurance from a young age, a pattern that may have its origin in her insecure attachment style with her parents. This forms a basis for an entrenched dependency which has occurred throughout her life and is now contributing to difficulties managing grief, and finding a sense of autonomy following her husband's death.

DIAGNOSIS

Bereavement or Grief Reaction
Dependent Personality Traits (or disorder)

Differential Diagnosis

Mild / Moderate Depressive Episode
Adjustment Disorder due to Grief Reaction

Less likely Differential Diagnoses

Major Depressive Disorder
Complicated Grief

Discussion of Diagnoses:

The information below is provided as background material when considering the diagnosis and differential diagnoses. The candidate will **achieve a 'surpass'** if they discuss the complexity of the diagnostic systems addressing grief.

Bereavement-related grief and major depression share some features, but are distinct and distinguishable conditions. Recognising major depression in the context of recent bereavement takes careful clinical judgment. The removal of the bereavement exclusion in the DSM-5 now permits the diagnosis of major depressive disorder after and during bereavement, and includes a note and a comprehensive footnote in the major depressive episode criteria set to guide clinicians in making the diagnosis in this context. The decision to make this change was widely and publically debated and remains controversial.

ICD 10 Relational Problems: V62.82 (Z63.4) Uncomplicated Bereavement

This category can be used when the focus of clinical attention is a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode—for example, feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss. The bereaved individual typically regards the depressed mood as 'normal', although the individual may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of 'normal' bereavement vary considerably among different cultural groups.

ICD 10 F43 Reaction to severe stress, and adjustment disorders: F43.2 Adjustment disorders

Adjustment disorders are states of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine.

DSM-5 Dependent Personality Disorder - 301.6 (F60.7)

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
- Needs others to assume responsibility for most major areas of his or her life.
- Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution.)
- Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
- Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
- Urgently seeks another relationship as a source of care and support when a close relationship ends.
- Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Diagnostic Features

The essential feature of dependent personality disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour, and fears of separation. This pattern begins by early adulthood and is present in a variety of contexts. The dependent and submissive behaviours are designed to elicit caregiving, and arise from a self-perception of being unable to function adequately without the help of others. Dependent behaviour should be considered characteristic of the disorder only when it is clearly in excess of the individual's cultural norms or reflects unrealistic concerns. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute dependent personality disorder.

Differential Diagnosis

- dependent personality disorder can be distinguished by its predominantly submissive, reactive, and clinging behaviour.
- reacts to abandonment with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support.
- strong need for reassurance and approval and may appear childlike and clinging by self-effacing and docile behaviour.
- feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships.
- dependent personality disorder must be distinguished from dependency arising as a consequence of other mental disorders (e.g., depressive disorders, panic disorder, agoraphobia) and as a result of other medical conditions.

ICD10 F60.7 Dependent Personality Disorder

Personality disorder characterised by pervasive passive reliance on other people to make one's major and minor life decisions, great fear of abandonment, feelings of helplessness and incompetence, passive compliance with the wishes of elders and others, and a weak response to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; there is often a tendency to transfer responsibility to others.

Personality (disorder): Asthenic; Inadequate; Passive; Self-defeating

DSM-5 Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, and hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in an MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of an MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humour that are uncharacteristic of the pervasive unhappiness and misery characteristic of an MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in an MDE. In grief, self-esteem is generally preserved, whereas in an MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focussed on the deceased and possibly about 'joining' the deceased, whereas in an MDE such thoughts are focussed on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

ICD10 F32 Depressive episode

In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called 'somatic' symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Rita Matthews, the community mental health nurse for Mrs. Mavis Davies, a 72-year-old Anglo-New Zealander who presented for the first time to the mental health service 5 weeks ago with distress, tearfulness, feelings of grief and being unable to cope at home. Her husband George had died three months ago from cancer.

Mrs. Davies was admitted to the inpatient psychiatric unit and quickly settled enough to return home after a week, but she did not want to be discharged. She had enjoyed the company of staff and other patients; she loved all the activities and wanted to remain on the ward. Mrs. Davies explained that she could not cope at home alone. She wanted to live on the ward, saying she needs help and felt unable to care for herself. She said that her husband had taken very good care of her, and now she needed someone else to take care of her. She felt incapable of being on her own. How was she going to know 'what clothes to wear or what to do every day?'

Mrs. Davies had very reluctantly left the ward five weeks ago but has since been frequently ringing both the inpatient and outpatient mental health services. Her behaviour is frustrating / distressing to staff due to her frequent calls and neediness. Staff are saying she seems unable to make decisions for herself, ringing staff to ask what she should wear for the day to suit the weather, to tell her how to pay her bills, and what to do about a myriad of things and decisions she needs to make in everyday life.

During admission, there was no evidence of disturbed sleep, concentration, appetite, energy levels or fatigue. Her mood was mildly low, with no history of elevated (high) mood. Her main worry was how she would care for herself and the difficulty she was having making everyday decisions, without her husband. She had times when she would focus on remembering her husband and feel sadness, emptiness and loss. There were other times when she felt that the intensity of her grief was getting less.

Last week you spoke with Mrs. Davies' daughter, June, who explained that the family is also getting frustrated and worried about her behaviour. June's brothers (Gregory and James) have returned to their homes because they can't tolerate their mother's intense and intrusive 'demands for attention', and inability to make decisions.

June commented that their father had 'managed' their mother for many years. He had always been a kind and tolerant man, and would only rarely get frustrated by her needy behaviour. She explained that their father always made the decisions even when he was very sick. June believes that her mother is sad about her husband's death and missing him terribly, but she also thinks there is something more going on with her mother. Now that their father is gone, June explained that they don't know what to do about their mother's behaviour, exclaiming: 'She's just so helpless'. During the admission they were told that the 'doctors were sure that she was not depressed – she is happy when she is with other people'.

You have spoken with the nurse-in-charge of the inpatient unit and the outpatient reception staff, who have all received multiple calls during the day and night from Mrs. Davies with a great need to have all her questions answered, and help with decision making. She will ring and ring until someone answers. Now staff are hesitant to answer the phone for fear it is Mrs. Davies. It is difficult to terminate the calls, especially as she is such a nice lady and they feel sorry for her. Mrs. Davies' calls are interfering with daily work and beginning to cause conflict on the ward. Some staff just want to hang up on her whilst other staff will talk with Mrs. Davies for long periods.

During all your contacts with Mrs. Davies over the past five weeks, there has been no evidence of deterioration in mood or escalation of grief. You have seen her twice weekly since discharge and taken multiple calls from her, and at no time have you thought she was becoming unwell with depression. Furthermore, there was no evidence of psychosis (odd behaviour, hearing voices, fear of being persecuted or controlled). She seems to have accepted her husband's passing after a long period of illness. Her daughter has taken over managing her father's estate and finances because this seems to escalate Mrs. Davies anxiety and help seeking behaviour. To the best of your knowledge there is no conflict between Mrs. Davies and her children over the will or the estate.

As Mrs. Davies' community mental health nurse you have organised this appointment with the psychiatrist. You are not entirely sure what is going on with Mrs. Davies, and you want to let the doctor know what has been happening. You wonder what is causing the problems the community mental health service is having with Mrs. Davies and what the diagnosis might be.

Background

Mrs. Davies' husband, George, died three months ago at age 74 after a long battle with lung cancer. During her husband's illness they received support and regular contact with the children and community / clinical support. It was a very difficult time for Mrs. Davies because she was not used to managing finances or making decisions. When her husband died her children stayed with her for a few weeks. She became increasingly distressed and refused to allow her daughter to leave her.

Mrs. Davies met George when she was 16 years old, and married when she was 18 years old. She describes herself as always being shy and cautious, even as a child. George was an engineer, and they lived a good life raising three children. When George retired they spent all their time together, and she became completely reliant on him for everything. Their children maintain contact by phone and infrequent visits, and do not want this burden on themselves.

Admission

Her daughter, June, felt Mrs. Davies' indecisiveness was worse than usual so took her to see the general practitioner. The GP was worried by her degree of distress and indecision, and wondered if she had depression. She was referred for admission six weeks ago. She settled well on the ward and did not require medication. On the ward the Occupational Therapist assessed her as having the ability to function independently in the home and socially. However, she sought out constant reassurance and validation, both from other patients and staff, which reduced her distress.

Mrs. Davies started to refer to particular staff as friends even when explained that the nursing staff function in their professional capacity, and not as friends. Attempts were made to manage some of the boundary issues with Mrs. Davies. Being on the ward and being expected to make so many of her own decisions was very distressing for her. She was supported by the Social Worker on the ward to begin to address the Will and bills. On discharge she was encouraged to consider attending groups and activities to meet others; she thought this was a good idea.

She continues to ring the ward in the morning when she gets out of bed, during the day and even during the night to check in with the staff regarding how she was coping, trying to get staff to help her make decisions about all kinds of things at home and in her life. She misses the ward wishing she could return. She was also ringing the community mental health nurse daily as well as the front reception in the community mental health service. This is causing problems in the community team as anyone who gets her on the phone has a very difficult time ending the call.

Medical and Psychiatric History

While in the hospital her memory was checked and there is no evidence of forgetfulness or problems like dementia. There were no changes to suggest an acute medical problem, or other disorders like high blood pressure or diabetes. She does not take any medicines.

You are not aware of any past psychiatric history or admissions to mental health units. There is no evidence of a significant depression, specific anxiety disorder, or psychotic disorder and there is no evidence of an acute mental illness. Mrs. Davies does not have any significant alcohol use, and she does not use drugs.

4.2 How to play the role:

As a community mental health nurse, you can dress in comfortable work attire and are well groomed. You present as relaxed but concerned about what is happening with Mrs. Davies, and the impact on the staff and yourself from the frequent contacts and requests of Mrs. Davies.

To give information as per the role, any questions asked that you do not have answers for, please say that you do not know or are uncertain, or will check and get back to the doctor.

4.3 Opening statement:

'Hello Doctor, I want to talk to you about Mrs. Davies before you see her.'

4.4 What to expect from the candidate:

The candidate will listen to your concerns as the community mental health nurse for Mrs. Davies.

They will ask questions and seek clarification about her history, admission to hospital and what is happening now. They will try to make sense of what you tell them and will try to explain to you what they think is causing Mrs. Davies to call so frequently, and what may explain her behaviour recently. If you do not have a scripted answer, explain that you do not know or are uncertain or will check and get back to the doctor.

The third task involves the candidate turning to the Examiner. At that time sit quietly and relax.

4.5 Responses you MUST make:

'She doesn't think she can take care of herself.'

'It seems she is trying to get anyone she can to make decisions for her.'

'She misses her husband, he made all the decisions for her.'

'What are we going to do, I don't understand why this is still going on?'

4.6 Responses you MIGHT make:

If asked if Mrs. Davies is suicidal

Scripted Response: ***'No suicidal thoughts, intent or plan.'***

If asked if Mrs. Davies is depressed

Scripted Response: ***'I think she is sad about George's death, but doesn't seem depressed.'***

If asked if Mrs. Davies is anxious

Scripted Response: ***'I haven't seen any evidence of significant anxiety or panic attacks.'***

4.7 Medication and dosage that you need to remember:

Nil

STATION 7 – MARKING DOMAINS

The main assessment aims are:

- Take a focussed history from the community mental health nurse in order to understand their concerns.
- Provide a psychological framework that explains the presentation.
- Describe relevant diagnoses and differential diagnoses to the examiner.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed collateral 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; elicits a complete and sophisticated understanding of complexity.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history with appropriate depth and breadth (history taking is hypothesis-driven); integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise; clarifying important positive and negative features; assessing for typical and atypical features.

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

- Explore the possibility of major 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):

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

Below the Standard (scores 1):

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

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

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

1.11 Did the candidate generate an adequate psychological explanation to make sense of the presentation? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

presents a sophisticated psychological explanation to accurately describe and explain the presentation.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient's predicament; incorporating relevant predisposing, precipitating, perpetuating and protective factors; commenting on missing or unexpected data; including a sociocultural formulation; analysing vulnerability and resilience factors.

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

- Identify three (3) psychological factors influencing the presentation.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; significant deficiencies including inability to synthesise information obtained; provides an inaccurate formulation.

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

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

**1.9 Did candidate describe the relevant diagnosis and differential diagnoses?
(Proportionate value – 30%)**

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment; accurately justifies a range of differential diagnoses.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to provide a diagnosis and differential diagnoses; accurately linking formulated elements to any diagnostic statement; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; considering adjustment disorders; excluding substance misuse as a contributing factor.

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

- a. Propose both diagnoses of grief / loss and Dependent Personality Structure / Disorder.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; inaccurate or inadequate diagnoses; errors or omissions are significant; does not offer any diagnosis.

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
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1.0 Descriptive summary of station:

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

1.1 The main assessment aims are to:

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

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

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

1.3 Station covers the:

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

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1.4 Station requirements:

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

2.0 Instructions to Candidate

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

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

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

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

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

Your tasks are to:

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

You will not receive any time prompts.

Station 8 - Operation Summary

Prior to examination:

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

During examination:

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

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player will open with:

‘Doctor, why do you need to talk to me?’

3.2 Background information for examiners

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

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

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

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

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

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

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

Background

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

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

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

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

Several reviews have found the most common psychiatric disorders are:

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

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

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

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

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

Pathophysiology

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

Risk Factors

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

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

Prognosis

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

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

Treatment

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

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

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

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

Risk

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

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

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

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

The medical risk of deterioration without correct treatment.

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

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

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

Diagnosis

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

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterised by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
- and**
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 2. The involved substance / medication is capable of producing the symptoms in Criterion A.
- and**
- C. The disturbance is not better explained by a depressive disorder that is not substance / medication-induced. Such evidence of an independent depressive disorder could include the following:
- The symptoms preceded the onset of the substance / medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance / medication-induced depressive disorder (e.g., a history of recurrent non-substance / medication-related episodes).
- and**
- D. The disturbance does not occur exclusively during the course of a delirium.
- and**
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.*

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

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

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

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

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

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

Your experience over past few days:

Your physical health is really getting you down, and you have been feeling very low in mood since coming to hospital.

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

History of your asthma and pneumonia:

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

Mental health symptoms:

If asked any of the following please provide this information -

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

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

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

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

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

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

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

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

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

Energy: You do get tired easily.

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

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

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

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

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

Your personal history:

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

4.2 How to play the role:

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

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

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

4.3 Opening statement:

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

4.4 What to expect from the candidate:

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

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

4.5 Responses you MUST make:

'It's really no use going on.'

'I know what a terrible person I am.'

4.6 Responses you MIGHT make:

See specific descriptions above.

4.7 Medication and dosage that you need to remember:

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

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

Pulmicort inhaler.

STATION 8 – MARKING DOMAINS

The main assessment aims are:

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

Level of Observed Competence:

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

- Elicit the paranoid belief about his wife and the doctor planning euthanasia.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; there are no psychotic symptoms elicited.

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

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

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

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to make the diagnosis; appropriately considers possible alternative explanations.

Achieves the Standard by:

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

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

- Explain the direct link between initiation of oral steroid and the development of the mood disorder.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; there is no link made between the patient having steroids and the emergence of the mood disorder.

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

1.9. Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <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; identifying that drug interaction risk between the oral antibiotic and prednisolone; clearly addresses difficulties in the application of the plan.

Achieves the Standard by:

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

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

a. Recommend tapering of prednisolone and prescription of an antipsychotic.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not discuss the prednisolone dose at all and fails to treat with an antipsychotic as this would impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

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

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <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 - 25%)

Surpasses the Standard (scores 5) if:

takes a liaison role in treatment planning; effectively negotiates complex aspects of care; works to ensure clear communication and treatment partnerships; aims to provide succinct and professional advice.

Achieves the Standard by:

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

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

a. Prioritise the monitoring of suicide risk until the mood disorder settles.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; there is no plan to monitor suicide risk.

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

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

GLOBAL PROFICIENCY RATING

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

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

The candidate is to assess Matthew, a 26-year old university student who has an established diagnosis of obsessive-compulsive disorder and has been on treatment for the past year. He has been referred by his GP for an assessment of the emergence of what she believes are psychotic symptoms. The candidate is to conduct a mental state examination to facilitate symptom clarification and then present the findings including the likely diagnosis to the examiner.

1.1 The main assessment aims are to

- Conduct a tailored mental state examination, including differentiating between psychotic symptoms and obsessive-compulsive symptoms based on form, content and insight.
- Differentiate between delusions and obsessions in the mental state examination, and present a preferred diagnosis and differential diagnoses.

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

- Elicit at least three (3) features of obsessions and compulsions e.g. repetitive, intrusive, ego dystonic, time consuming, behaviours designed to reduce anxiety.
- Identify the delusional belief related to being charged by the police for a misdemeanour.
- Justify the possibility of OCD with poor insight or with delusion.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Core Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis), Scholar (Teaching and Presenting)

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1.4 Station requirements:

- Standard consulting room
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Young male in mid-20's who is casually dressed, polite and cooperative.
- 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 private practice.

You are about to see Matthew Pinkerton, a 26-year-old man. His General Practitioner (GP) is concerned about the emergence of recent symptoms, and so has referred him for an assessment. Matthew has previously been diagnosed with obsessive-compulsive disorder one year ago, and has been reasonably stable on Fluoxetine 80 mg daily.

Your tasks are to:

- Conduct a mental state examination that addresses the GP's concerns.
- Present your mental state examination and elaborate on the key findings **to the examiner**.
- Justify the most likely diagnosis and differential diagnosis **to the examiner**.

You are not required to complete a detailed cognitive assessment.

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.
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

During examination:

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

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

You have no opening statement.

The role player opens with the following statement:

'Hello, I've been referred to you, but I am not sure how you can help me.'

3.2 Background information for examiners

In this station the candidate is expected to identify that this patient has now developed a new fixed belief that is delusional in nature on a background of an established diagnosis of OCD. The candidate is expected to identify the differences in phenomenology between the pre-existing obsessive-compulsive symptoms, and the recent development of a delusion. They are then to explore the associated impaired insight regarding this new belief which points to a possible diagnosis of OCD with poor insight / delusions.

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

- Elicit at least three (3) features of obsessions and compulsions e.g. repetitive, intrusive, ego dystonic, time consuming, behaviours designed to reduce anxiety.
- Identify the delusional belief related to being charged by the police for a misdemeanour.
- Justify the possibility of OCD with poor insight or with delusion.

A surpassing candidate may present both positive and negative findings in a well-structured, sophisticated manner and identify the limitations of diagnostic classification systems in guiding treatment.

Obsessive-Compulsive Disorder (OCD) and Delusional Disorders (DD) have been recognised with increased frequency in recent years, and the propensity of some OCD subjects to become delusional has become a focus of interest.

There has been re-emergence of 19th century proposals that the two conditions may be linked. Obsessionality in the context of a paranoid disorder was taken to indicate that obsessions could be prodromal for schizophrenia. However, obsessionality is not seen in this way now. Rasmussen and Eisen reported that 67 of 475 OCD patients had psychotic symptoms like delusions, hallucinations and thought disorder. They divided their 'psychotic' 'obsessionals into four groups:

- those meeting criteria for both OCD and schizophrenia.
- OCD and schizotypal personality with magical thinking.
- OCD and DD.
- OCD without insight.

The obsessive and compulsive (OC) phenomena observed in patients with psychotic disorder are similar to those of the traditional neurotic obsessive-compulsive disorder. These phenomena include contamination, sexual, somatic, religious, aggressive, and somatic themes with or without accompanying compulsions and intrusiveness. Many early clinicians considered such OC phenomena as a prodrome or an integral part of psychotic illness, and some considered the presence of OC symptoms in schizophrenia a predictor of better clinical outcome. However, such diagnostic practice remained controversial until the 1980s as the presence of OC symptoms in schizophrenia contradicted the diagnostic convention. This was based on distinguishing three unique, nonoverlapping diagnostic categories in mental illness: namely, neurotic as opposed to psychotic disorders, with borderline personality organisation emerging to define those individuals who fell between this dichotomy.

In the 1980s a more descriptive and less psychoanalytically driven nosology emerged, which led to various terms such as 'malignant OCD', 'psychotic OCD', and 'schizo-obsessive compulsive disorder' to describe coexisting OC symptoms in schizophrenia. However, in clinical practice the presence of OC symptoms were frequently overlooked and therefore not treated.

The epidemiological and clinical evidence for the interface and overlap between OC phenomena and certain neuropsychiatric disorders has been well established. Neuropsychiatric disorders often associated with OCD include Tourette syndrome, autism, Sydenham chorea, trichotillomania, body dysmorphic disorder, hypochondriasis, and dissociative and eating disorders. During the course of illness, these patients often show an overlap of overvalued ideations and delusional manifestations. Epidemiological studies have also indicated that the risk of psychosis is greater in patients with OCD than in the general population.

Emerging evidence suggests more than one pathogenesis in OC schizophrenia. The OC symptoms in patients with schizophrenia may clinically present as:

- A prodrome in schizophrenic illness – they precede the onset of schizophrenia and may resolve or attenuate after the onset of psychosis.
- A coexisting independent disorder presenting before the onset of psychotic symptoms - may persist or worsen regardless of progress of the schizophrenic illness as an independent disorder. Patients in this category may have previously met the criteria for OCD, and subsequently develop psychosis in the course of chronic and often treatment-refractory illness that currently meets the criteria for schizophrenia. Patients in this category exhibit variable degrees of insight and resistance regarding their OC symptoms during the course of illness. Patients in this group often have a worse clinical course and outcome than patients with non-OC schizophrenia
- Part of active psychotic illness - in some patients, OC symptoms develops as a part of an active psychotic process that emerges along with acute psychosis and usually resolves with the overall improvement in psychosis. Patients in this group have an unequivocal diagnosis of schizophrenia, with little or no insight into their OC symptoms.
- Obsessive ruminations during recovery or the remission phase - as the psychotic symptoms improve, the OCS may become attenuated and present as obsessive rumination or obsessive doubt, which may resolve with further improvement. Patients in this group show varying degrees of insight and resistance regarding their obsessions and show little difference in clinical course and prognosis compared with non-OC schizophrenia patients
- De novo OC symptoms associated with second generation antipsychotic treatment - emergence (de novo) or exacerbation of OCS following treatment with second generation antipsychotics that possess a potent anti-serotonergic receptor profile has challenged clinicians in recent years. This group includes clozapine, olanzapine, risperidone, quetiapine, aripiprazole, and ziprasidone. In particular, clozapine has been most commonly associated with the emergence of de novo OCS.

Due to the diverse nature of clinical presentation and presence of multiple pathogeneses, it is important to be familiar with the varying presentations of OCS in schizophrenia, as each pathogenesis may require a specific treatment intervention. Ascertaining pathogenesis during a single cross-sectional evaluation can often be difficult. OC schizophrenia therefore, may require multiple and longitudinal assessments to ascertain its pathogenesis and formulate treatment strategy.

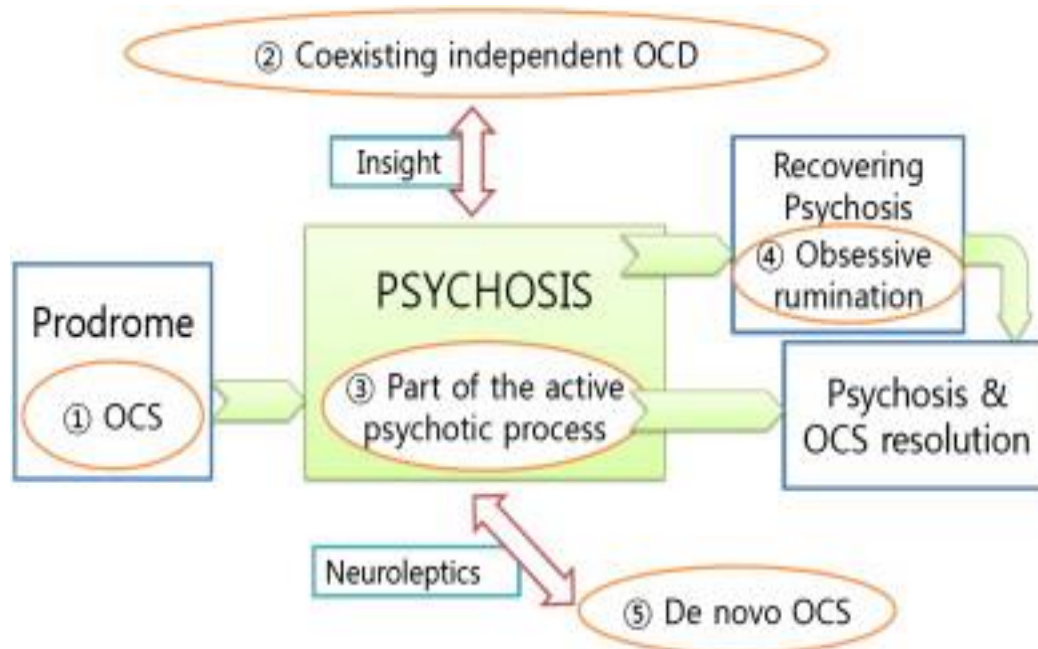


Fig. 1 Pathogenesis of obsessive-compulsive symptoms (OCS) in schizophrenia. OCD, obsessive-compulsive disorder (from Rasmussen and Eisen).

OCD was previously identified by the American Psychiatric Association as an anxiety disorder but is now a separate diagnosis with its own chapter, 'Obsessive-Compulsive and Related Disorders' in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

DSM-5 Diagnostic Criteria for Obsessive-Compulsive Disorder (300.3)

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralise them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviours or mental acts.

- B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalised anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualised eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

Specify if:

With good or fair insight: The individual recognises that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight / delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

Tic-related: The individual has a current or past history of a tic disorder.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Association.

According to the ICD-10: Obsessive-compulsive disorder F42-

Clinical Information

- A disorder characterised by the presence of persistent and recurrent irrational thoughts (obsessions), resulting in marked anxiety and repetitive excessive behaviours (compulsions) as a way to try to decrease that anxiety.
- An anxiety disorder characterised by recurrent, persistent obsessions or compulsions. Obsessions are the intrusive ideas, thoughts, or images that are experienced as senseless or repugnant. Compulsions are repetitive and seemingly purposeful behaviour which the individual generally recognises as senseless and from which the individual does not derive pleasure although it may provide a release from tension.
- An anxiety disorder in which a person has intrusive ideas, thoughts, or images that occur repeatedly, and in which he or she feels driven to perform certain behaviours over and over again. For example, a person may worry all the time about germs and so will wash his or her hands over and over again. Having an obsessive-compulsive disorder may cause a person to have trouble carrying out daily activities.

- Anxiety disorder characterised by recurrent, persistent obsessions or compulsions: obsessions are the intrusive ideas, thoughts, or images that are experienced as senseless or repugnant; compulsions are repetitive and seemingly purposeful behaviour which the individual generally recognises as senseless and from which the individual does not derive pleasure although it may provide a release from tension.
- Disorder characterised by recurrent obsessions or compulsions that may interfere with the individual's daily functioning or serve as a source of distress.
- Obsessive-compulsive disorder (OCD) is classified as a type of anxiety disorder in ICD-10. ... Examples of obsessions are a fear of germs or a fear of being hurt. Compulsions include washing your hands, counting, checking on things or cleaning. ... It tends to run in families. The symptoms often begin in children or teens. Treatments that combine medication and therapy are often effective.

Codes

- F42 Obsessive-compulsive disorder
 - F42.2 Mixed obsessional thoughts and acts
 - F42.3 Hoarding disorder
 - F42.4 Excoriation (skin-picking) disorder
 - F42.8 Other obsessive-compulsive disorder
 - F42.9 Obsessive-compulsive disorder, unspecified

Type 2 Excludes

- obsessive-compulsive personality (disorder) (F60.5)
- obsessive-compulsive symptoms occurring in depression (F32-F33)
- obsessive-compulsive symptoms occurring in schizophrenia (F20.-)

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Matthew Pinkerton, a 26-year-old single man, living with your parents. You are a university student and have completed three semesters of a four-year commerce degree. You are now in your fourth semester.

A psychiatrist you saw for a one-off appointment around a year ago diagnosed you with a disorder called Obsessive-Compulsive Disorder or OCD. OCD is a mental health disorder that affects people of all ages and walks of life, and occurs when a person gets caught in a cycle of obsessions and compulsions.

Obsessions are unwanted, intrusive thoughts, images or urges that trigger intensely distressing feelings.

Compulsions are behaviours an individual engages in to attempt to get rid of the obsessions and / or decrease his or her distress.

You had been struggling with obsessive-compulsive symptoms since you were 20 years old, but these were not very troubling until a year ago. You have been taking Fluoxetine 80mg every morning with generally good effect. You have no side effects from this medicine.

However, your symptoms have recently got worse and your GP was quite concerned about how to manage them.

Current symptoms:

About 2 months ago you travelled to Wellington with your parents for a family holiday. Since returning you have been feeling uneasy while driving your car. In particular, you find yourself looking in the rear-view mirror repeatedly to make sure you have not hit something or someone. You have this constant doubt that you could have hit a pedestrian, and you keep looking for a police car following you and listen out for sirens of emergency vehicles. You have often retraced your route to check that you have not hit someone or something. When you get these thoughts your driving time is greatly lengthened, and you end up missing classes. You often involve your parents by insisting that they come along with you, and be on the lookout to ensure you have not hit anyone and seek their reassurance - even driving back with them checking the route taken. Over the last four weeks you have found yourself being constantly worried that the police are going to lay charges for hitting a pedestrian, and not stopping to help out. You have started scanning the environment for police officers and vehicles. It feels like this thought has taken over your life to the extent of affecting your sleep and remaining anxious all through the day, which is worse whenever you hear emergency vehicles.

Background to your symptoms:

You noticed that you were spending a lot of time checking the door – as to whether it was locked properly and would have to keep on doing until you felt sure. This would take a lot of time and would delay you in reaching university in time. This would involve the lock on your front door. Although you knew that you had locked the door, you were not able to rid the thought in your mind and would keep doubting that the door had been locked. There have been many occasions when you decided that you will not check the door more than couple of times, however that made you feel quite uncomfortable and anxious that you could not stick to your decision. You can spend up to 2-3 hours each day checking the doors. This has resulted in you missing your classes at times as well as going out with mates.

The checking behaviour has reduced significantly over the last year after starting treatment, and is now sufficiently under control.

Along with the door checking, you also have repeated doubts about germs on the toilet seat. You would worry about catching some illness and then spreading it to others. These doubts make you repeatedly check the toilet seat and repeatedly clean it with wipes until you feel 'just right'. This has resulted in you spending lot of time in the toilet but also avoiding public toilets, as well as spending a lot of money on cleaning agents on a weekly basis. These obsessions and compulsions have been more manageable in the last few months.

The following information is not to be provided unless the candidate specifically attempts to explore details of the new symptom described above.

You are getting more convinced that the police have you under surveillance for this accident that you are yet to discover. You keep seeing similar looking people around you in uni and on the streets, and you know that these are plain clothes detectives. It is possible that they have your home under surveillance from a neighbouring property. Your parents are getting concerned that you are getting paranoid by the day. You seem to be quite certain that you will be arrested and will rot in prison for this misdemeanour, and believe that this news is also going to be published in the newspapers shortly. Your day-to-day functioning has been significantly affected.

You are able to distinguish between these concerns and the other obsessive-compulsive symptoms. With the other checking behaviour, you are aware that you would feel compelled to check and that by doing so the anxiety would reduce. However, no amount of checking makes these new concerns go away and so you do not think this is part of your OCD.

If asked, you do not:

- hear voices, see things that others can't see, or experience any other strange smells, tastes or sensations.
- think that people are talking about you or any other people want to hurt you.
- think that people can read your thoughts or insert their thoughts into your mind. Your thoughts are under your own control.
- experience any depressive symptoms like low mood or lack of pleasure.
- have tic movements or Tourette's disorder.
- have any other anxiety disorder symptoms like panic attacks or social anxiety.
- have any repeated thoughts or worries about your body shape.
- give excessive attention to detail, or hoard things.

You do not use drugs or alcohol.

No one in your family has any mental health problems.

You have never been hospitalised.

You have never been suicidal or attempted harm yourself.

You do not feel the need to attack or hurt anyone to keep yourself or your family safe.

Your personal history:

You are the only child of loving parents, both of whom are accountants.

You have no bad memories from your childhood.

You have always been neat and meticulous as a child, but did not have intrusive thoughts until you were 20 years old.

You are an average student.

After you left school you took a break from studies for 4 years to travel (mainly around New Zealand and Australia) and work. You have mostly worked in retail and have held down jobs, and were often complimented on your neatness.

4.2 How to play the role:

Young 26-year-old Caucasian man, reasonably groomed and dressed. Appearing anxious, preoccupied. Initially you are hesitant in your speech though you warm up within a minute.

4.3 Opening statement:

'Hello, I've been referred to you, but I am not sure how you can help me.'

4.4 What to expect from the candidate:

The candidate is expected to talk with you about your symptoms mainly focussing on clarifying obsessions and compulsions. They may also ask you a range of questions related to delusions, psychotic symptoms, and how strongly you believe what is happening to you. The candidate will then speak to the examiner about their findings and provide justification for their opinion.

4.5 Responses you MUST make:

'Can you do something about the police?'

'I don't want to go to jail.'

'Do you believe me when I say this is really happening?'

4.6 Responses you MIGHT make:

If asked whether you have actually been charged for anything by the police.

Scripted Response: *'No, but they will come for me soon.'*

If asked whether you take your medicines regularly.

Scripted Response: *'I have never skipped a single dose.'*

4.7 Medication and dosage that you need to remember:

Fluoxetine 80mg every morning.

You have no side effects from your medicines.

You have not been on any other medicines.

You have not received any psychological treatments for your illness and are not interested in these.

STATION 9 – MARKING DOMAINS

The main assessment aims are to:

- Conduct a tailored mental state examination, including differentiating between psychotic symptoms and obsessive-compulsive symptoms based on form, content and insight.
- Differentiate between delusions and obsessions in the mental state examination, and present a preferred diagnosis and differential diagnoses.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate undertake appropriately detailed and focussed Mental State Examination? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

the candidate is clearly able to distinguish between obsessions and delusions; demonstrates accurate prioritisation and achieves the overall standard with a superior performance.

Achieves the Standard by:

demonstrating capacity to conduct a thorough, organised and accurate mental state examination; assessing key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; adequately exploring psychotic symptoms; testing quality of beliefs in order to elicit delusional intensity.

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

- Elicit at least three (3) features of obsessions and compulsions e.g. repetitive, intrusive, ego dystonic, time consuming, behaviours designed to reduce anxiety.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; significant deficiencies in technique, organisation, accuracy; does not explore obsessions and compulsions, and their features at all.

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

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

6.0 SCHOLAR

6.3 Did the candidate demonstrate an appropriately skilled approach to presenting Mental State Examination and pertinent findings? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

the candidate presents both positive and negative findings on a well-structured, sophisticated manner with good prioritisation; systematically highlights the pertinent findings.

Achieves the Standard by:

presenting the key elements of a comprehensive mental state assessment; presenting a thorough, organised and accurate mental state examination; including key aspects of MSE; characterising the level of insight related to different aspects of symptoms, including poor insight for delusional beliefs.

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

- Identify the delusional belief related to being charged by the police for a misdemeanour.

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.

Below the Standard (scores 2 or 1):

scores 1 if the candidate does not qualify the insight and does not justify it; does not apply any structure to their presentation; misses major aspects of the MSE; does not comment on presence of obsessive and compulsive phenomena; assesses insight to be good.

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

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

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; adequately prioritising of conditions relevant to the obtained history and findings, providing appropriate and accurate level of detail; considering a prodrome of schizophrenia or the presence of two independent illnesses; providing diagnoses for exclusion; excluding the role of personality or possible substance misuse.

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

- a. Justify the possibility of OCD with poor insight or with delusion.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; inaccurate diagnoses and differential diagnoses; errors or omissions in justification are significant and adversely affect conclusions.

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2
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<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>5</p> <p>5-8</p> <p>9</p>
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1.0 Descriptive summary of station:

In this station, a 45-year-old veteran who has Post Traumatic Stress Disorder (PTSD) and some current psychosocial stressors presents with questions regarding non-pharmacological management of PTSD. The candidate is to address his concerns, outline various psychological interventions for PTSD, specifically including Trauma-focussed Cognitive Behavioural Therapy and Eye Movement Desensitisation and Reprocessing, and provide ideas of psychosocial rehabilitation interventions.

1.1 The main assessment aims are to:

- Demonstrate competence in engaging the patient and addressing his concerns, and identify factors contributing to his presentation.
- Discuss the components, procedure and effectiveness of Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).
- Outline other psychotherapeutic interventions for PTSD that have some evidence base and recommend appropriate interventions.

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

- Explain exposure as a part of TF-CBT.
- Accurately outline the process of EMDR.
- Outline at least two (2) other psychological interventions for PTSD that have an evidence base.
- Identify at least three (3) psychosocial factors and recommend appropriate interventions.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Therapy; Formulation - Communication), Communicator (Patient Communication – Disclosure)

References:

- Australian Centre for Posttraumatic Mental Health (ACPMH) (2013) *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder*.
- Clinical Practice Guideline for the Treatment of Post Traumatic Stress Disorder (PTSD) in Adults, American Psychological Association, APA Policy, February 2017
- Department of Veterans Affairs and Department of Defence (2010) *VA/DoD clinical practice guideline for management of post-traumatic stress*, <https://www.healthquality.va.gov/PTSD-FULL-2010c.pdf>
- EMDR International Association. <https://emdria.site-ym.com>
- National Institute for Clinical Excellence (NICE) (2005) *The management of PTSD in adults and children in primary and secondary care*
- Seidler GH¹, Wagner FE. *Comparing the efficacy of EMDR and trauma-focussed cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study*. *Psychol Med*. 2006 Nov;36(11):1515-22. Epub 2006 Jun 2.
- Swinson RP, Anthony MM, Bleau P, et al, for the Canadian Psychiatric Association (2006) Chapter 8: *Posttraumatic stress disorder: Clinical practice guidelines: Management of anxiety disorders*. *Canadian Journal of Psychiatry* 51 (Suppl 2) 57S-63S

1.4 Station requirements:

- Standard consulting room
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: 40 to 45-year-old man, casually attired.
- 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 a community mental health team.

You are about to see Mr Daniel Thomas, a 45-year-old army veteran with a history of Post Traumatic Stress Disorder (PTSD). He was diagnosed 9 months ago. He was medically retired and he receives full army pension. He lives in Auckland with his ex-partner Margaret and their 11 year-old-son, Nathan. His parents live in Christchurch. He is unemployed.

He is on the following medication regime (Paroxetine 60mg mane, Quetiapine 100mg nocte, Prazosin 2mg nocte, Pregabalin 300mg BD), and his condition is partially controlled. He does not use alcohol or drugs. He is not at risk to himself or others.

He wants to explore non-pharmacological options for better control of his symptoms, particularly specific psychological interventions for PTSD.

Your task is to:

- Address Mr Thomas's concerns and interest in treatment options.
- Explore other factors contributing to his presentation and recommend appropriate interventions.

You are not expected to do a mental state examination or risk assessment.

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.
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

During examination:

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

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'Doctor, does cognitive therapy work for my condition?'

3.2 Background information for examiners

In this station the candidate is expected to provide Mr Thomas with information about psychological interventions for PTSD, and respond to his questions about TF-CBT and EMDR. The candidate is also expected to identify that Mr Thomas has a number of psychosocial stressors for which they can provide recommendations on appropriate psychosocial rehabilitation interventions.

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

- Explain exposure as a part of TF-CBT.
- Accurately outline the process of EMDR.
- Outline at least two (2) other psychological interventions for PTSD that have an evidence base.
- Identify at least three (3) psychosocial factors and recommend appropriate interventions.

Better candidates will be able to provide clear details of the key therapies in a manner that indicates familiarity with the techniques. Their use of language and terminology will be adapted to the needs of the patient. They will also demonstrate the ability to sensitively engage the patient without causing distress or anxiety.

Approaches to psychological management of PTSD

According to the RANZCP PTSD practice guidelines:

- Guidelines are often situation-specific.
- All of the guidelines are considered useful.
- All guidelines emphasise careful diagnosis and treatment planning.
- All guidelines emphasise the role of psychotherapeutic treatment and the limitations of the role of pharmacotherapy.
- All guidelines emphasise the desirability of early interventions, although clear data on prevention is still lacking.

All the widely used protocols include education about PTSD and its treatment, which includes exposure related to the traumatic event. The amount and quality of evidence varies for different interventions.

The approaches differ in terms of intensity of exposure, varying from gradually increasing exposure using written accounts of traumatic events to extensive exposure using vivid imagery and exposure to situations that resemble the trauma site

Treatments like TF-CBT and EMDR generally include two key factors: they assist patients to confront the memory of their traumatic experience(s) in a controlled and safe environment; and identify, challenge and modify any biased or distorted thoughts, and memories of their traumatic experience as well as any subsequent beliefs about themselves, and the world that are getting in the way of their recovery.

Some interventions that may involve elements of trauma-focussed work are not included in the guidelines, either because they have not yet been properly tested (e.g. brief psychodynamic therapy), or because they have been tested and found to be less effective than recommended interventions (e.g. hypnotherapy and supportive counselling).

Psychological interventions for PTSD

According to the *Australian guidelines for the treatment of adults with acute stress disorder and post traumatic stress disorder*, Grade A recommendations indicate that the body of evidence can be trusted to guide practice.

1. Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) – Grade A:

The term TF-CBT is a subset of trauma-focussed psychological treatment. It was originally developed for use in traumatised children and adolescents. The two core interventions of TF-CBT for PTSD are exposure, and cognitive restructuring. TF-CBT is a short-term intervention that generally lasts anywhere from eight to 25 sessions, and these structured psychological interventions aim to address the emotional, cognitive and behavioural sequelae of exposure to traumatic events. It has been shown to be superior to therapies which do not involve talking about the trauma – creating the trauma narrative - and it is as effective as other evidence-based therapies for PTSD such as Eye Movement Desensitisation and Reprocessing (EMDR). A common approach, for example, would be to use exposure alongside psychoeducation, anxiety management, cognitive restructuring and relapse prevention to treat PTSD.

Desensitisation / graded exposure is a core component of TF-CBT. Controlled and planned exposure to the trauma narrative, and reminders of the trauma or emotions associated with the trauma, are used to help the patient reduce avoidance and maladaptive associations with the trauma. Discussing the trauma or going through exposure exercises may trigger intense emotions or bring up memories of the trauma that are particularly difficult. It is crucial to undertake TF-CBT in the context of a safe, stable, and supportive environment.

2. Eye Movement Desensitisation and Reprocessing (EMDR) – Grade A:

EMDR, a treatment for PTSD was developed by Shapiro in the late 1980's. EMDR is based on the assumption that, during a traumatic event, overwhelming emotions or dissociative processes may interfere with information processing. This leads to the experience being stored in an unprocessed way, disconnected from existing memory networks.

Although the exact mechanism of action of EMDR is not well understood, in EMDR the person is asked to focus on trauma-related imagery, negative thoughts, emotions, and body sensations while simultaneously moving their eyes back and forth following the movement of the therapist fingers across their field of vision for 20-30seconds or more. This process may be repeated many times. It is proposed that this dual attention facilitates the processing of the traumatic memory into existing knowledge networks, although the precise mechanism involved is not known. The unique feature of EMDR is the use of eye movements as a core and fundamental component throughout treatment.

Therapy commences with history taking of the specific problem and associated symptoms and behaviours, from which specific treatment targets for EMDR are developed. These targets include the event(s) from the past that created the problem, the present situations that cause distress, and the key skills or behaviours the patient needs to learn to move forward. Detailed in-depth discussion of disturbing memories is not required at this stage. In the next phase of therapy, the patient is taught specific techniques to rapidly deal with emotional disturbances that may arise. At the same time the therapist outlines the theory of EMDR.

The therapist then identifies the aspects of the target to be processed, and the patient selects a specific picture or scene from the target event that best represents the memory. A statement is chosen that expresses a negative self-belief associated with the event, and another more appropriate positive self-statement is identified that represents what the patient would rather believe. Ratings of distress are used as a measure of improvement as the targeted event changes and its disturbing elements are resolved. During desensitisation, the therapist will lead the person in sets of eye movement (or other forms of stimulation) with appropriate shifts and changes of focus until the level of distress is zero. During treatment more positive cognitions are strengthened and installed. The goal is to concentrate on and increase the strength of these positive beliefs that the person has identified to replace the original negative beliefs.

Based on evidence that indicate a physical response to unresolved thoughts (often referred to as motoric memory) successful therapy should also enable a patient to bring up the original target without feeling bodily tension. Each session should end with the person feeling in control. If the processing of the traumatic target event is not complete at the end of the session, the therapist must assist the person to apply a variety of self-calming techniques in order to regain a sense of balance. As with any form of good therapy, it is important to determine the success of the treatment over time.

3. Exposure therapy:

The key objective of exposure therapy is to help the person confront the object of their anxieties. The notion that if people can be kept in contact with the anxiety provoking stimulus for long enough, they're anxiety will inevitably reduce. Exposure therapy for PTSD involves confronting the memory of traumatic experiences in a controlled and safe environment (imaginal exposure), as well as confronting trauma - related avoided situations and activities through in viable exposure. The importance of grading the exposure, often using a hierarchy, prolonging the exposure until the anxiety has reduced and repeating the exposure item until it evokes minimal, anxiety are central to traditional exposure approaches.

Prolonged exposure works on the idea is that facing up to the memory in a planned way will lead to reduction of the negative emotions connected to the memory - so that remembering or being reminded is not associated with distress. When the memory or reminders are less distressing, the person does not have to avoid them and can have a more normal life.

4. Cognitive therapy:

In the treatment of PTSD, cognitive therapy helps the individual to identify, challenge and modify any biased or distorted thoughts and memories of the traumatic experience, as well as any subsequent maladaptive or unhelpful beliefs about themselves, and the world that they may have developed.

5. Cognitive processing therapy:

This is a particular form of cognitive therapy, refined specifically for the treatment of PTSD. Treatment focusses mainly on identifying unrealistic and unhelpful thoughts a person has about the trauma. It helps the person challenge the unhelpful thoughts and beliefs, and replace them with a rational alternative in an adaptation of standard cognitive therapy approaches. It is a 12-session cognitive behavioural manual lies treatment for PTSD that systematically addresses key post-traumatic teams, including safety, trust, power and control, self-esteem and intimacy.

6. Group therapy:

This is not an intervention per se, but a vehicle for delivering an intervention. They have included supportive, psychodynamic, cognitive behavioural approaches (including exposure, cognitive processing therapy, problem solving). The presence of other individuals with similar experiences may help overcome a belief that the therapist cannot be helpful because he or she has not experienced the specific trauma. The group may also be used to promote a non-judgemental approach towards behaviour required for survival during the traumatic event.

7. Brief psychodynamic psychotherapy:

Psychodynamic therapy encourages the individual to use the supportive relationship with a therapist, and the transference that occurs within that relationship, to verbalise and reflect upon their experiences. This process allows unconsciously held thoughts, urges and emotions to be brought into conscious awareness, which in turn allows the cognitive, emotional and social aspects of experience to be integrated into a meaningful structure that helps the person to accept and adapt to their experiences.

Brief psychodynamic therapy focusses on the emotional conflicts caused by a specific traumatic event. The patient is encouraged to put their experience into words, and examine the meaning that the event and surrounding circumstances holds for them. Through this retelling, the therapist assists the individual to integrate the event and re-establish a sense of purpose and meaning in life.

8. Hypnosis:

This is not an intervention in itself. It is the induction of a state of relaxation and receptivity that makes intervention easier to implement. Hypnosis in PTSD may be used as a precursor to several interventions including imagery, stress management techniques, ego strengthening self-talk, and exposure.

9. Internet – mediated therapy:

This approach is likely to be particularly useful for people living in remote areas, for those who are physically disabled and have restored mobility, or who are unwilling to seek face-to-face therapy due to anxiety or fear of stigmatisation. Web-based treatment for PTSD usually includes psychoeducation, symptoms management, exposure, and cognitive reappraisal, all of which involve structured writing assignments that can be submitted to the therapist for feedback.

10. Interpersonal therapy (IPT):

It is a time-limited therapy that was originally designed for the treatment of Depression. IPT considers that interpersonal relationships are important to the formation, and maintenance of psychological problems due to a strong relationship between symptoms and social environment, that is, interactions with other people affect psychological wellbeing and vice versa. IPT focusses on identifying specific problems and patterns in personal relationships, and on building skills to improve interpersonal functioning and increase social support. It may include addressing grief over lost relationships, different expectations in relationships, changing roles in relationships, and improving social skills.

11. Mindfulness-based therapies:

This includes acceptance and commitment therapy (ACT), mindfulness-based cognitive behavioural therapy (MCBT) and mindful meditation. Mindfulness can be defined as 'paying attention in a particular way, on purpose, in the present moment and non-judgementally'.

12. Narrative exposure therapy (NET):

It was originally developed both to treat survivors and to document human rights violations, in NET, the person is asked to construct a narrative of their life from early childhood to present, focussing in detail on the traumatic events and elaborating on the associated thoughts and emotions. It is proposed that NET works in two ways: promoting habituation to traumatic memories through exposure and reconstructing the individual's autobiographic memory.

Psychosocial rehabilitation interventions for PTSD

Psychosocial rehabilitation interventions are used to facilitate independent living, socialisation and effective life management in people who have chronic mental health conditions. Components of psychosocial rehabilitation include social skills training, housing support, vocational rehabilitation, case management and family support. Psychosocial rehabilitation often occurs alongside other treatments. It is important to consider early psychoeducation of the individual and family members, maximising existing social supports or creating new ones, and providing vocational support to enable the individual to maintain their optimal work / study performance.

Social emotional rehabilitation

Social emotional rehabilitation (SER) has three components:

- social skills training, which focusses on practising basic conversational skills, particularly those important for creating and maintaining social networks.
- anger management and problem-solving skills training, which was designed to reduce temper outbursts by introducing alternate ways of expressing anger, teaching problem-solving and emotional regulation skills as well as teaching veterans how to communicate assertively in and nonthreatening way.
- veterans issues management where veterans are taught how to talk to civilian support, combat trauma and other military issues in a way that fosters understanding of these issues by the veteran's other support network.

Vocational rehabilitation

This is to help the person with PTSD return to an optimal level of functioning. It could be paid employment or voluntary work, study, and other key roles in society, such as parenting. Depending on the current level of functioning, interventions may involve supporting the veteran to stay in his or her current role of employment or to return to that role in a supported and graduated fashion.

Psychosocial rehabilitation helps the person to regain the best possible level of social functioning, and occupational functioning, which is fundamental to quality of life.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Daniel Thomas, a 45-year-old army veteran. You are divorced but currently living with your ex-partner Margaret and your 11-year-old son, Nathan. You were diagnosed with Post Traumatic Stress Disorder (which is usually shortened to PTSD) 9 months ago.

The reason you have come to see the doctor today is that while your PTSD symptoms have reduced on medication, the nightmares and flashbacks (see below) are still very distressing, and you are keen to get some help with this. However, you do not wish to take more tablets or change the ones you are on.

The background to your symptoms is based on your experience in the army which you joined from the age of 19. You were a Crew Commander for few years before medical retirement. You were deployed to Afghanistan between 2010 and 2013. You witnessed and were a part of violent encounters, but you do not wish to talk about these in any detail today. You were medically retired as you sustained a knee and hand injury in combat when your LAV crashed after being shot at in early 2013; but these physical injuries are no longer a significant problem for you.

You developed PTSD on deployment in Afghanistan, and with regards to PTSD, you experience:

- Nightmares of being in active conflict and of gun firing.
- You wake up sweating and anxious, and this affects your sleep.
- You have real difficulty getting to and staying asleep, and you have previously tried a few medications.
- You have flashbacks, but it is less severe compared to how it was few months ago. These occur every few days and without specific triggers. In the flashback it feels like you are reliving the terrible experiences you underwent.
- You get easily irritated and become angry.
- You avoid going out as you are always on the look-out for any kind of threats, but this is better with medications.
- You do not have panic attacks (sudden onset of intense anxiety), but often feel on edge.

You do feel down at times, but don't think you are depressed. Your appetite, energy levels, concentration are 'not bad'. You don't feel suicidal or you don't have thoughts of harming yourself or others. You have never felt that people are out to get you and you do not hear or see things that others do not.

Your current medications are:

Paroxetine 60 milligrams in the morning, quetiapine 100 milligrams at night, prazosin 2 milligrams at night for nightmares, and pregabalin 300 milligrams twice a day for pain. You have tried few other antidepressants, but you don't remember the names, and few pain killers. You don't want any more tablets.

Talking therapies:

With regards to therapy, you initially saw a psychologist through the New Zealand Veterans Affairs, but you didn't like her and so stopped going after 3 sessions. Now, you are keen to try some talking treatment again.

You have had no admissions to psychiatric hospitals. You had few surgeries over the years to both knees (ligament damage and repair), and right hand (for a fracture) following the incident in Afghanistan in 2013.

You don't have any other medical problems. You are not allergic to any treatment.

Social history:

You were living with your parents in Christchurch for few years but moved to Auckland six months ago to live close to your 11-year-old son. As you don't have any accommodation yet, you are staying with an ex-partner. Your marriage began to break up three years ago because you had started getting irritable, and having angry verbal outbursts. You have been separated from her for two years as she was annoyed with your PTSD symptoms and anger outbursts. You have never been violent towards any of your family.

You are a carpenter by trade. You were working casual hours in a warehouse in Wellington. You have been unemployed since you moved 6 months ago. You are keen to go back to work as you have always tried to work.

Your sleep is affected by nightmares and this is affecting your day. You are snappy and angry. This has started to annoy Margaret, and she has been asking you to 'get out'. She says that you are lazy, and that you should be better by now as you are on so many tablets. You spend few hours at night playing on the computer and watch TV. You sleep at 12 or 1 am.

You are worried you will be homeless.

The veterans affairs services should play a significant part in your wellbeing, and are probably an important support for you. Your RSL / RSA advocate / support person had suggested you discuss with your doctor about 'rehab' for PTSD. You don't know what that is all about.

You have no other supports here. You have few mates who suffer from similar problems, but not many of them talk about their problems. You feel isolated at times.

You don't drink alcohol or use any recreational drugs. You smoke 10 cigarettes / day. You were never on addictive pain killers or sleeping tablets.

You are worried about taking more tablets as few of your mates who committed suicide were on tablets. You are keen to try therapy.

Background information to assist you to understand your role - the candidate is not expected to ask you about this information:

As an armoured combat specialist you were trained to operate the New Zealand Light Armoured Vehicle (NZLAV), providing the army with a light armoured vehicle capability (the NZLAV is a highly mobile eight wheeled armoured vehicle used by day and night with early warning systems that enhance survivability, and communication equipment to receive and share information). As part of a tight-knit crew of three, you operated the NZLAV in a combat role in Afghanistan. You and your crew manoeuvred the vehicle to directly engage with an enemy, gather information and provide protected mobility to soldiers from other trades across the army. You had to be able to operate in the confined space of the vehicle, for extended periods, at all times and in all environmental conditions. You also had to be able to quickly process and react to all that you saw and heard, under challenging operational conditions. You initially trained as a Gunner and completed further training to become a Crew Commander.

The NZ Defence Force was in Afghanistan from 2003, and the last staff left in April 2013; you were evacuated in February 2013. Since 2015 military personnel have been deployed alongside the Australian Defence Force to train Iraqi Security Forces personnel. You have not been deployed to Iraq as you were medically retired from the army in late 2013.

<p>New Zealand Veteran Affairs:</p> <ul style="list-style-type: none"> • providing support to those with Qualifying Service, their family and whānau, so they can be well at home, at work, and in their communities. • working with other organisation that also support and advocate for veterans. • helping coordinate commemorative activities • maintaining over 180 Service Cemeteries throughout NZ. 	<p>Australian Veteran Affairs (very similar supports):</p> <ul style="list-style-type: none"> • providing support for access to benefits and payments, including compensation and income support. • helping access to health and wellbeing services, including health cards and addressing homelessness. • Access to consultation and grants. • maintaining commemoration and war graves, providing education and supporting anniversaries.
<p>Royal New Zealand Returned and Services Association (RSA):</p> <p>RSA offers financial assistance, advocating for service benefits, and connections and comradeship.</p>	<p>Returned & Services League of Australia (RSL):</p> <p>RSL offers very similar services to veterans and their families by offering care, financial assistance and advocacy, along with commemorative services that help all Australians remember the Fallen.</p>

What is Post Traumatic Stress Disorder (PTSD):

PTSD can develop after a person has been exposed to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the traumatic event(s) as they occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend (the event causing threatened or actual death of a family member or friend must have been violent or accidental).
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse; this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.)

The person then develops specific types of problems:

- Intrusion symptoms; re-experiencing intrusive distressing recollections of the traumatic event; flashbacks; nightmares; intense psychological distress or physical reactions, such as sweating, heart palpitations or panic when faced with reminders of the event.
- Negative mood: persistent loss of ability to experience positive emotions; loss of interest in normal activities and restricted emotions.
- Dissociative symptoms: altered sense of reality of one's surroundings or oneself; feeling detached from others; inability to remember certain aspects of the trauma.
- Avoidance and emotional numbing—avoidance of activities, places, thoughts, feelings, or conversations related to the event.
- Hyperarousal—difficulty sleeping; irritability; difficulty concentrating; hypervigilance; exaggerated startle response.

4.2 How to play the role:

You start with the opening statement and then let the candidate provide you with information.

You appear keen, attentive and interested in what the candidate has to say, and how they respond to your questions.

The candidate should use language that you are able to understand, and if not, you can ask them to explain further. They should be sensitive to your social situation, and provide advice and options for you to consider.

4.3 Opening statement:

'Doctor, does cognitive therapy work for my condition?'

4.4 What to expect from the candidate:

The candidate is to briefly outline various psychological (talking therapy) treatments for PTSD as you don't want to change any tablets. The candidate is expected to discuss a range of options but to also explain two specific therapies called Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).

When you tell the candidate that you are worried about being kicked out by your ex-partner (becoming homeless), that you are keen to work (vocation), and that your family including your ex-partner does not understand your condition, the candidate should talk about psychosocial rehabilitation interventions like providing explanations (psychoeducation) for you, and your family about your condition and treatment, referring / recommending you for vocation training or retraining, social skills training, and discussing about the possible role of engaging with a rehabilitation coordinator to help you find accommodation, and implement the interventions mentioned.

Australian candidates may talk about **'Mates4Mates'** which provide national and regional integrated support programs across five key areas:

- Physical rehab and wellbeing services
- Psychological services
- Employment and educational services
- Evidence based individual and group therapies
- Rehabilitation adventure challenges
- Social connection services

Australian candidates will also use the term RSL and not RSA: please use the term *'Returned Services'* as opposed to the RSA - if asked you can confirm that you are linked in with RSA / RSL, and if you are aware of what they offer.

4.5 Responses you MUST make:

'There is something called 'eye movement treatment', what do they do?'

'Are there any other treatments that work well?'

'No one understands what I am going through, Margaret will kick me out!'

4.6 Responses you MIGHT make:

If asked if you are attending any group therapies – you are not.

If asked about any reliable supports –

Scripted Response: *'My sister lives in Hamilton and my parents in Christchurch.'*

4.7 Medication and dosage that you need to remember:

You do not have to remember these as the candidate is given them –

- Paroxetine 60milligrams in the morning
- Quetiapine 100milligrams at night
- Prazosin 2milligrams at night
- Pregabalin 300milligrams twice a day

STATION 10 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate competence in engaging the patient and addressing his concerns, and identify factors contributing to his presentation.
- Discuss the components, procedure and effectiveness of Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).
- Outline other psychotherapeutic interventions for PTSD that have some evidence base, and recommend appropriate interventions.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge about TF-CBT? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

a clear understanding of levels of evidence for TF-CBT; incorporates theory smoothly into description; choice and rationale for TF-CBT is clearly outlined; systematically discusses components and procedure of the intervention.

Achieves the Standard by:

demonstrating the understanding of the evidence based psychological treatment of TF-CBT for PTSD; demonstrating understanding and knowledge of what TF-CBT is; outlining the key components of TF-CBT; providing information about the procedure and its effectiveness; accurately outlining the components of TF-CBT; explaining how TF-CBT varies to other forms of CBT.

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

- Explain exposure as a part of TF-CBT.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered.

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not identify TF-CBT as a recommended intervention; provides significantly inaccurate information about TF-CBT.

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

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

1.14 Did the candidate demonstrate an adequate knowledge about EMDR? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:

provides a clear understanding of levels of evidence for EMDR including its rating in international guidelines; choice and rationale for EMDR is clearly outlined; systematically discusses components and procedure of the intervention.

Achieves the Standard by:

demonstrating understanding of the evidence based psychological treatment of EMDR for PTSD; demonstrating understanding and knowledge of what EMDR is, the procedure and its effectiveness; accurately outlining the specific details of EMDR; outlining the phases of preparation for EMDR; explaining that the mechanism of action is not well understood; describing how to mitigate risks for the patient.

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

- Accurately outline the process of EMDR.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered.

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; does not identify EMDR as a recommended intervention; provides significantly inaccurate information about EMDR.

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

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

1.12 Did the candidate outline other psychological treatments for PTSD? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

a clear understanding of levels of evidence to support treatment options; accurate explanation of a range of options.

Achieves the Standard by:

demonstrating the understanding of other psychological treatments for PTSD; outlining choice and rationale for specific psychotherapies; presenting options in language that the patient can understand; sensitively responding to patient verbal and non-verbal communication; providing information that is accurate and suitable to the specific needs and circumstances of the patient; including options like - mindfulness based therapies, internet-based therapies, group therapy, brief psychodynamic psychotherapy, hypnosis, interpersonal therapy (IPT), narrative exposure therapy.

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

a. Outline at least two (2) other psychological interventions for PTSD that have an evidence base.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate is able to identify that some are non-specific treatments for PTSD.

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; information is inaccurate; unsuitable for patient's needs or circumstances.

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

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

2.0 COMMUNICATOR

2.2 Did the candidate demonstrate capacity to identify current psychosocial stress and discuss appropriate interventions with the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

comprehensively applies the principles of working closely with patient / families / carers; systematically identifies all the current stressors and addressed them. Obtains consent from patient to discuss with rehabilitation coordinator.

Achieves the Standard by:

identifying the stress of the following - that the patient will be homeless, unemployment status, inadequate knowledge of the family about his condition and treatment, anger potentially affecting filial relationships - particularly with son, social isolation, financial difficulties; discussing interventions like psychoeducation of patient, family including son, anger management strategies, vocational training and re-training, social skills training; considering voluntary work; offering group sessions / therapy; recommending sleep hygiene techniques.

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

a. Identify at least three (3) psychosocial factors and recommend appropriate interventions.

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. Identifies 4 or more stress and manages them appropriately. Discusses the importance of continuing medications.

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality, does not identify any psychosocial stress factor and fails to manage.

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

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

GLOBAL PROFICIENCY RATING

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

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

The candidate is required to assess opioid withdrawal and dependence in a 29-year-old woman who has been taking an increasing amount of oxycodone for her back pain. She is a patient in an acute psychiatry inpatient unit where she was admitted for management of suicidal ideation after her boyfriend left her. She has not taken oxycodone for 3 days, and now presents with a range of opioid withdrawal symptoms. The candidate is expected to communicate appropriately the findings of opioid dependence, and withdrawal to the patient. In addition, the candidate is expected to explain to the patient the management of opioid dependence / withdrawal.

1.1 The main assessment aims are to:

- Obtain a focussed history on opioid dependence and withdrawal.
- Communicate the findings appropriately to the patient.
- Explain the management plan for opioid dependence / withdrawal.

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

- Establish the time and amount of last opioid medication use.
- Explain the link between opioid dependence and recent development of withdrawal.
- Discuss both symptomatic treatments and opioid substitution therapy for the management of opioid withdrawal.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Substance Use Disorders
- **Area of Practice:** Addictions
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Management – Treatment Contract), Communicator (Synthesis).

References:

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Brandish, E. K., Owen, C. T., & Sinclair, J. M. (2017). Acute management of alcohol and other drug problems. *Medicine*, 45(2), 68-73.
- Foote, E., & Dukes, C. H. (2017). Acute management of substance-related and addictive disorders: a review. *Psychiatric Annals*, 47(4), 192-199.
- National Guidelines for Medication-Assisted Treatment of Opioid Dependence: Online ISBN: 978-1-74241-945-9. Commonwealth of Australia 2014.
- New Zealand Practice Guidelines for Opioid Substitution Treatment. Ministry of Health. 2014. Wellington.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Woman in late 20s
- 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 acute inpatient unit.

Kylie is a 29-year-old woman who was admitted last night with acute suicidal ideation. She had an argument with her boyfriend Jason, and he left her a week ago. Kylie is afraid he may not come back, and she had felt that she would rather die. She has no history of previous suicide or self-harm attempts. Her suicidal ideation has settled since the admission.

The nurse looking after Kylie for today has asked for a consultant review. Kylie is upset, and is asking for pain medication for back pain. Basic observations taken this morning are within the normal range.

Your tasks are to:

- Take a relevant history to ascertain the diagnosis.
- Explain your findings and short term management options to Kylie.

You will not receive any time prompts.

No physical examination is required in this station.

Station 11 - Operation Summary

Prior to examination:

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

During examination:

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

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'Doctor, I don't feel suicidal anymore, I just feel terrible.'

3.2 Background information for examiners

In this station the candidate is expected to obtain a focussed history of opioid dependence, and withdrawal from a 29-year-old woman who has been taking an increasing amount of oxycodone for her back pain. She has not taken oxycodone for 3 days, and now presents with a range of opioid withdrawal symptoms. The candidate is expected to synthesise the findings of opioid dependence and withdrawal, and communicate it appropriately to the patient. In addition, the candidate is expected to explain to the patient the management of opioid dependence / withdrawal.

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

- Establish the time and amount of last opioid medication use.
- Explain the link between opioid dependence and recent development of withdrawal.
- Discuss both symptomatic treatment and opioid substitution therapy for the management of opioid withdrawal.

A surpassing candidate achieves the overall standard with a superior performance in a range of areas; demonstrates a superior knowledge of the treatment of opioid withdrawal; clearly differentiates treatment of opioid withdrawal from ongoing treatment for opioid dependence; integrates information in a manner that can effectively be utilised by the patient; suggests the use of an opioid withdrawal scale to guide treatment.

Diagnosis of opioid dependence

Dependence on opioid drugs can develop rapidly. Furthermore, the proportion of people who start injecting opioids and become dependent (25-50%) is much higher than the proportion of people who use alcohol, sedative-hypnotics or psychostimulants and progress to dependence.

The features of opioid dependence include rapid development of tolerance, progressive orientation of the person's life around using, very strong cravings for use, risky behaviours (like committing crimes to support their dependence, using shared injecting equipment), and unpleasant withdrawal symptoms.

Evidence of opioid dependence

- A diagnosis of opioid dependence from history and examination of patient.
- A positive urine or oral fluid drug screens for opioids.
- Objective signs of opioid withdrawal.
- Recent sites of injection (depending on route of administration of opioids).

Detecting the person at risk of withdrawal

A person who is dependent on opioids is at risk of withdrawal when they cease their drug use, although the withdrawal symptoms are rarely life threatening or associated with significant aberrations of mental state. Opioid withdrawal is uncomfortable but not usually life-threatening, whereas opioid toxicity can lead to death. As opioid withdrawal is unpleasant it commonly leads to resumption of drug use. So, on presentation it is important to fully assess the person for their level of opioid dependence, and the likelihood of opioid withdrawal.

The pattern of symptoms is similar for withdrawal from different types of opioids (e.g. heroin, morphine, codeine, methadone), although the severity and duration of symptoms vary according to the type of opioids and the mode of reduction. Longer acting opioids (e.g. codeine, methadone) are associated with more protracted withdrawal symptoms than short-acting opiates (e.g. heroin). A sudden cessation of heroin use produces withdrawal symptoms of greater severity, but shorter duration than withdrawal symptoms associated with a cessation of methadone.

Untreated oxycodone withdrawal tends to start within 8-16 hours after the last dose. In general, oxycodone withdrawal peaks 72 hours after cessation of use and resolves in 7-10 days. However, oxycodone withdrawal symptoms may last from couple of hours to several days.

Drug seeking behaviour becomes prominent through requests for medication or attempts to self-medicate. The physical syndrome of opioid withdrawal resembles a severe bout of influenza.

The following table outlines the major signs and symptoms associated with opioid use.

Signs of Opioid Intoxication	Signs of Opioid Overdose	Signs and Symptoms of Opioid Withdrawal
Constriction of pupils Itching and scratching Sedation and somnolence Lowered blood pressure Slowed pulse Hypoventilation	Pinpoint pupils Loss of consciousness Respiratory depression Hypotension Bradycardia Pulmonary oedema	Dilation of pupils (mydriasis) Lacrimation Rhinorrhoea Anxiety and restlessness Dysphoria Muscle, joint and bone ache Muscle cramps Abdominal cramps Nausea, vomiting, anorexia Diarrhoea Sweating and piloerection Hot and cold flushes Palpitations and tachycardia Fatigue and insomnia Yawning Raised blood pressure

Assessment of opioid withdrawal

The following questions should be asked specifically about opioid use:

- route of use
- time and amount of last use (to anticipate onset / resolution of intoxication and withdrawal syndromes)
- quantity, frequency and pattern of use (over last week or month)
- context of use to identify associated risks, for example, needle sharing, clubbing and high-risk sexual behaviour
- features of dependence
- history of withdrawal and complications, such as seizures, delirium and psychosis
- co-morbidity including psychiatric symptoms.

A collateral history should be obtained from family, friends, bystanders, paramedics and old notes. Consult other health professionals involved in the patient's care, for example the general practitioner and community mental health team where possible.

Severity of withdrawal symptoms can be determined by applying standardised tools / questionnaires, for instance, the Clinical Opioid Withdrawal Scale (COWS):

Clinical Opioid Withdrawal Scale (COWS)	INTERVAL	0	30 mins	2 hours	4 hours
DATE: DD / MM / YYYY	TIME				
		Score	Score	Score	Score
Resting Heart Rate (measure after lying or sitting for 1 minute): 0 HR 80 or below 1 HR 81-100 2 HR 101-120 4 HR greater than 120					
Sweating (preceding 30 minutes and not related to room temp / activity): 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face					
Restlessness (observe during assessment): 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs / arms 5 unable to sit still for more than a few seconds					
Pupil size: 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible					
Bone or joint aches (not including existing joint pains): 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints / muscles 4 patient is rubbing joints / muscles plus unable to sit still due to discomfort					
Runny nose or tearing (not related to URTI or allergies): 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks					
GI upset (over last 30 minutes): 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhoea 5 multiple episodes of vomiting or diarrhoea					
Tremor (observe outstretched hands): 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching					
Yawning (observe during assessment): 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times / minute					
Anxiety or irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult					
Gooseflesh skin 0 skin is smooth 3 piloerection (goosebumps) of skin can be felt or hairs standing up on arms 5 prominent piloerection					
SCORE INTERPRETATION: 5-12 = MILD 13-24 = MODERATE 25-36 = MODERATELY SEVERE > 36 = SEVERE WITHDRAWAL		TOTAL	TOTAL	TOTAL	TOTAL
		INITIALS	INITIALS	INITIALS	INITIALS

The ICD-10 and DSM-5 opioid dependence / withdrawal diagnostic criteria are:

ICD-10 F11.23 Opioid dependence with withdrawal	DSM-5 Opioid withdrawal
<p>Criteria for dependence (mild, moderate, severe)</p> <ul style="list-style-type: none"> ▪ Compulsion to use ▪ Impaired control over drug use ▪ Withdrawal symptoms ▪ Increased tolerance ▪ Priority of drug use ▪ Continued use despite harmful effect <p>Withdrawal State A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a substance after repeated, and usually prolonged and / or high dose, use of that substance. Onset and course of the withdrawal state are time-limited and are related to the type of substance and the dose being used immediately before abstinence.</p>	<p>A. Either of the following:</p> <ul style="list-style-type: none"> - cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer) - administration of an opioid antagonist after a period of opioid use <p>B. Three (or more) of the following, developing within minutes to several days after Criterion A:</p> <ul style="list-style-type: none"> - dysphoric moods - nausea or vomiting - muscle aches - lacrimation or rhinorrhoea - pupillary dilation, piloerection, or sweating - diarrhoea - yawning - fever - insomnia <p>C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p> <p>D. The signs or symptoms are not due to another medical condition and are not better accounted for by another mental disorder, including intoxication or withdrawal from another substance.</p>

Opioid use and pain

Patients with opioid tolerance and dependence require higher doses of opioid analgesic drugs to achieve reasonable pain relief. Repeated requests for analgesia or specifically for opioid drugs beyond what would be expected from the clinical circumstances can indicate a substance use disorder. Complex issues, like high risk behaviours, significant misuse of other drugs, doctor shopping, serious comorbid physical or mental health conditions should be explored. It is safe to provide higher doses to treat pain if the patient is reviewed regularly and monitored for evidence of toxicity.

Opioid substitution is not suitable for all patients and should also only be used as part of the patient's rehabilitation if clinically indicated. Alternative therapies include acute management of withdrawal, abstinence-focussed programs, behavioural interventions like contingency management approaches, and self-directed interventions such as Narcotics Anonymous.

However, certain psychiatric and medical conditions (e.g. chronic pain) can be destabilised during detoxification and attempts to sustain an opioid-free lifestyle. These patients are often better advised to consider opioid substitution treatment / therapy (OST). If substitution treatment is prescribed, this should be viewed as managing the opioid dependence; pain should be treated separately, as it is for other patients, while acknowledging their altered tolerance.

There are two indications for OST: brief treatment of opioid withdrawal and prolonged maintenance therapy. Evidence indicates that the former is used in acute settings, but only the latter has good correlation with long-term outcomes like remission and recovery.

For patients that are opioid-dependent and not already on OST who need to remain in hospital for an extended period, substitution therapy may be required to manage detoxification or prevent withdrawal while other medical conditions are treated. Specialist input from a clinician with experience in methadone or buprenorphine prescribing should be sought.

Management of opioid withdrawal

The primary aim of a managed opioid withdrawal is to reduce acute physical and psychological discomfort. The severity of withdrawal is influenced by a number of factors, including the duration of a client's opioid use, the use of other substances (such as benzodiazepines), and general physical health and psychological factors, such as the client's reasons for undertaking withdrawal and their fear of withdrawal. Severity of opioid withdrawal is determined by the dose (the greater the dose, the more severe the withdrawal symptoms), rate of reduction (the more rapid the rate of reduction, the more severe the withdrawal symptoms) and type of opioid used (withdrawal from short-acting opioids can be more severe than withdrawal from long-acting opioids).

As the severity of withdrawal depends on psychological as well as pharmacological factors, the psychological management during withdrawal is as important as the medication regime.

Good communication is vital, e.g. taking the time to explain the likely course of the symptoms and acknowledge distress and frustration, being up-front and honest about the fact that although treatments reduce discomfort, they may not eradicate all symptoms, as this may not be safe. For example, higher doses of benzodiazepines can cause respiratory depression. A collaborative, empathic and non-judgemental approach can reduce symptoms that can be worsened by stress, and supportive care includes reassurance, attendance to hydration and nutrition. Reassurance should be provided to the patient that their withdrawal will be managed symptomatically. Complementary medications, massage, acupuncture and other physical / body therapies may be useful. Any specific treatment provided needs to be explained, including how often, and what the patient can expect to achieve. Clear boundaries and expectations should be explained and agreed upon with the patient.

Pharmacological support includes the prescription of medications for symptomatic relief, including non-opioid analgesics, anti-emetics, clonidine, benzodiazepines and antispasmodics. Pharmacologic management options include full or partial opioid agonists (e.g., methadone, buprenorphine), alpha-2 adrenergic agonists (e.g., clonidine), and an opioid antagonist (e.g., naltrexone) in combination with clonidine, with sedation, or with general anaesthesia. Opioid agonists and clonidine have all been shown to reduce COWS scores, with the opioid agonists having greater efficacy than clonidine alone.

Symptoms

Suggested treatments

Muscle aches / pains	Paracetamol 1000 mg, every 4 hours p.r.n. (max 4000 mg in 24 hours)
Nausea	Metoclopramide 10 mg, three times a day p.r.n. or Prochlorperazine 5 mg, three times a day p.r.n.
Abdominal cramps	Hyoscine 20 mg, every 6 hours p.r.n.
Diarrhoea	Loperamide 2 mg p.r.n. (maximum 16mg / 24 hrs)
Sleeplessness	Temazepam 10-20 mg at night
Agitation or anxiety	Diazepam 5 mg four times a day p.r.n.
Restless legs	Diazepam (as above)
Sweating or agitation	Clonidine 75 mcg every 6 hours (ensure blood pressure >90 mmHg systolic or >50 mmHg diastolic and heart rate >50 bpm)

In the management of opioid withdrawal, **clonidine** is typically administered orally as two to four doses per day, with the total dose adjusted daily according to withdrawal symptoms and side effects (particularly blood pressure). A test dose of 150mcg is often administered to check for hypotensive effects. If tolerated, treatment is continued at 12-15mcg/kg/day in four divided doses. Maximal doses are generally required for only a few days around the time of maximum withdrawal, usually two to four days after cessation of opioids. Doses are then tapered and ceased seven to ten days after cessation of opioids. Most protocols suggest 0.1 mg every 4 to 6 hours as needed for withdrawal on the first day, increasing by 0.1 or 0.2 mg per day to a maximum of 1.2 mg total daily dose, with careful monitoring of blood pressure and withdrawal symptoms.

Benzodiazepines can also be used for anxiety, agitation and insomnia but as they have a high potential for dependence they should be used with caution and only under close supervision.

Relapse risk is thought to be related, in part, to post-acute opioid withdrawal, which includes symptoms similar to acute opioid withdrawal but reduced in intensity. Some patients experience reduced blood pressure, decreased heart rate and body temperature, and miosis. Opioid agonist maintenance treatment with either methadone or buprenorphine alleviates this relapse risk, reduces the risk of developing infectious diseases by reducing injection drug use, stops post-acute withdrawal symptoms, and improves health and immune function.

While a range of health benefits often result from managed withdrawal, there is no evidence detoxification alone contributes to lasting abstinence from opioids in the longer term. Relapse after opioid withdrawal is very common; therefore, a negotiated and detailed relapse prevention plan with the individual patient should be developed. The plan should always include the role of the client's support people and may include a residential treatment option.

Opioid substitution therapy (OST) should not be initiated until the prescribed dose and last dosing details have been confirmed. If someone is already on OST it should not be ceased because someone is in hospital. Adjustments may be required because of missed doses or the current clinical situation.

The COWS can be used to assist in determining an initial dose of methadone (in a methadone maintenance clinic) or of buprenorphine to be used to reduce withdrawal symptoms. The dose is then increased until all withdrawal symptoms have subsided. Fewer than 10% of people not connected to addictions treatment immediately after detoxification are able to maintain their sobriety, so all patients should be offered maintenance therapy.

The standard regime for opioid detoxification is based on the use of **buprenorphine**. The recommended dose is 4-24mg once daily. It is recommended that an interval of at least 2-3 days be available from the time of the last buprenorphine dose to the time of planned discharge. Duration of dosing will be determined by the length of admission available, e.g. in a 7-day admission, treatment will be limited to the first 4-5 days.

The sublingual preparation is well suited to individuals who cannot tolerate oral medications. Caution should be used in prescribing buprenorphine or other opioids in individuals with certain medical conditions. The clonidine-diazepam regime may be preferred for such patients; it is used to manage arousal from opioid cravings.

There is little literature on the use of buprenorphine with prescribed opioids. The following information is related primarily to heroin and methadone but is likely to be relevant to the other opioids.

The aim of using buprenorphine in withdrawal is the reduction of withdrawal symptoms and cravings; it is *not* the complete removal of all symptoms or the intoxication of the patient. The clinician should discuss patient's expectations of the medication with them and address any misconceptions. In general, buprenorphine is well suited to use in inpatient withdrawal settings, given its ability to alleviate the discomfort of withdrawal symptoms without significantly prolonging their duration.

The following principles regarding doses should be understood by the patient:

- Buprenorphine doses that are too high can result in increased rebound withdrawal, prolonged duration of symptoms, increased side-effects, and increased cost of the medication.
- Alternatively, use of doses that are too low can result in unnecessary withdrawal discomfort, continued use and treatment drop-out.
- Continued use or cravings may not be due to inadequate doses of medication. For example, patients who continue to associate with other heroin users, and are present when others are acquiring or using heroin, can expect to have cravings regardless of their dose of buprenorphine.

Buprenorphine is a partial opioid agonist. It can precipitate opioid withdrawal in someone who has recently used any opioid, e.g. heroin (within the past 6 hours) or methadone.

All doses of **methadone** should be supervised, where possible, and a clinician (doctor, nurse, pharmacist) should review the patient daily during the first week of treatment, corresponding to the greatest risk period for methadone-related overdose. The review provides an opportunity to assess intoxication (e.g. sedation, constricted pupils) or withdrawal symptoms, side effects, other substance use and the patient's general well-being.

- Commence with 20 to 30mg daily. Lower doses (e.g. 20mg or less) are suited to those with low or uncertain levels of opioid dependence, with high risk polydrug use (alcohol, benzodiazepines) or with severe other medical complications. Higher doses (30-40mg) should be considered with caution if clinically indicated, at the discretion of the prescriber. Consultation with a specialist is recommended before commencing.
- Patients at doses greater than 40mg the risk overdose.
- Dose increases should be made following review of the patient and should reflect side effects, features of withdrawal (suggesting not enough methadone) or intoxication (suggesting too much methadone or other drug use), ongoing cravings and substance use.

- Dose increments of 5 to 10mg every three to five days will result in most patients being on doses of between 30 and 50mg by the end of the first week, and 40 to 60mg by the end of the second week.
- Supplementary doses can be considered for patients returning in severe withdrawal 4 to 6 hours after dosing, but only after review by the prescriber. This requires coordination between the prescriber and dispenser.
- The dose should be gradually increased in order to achieve cessation (or marked reduction) in unsanctioned opioid use, and alleviation of cravings and opioid withdrawal features between doses, whilst minimising methadone side effects. Daily methadone doses above 80mg will also markedly reduce the effects of any ongoing heroin or other opioid use.

Naltrexone hydrochloride is a pure opioid antagonist which markedly attenuates or completely blocks, reversibly, the subjective effects of intravenously administered opioids. It has been used in this situation to hasten withdrawal symptoms, without increasing patient discomfort. The evidence on the effectiveness of naltrexone maintenance treatment is limited by low rates of retention in studies, and the small number of comparable studies. Current evidence indicates no significant difference in treatment retention or abstinence for people treated with naltrexone, with or without adjunctive psychosocial therapy, compared to placebo or psychosocial therapy alone.

The best approach to initiation of naltrexone maintenance treatment is to manage withdrawal from opioids with small doses of buprenorphine before commencing naltrexone. Introduce naltrexone with caution if there is any uncertainty about time of last opioid use. An interval of five days between last buprenorphine and first naltrexone is recommended for generalist settings. If heroin was the last opioid used, an interval of 7 days is recommended, and 10-14 days if methadone was the last opioid used. If a faster transition is desired, seek specialist advice or referral. Urine drug screening is of little use during naltrexone induction. The best approach is to advise the patient that the first dose of naltrexone may precipitate withdrawal if opioids have been used recently. If there is a risk of precipitated withdrawal due to uncertain recent opioid use, seek specialist advice.

Commence naltrexone at 25mg per day for three days, then increase to 50mg per day if tolerated. Note that the onset of withdrawal triggered by naltrexone can be delayed following buprenorphine treatment.

3.3 The Standard Required

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

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

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

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Kylie, a 29-year-old single woman who has been in a relationship with Jason for the past 3 years. You had an argument with Jason, and he left you a week ago. You have been feeling sad and suicidal since. You have been staying at home feeling miserable, and forgot to pick up the medication you take for your back pain. You haven't had any pain medication for **3 days**. This is the first time you have gone without the medication. Last night you felt sick and impulsively decided you could not face living without Jason, and felt acutely suicidal. This led to your friend Jane bringing you to hospital because you were so upset. You have never attempted to take your life before; and currently you are relieved to be alive and don't have a plan to take your life.

How you are feeling today

However, physically you are in a lot of pain, especially backache and aches in your muscles. You have also been struggling with agitation, restlessness and anxiety. You also have stomach cramps, diarrhoea, nausea and vomiting. You have been bothered by a runny nose and sweating, and feel you are coming down with flu as you are shivering even though it is not that cold outside.

History of opioid drug use

You started using pain medication (codeine) after a back injury following a car accident 2 years ago, which put you off work for a few months. If asked, you can point to the general area of your lower back as the part that hurts. You have been to several doctors and have tried various pain medications - so many you can't recall all the names but know that paracetamol and Brufen® don't work. For the past **6 months** you have been taking **oxycodone** 20milligram tablets. Your GP prescribes these tablets and you are supposed to take them every 12 hours (i.e. twice a day). However, in the last **2 months** you have been taking them every 3 to 4 hours because it doesn't seem to reduce your ongoing back pain. You never saw a problem in this as the pain is real and the medication helps; and you have never tried to stop it.

You were using up your supply of oxycodone tablets very quickly. A month ago, you had to lie to your GP that you had lost all your oxycodone tablets, and she prescribed you with another 3 months of the medication. When your boyfriend found out about your increasing use, and your recent lying to the doctor he became angry, and both of you ended up in an argument that led to him calling you a *junkie* and walking out. You have had no contact with him for the past week. He is not responding to your calls or messages.

If asked, you have never injected any drugs or medicine yourself.

How you felt in the last week

Prior to Jason leaving you a week ago, you had been coping well. Your sleep has always been poor but for the past 2 days you haven't been able to sleep at all. There has been no change in your appetite. You feel tired occasionally but can get on with things. You felt you wouldn't be able to cope without Jason. You want things to improve, and now think that if you come off the pain medication you will get your boyfriend back.

Before last week, you have had bad days like everyone else, but they never lasted for more than a day or two. You have never had a period of persistently low mood, loss of motivation or loss of interest in everything. You never felt high / elevated or euphoric. You have never seen or heard things that other people do not, never had strange beliefs of being watched or monitored. You have never seen a psychiatrist or psychologist.

Your past medical history

Apart from your back injury, you have had no other medical problems and you are not allergic to any medication. If asked specifically, you can say that you have been constipated on and off for the past couple of months, but thought it was because of a lack of exercise and a poor diet, and you have not done anything about it.

Your personal history

Both your parents (in their late 50s) are alive and well. You have one younger brother Paul (age 22). Your mother suffered from anxiety and your brother has been addicted to many drugs, you are not sure which and you don't have much to do with him. There is no other mental illness in the family. You get along well with your parents, but they are unaware of the current situation and you do not want to worry them.

You had a happy childhood; you always worked hard to be the best. You didn't have many friends, but you got along at school. You went to college and finished accounting. You were never in any serious relationship until Jason. You worked as an account person in a local supermarket until the car accident 2 years ago, after which it is hard for you to work as you cannot sit for long periods of time. You have had a few brief jobs since then and are now living off your savings, and get some financial help from your parents at times.

You drink socially (1 to 2 glasses of wine every week), and have avoided illicit drugs. Until recently, you didn't feel you have a drug problem but since the conflict with your boyfriend you realise that your use of the painkillers may be excessive, and you want to sort out the problem. You do not gamble.

You have not ever been in trouble with the police, and there are no outstanding legal issues.

Discuss these symptoms only if specifically asked:

With regards to symptoms of opioid **dependence**:

- Compulsion to take oxycodone – you cannot cope without the medications.
- Impaired control over use – you have lied to your GP for more medication.
- Increased tolerance – you need more and more medicine to get the same effect to control the pain.
- Priority of drug use – you have been neglecting usual chores and relate this to back pain and need for medication.

If asked the specifics of your use of oxycodone:

- You have been taking one 20milligram tablet every 3-4 hours every day for the last 2 months: so about 5 times a day.
- You don't wake up at night to take another tablet but need one first thing in the morning as you don't feel too well in the morning.

With regards to symptoms of opioid **withdrawal** you are experiencing the following for the past 2 days:

- Tears, running eyes
- Running nose
- Sweating
- Gooseflesh
- Hot and cold flushes
- Tiredness
- Yawning
- Restlessness
- Poor sleep
- Muscle aches, leg cramps
- Joint pain, particularly backache
- Stomach cramps, diarrhoea,
- Nausea, vomiting, loss of appetite
- Unpleasant mood

You thought it was 'the flu' and so have taken paracetamol but the pain is really bad now.

4.2 How to play the role:

You are feeling sad and upset because your boyfriend has left you. You did think of taking your life yesterday if Jason is not coming back, but this thought has subsided since you were admitted to the hospital last night. You find the hospital environment supportive and you are not feeling lonely.

You have been taking medications for back pain, and you think your boyfriend misunderstands you as he thinks of you having a drug problem. You want this to be clarified, and are willing to do anything to get things back in control and get your boyfriend back. You do not believe you have an addiction. You do wonder whether you might be coming down with a flu, as opposed to withdrawing from opioids. On occasion you will yawn, and use a tissue to wipe your 'runny nose' at times.

4.3 Opening statement:

'Doctor, I don't feel suicidal anymore, I just feel terrible.'

4.4 What to expect from the candidate:

The candidate should explore your report of feeling terrible. The candidate will ask you about your regular medication.

Do not tell the candidate you are taking oxycodone unless they ask you about any regular medication you might take. The candidate will then clarify the details of opioid use and withdrawal symptoms, and other aspects of history that may influence their management plan. They should explain to you what opioid withdrawal is, how this is treated, and what to expect during withdrawal.

4.5 Responses you MUST make:

'I am in a lot of pain! Can you do something about it?'

4.6 Responses you MIGHT make:

'Can you help me to come off oxycodone?'

'How can something my doctor prescribes be so bad?'

IF the candidate did not explore symptoms of opioid withdrawal, you will say:

'Can you do something about my nausea and diarrhoea?'

4.7 Medication and dosage that you need to remember:

Oxycodone (oxi-co-done) 20mg tablets for pain.

Your GP has prescribed it for every 12 hours, but you have been taking it every 3 to 4 hours.

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- Obtain a focussed history on opioid dependence and withdrawal.
- Synthesis the findings and communicate it appropriately to the patient.
- Explain the management plan for opioid dependence / withdrawal.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately a detailed and focussed history on opioid dependence and withdrawal? (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 when eliciting a detailed history to confirm the diagnosis of opioid dependence and withdrawal.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; eliciting the key issues; attuning to patient disclosures, including non-verbal communication; obtaining relevant history on opioid dependence and eliciting symptoms of opioid withdrawal; enquiring about other substances of abuse including alcohol, prescription medication and illicit drugs; taking into account psychosocial stressors and support network; any omissions to be minor and not materially adversely impact on the obtained content.

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

- Establish the time and amount of last opioid medication use.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; focusses only on the self-harm and suicidality which results in significant deficiencies and substantial omissions in history; does not elicit history of opioid dependence and withdrawal.

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

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

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills when explaining the diagnosis of opioid dependence and withdrawal to the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

integrates information in a manner that can effectively be utilised by the patient; provides succinct and professional information; considers protective and vulnerability factors.

Achieves the Standard by:

prioritising and synthesising information; correctly communicating findings of an opioid dependence and withdrawal in suitable language, with appropriate detail and sensitivity; being responsive to the patient's embarrassment; demonstrating discernment in selection of content; utilizing a biopsychosocial approach; identifying relevant predisposing, precipitating perpetuating and protective factors with communicating diagnosis in appropriate language.

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

- Explain the link between opioid dependence and recent development of withdrawal.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; provides grossly inaccurate or incorrect information; unable to communicate the diagnosis of opioid dependence or withdrawal.

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

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

1.0 MEDICAL EXPERT

1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient including suitably incorporating patient goals / preferences? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; demonstrates a superior knowledge of the treatment of opioid withdrawal; differentiates treatment of opioid withdrawal from ongoing treatment for opioid dependence; uses an opioid withdrawal scale (e.g. COWS) to guide treatment; identifying the need to address pain management separately to opioid addiction; discuss two or more pharmacological options used for the management of opioid withdrawal (methadone, buprenorphine, naltrexone, or clonidine).

Achieves the Standard by:

Including aspects of management of both withdrawal and dependence; demonstrating the ability to communicate immediate treatment plan; sufficiently addressing symptoms of opioid withdrawal e.g. nausea, diarrhoea; clearly communicating indications for ongoing treatment, range of options, risks and recommendations; working within patient treatment goals and negotiating targeted outcomes; offering psychoeducational material; outlining specific treatment components such as systematic monitoring and routine supportive care; addressing ongoing pain management.

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

- a. Discuss both symptomatic treatments and opioid substitution therapy for the management of opioid withdrawal.

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

Below the Standard (scores 2):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; difficulty tailoring treatment to the patient's specific circumstances.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; inaccurate or incorrect treatment of opioid withdrawal and dependence which impacts adversely on patient care.

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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