

**1.0 Descriptive summary of station:**

In this station the candidate is to assess a 40-year-old Indian woman's complaints of multiple aches and pains. The aim is to sensitively explore the history taking into account the underlying cultural issues in order to clarify the diagnosis of depression and offer treatment.

**1.1 The main assessment aims are to:**

- Explore a depressive history in a manner that sensitively identifies underlying cultural issues in the patient.
- Synthesise the obtained information and explain to the patient the diagnosis and management strategies.
- Explore psychosocial history to identify role of in-laws and husband in her level of stress, and assess the candidate's ability to deal with patient's resistance to accept antidepressant treatment.

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

- Explore physical symptoms to support or refute clinical depression.
- Identify that the patient is dependent on husband's permission to accept treatment.
- Demonstrate recognition of the role the in-laws play in her level of stress and acceptance of treatment.
- Diagnose major depressive disorder as the preferred diagnosis.
- Incorporate the patient's preference of traditional treatment into the management plan.
- Approach the patient's resistance to accept treatment in a sensitive manner.

**1.3 Station covers the:**

- RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of: Mood Disorders, Other Skills (Culture)
- Area of Practice: Adult Psychiatry
- CanMEDS Domains: Medical Expert, Communicator
- RANZCP 2012 Fellowship Program Learning Outcomes: Medical Expert (Assessment – Data Gathering Content; Diagnosis; Management – Treatment Contract), Communicator (Cultural Diversity)

**References:**

- Cheung F M, Lau B W K, Waldmann E. Somatisation among Chinese depressive in general practice. *Int J Psychiatry Med* 1981;(10):361-37
- Desjarlais R, Eisenberg L, Good B, & Kleinman A(eds): 1995, *World Mental Health: Problems and Priorities in Low-income countries*. Oxford: Oxford University press
- Eisenberg L. Treating depression and anxiety in Primary Care. *New England Journal of Medicine*. 1992; 326, 1080-1084
- Gautam S & Jain N. Indian Culture and Psychiatry. *Indian J Psychiatry* 2010; (52 (Suppl1))
- Kirmayer LJ: Culture, affect and somatization, parts 1 and 2. *Transcultural Psychiatr Res Rev* 1984; 21:159-188, 237-262
- Kirmayer L.J. The body's insistence on meaning: metaphor as presentation and representation in illness experience. *Medical Anthropology Quarterly*, 1992; 6, 323-346
- Kleinman A. 2004. Culture and Depression. *The New England journal of medicine*. 351 (10) 951-953
- Kleinman A & Good, B. 1985. *Culture and Depression: Studies in the Anthropology and cross cultural Psychiatry of Affect and Disorder*. Berkeley: Californai University press
- Raguram R., Weiss, M. G., Keval, H., & Channabasavanna, S. M. Cultural dimensions of clinical depression in Bangalore, India. *Anthropology & Medicine*. 2001; 8, 31-46
- Raguram R, Mitchell G Weiss, SM Channabasavanna, Gerald M Devins: Stigma, Depression and Somatisation in South India. *Am J Psychiatry* 1996, 153: 1043-1049
- Raguram R, Weiss, M.G. , Channabasavanna, S.M. & Devins, G.M. Stigma, depression and Somatisation: a report from South India. *American Journal of Psychiatry*. 1996;153, 1043-1049

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: 40-year-old woman of Indian background; casually but neatly dressed.
- 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 clinic in a community setting.

You are about to see Simran, a 40-year-old Indian woman referred by her local GP Dr Keogh. She has come to your clinic with a referral letter:

*Dear Colleague:*

*Thank you for seeing Simran for an opinion regarding her complaints of multiple aches and pains. Simran has been seeing me for the last few months. She has been coming in quite frequently requesting treatment for pain in multiple areas of her body including headaches, back pain, neck pain and abdominal pains which appear to fluctuate. There has been no relief with analgesics. I have completed a range of blood tests including Vit D, B12, FBC, TFT and an abdomen ultrasound which have been normal.*

*These aches and pains have resulted in Simran spending extended periods in bed. She struggles with household tasks and has been withdrawing from family activities.*

*I believe that Simran has been experiencing depression and have offered her antidepressants which she has repeatedly declined. She has finally agreed to see you, after a lot of negotiation.*

*Thank you for your opinion regarding diagnosis and treatment.*

Your tasks are to:

- Conduct a focussed and relevant psychiatric assessment with Simran.
- Based on your identified issues, explain your diagnosis and differential diagnoses to Simran.
- Discuss treatment options with Simran.

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

## 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.
- 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 of the 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 **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.

There are no scripted prompts.

The role player opens with the following statement:

*'You are only a mental doctor; I don't know how you are supposed to help me with my aches and pains.'*

#### 3.2 Background information for examiners

The candidate is expected to take a focussed history presenting with multiple physical aches and pains from a 40-year-old married Indian woman. They are required to identify and consider the impact of her cultural background on how she copes with changing family dynamics in order to clarify the diagnosis of depression. They are further required to offer treatment to the patient and deal effectively with the patient's resistance to accept treatment.

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

- Explore physical symptoms to support or refute clinical depression.
- Identify that the patient is dependent on husband's permission to accept treatment.
- Demonstrate recognition of the role the in-laws play in her level of stress and acceptance of treatment
- Diagnose major depressive disorder as the preferred diagnosis.
- Incorporate the patient's preference of traditional treatment into the management plan.
- Approach the patient's resistance to accept treatment in a sensitive manner.

To be able to justify the diagnosis of clinical depression, the candidate should be able to establish the criteria for clinical depression according to either the DSM or ICD.

A surpassing candidate may recognise the significance of the family role and identify aches and pains as "cultural idioms of distress", and incorporate this when carefully addressing the patient's resistance to accept treatment in a very sensitive manner.

#### DSM-5 Diagnostic Criteria for Major Depression

- 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, 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.
- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode. **(Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.)

### ICD-10 Criteria for Depression

The depressive episode should last for at least 2 weeks.

- G2. There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode at any time in the individual's life.
- G3. Most commonly used exclusion clause. The episode is not attributable to psychoactive substance use or to any organic mental disorder.

Somatic syndrome - some depressive symptoms are widely regarded as having special clinical significance and are called 'somatic'. (Terms such as biological, vital, melancholic, or endogenomorphic are used for this syndrome in other classification.)

A fifth character may be used to specify the presence or absence of the somatic syndrome. To qualify for the somatic syndrome, four of the following symptoms should be present:

1. marked loss of interest or pleasure in activities that are normally pleasurable;
2. lack of emotional reactions to events or activities that normally produce an emotional response;
3. waking in the morning 2 hours or more before the usual time;
4. depression worse in the morning;
5. objective evidence of marked psychomotor retardation or agitation (remarked on or reported by other people);
6. marked loss of appetite;
7. weight loss (5% or more of body weight in the past month);
8. marked loss of libido.

In the ICD-10 clinical descriptions and diagnostic guidelines, the presence or absence of the somatic syndrome is not specified for severe depressive episode, since it is presumed to be present in most cases.

### F32.0 Mild Depressive Episode

- A. The general criteria for depressive episode must be met.
- B. At least two of the following three symptoms must be present:
  1. depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks;
  2. loss of interest or pleasure in activities that are normally pleasurable;
  3. decreased energy or increased fatigability.

- C. An additional symptom (or symptoms) from the following list should be present, to give a total of at least four:
1. loss of confidence and self-esteem;
  2. unreasonable feelings of self-reproach or excessive and inappropriate guilt;
  3. recurrent thoughts of death or suicide, or any suicidal behaviour;
  4. complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation;
  5. change in psychomotor activity, with agitation or retardation (either subjective or objective);
  6. sleep disturbance of any type;
  7. change in appetite (decrease or increase) with corresponding weight change.

A fifth character may be used to specify the presence or absence of the 'somatic syndrome':

F32.00 Without somatic syndrome; F32.01 With somatic syndrome.

### **F32.1 Moderate Depressive Episode**

1. The general criteria for depressive episode must be met.
2. At least two of the three symptoms listed for mild depression, criterion B, must be present.
3. Additional symptoms from mild depression, criterion C, must be present, to give a total of at least six.

A fifth character may be used to specify the presence or absence of the 'somatic syndrome':

F32.10 Without somatic syndrome; F32.11 With somatic syndrome.

### **Cultural aspects relevant to the case**

Cultural factors influence and shape the experience and expression of perceived distress. The personal impact and the significance of symptoms are evident in the patient's narrative that elaborates meaning and causation regarding culturally shaped ideas about the body in sickness and health. Bodily pains in patients are based in the context of their local worlds.

From a cultural perspective, epidemiological surveys of patients attending primary health care facilities in developing countries have indicated that as many as one-fifth to one-third of them have depressive illness as a primary or secondary reason for seeking care (Desjarlais et al., 1995). Despite their frequency, depressive disorders are less likely than many other health problems to be recognised and treated by clinicians even in Western cultures (Eisenberg, 1992).

Unfortunately, in routine medical encounters the social dimensions of the suffering body are often conceptualised as disconnected events within the individual's biological body. Depressive experience is interpreted through somatisation to be a less stigmatising and therefore more tolerable condition.

In the DSM-IV it was recognised that in some cultures depression may present with somatic complaints, such as headaches, gastrointestinal disturbances and unexplained pains, these must be distinguished from somatic presentations of depressive illness, symptoms of which include loss of appetite, constipation, weight loss, loss of libido, and insomnia.

Cross cultural epidemiological studies suggest that somatisation of depression is a common phenomenon in non-Western societies. In India, researchers have also emphasised the somatic presentation of depressive illness in psychiatric settings. It has been consistently observed that patients with depression in India have more somatic symptoms than their counterparts in the West (Teja et al., 1971). Raguram et al. (2000) tried to examine how patients in India actually understand and construct the experience of depression, and tried to explore the many ways in which they act in response to their distress.

In a study of depressed Chinese patients coming for treatment in general practice, Cheung et al. noted that an overwhelming majority of them complained primarily of somatic symptoms. Cheung suggested that Chinese patients suppress or disguise their deep feelings owing to fear of the powerful social stigma that attaches to mental illness in their culture.

In a study of epilepsy-related stigma, Kleinman et al. pointed out that there could be several factors operating in the affected people including reduced self-esteem and power, ostracism affecting marital prospects and marital life, and fears about disclosure.

Kleinman, based on research in China, concluded: "Depressive affect is socially and culturally unsanctioned and therefore suppressed. Somatisation is sanctioned and expressed, and it carries both cultural cachet and social efficacy."

A study conducted by Raguram et al. (2001), found a positive relationship between the severity of depressive symptoms and the scores on a stigma scale demonstrated that higher levels of depression were experienced as more stigmatising. They found that symptom expression was governed by the perceived stigma attached to psychological problems.

In India, patients report somatic symptoms spontaneously, but report psychological symptoms upon being probed (Raguram et al. 2001; Jadhav et al. 2001).

The social meaning of somatic symptoms is less distressing because they closely approximate experiences that everyone has from time to time. Depressive symptoms, on the other hand, are considered to be private and even dangerous. Like in the Kleinman study above, symptoms are experienced as socially disadvantageous; they might interfere with marriage, diminish social status and compromise the self-esteem required to perform effectively in society.

It is imperative that clinicians attend not only to questions of diagnosis and clinical formulation according to professional concepts, but also to the experience and meaning of their patients' problems. Raguram et al. (2001) comment that a culturally sensitive enquiry helps in the development of treatment strategies that are congruent with the cultural concepts and needs of patients.

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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



## 4.0 Instructions to the Role Player

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

You are Simran, a 40-year-old married mother of two young daughters (Hema and Deepti, aged 10 and 8 years respectively). Your parents-in-law currently live with you and your family.

#### Reason for referral:

You have been referred to a community mental health centre by your GP Dr Keogh. Since last year or so, you have started getting increasing aches and pains. Plus, you have started to feel dull and dreary, and increasingly worried about the strain you are putting on your family.

#### Kinds of symptoms you have been experiencing:

You have been suffering with multiple aches and pains, and have experienced headaches quite often. These headaches mostly feel like a '*band around your head*', which is dull, continuous and in the forehead region.

In relation to the headache you do **not** experience:

- changes in your eyesight or sensitivity to light
- any change in the headache with change in posture
- any nausea or vomiting
- headaches on a daily basis, but they are very common almost every other day.

You have also experienced abdominal pains, spread all over your abdomen, which are not associated with any nausea, vomiting or diarrhoea. You have also intermittently experienced aches in your arms and legs which mostly come and go without any reason.

You had similar problems with aches and pains around eight years ago, when your parents were having ongoing conflict related to some financial difficulties. However, the symptoms disappeared on their own after the financial crisis resolved.

#### If asked:

**Sleep and energy levels:** In the last 6-7 months, you have started to have interrupted sleep, and feel worried and tense about how to get through each day. You often find that you wake up in the middle of the night and are unable to get to sleep again, lying awake for half an hour to an hour. This has been happening up to 1-3 times in the night. You do not feel refreshed when you get up in the morning. Over the two or three months you have started to feel more exhausted and tired during the day. However, you are still able to cook, clean and manage the household tasks everyday.

**Socialising and enjoyment:** You used to be described by your friends as '*happy-go-lucky*' and had a good group of friends while in India, but after moving to Perth, have felt socially isolated. You are now unable to enjoy things, particularly playing with your children, as you have in the past. You used to enjoy watching TV, and had started making friends with other parents through your kids' school. You are now really worried that you are losing the excitement and zest about living in Australia, and have started wishing you could go back to your parents in India.

**Appetite and weight:** You are generally eating as before, but you do not enjoy food as much, but eat because you have to. You haven't lost any weight.

**Sexual function:** If asked, you do not enjoy sex with Rajiv any more. However, though not interested, you feel the need to give in to Rajiv's desire for sex.

You feel bad about being unable to fulfil your duties as a wife and mother and feel guilty about your failure at times. However you do not think that you are a bad person or deserve to be punished. You do not feel hopeless but do feel somewhat helpless in your current situation.

#### You and your family:

You have been married for 15 years - through an arranged marriage to Rajiv in Amritsar when you were 25 years old. You only met him a couple of times before the wedding. However, the marriage was acceptable to you as it was the norm within your peer group and culture. Rajiv had studied a Diploma in Engineering in India and migrated to Australia along with your children in early 2011. You are trained as a primary school teacher.

While you had been very excited and optimistic about this move to Perth, things did not go as well as you had hoped. Your husband struggled initially in getting a job based on his Indian qualifications, and ended up driving a taxi to support the family for a few months. He then completed a Diploma in IT and finally got a stable job in the last year. However, financially the income does not seem quite enough to take care of the needs of your growing family.

You are worried and anxious about meeting the needs of the family, development of the children, financial situation and what would it entail to be able to start working as a teacher in the Australia.

Over the last few months your husband has been suggesting that you start looking for a job to assist in the financial situation. You are quite reticent to start looking for jobs as you do not know whether your qualification will be recognised, and what examinations would you have to take to get recognised as equivalent as a qualified teacher in the Australian system.

Moreover, your husband's parents also moved over from India six months ago to live with you. They are frail and elderly, and this has placed additional pressure on you to attend to their day-to-day needs as well as health needs. Your husband wishes that you all live together as a "joint family". You feel very ambivalent about this, as while this may have been the norm in India, you feel that you have changed as a person after living in Australia for the last six years, and now would struggle to fit into this 'traditional' system again.

More and more you have been feeling that you have a right to be more independent, and have reservations about this arrangement which you feel would impact on your finances as well as your time with your husband and children. You also see that in Australia it is not automatically expected that you should be living with your parents, and you feel that while it is important to have a good relationship with them, you see it is going to be difficult to live with them on an ongoing basis.

However, you find it difficult to explain your feelings to Rajiv as you feel he is very traditional in his thinking and would not understand your point of view. Moreover, you feel that Rajiv does not really understand all the household responsibilities you have to bear as he works long hours, and even when home, does not really help around the house. This has also caused increasing conflict between you both. Rajiv sees it as your 'duty' but you feel that he needs to chip in to help at home as well as trying to meet his parents' needs.

You had been toying with the idea of not pursuing teaching career but to do a diploma in beauty therapy that can set you up to earn quickly and give you more flexible working hours. While Rajiv was initially supportive, now he feels you should follow his parent's wishes and this idea is not liked by your in-laws. This has been very upsetting to you as you feel you should have the right to make these choices individually rather than always listen to them.

You have recently started experiencing increased conflict with your husband in relation to his choices about your career. You are also finding it difficult to deal with increasing demands from your in-laws since they started living with all of you. You do not get any 'down time' and believed that they interfere with how you spend time with your two gorgeous little daughters. You also feel that your husband would like to have a son, but you do not wish to have any more children.

You have followed Hinduism as a religion, and you have always been taught to take care of parents and their needs, and that it is your duty to take care of them and agree with what your husband says. You are therefore conflicted with the values that you have been taught and seen while growing up, and with what emotions and thoughts that you are experiencing now. You have become more stressed since Rajiv's parents arrived from India, and at times you view them as quite demanding but do your best to take care of their needs.

If you are asked about your personal history:

Your birth and early development has been unremarkable. You are the eldest of three siblings, all of whom still live in India. Your youngest brother has just joined the family business. Your middle sister has recently divorced because of some issues which you are unclear about.

Your parents live in Amritsar, and your memories of your childhood are of your parents arguing over financial issues. You were closer to your mother who took care of your needs as a child. You remember her as being quite unwell for long periods of time, and recall that she used to cry in pain and repeatedly visited doctors, but are not aware if she was diagnosed with a specific illness.

Looking back on those times, it appeared that going to all those doctors provided little benefit. With this in mind, and in light of the fact that your GP has not been able to help you with your pains, you are not convinced that Western medicine can really help you. When you were in India, you recall your relatives suggesting Ayurvedic treatment for ailments. You are more interested in searching for traditional methods to manage pain and help your body to relax like yoga, massage and Ayurveda.

You qualified as a school teacher in India, and had been working as a primary school teacher for three years before getting married. However, you have not thought of exploring work opportunities after coming to Australia as you have been taking care of your children because you could not afford after school care or child care.

#### Psychiatric history and symptoms:

You have never been diagnosed as having depression and you do not feel depressed. You have never attempted or thought about suicide, but at times do wonder if your family may be better off without you given that you are not getting well.

You have never experienced a high / elevated mood (mania). You do not suffer from chronic feelings of anxiety.

You do not think you have ever had a psychotic episode – if asked, you can ask the candidate to explain what they mean by the word ‘psychosis’. You have never heard voices or seen things that other people do not, you do not get messages from the TV that are directed specifically at you, you do not think anyone is trying to harm you. You do not believe that your symptoms are due to any part of your body rotting or that you have a terrible illness.

You have never drunk alcohol or used illegal drugs.

You have a family history of your mother experiencing similar symptoms - aches and pains and feeling tired, unable to work, not enjoying life as much but carrying on. Your mother has never visited a psychiatrist or taken any antidepressants. Your mother continues to suffer from aches and pains, and continues to not be able to meet her duties to a level that she would like to.

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

You are a casually but neatly dressed Indian woman who is anxious about seeing a psychiatrist. You come across as being worried and a bit sad, and find it difficult to cheer up during the interview. However, you deny being depressed although you do acknowledge some extent of sadness, even though you have many symptoms of depression (as described earlier).

If the candidate asks you about family factors / concerns, you hesitate to bring up the issues that are occurring at home. However, if the candidate sensitively explores the issues with you, you can bring them up.

If asked, you are willing to talk about your ambitions, how you would want to be more independent and that you do not want the situation at your family of origin to be repeated.

You quite hesitatingly accept any help being offered but wonder how your husband is going to view it. You feel ashamed and stigmatised to having been referred to a Psychiatrist, and unsure whether antidepressants is the right choice for you.

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

*‘You are only a mental doctor; I don’t know how you are supposed to help me with my aches and pains.’*

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

The candidate should ask you a series of questions about why you have been referred, about your aches and pains and your personal background. The candidate is then expected to describe what they think you are suffering from and in a sensitive, empathic manner, explain how he / she can assist in understanding your aches and pains, and make treatment recommendations.

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

*‘These days I feel so dull and dreary.’*

*‘I would prefer to try traditional options first like Ayurveda, yoga or massage.’*

*‘At times worried about my husband’s reactions as to how I am coping.’*

*‘I’m not sure my husband will agree to me taking medication.’*

#### 4.6 Responses you MIGHT make:

Anticipated Question: If asked about how supportive your husband is.

Scripted Response: ***'I can see my husband really getting frustrated with me. He is supportive in his own typical way.'***

Anticipated Question: If asked about your in-laws.

Scripted Response: ***'I am finding it quite difficult to get used to how they want us to live.'***

Anticipated Question: If asked whether you feel depressed

Scripted Response ***'I do not know what you mean by that, I feel dull and dreary.'***

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

You are not on any medicines at present.

You took paracetamol and ibuprofen previously for you pain but did not find them helpful.

You have not had and do not want any stronger pain medicine.

## STATION 1 – MARKING DOMAINS

### The main assessment aims are:

- Explore a depressive history in a manner that sensitively identifies underlying cultural issues in the patient.
- Synthesise the obtained information and explain to the patient the diagnosis and management strategies.
- Explore psychosocial history to identify role of in-laws and husband in her level of stress, and assess the candidate's ability to deal with patient's resistance to accept antidepressant treatment.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 15%)

##### **Surpasses the Standard if:**

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

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

demonstrating use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; taking hypothesis-driven history; integrating key sociocultural issues relevant to the assessment; 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.

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

- Explore physical symptoms to support or refute clinical depression.

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

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

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

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

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

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

#### 2.0 COMMUNICATOR

#### 2.4 Did the candidate demonstrate a culturally sensitive approach to patient? (Proportionate value - 30%)

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

demonstrates a sophisticated and knowledgeable approach to cultural aspects of patient engagement; successfully negotiate inclusion of husband and in-laws in the treatment plan.

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

recognising and incorporating cultural expectations in the assessment; adapting assessment and management to the specific cultural needs; considering whether to use cultural health workers; identifying a range of culturally relevant issues for the patient.

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

- Identify that the patient is dependent on husband's permission to accept treatment
- Demonstrate recognition of the role the in-laws play in her level of stress and acceptance of treatment.

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

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

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

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

ignores sociocultural aspects of the scenario; insensitive / dismissive approach to cultural issues of the patient; is rude or trivialises the patient's needs.

2.4. Category: CULTURAL DIVERSITY	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	

**1.0 MEDICAL EXPERT**

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

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

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment particularly with regard to cultural context.

**Achieves the Standard by:**

demonstrating capacity to integrate available information in order to formulate a differential diagnosis; demonstrating detailed understanding of diagnostic systems for diagnosis and differential diagnosis; adequately prioritising of conditions relevant to the obtained history and findings; identifying relevant predisposing, precipitating perpetuating and protective factors; communicating in appropriate language and detail, and according to good clinical judgment. Considers adjustment disorder, somatisation disorder and possible physical illnesses such as hypothyroidism

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

- a. Diagnose a major depressive disorder as the preferred diagnosis.

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

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

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

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

inaccurate or inadequate diagnostic formulation; errors or omissions are significant and materially adversely affect conclusions.

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

**1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient? (Proportionate value - 25%)**

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

clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; incorporates individual vulnerabilities and resilience factors into a carefully tailored plan.

**Achieves the Standard by:**

demonstrating the ability to: communicate a culturally acceptable treatment plan; clearly explain indications for treatment, range of options, and recommendations; attempt to work within patient treatment goals, including suitable consideration of patient preferences for alternative interventions like yoga/massage; encourage inclusion of the husband in treatment planning; reasonably establish that the patient understands the treatment recommendations; adequately inform of treatment risks / benefits, including potential adverse outcomes; employ a psychologically informed approach.

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

- a. Incorporate the patient's preferences of traditional treatment into the management plan
- b. Approach the patient's resistance to accept treatment in a sensitive manner.

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

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

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

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

description of the management plan lacks structure; inaccuracies or errors about specific therapies impact adversely on patient care; difficulty tailoring treatment to the patient's specific circumstances.

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

**GLOBAL PROFICIENCY RATING**

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

This is a VIVA station about a terminally ill health professional under palliative care. The candidate is expected to explain the psychological mechanisms at play for a person facing impending death and then delineate the step-wise management of this relatively young person dying, leaving behind a young family; all of these occurring within a short time frame.

### 1.1 The main assessment aims are:

- To explain the important psychological issues and the impact of impending death for a person with a terminal illness.
- To describe a pragmatic approach to manage a relatively young person who is dying of terminal illness in a consultation liaison psychiatry setting.
- To discuss the supportive management of family / friends facing the impending death and the aftermath of death of their loved one.

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

- Accurately identify the five stages of the Kübler-Ross model.
- Prioritise a grief process over a formal psychiatric disorder.
- Recommend involvement of a psychologist in support of patient and family members.
- Consider pharmacotherapy in the patient along with the palliative care physician.
- Identify the need to address the grief experience of each family member.

### 1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders, Other Skills (Ethics)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Scholar, Medical Expert, Collaborator, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Scholar (Application of Knowledge), Medical Expert (Formulation), Collaborator (Teamwork – Treatment Planning), Communicator (Patient Communication – To Patient / Family / Carer)

#### **References:**

- The Psychiatry of Palliative Medicine, The Dying Mind by Sandy Macleod, [www.radcliffe-oxford.com](http://www.radcliffe-oxford.com), 2009
- Comprehensive Textbook of Psychiatry, 7<sup>th</sup> Edition, Kaplan and Saddocks; Lippincott Williams and Wilkins
- Lindemann E: Symptomatology and management of acute grief. *Am J Psychiatry* 101: 141, 1944
- Freud S: Mourning and melancholia. In *Standard Edition of the Complete Psychological Works*, vol 14. Hogarth Press, London, 1953-1966
- Massachusetts General Hospital Psychiatry Update and Board Preparation, 3<sup>rd</sup> edition, Theodore A. Stern, John B. Herman and Tristan Gorrindo, MGH Psychiatry Academic Publishing, Boston, USA

### 1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- No role player as VIVA station.
- 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. There is no role player in this station.**

You are a junior consultant psychiatrist in a Consultation Liaison Service. The palliative care team have referred Julie, who is a 43-year-old registered nurse, for a psychiatric assessment.

The history available is that Julie was well until 11 weeks ago when she went to her GP with a persistent chest infection. A chest X-ray revealed multiple metastatic lesions in her lungs. Following a comprehensive oncology evaluation, Julie was diagnosed with terminal metastatic adenocarcinoma of the large bowel with lung metastases.

A week ago Julie was admitted under the palliative care team for pain management. She is on a morphine subcutaneous pump which is effective in keeping her comfortable. The palliative care team has excluded any major physical comorbidities including delirium.

The palliative care staff note that Julie is increasingly irritable. She has also been refusing to see her friends and family including her husband Robert, sons (15 year old Sean & 13 year old Joshua) and mother Susan.

Her husband, Robert, has approached the staff upset about his wife's emotional state and informed them that Julie is not behaving 'normally' referring to her irritability and refusal to see people. Robert wants help to 'sort it out' so that he and his sons can say goodbye properly to Julie.

Please note that Julie has no previous psychiatric issues and was well until 11 weeks ago.

**Your tasks are to:**

- Explain your understanding of this clinical scenario.
- Explain your diagnosis of the psychological responses in a person with terminal illness.
- Present your initial approach to address this referral.
- Outline how to include Julie's family / friends in the management during the terminal phase of her illness and the assistance they may require after her death.

**You will not receive 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.

### 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**, check the candidate ID number on entry.
- There are no prompts so you may elect not to use a timer.
- DO NOT redirect or prompt the candidate.
- If the candidate asks you for information or clarification say:  
*'Your information is in front of you – you are to do the best you can'.*
- At **fifteen (15) minutes**, 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. There are no prompts or questions to ask.

If asked by the candidate, your response is:

***'Your information is in front of you – you are to do the best you can'.***

#### 3.2 Background information for examiners

In this consultation-liaison viva station the candidate is expected to explain the important psychological responses and impact of impending death on a person with a terminal illness, and then to describe a pragmatic approach to provide interventions for a relatively young person who is terminally ill. Finally, the candidate is to discuss how they would include family / friends facing the impending death and after death of their loved one.

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

- Accurately identify the five stages of the Kübler-Ross model.
- Prioritise a grief process over a formal psychiatric disorder.
- Recommend involvement of a psychologist in support of patient and family members.
- Consider pharmacotherapy in the patient along with the palliative care physician.
- Identify the need to address the grief experience of each family member.

A surpassing candidate may:

- Intergrate the Psychological theories in a sophisticated manner to explain the case.
- Clearly address the complexities in this case in the initial management approach.
- Convey the management of the various levels of issues in a clear, concise manner.

#### **Definitions**

The terms grief and bereavement are not consistently applied. In 1982 the Institute of Medicine appointed a Committee on Health Consequences of the Stress of Bereavement, composed of multidisciplinary clinicians and researchers to study bereavement factors and their impact on general and mental health. The following definitions were agreed:

Grief	- the feelings and associated behaviours, such as crying, accompanying the awareness of irrevocable loss (not necessarily, but including, loss through death)
Grieving process	- the changing affective state over time
Bereavement	- the fact of loss through death.
Bereavement reaction	- any psychological, physiological or behavioural response to bereavement
Bereavement process	- an umbrella term that refers to the emergence of bereavement reactions over time
Mourning	- outward expression of loss & grief after death. Involves rituals and other actions that are specific to a person's culture like funerals, visitations and rituals.

Bereavement and mourning are part of the grieving process. Bereavement reactions involve alterations in feeling states, coping strategies, interpersonal relationships, biopsychosocial functioning, self-esteem and world view that may last indefinitely.

Features of grief and bereavement often resemble a brief depressive episode with the following experiences:

- sadness
- insomnia
- diminished appetite
- loss of interest
- guilt is common
- passive wish to be dead to join the dead one though not actively suicidal.

The experience and expression of grief is affected by a multitude of factors including the following:

- type of loss e.g. abrupt or not, long term relationship or not (in this case, given the nature, grief will be significant)
- cultural norms
- personality style.

### **Phenomenology of Grief**

Manifestations of grief reflect the individual's:

- personality make-up e.g. a secure and confident individual vs. a neurotic and anxious person
- previous life experiences
- past psychological health
- intercurrent life events
- nature of the relationship
- significance of the loss
- existing social networks
- other resources.

The grieving person may experience several phases, starting with shock or disbelief (which could last for hours or days), followed by a gradual realisation and acceptance of the loss (could last for as long as several months). This phase is characterised by waves of negative emotions (including sadness, anger and hopelessness) between normal periods of functioning. After an average of six months to two years, the grieving person generally begins to accept the reality of the loss and begins to return to a functioning life.

It is normal for a person to experience symptoms from these phases when reminded suddenly of the loss but these are much briefer and contained as compared to the earlier times. Functioning is the important indicator to monitor and the inability to revert back to previous level of functioning indicates the presence of a disorder requiring further evaluations.

Despite individual variations in the bereavement / grief process, all models seem to have three overlapping phases or states. These are:

1. initial shock, disbelief and denial
2. an intermediate period of discomfort and social withdrawal
3. a final culminating period of restitution and reorganisation.

In the first or shock and denial phase, disbelief and numbness predominates. As numbness turns to intense feelings of separation, various searching behaviours take over like pining, yearning and protest.

In 1944, in the first study on grief, Erich Lindemann described six stages of acute grief during acute anguish. These are:

1. Intense somatic distress occurring in waves and manifest by tight throat, choking, sighing, empty feeling, weakness, tenseness and mental pain. Withdrawal from supports and friends are common.
2. Thoughts of dying and leaving loved ones predominate and for family members, thoughts of the person dying predominate.
3. Overwhelming feelings of guilt; and blame can easily be attributed to self and others.
4. Irritation and anger can be directed inwards or towards loved ones.
5. Restlessness, agitation, aimlessness and lack of motivation are accompanied by abandonment of usual habits.
6. Identification phenomena where those left behind take on the habits of the dying person, especially in the final stages.

This could last weeks or months and usually transitions gradually, with support, to wellness and return to wellbeing.

In the last phase or stage of restitution (or reorganisation) the extent of the grief and bereavement is recognised. People develop an awareness of the extent of what their loss and grieving has accomplished. Attention shifts to life apart from the gravely ill and subsequently dead person. Hallmark of restitution is when survivors recognise that they can return to work, resume old roles, acquire new ones, experience pleasure, and seek companionship and love.

The stages described above do not prescribe one correct course of grief. The theories are more of a guideline that describes an overlapping and changeable process that varies between individual survivors.

The best known Kübler-Ross model (five stages of grief) postulates a series of emotions experienced by survivors of an intimate's death. The model was first introduced by Swiss psychiatrist Elisabeth Kübler-Ross in her 1969 book, *On Death and Dying*, and was inspired by her work with terminally ill patients and those faced with death at the University of Chicago medical school. Despite the book being accepted by the general public its validity is not consistently supported in the research literature.

Similar to stages described above, Kübler-Ross noted later in life that the stages are not a linear and predictable progression but rather, these are a collection of five common experiences for the bereaved that can occur in any order, if at all.

The stages, known by the acronym **DABDA**, include:

- **Denial** – The first reaction is denial. In this stage individuals believe the diagnosis is somehow mistaken, and cling to a false, preferable reality.
- **Anger** – When the individual recognises that denial cannot continue, they become frustrated, especially at proximate individuals. Certain psychological responses of a person undergoing this phase could be: 'Why would this happen?'; 'Why me? It's not fair!'; 'How can this happen to me?'; 'Someone is to blame?'
- **Bargaining** – The third stage involves the hope that the individual can avoid the cause of grief. Usually, the negotiation for an extended life is made in exchange for a reformed lifestyle. People facing less serious trauma can bargain or seek compromise.
- **Depression** – In the fourth stage, the individual despairs at the recognition of their mortality. 'I'm so sad, why bother with anything?'; 'I'm going to die soon, so what's the point?'; 'I miss my loved one, why go on?'. In this state, the individual may become silent, refuse to see visitors and spend much of the time in a mournful or sullen state.
- **Acceptance** – In this last stage, individuals embrace mortality or inevitable future, or that of a loved one, or accept some other tragic event; 'It's going to be okay.'; 'I can't fight it, I may as well prepare for it.'. People dying may precede the survivors in this state, which typically comes with a calm, retrospective view for the individual, and a stable condition of emotions.

Kübler-Ross later expanded her model to include any form of personal loss, such as:

- the death of a loved one
- the loss of a job or income
- major rejection
- the end of a relationship or divorce
- drug addiction
- incarceration
- the onset of a disease or chronic illness
- an infertility diagnosis
- even minor losses.

### Application to this scenario:

Psychological responses of a person facing death: end of life distress is the predicament presented in this scenario with evidence of 'denial', 'anger' or a sense of the patient wanting to isolate herself from the living.

There are complex and emotional aspects that are relevant which include:

- sudden change to health
- terminal state discovered recently
- already in stage of palliation / end of life care
- young age of the terminally ill person
- presence of a family with young children
- feelings of anger / irritability and in denial
- patient suffering
- husband and children suffering
- patient's mother and friends being pushed away
- whether she could manage her own pain better.

Specific to this scenario is the issue of a health professional losing control of their health and being in a situation of increasing dependence. The candidate may also consider the impact of intervening in the care of a fellow health professional who was functioning until recently.

The candidate should outline possible steps in management:

- Careful assessment to exclude any treatable psychiatric disorder.
- Referral to the hospital psychologist or to the CL service psychologist with an aim to address the acute anguish of the patient in the limited time left, but also help her leave behind some form of legacy for her children and family.
- Speaking with the patient about her feelings and trying to establish if there is anything she may think might be helpful e.g. regrets that could be resolved or any other uncompleted wishes.
- Seeking the patient's permission for a meeting with her and her husband so that her views and those of her husband can be shared and plans can be made.
- Offering to refer the husband and sons for grief counselling; consider the needs of her mother. Ensure that any interventions for the children are age appropriate.
- Consideration of short term anxiolytic medication such as benzodiazepines and / or an antidepressant medication.
- Consider the possibility of a small dose of a second generation antipsychotic to assist with delirium features and / or ruminative thinking.
- Pharmacotherapy that could be considered in a patient in the terminal stages include the following:
  - Benzodiazepines e.g. Midazolam or Lorazepam or Clonazepam or Diazepam for relief of distress, to calm patient and help them sleep.
  - Use of the stimulant (e.g. Methylphenidate) in the terminal stages could improve the affect and energy levels, improve overall cognition, assist in dissipating opioid related sedation such that it may enable the person to conclude their affairs.
- There is an urgency, much like that described by the husband to improve what can be improved, to enable all the present family members to spend time together that is meaningful.
- Better candidates will clearly identify this and also not forget to incorporate the broader family and the patient in treatment management.

Each of the family members is undergoing a grieving process that has not crystallised until the death of their wife, mother and daughter. They will be in the early stages of grief with the mourning expected when the patient dies. It is crucial to involve community agencies that could provide age matched assistance to each of the individuals. The agencies include:

1. Supporting Family agencies
2. School based counsellors
3. Faith based supports

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## STATION 2 – MARKING DOMAINS

### The main assessment aims are:

- To explain the important psychological issues and the impact of impending death for a person with a terminal illness.
- To describe a pragmatic approach to manage a relatively young person who is dying of terminal illness in a consultation liaison psychiatry setting.
- To discuss the supportive management of family / friends facing the impending death and the aftermath of death of their loved one.

### Level of Observed Competence:

#### 6.0 SCHOLAR

#### 6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature in relation to this scenario? (Proportionate value - 20%)

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

candidate acknowledges that scientific information is not in a state of known versus unknown but is the subject of debate; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge; may be aware of more than one model of grief and loss.

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

identifying key aspects of the available literature; commenting on the voracity of the available evidence; specifying the key proponents of current knowledge base; discussing major strengths and limitations of available evidence; describing the relevant applicability of theory to the scenario; recognising how research has led to a greater understanding of how to develop core clinical skills.

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

- Accurately identify the five stages of the Kübler-Ross model.

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

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

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

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

unable to demonstrate adequate knowledge of the literature / evidence relevant to the scenario; inaccurately identifies or applies literature / evidence.

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

#### 1.0 MEDICAL EXPERT

#### 1.11 Did the candidate provide an adequate explanation of the psychological impact of impending death on this patient? (Proportionate value - 20%)

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

candidate provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation.

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

identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating medical, psychological and sociological information; accurately applying recognised theories and evidence; accurately linking formulated elements to any diagnostic statement; including a sociocultural formulation; analyses vulnerability and resilience factors; considers differential diagnoses which may include adjustment disorder, major depression and delirium

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

- Prioritise a grief process over a formal psychiatric disorder.

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

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

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

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

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

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

**3.0 COLLABORATOR**

**3.2 Did the candidate describe an appropriate initial management plan and involve the treating team in developing these plans? (Proportionate value - 40%)**

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

communicating proposed plans clearly and with good judgment to involved others; suitably engaging necessary other health professionals; expressing views and expectations candidly and respectfully; effectively negotiates complex aspects of care.

**Achieves the Standard by:**

communicating plans clearly and with good judgment to involved others; suitably engaging necessary other health professionals; expressing views and expectations candidly and respectfully, ensures a biopsychosocial approach.

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

- a. Recommend involvement of a psychologist in support of patient and family members
- b. Consider pharmacotherapy in the patient along with the palliative care physician.

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

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

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

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

errors or omissions impact adversely on the proposed plan; plan lacks structure; not tailored to patient's needs.

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

**2.0 COMMUNICATOR**

**2.1 Did the candidate demonstrate an appropriate professional approach to involving and caring for the patient's family during the illness and after her death? (Proportionate value - 20%)**

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

able to generate a complete and sophisticated understanding of complexity; intends to tailor interactions to maintain rapport within the therapeutic environment; demonstrates the importance of ensuring respectful and open communication.

**Achieves the Standard by:**

prioritising ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the client taking regard of culture, gender, ethnicity etc; providing education; communicating plans and discussing acceptability; negotiating alternatives; recognising confidentiality and bias.

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

- a. Identify need to address the grief experience of each family member.

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

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

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

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

errors or omissions materially adversely impact on alliance; inadequately reflects on relevance of information obtained; does not consider the after care for the family.

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

**GLOBAL PROFICIENCY RATING**

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

In this station the candidate must assess Carol, a 28-year-old woman referred by her GP with a history of 'funny turns', anxiety and difficulty sleeping. Carol has a history of trauma and the candidate is expected to elicit and provide a formulation to the examiner, identifying PTSD and dissociation as the preferred diagnosis.

**1.1 The main assessment aims are:**

- To evaluate the candidates' ability to assess PTSD and associated symptoms of dissociation.
- To provide a sophisticated formulation for PTSD with dissociation incorporating the role of previous trauma.
- To apply relevant theories to the formulation.

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

- Establish a history of specific trauma relevant to PTSD symptoms presented.
- Enquire about depersonalisation symptoms.
- Confirm the diagnosis of PTSD with dissociative symptoms.
- Identify at least two of the most appropriate differential diagnoses.
- Explore the relevance of trauma with sensitivity.
- Apply a relevant theory when providing a formulation for her PTSD.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders, Core Psychiatric Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis; Formulation), Communicator (Patient Communication – To Patient / Family / Carer)

**References:**

- Levin, A.P, Kleinman S.B. and Adler J.S. (2014) DSM-5 and Posttraumatic Stress Disorder *Journal of the American Academy of Psychiatry and Law* 42:146–58.
- Mueller-Pfeiffer C et al (2013), Characteristics of Child Maltreatment and Their Relation to Dissociation, Posttraumatic Stress Symptoms, and Depression in Adult Psychiatric Patients *Journal of Nervous and Mental Disease* 201: 471 – 477.
- Simeon, D., Guraknik, O., Schmeidler, J., Sirof, B., & Knutelska, M. (2001). *The role of childhood interpersonal trauma in depersonalisation disorder. American Journal of Psychiatry*, 158(7), 1027-1033.
- Van der Kolk, B. A., David, P., Roth, S., Mandel, F., McFarlane, A. C., & Herman, J. (1996). *Dissociation, somatisation, and affect dysregulation: The complexity of adaptation to trauma. American Journal of Psychiatry*, 153 July 1996 Festschrift supplement(7), 83-93.
- Wolf E. J. et al (2012) A Latent Class Analysis of Dissociation and Posttraumatic Stress Disorder Evidence for a Dissociative Subtype, *Archives of General Psychiatry*, 69(7):698-705.

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female, late 20s.
- 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 outpatient setting.

A GP has referred a 28-year-old woman called Carol. His letter reads:

*'Please can you see Carol, a school teacher who is well known to me since 2011, although I don't know too much about her distant past. She presented to me about a month ago with difficulty sleeping and anxiety. When I saw her she described 'funny turns' where she feels she cannot connect with her students. These have interfered with her ability to teach and as a result she had to take sick leave.*

*There is no history of hypertension or a head injury and she has seen both a cardiologist and neurologist and had a normal CT and EEG, and bloods. I therefore do not believe that these 'turns' are cardiac or neurological.*

*From a psychiatric perspective, I could not elicit any psychotic symptoms and she has no history of drug or alcohol use. I am rather at a loss about her diagnosis so I gave her some zopiclone to help with sleep but she is not keen on medication.'*

### Your tasks are to:

- Take a focussed psychiatric history from Carol with sufficient detail to establish a diagnosis and formulation.
- Present a detailed explanatory formulation, diagnosis and differential diagnoses **to the examiner**.

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

### 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 of the cue for the scripted prompt you are to give at ten (10) minutes.
- 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 **twelve (12) minutes**, as indicated by the timer, if the candidate has not already begun, provide the following prompt:  
***'Please proceed to the second task.'***
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

#### At conclusion of examination:

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

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

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

***'My GP thought I should come and see you as I feel like I don't know who I am anymore.'***

At **twelve (12) minutes**, as indicated by the timer, if the candidate has not already begun, provide the following prompt:

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

#### 3.2 Background information for examiners

In this station the candidate is expected to take a focussed history from a young woman who is experiencing 'funny turns' associated with anxiety and insomnia. The candidate is to elicit a history of trauma and conclude that she is suffering from PTSD with associated symptoms of dissociation, incorporating the role of previous trauma in the formulation.

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

- Establish a history of specific trauma relevant to PTSD symptoms presented.
- Enquire about depersonalisation symptoms.
- Confirm the diagnosis of PTSD with dissociative symptoms.
- Identify at least two of the most appropriate differential diagnoses.
- Explore the relevance of trauma with sensitivity.
- Apply a relevant theory when providing a formulation for her PTSD.

A surpassing candidate may synthesis the following material and also distinguish the difference between dissociative SYMPTOMS and dissociative DISORDERS.

There has long been a recognised link between trauma and mental and emotional disturbance, specifically that severe trauma can seriously affect people on an ongoing basis. In her classic book 'Trauma and Recovery' Judith Herman (1992) describes trauma as events that overwhelm the ordinary adaptations to life and are characterised by terror and helplessness (pp. 33-35). This can have long-term self-perpetuating effects where the overwhelming events remain unintegrated in the psyche, damaging both one's sense of self and relational capacities. She notes that for those whose trauma included a physiological freeze response (frozen with terror) are particularly prone to later problems. Where the trauma is from childhood, she identifies three major forms of adaptation: dissociative symptoms, a fragmented identity, and difficulty regulating emotional states (p. 110).

#### **Dissociative Symptoms**

Dissociation is a word that is used to describe the disconnection or lack of connection between things usually associated with each other. Dissociative symptoms include depersonalisation (feeling unreal), derealisation (feeling as if the world is unreal) or blanking out.

Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness (Anderson & Alexander, 1996; Frey, 2001; International Society for the Study of Dissociation, 2002; Maldonado, Butler, & Spiegel, 2002; Pascuzzi & Weber, 1997; Rauschenberger & Lynn, 1995; Simeon et al., 2001; Spiegel & Cardena, 1991; Steinberg et al., 1990, 1993). In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. For example, someone may think about an event that was tremendously upsetting yet have no feelings about it. Clinically, this is termed emotional numbing, one of the hallmarks of post-traumatic stress disorder.

Fragmented identity is associated with an unstable changeable personality or an internal sense of fragmentation. Difficulty regulating emotional states refers to symptoms of emotional instability and reactivity.

The psychological process of dissociation is commonly found in people seeking mental health treatment (*Maldonado et al., 2002*). Dissociation may affect a person subjectively in the form of 'made' thoughts, feelings, and actions. These are thoughts or emotions seemingly coming out of nowhere, or finding oneself carrying out an action as if it were controlled by a force other than oneself (*Dell, 2001*). Typically, a person feels 'taken over' by an emotion that does not seem to make sense at the time. Feeling suddenly, unbearably sad, without an apparent reason, and then having the sadness leave in much the same manner as it came, is an example. Or someone may find himself or herself doing something that they would not normally do but unable to stop themselves, almost as if they are being compelled to do it. This is sometimes described as the experience of being a 'passenger' in one's body, rather than the driver.

There are five main ways in which the dissociation of psychological processes can change the way a person experiences living: depersonalisation, derealisation, amnesia, identity confusion, and identity alteration. There are several types of dissociative disorders, all of which cause a change in consciousness, memory, identity, or how one views his or her surroundings. The change can come on abruptly or slowly, and it may not happen all the time.

There are four types of dissociative disorders:

- **Depersonalisation / Derealisation Disorder:** a person feels 'detached from' their thoughts or body. For example, they may feel as though they are floating outside their body, looking at people through a window, or in a dream. Despite these experiences, the person still stays in touch with reality.
- **Dissociative Amnesia:** where a person has one or more experience of being unable to remember or recall important information about themselves. This difficulty in remembering information goes beyond simple forgetfulness. The information that the person cannot recall is usually about some kind of traumatic or stressful event.
- **Dissociative Identity Disorder:** used to be called, 'Multiple Personality Disorder' where a person will have two or more separate identities that each have their own way of thinking and relating to the world. To have this disorder, a minimum of two of these identities must also take control over the person's behaviour again and again. The person with dissociative identity disorder may also have difficulty remembering personal information that, like dissociative amnesia, goes beyond simple forgetfulness.
- **Dissociative Disorder Not Otherwise Specified:** this term is used to describe a dissociative disorder where the main feature is still some kind of dissociative experience, but criteria for other dissociative disorders are not present.

Dissociative disorders are common among people with other disorders. For example, some studies have found that over 10 percent of people with psychiatric disorders in treatment have had some kind of dissociative disorder.

In addition, people who have experienced abuse and / or neglect in childhood may be particularly at risk for developing a dissociative disorder. For example, one study found that 71 percent of people with a dissociative disorder experienced physical abuse in childhood, and 74 percent indicated that they had been sexually abused as a child (*Foote, B. 2006*).

### **PTSD and Dissociation**

Individuals with PTSD also may be more likely to have a dissociative disorder. For example, a study of 628 women from the general community found that, of those with a dissociative disorder (the most common of which was dissociative disorder not otherwise specified, followed by dissociative amnesia), 7 percent also had a PTSD diagnosis (*Sar V, Akyuz G. Dogan O. (2007)*).

### **The Link Between Trauma and Dissociation**

The relationship between traumatic experiences and dissociative symptoms is well-established in the literature and can be found in studies from many cultures and countries worldwide (e.g. *Baita, 2006; Gingrich, 2006; Sar et al., 2014*).

## Depersonalisation

Depersonalisation is the sense of being detached from, or 'not in' one's body. This is what is often referred to as an 'out-of-body' experience. However, some people report rather profound alienation from their bodies, a sense that they do not recognise themselves in the mirror, recognise their face, or simply feel not 'connected' to their bodies in ways which are challenging to articulate (Frey, 2001; Guralnik, Schmeidler, & Simeon, 2000; Maldonado et al., 2002; Simeon et al., 2001; Spiegel & Cardeña; Steinberg, 1995). Depersonalisation is often associated with trauma. It can sometimes present like atypical depression and is often co-morbid with it (Baker et al., 2003, p. 428). The symptoms include feeling emotionless and detached from various aspects of self (Depersonalisation Research Unit DRU, 2001, p. 128) and 'feelings of having the mind empty of thoughts, memories or images, and an inability to focus and sustain attention' (Sierra & Berrios, 2000, p. 154). Clients may report such things as 'I don't feel like a person' or 'Most of the time I'm feeling empty' or 'It's very rarely that I can conjure up memory or emotions about the past or anything like that, because normally I can't'.

Physiologically depersonalisation is understood as a 'heightened arousal combined with a dampening of emotional response, [and] is widely viewed as a defence mechanism in the face of severe stress, life-threatening situations or trauma' (DRU, 2001, p. 129). This view is shared by Sierra & Berrios who contend that depersonalisation 'results from two simultaneous mechanisms: an inhibition of emotional processing, and a heightened state of alertness' (2000, p. 154).

## Derealisation

Derealisation is the sense of the world not being real. Some people say the world looks phony, foggy, far away, or as if seen through a veil. Some people describe seeing the world as if they are detached, or as if they were watching a movie (Steinberg, 1995).

## Post-Traumatic Stress Disorder (PTSD)

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The diagnostic criteria are specified below.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

**Criterion A: stressor** - The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

**Criterion B: intrusion symptoms** - The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may re-enact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

**Criterion C: avoidance** - Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

**Criterion D: negative alterations in cognitions and mood** - Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., 'I am bad', 'The world is completely dangerous').
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

**Criterion E: alterations in arousal and reactivity** - Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behaviour
2. Self-destructive or reckless behaviour
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

**Criterion F: duration** - Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

**Criterion G: functional significance** - Significant symptom-related distress or functional impairment (e.g., social, occupational).

**Criterion H: exclusion** - Disturbance is not due to medication, substance use, or other illness.

**Specify if: With dissociative symptoms.**

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

1. Depersonalisation: experience of being an outside observer of or detached from oneself (e.g., feeling as if 'this is not happening to me' or one were in a dream).
2. Derealisation: experience of unreality, distance, or distortion (e.g., 'things are not real').

**Specify if: With delayed expression.**

Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

The addition of a dissociative subtype of PTSD in DSM-5 was based on three lines of evidence:

1. Several studies using latent class, taxometric, epidemiological, and confirmatory factor analyses conducted on PTSD symptom endorsements collected from Veteran and civilian PTSD samples indicated that a subgroup of individuals (roughly 15 - 30%) suffering from PTSD reported symptoms of depersonalisation and derealisation (1-3).
2. Neurobiological evidence suggests depersonalisation and derealisation responses in PTSD are distinct from re-experiencing / hyperarousal reactivity.
3. Early evidence suggests that symptoms of depersonalisation and derealisation in PTSD are relevant to treatment decisions in PTSD (*reviewed in Lanius et al., 2012;5*); e.g. respond better to treatments that included cognitive restructuring and skills training in affective and interpersonal regulation in addition to exposure-based therapies (7,8).

**ICD-10 describes PTSD as:**

- A.** Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.
- B.** Persistent remembering or 'reliving' the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.
- C.** Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).
- D. Either (1) or (2):**
  - 1)** Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor
  - 2)** Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:
    - difficulty in falling or staying asleep;
    - irritability or outbursts of anger;
    - difficulty in concentrating;
    - hyper-vigilance;
    - exaggerated startle response.
- E.** Criteria B, C (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately).

ICD-10 does not specifically identify dissociative symptoms as a specifier for PTSD like DSM-5 does.

**ICD-10 Dissociative [conversion] Disorders** are made up of a separate grouping made up of Dissociative amnesia; Dissociative fugue; Dissociative stupor; Trance and possession disorders; Dissociate motor disorders; Dissociative convulsion; Dissociate anaesthesia and sensory loss; Mixed dissociative [conversion] disorders. Other dissociative [conversion] disorders include Ganser's syndrome, Multiple personality disorder, Transient dissociative [conversion] disorders occurring in childhood and adolescence, Other specified dissociative [conversion] disorders, and Dissociative [conversion] disorder, unspecified.

**Formulation:**

Various theories have been proposed to explain the development and maintenance of post-traumatic stress disorder (PTSD).

The most prominent current theories of emotional processing, dual representation, and the cognitive model of PTSD draw on earlier work, in particular conditioning, information processing, and classical cognitive theory.

Psychodynamic and attachment theory have also influenced thinking in this area. The latest theories combine stimulus and response elements with meaning, interpretation, and appraisal; they argue that successful processing depends on being able to access and assimilate new information within pre-existing schemas. From a biological perspective, the classic fight-or-flight response to perceived threat is a reflexive nervous phenomenon that has obvious survival advantages in evolutionary terms. However, the systems that organise the constellation of reflexive survival behaviours following exposure to perceived threat can under some circumstances become dysregulated in the process. Chronic dysregulation of these systems can lead to functional impairment in certain individuals who become 'psychologically traumatised' and suffer from post-traumatic stress disorder (PTSD).

A body of data accumulated over several decades has demonstrated neurobiological abnormalities in PTSD patients. Some of these findings offer insight into the pathophysiology of PTSD as well as the biological vulnerability of certain populations to develop PTSD. Several pathological features found in PTSD patients overlap with features found in patients with traumatic brain injury, paralleling the shared signs and symptoms of these clinical syndromes. Social factors are also recognised as playing a significant role in the development and maintenance of PTSD. Social factors that moderate the response to traumatic events include:



- Community function and support
- Family function and support
- Displacement
- Disconnection
- Living conditions
- Material loss
- Loss of role
- Food
- Finance
- Disorganised services
- Employment
- Leisure activities

The preferred diagnosis is PTSD with dissociative symptoms.

The candidate should consider important differential diagnoses, the most appropriate being:

- PTSD
- Major Depressive Disorder
- Dissociative Disorder NOS
- Panic Disorder
- Anxiety Disorder NOS
- Borderline Personality Disorder

### 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 well-being 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.

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

## 4.0 Instructions to the Role Player

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

Your name is Carol and you are 28 years old. You are a teacher and are married to Nick who is a 29-year-old builder. You have been referred to an outpatient mental health service by your GP, Dr Maddison.

You are coming to this appointment today as you are worried because you are finding it very difficult to concentrate in the classroom. You have had several strange episodes when students have asked you questions and you find that even though you can hear them it seems as if they are far away. At these times, you feel detached / disconnected and as if you are outside your body looking on.

On two occasions, you have left the classroom and found yourself in the staff toilet without consciously being aware you had meant to go there. You have no idea what you did or said before leaving the class which is very embarrassing. You have even wondered if you are blacking out or having a fit.

You have had some tests organised by your GP and 2 medical specialists, and they have found nothing wrong. Despite this you are now on sick leave.

You have started to feel desperate as this has been going on for 4 weeks now and you have been off work for 2 weeks. You are worried you will lose your job and this worry is stopping you from falling asleep. You have even started to feel like it would be easier if you were just dead. If you are asked if you would commit suicide, you are sure that you could never harm yourself. The reason you are so sure is because of the distress it would cause your parents whom you saw in great pain when your brother was murdered (see details under personal background and family circumstances below).

If asked about your opinion of your future or future plans: you feel as if you have no future especially if you can't work (which you usually take great pride in), and you are worried about your relationship with your husband as you now feel distant from him (as well as everyone else). The idea of having children seems impossible which makes you worry more about your relationship.

If you are asked by the candidate: you do not have strange experiences like seeing things or hearing voices; you are not paranoid (you don't feel threatened by anyone) or hold any other beliefs that others don't think are real. You do not drink alcohol and have never used drugs. You have never been referred to a psychiatrist before and have never been admitted to a psychiatric hospital.

#### About your personal trauma background and family circumstances:

You have a difficult relationship with your parents whom you find intrusive and critical. You try to keep them at arm's length, and purposefully work and live on the other side of Perth from them. You have never confronted them about how you feel about their behaviour as you think this will make matters worse. Your mother, Annette, suffers from bouts of depression and your father Martin drinks too much. Both these issues have worsened since your brother's murder. You have a sister, Debbie, who is 2 years older than you and lives in England and with whom you have little contact.

You were sexually abused between ages of 11 and 14 by a male extended family member (your paternal aunt's husband - your father's sister's husband George). You have never disclosed this to your parents or had any specific sexual abuse counselling. You try not to think about this and block it out so don't really feel anything (well you say you don't).

When you were 16 your older brother Simon was shot in somewhat unclear circumstances which may have involved a drug deal. You were very traumatised by this and particularly by what was written in the papers, and the intrusive nature of the press on you and your family. The perpetrator was convicted for murder but the motive was never established. You had some brief counselling through victim support at the time of your brother's death and at that time disclosed the sexual abuse to that counsellor but you did not want to take things any further. You feel that your brother's death, and the events around that 'took over' and blocked out the previous experiences with your uncle.

You have never sought counselling since then, preferring to throw yourself into work and sport and 'get on with your life' with Nick, and have tried not to think about things from the past too much. Living on the other side of the city away from childhood haunts also helps you not to be reminded of him and you generally don't accept invitations to meet up with childhood associates or attend functions in that area of the city. You also tend to avoid family gatherings - of which there are few anyway. You have not been aware of being distressed over the last few years and would describe yourself as calm. You and Nick don't discuss much

about how either of you feel about things in general and don't argue about things. You are aware that people see you as unemotional and also that you don't seem to get as excited or enjoy things as much as other people. You have had flashbacks over the years more often to do with your brother e.g. of the press crowding around the house when you were trying to get to the car and have been surprised when you have also had flashbacks of the sexual abuse as you thought you had 'dealt with this'. You try to never watch the news on TV as you feel very upset and angry when you see the press asking family members questions after a traumatic event.

The perpetrator of your brother's murder is now due for release from prison and you suddenly find yourself unable to function. You have great difficulty in getting to sleep and staying asleep (which has been a long term issue but is currently even worse than ever) and have experienced a panic attack for the first time recently, waking you from sleep (woke up terrified, sweating, heart racing, hyperventilating, feeling like you are having a heart attack) with nightmares, low mood, tearfulness. You find that you no longer can get interested in or care about your students and are struggling with your own study and assignments.

#### About your medical care:

You have had the same GP, Dr Maddison, for the past 6 years since you moved to where you now live and work. You have seen her regularly for contraception and minor illnesses or sports injuries. You have some trust in her and have told her a little about what happened with your brother and a little about your plans / concerns about having children e.g. how it will impact on your career / study.

In response to your recent symptoms, your GP has examined you and referred you to see a cardiologist (heart specialist) and a neurologist (nerve / brain specialist) who have also examined you and run some tests. One test was a scan of your brain and another was called an EEG - that was like a heart tracing test.

They have not found any explanation for your symptoms and the GP thinks you might be depressed. The GP has given you some sleeping tablets but they are not helping and now wants you to take medication for depression but you are hesitant and frightened it will make you feel worse. You took an antidepressant for a short period after your brother died but you didn't think it helped you, and it didn't agree with you (headaches and nausea). You can't remember what the antidepressant was called and are reluctant to try one again so your GP has referred you to mental health for further advice.

#### About your social life and marriage:

You met your husband Nick through Touch Rugby-Football when you were 20. You live in your own home which Nick renovated. You are very focussed on your job and are also studying further papers in education and are hoping to gain a Master's degree in education. While you and Nick socialise a little with some members of his family and colleagues of yours from work, the two of you have been busy with the house renovation and you with your study. You gave up Touch a couple of years ago, as you were studying but Nick still plays. You have no children but have talked about it and Nick is keen for this to happen soon. You are quite ambivalent about having children but have not disclosed this to Nick as you are worried that this will affect your relationship.

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

Plain slightly formal casual clothing: conservative skirt and top, flat shoes, tidy grooming but no make-up. Sit in upright posture, knees together, feet flat on floor, hands folded in lap.

You are ill at ease but sitting still, looking down or ahead, with very little eye contact with the candidate. Your speech is soft and monotonous in tone and you do not really talk unless it is in response to questions with little spontaneity.

You can give the candidate one or two shy smiles but not much emotional expression / reaction overall. Not angry or hostile.

## **4.3 Opening statement:**

***'My GP thought I should come and see you as I feel like I don't know who I am anymore.'***

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

Candidate should ask you about your mood (low and sad and numb), concentration (bad), memory(okay), sleep (terrible-can't get to sleep, can't stay asleep), appetite (never been great and currently not much different), enjoyment of things and interest (non-existent), anxiety (you are not aware of worrying about anything in particular), panic attacks (yes), repeated, unwanted thoughts – obsessions - about things like excessive cleanliness or compulsive checking or cleaning (no), fear of being in social situations (no, but you don't socialise much and feel like you don't like people).

#### 4.5 Responses you MUST make:

*'It's like I am watching from outside my body.'*

*'I feel like I'm fake, it's as if I'm not real.'*

*'At the time my brother's death took over my life.'*

#### 4.6 Responses you MIGHT make:

Anticipated Question: Do you feel like you are numb or you have lost your identity?

Scripted Response:

*'Yes — although I'm not sure I have ever really felt like I was truly part of things.'*

*'I don't think I have ever known who I am.'*

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

Zopiclone 7.5 milligrams one tablet at night to help with sleep.

## STATION 3 – MARKING DOMAINS

### The main assessment aims are:

- To evaluate the candidates' ability to assess PTSD and associated symptoms of dissociation.
- To provide a sophisticated formulation for PTSD with dissociation incorporating the role of previous trauma.
- To apply relevant theories to the formulation.

### 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 incorporating questions which clearly differentiate between the Dissociative Disorders and PTSD with dissociative symptoms.

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

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; history taking is hypothesis-driven; eliciting key issues relevant to the patient's problems and circumstances including: relevant PTSD symptoms e.g. re-experiencing event, negative emotion, autonomic hyperarousal; integrating key psychosocial issues relating to the trauma; exploring dissociative symptoms; completing a risk assessment relevant to mood and trauma related symptoms.

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

- Establish a history of specific trauma relevant to PTSD symptoms presented
- Enquire about depersonalisation symptoms.

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

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

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

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

does not ask if there is a history of trauma; does not ask about symptoms of PTSD or dissociation.

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

#### 1.9 Did the candidate describe the relevant diagnosis and differential diagnosis? (Proportionate value - 25%)

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

concludes and justifies PTSD with dissociative symptoms and rules out other forms of PTSD and other dissociative disorders. 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 the conditions relevant to the obtained history and findings, utilising a biopsychosocial approach, and / or identifying relevant predisposing, precipitating perpetuating and protective factors.

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

- Confirm the diagnosis of PTSD with dissociative symptoms
- Identify at least two of the most appropriate differential diagnoses.

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

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

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

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

inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusion. Does not include PTSD or Dissociation in differential diagnosis.

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

**2.0 COMMUNICATOR**

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

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

able to generate a complete and sophisticated understanding of the complexity of issues for this person; effectively tailors interactions to maintain rapport within the therapeutic environment tailoring the approach to be able to sensitively gather enough information.

**Achieves the Standard by:**

demonstrating empathy and the ability to establish rapport with an anxious and traumatised female; forming a partnership using language and explanations tailored to an individual who has a history of trauma and recent poor functioning; effectively managing challenging communication.

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

- a. Explore the relevance of trauma with sensitivity.

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

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

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

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

would adversely impact on alliance by being overly pushes for information with an intrusive manner or is avoidant approach to gathering information; demonstrates lack of understanding of the patient; inadequately reflects on relevance of information obtained; unable to maintain rapport.

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

**1.0 MEDICAL EXPERT**

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

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

provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation. Includes several explanatory models which are relevant for this particular patient.

**Achieves the Standard by:**

identifying and succinctly summarising important aspects of repeat past trauma and vicarious trauma; incorporating accurate observation of the mental state phenomenology of dissociation; synthesising the information using a biopsychosocial framework; integrating enough of the medical, developmental, psychological and sociological information to plausibly explain symptoms in this person; accurately describing evidence of theories such as emotional processing, cognitive, biological, stimulus and response, psychodynamic; analyses vulnerability and resilience factors; commenting on missing or unexpected data, particularly with a traumatic past; accurately linking formulated elements to any diagnostic statement (**NB: diagnosis is marked separately**)

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

- a. Apply a relevant theory when providing a formulation for her PTSD.

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

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

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

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

significant deficiencies including inability to synthesise information obtained; failure to question veracity where this is important; does not formulate PTSD.

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

**GLOBAL PROFICIENCY RATING**

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

In this station the candidate is expected to take a brief history from a patient Jack Flynn, a 36-year-old man with bipolar disorder, who wants to stop his current psychotropic medication. He is insisting on switching to medicinal cannabis. The candidate must demonstrate their level of knowledge regarding the evidence for medicinal cannabis and that they are able to negotiate with the patient to continue current treatment.

### 1.1 The main assessment aims are:

- To demonstrate the ability to take a brief history to confirm that the patient's mood symptoms are stable and that there is no reason to change medication.
- To demonstrate an awareness of the indications for medicinal cannabis and its role in the current clinical environment.
- To demonstrate the ability to provide advice and negotiate reconsideration of medicinal cannabis.

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

- Identify that the patient's bipolar disorder is stable.
- Elicit weight gain as the major driver for desire to change treatment.
- Clearly advise the patient that medicinal cannabis is not indicated for mood disorders.
- Recommend options for management of weight gain.
- Explain the most evidence-based indications for medicinal cannabis that are likely to meet legislative requirements.
- Identify that it is still illegal for the patient to grow cannabis.

### 1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Collaborator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Management – Treatment Contract), Collaborator (Relationships), Professional (Compliance & Integrity)

#### References:

- Adler JN, Colbert JA. Clinical decisions: medicinal use of marijuana — polling results. *N Engl J Med* 2013; 368: e30.
- Belendiuk KA, Baldini LL, Bonn-Miller MO, Narrative review of the safety and efficacy of marijuana for the treatment of commonly state-approved medical and psychiatric disorders, *Addiction Science & Clinical Practice*, 10/10 (2015), para. 14, <http://www.ascpijournal.org/content/10/1/10>.
- Carter GT, Flanagan AM, Earleywine M, et al. Cannabis in palliative medicine: improving care and reducing opioid-related morbidity. *Am J Hosp Palliat Care* 2011; 28: 297-303.
- Compton M,T. Marijuana and Mental Health. 18 May 2016. American Psychiatric Association Publishing; 1000 Wilson Boulevard, Suite 1825, Arlington, VA, 22209.
- Joy JE, Watson SJ Jr, Benson JA Jr, editors. *Marijuana and medicine: assessing the science base*. Washington, DC: National Academy of Sciences, 1999. <http://www.nap.edu/readingroom/books/marimed>
- Kleijnen Systematic Reviews Ltd, *Systematic review of cannabis for medical use* (York: Kleijnen Systematic Reviews Ltd, September 2014).
- Martin JH, Bonomo YA. Medicinal cannabis in Australia: the missing links. *Med J Aust* 2016; 205 (9): 425.
- Mather, LE, Rauwendaal, ER, Moxham-Hall, VL, Wodak, AD. (Re)introducing medicinal cannabis. *Med J Aust* 2013; 199 (11): 759-761.

- Penington, DG. Medical cannabis: time for clear thinking. *Med J Aust* 2015; 202 (2) Pages:74 – 76.
- Porter BE, Jacobson C Report of a parent survey of cannabidiol-enriched cannabis in pediatric treatment resistant epilepsy. *Epilepsy Behav* 2013; 29: 574-577.
- Victorian Law Reform Commission, Medicinal Cannabis Report, August 2015.
- Whiting, Penny et al. Cannabinoids for medical use: a systematic review and meta-analysis. *JAMA* 2015; (vol 313) June23/30: no.24.
- Wilsey B, Marcotte T, Deutsch R, et al. Low-dose vaporized cannabis significantly improves neuropathic pain. *J Pain* 2013; 14: 136-148.
- Therapeutic Uses of Cannabis: Report and Evidence (House of Lords Papers) Select Committee on Science and Technology Second Report March 2001. <http://www.publications.parliament.uk/pa/ld200001/ldselect/ldsctech/50/5002.htm>
- Information for Health Care Providers – Health Canada [http://www.hc-sc.gc.ca/dhp-mps/alt\\_formats/pdf/marihuana/med/infoprof-eng.pdf](http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marihuana/med/infoprof-eng.pdf)
- Barnes M, Barnes J, Cannabis: The Evidence for Medical Use, May 2016 [http://www.drugsandalcohol.ie/26086/1/Cannabis\\_medical\\_use\\_evidence.pdf](http://www.drugsandalcohol.ie/26086/1/Cannabis_medical_use_evidence.pdf)
- The Health Effects of Cannabis and Cannabinoids: The current state of evidence and recommendations for research - A report of the National Academies of Sciences Engineering Medicine in the <https://www.nap.edu/catalog/24625/the-health-effects-of-cannabis-and-cannabinoids-the-current-state>

#### 1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male (must be slightly overweight), late 30s, dressed casually.
- Pen for candidate.
- Timer and batteries for examiner.



## 2.0 Instructions to Candidate

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

You are working as a junior consultant in a community psychiatry clinic.

One of your patients, 38-year-old Jack Flynn, has come to see you for a regular check-up of his bipolar disorder which was diagnosed 12 years ago, and has been well controlled over the last 2 years. Jack would like you to prescribe medicinal cannabis.

### Your tasks are to:

- Discuss with Jack his request to get access to medicinal cannabis for treatment of his bipolar disorder.
- Negotiate a treatment plan with Jack.

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

### At conclusion of examination:

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

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

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

***'Doc, I am keen to change my medication.'***

#### 3.2 Background information for examiners

This station aims to assess the candidates' ability to take a brief history from a stable bipolar patient who wants to stop his current psychotropic medication. They are expected to be able to demonstrate their level of knowledge regarding the evidence for medicinal cannabis and use this knowledge to negotiate with the patient to continue current treatment based on lack of evidence for medicinal cannabis in bipolar disorder.

To ensure that the patient is stable and that the request is not part of a relapse, the candidate would be expected to briefly assess the patient's mental state.

Risk assessment may be undertaken by the candidate and could include important aspects of the history, for instance:

- Pattern of illness: highs and lows, hospitalisations, treatments
- Problems or losses from either mania or depression e.g. job, relationship

In attempting to better understand the patient's request the candidate should consider issues like:

- Duration of current treatment regime
- Rationale for wanting to cease treatment
- Knowledge of and reason for considering medical cannabis.

When discussing treatment options, the pros and cons of stopping medication for any reason should be considered.

It is critical that the candidates work in a non-judgemental collaborative manner and allow the patient to explore his options for treatment.

With respect to medicinal cannabis, candidates are expected to demonstrate knowledge of the common indications for medicinal cannabis in countries where it is allowed and understand the level of availability in Australia / New Zealand.

There is no robust evidence to support the use of medicinal cannabis in bipolar disorder and the candidate must manoeuvre their way through a negotiation to end the station with some degree of acceptance by the patient.

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

- Identify that the patient's bipolar disorder is stable.
- Elicit weight gain as the major driver for desire to change treatment.
- Clearly advise the patient that medicinal cannabis is not indicated for mood disorders.
- Recommend options for management of weight gain.
- Explain the most evidence-based indications for medicinal cannabis that are likely to meet legislative requirements.
- Identify that it is still illegal for the patient to grow cannabis.

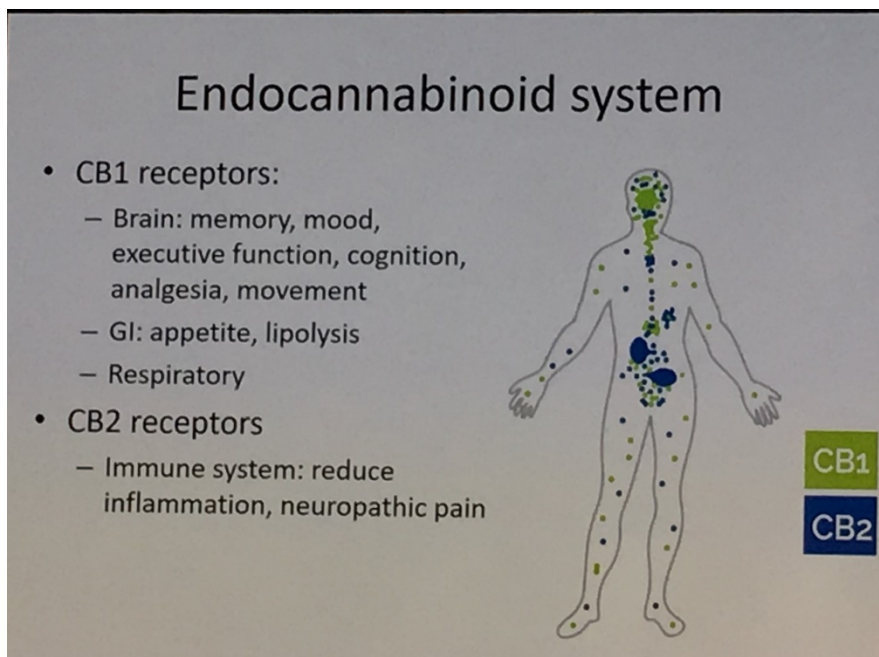
A surpassing candidate may:

- Be able to incorporate the variances in legislation or the controversies related to production, monitoring and distribution as part of their discussion with the patient.

## Cannabinoids

Cannabinoids are classified here as:

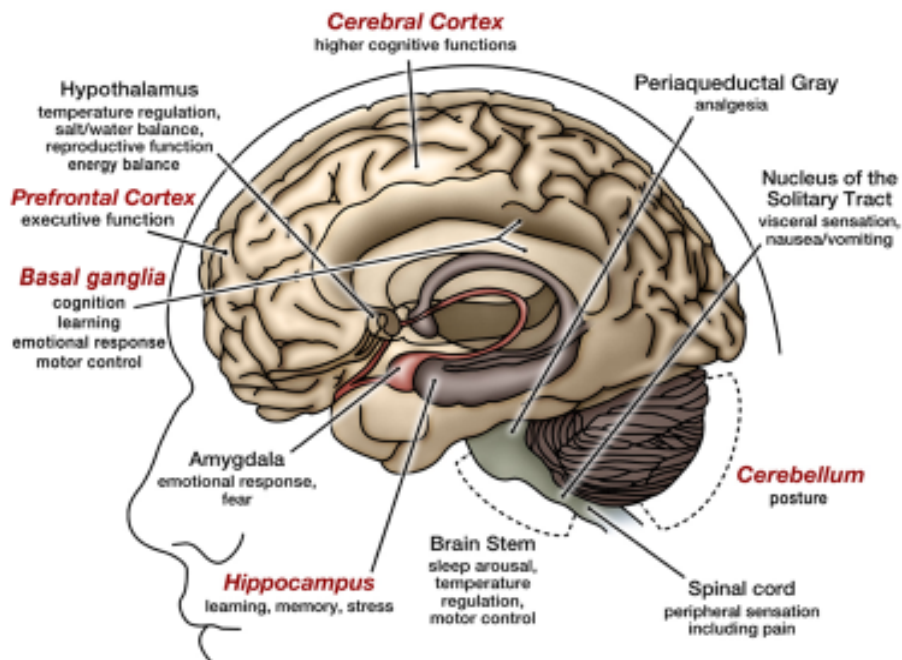
- Phytocannabinoids – plant leaves, flowers, stems, and seeds collected from the *Cannabis sativa* plant and ingested in some form (cigarettes, vapour).
- Endogenous – cannabinoids including *N*-arachidonylethanolamine or anandamide (AE) or 2-arachidonoylglycerol (2-AG). AE and 2-AG activity can be manipulated by inhibiting their corresponding hydrolases FAAH or MAGL, preventing their degradation.
- Purified naturally occurring cannabinoids purified from plant sources: including cannabidiol (CBD) and delta-9-tetrahydrocannabinol (THC).
- Synthetic cannabinoids synthesised in a laboratory: examples include CB1 agonists (CPP-55, ACPA), CB2 agonists (JWH-133, NMP7, AM1241), CB1/CB2 nonselective agonist (CP55940), ajulemic acid (AJA), nabilone, and dronabinol.



As well as THC and CBD, the marijuana plant contains more than 100 other cannabinoids, most of which are non-psychoactive, as well as terpenes. CB<sub>1</sub> receptors are among the most abundant G protein-coupled receptors in the brain, present in almost every brain region and on many different types of neurons. CB<sub>1</sub> receptors are particularly abundant in brain regions such as the hippocampus, cortex, cerebellum, and basal ganglia.

## Brain regions that express the CB<sub>1</sub> cannabinoid receptor

Red = abundant CB<sub>1</sub> receptor expression    Black = moderately abundant CB<sub>1</sub> receptor expression



In Australia and New Zealand there is widespread use of illicit cannabis as a medicine which suggests that there is significant demand even though this use is neither supervised nor regulated. Concerns have been raised that there are no current legally available products of medicinal cannabis and therefore no oversight by appropriate health professionals. The risks are that illegal products may contain unknown ingredients that can put people at risk; that it is difficult to monitor appropriate dosages; and there are risks of interactions and reactions with other medications.

There is disagreement as to whether medicinal cannabis should be made legal despite several states legislating towards this. People argue from both sides; that it is too fast and too soon based on insufficient clinical evidence versus those who claim that enabling legal access has not come soon enough for people suffering specific disorders.

According to Whiting, Penny et al, the term Medicinal Cannabis has been defined as cannabis used 'as a medical therapy to treat disease or alleviate symptoms'. The Victorian Law Reform Commission noted that the use of cannabis to attempt to cure or reduce severity of symptoms due to illness distinguishes it from recreational cannabis.

Pennington would argue that 'cannabis can never be a pharmaceutical agent in the usual sense for medical prescription, as it contains a variety of components of variable potency and actions, depending on its origin, preparation and route of administration'.

### Evidence

Mather et al refer to a German medical review that found 'a preponderance of favourable controlled trials for treatment of a range of conditions including spasticity resulting from disseminated sclerosis (nine favourable, three unfavourable), chemotherapy-induced nausea and vomiting (40 favourable, one unfavourable), HIV / AIDS-related cachexia (seven favourable, none unfavourable), cancer-related cachexia (three favourable, one unfavourable), chronic neuropathic pain (12 favourable, two unfavourable) and other chronic (cancer, rheumatism, fibromyalgia) pain (11 favourable, two unfavourable)'.

Medicinal cannabis is not curative for the indicated disorders, but it can relieve the symptoms associated with them. It may also enable other medication to be given at a lower dosage, especially morphine, and reduce their side effects. Side effects of marijuana that usually do not last long can include dizziness, drowsiness, short-term memory loss and euphoria. More serious side effects include severe anxiety and psychosis.

The FDA requires clinical trials to determine the benefits and risks and so far, researchers have not conducted enough large-scale clinical trials that show that the benefits of the marijuana plant (as opposed to its cannabinoid ingredients). The American Medical Association reviewed the evidence in 2009 and recommended rescheduling cannabinoid-based medicines to allow their legal prescription in the United States. Research into cannabinoids has led to two FDA-approved medications that contain cannabinoid chemical. At least 23 US states have legalised use of cannabis for medical conditions, as has Canada, followed by countries who are also legalising medicinal use of cannabis.

In July 2015 the NSW government announced Australia's first clinical trial of medicinal cannabis in terminally ill cancer patients using pharmaceutical grade cannabis sourced from commercial suppliers overseas.

### **Diagnostic Indications for Medicinal Cannabis:**

Preclinical and a range of small clinical trials with marijuana and its extracts have been undertaken in the treatment of numerous diseases and conditions. The evidence continues to be mainly anecdotal, limited to small trials or hampered by poor design.

- The use in epilepsy is among its historically oldest indications of cannabis. Animal experiments provide evidence of the antiepileptic effects of some cannabinoids. There are case reports of its use in otherwise unmanageable seizure disorder and there is feedback from parents that cannabis reduces seizures in Dravet syndrome (a rare genetic myoclonic epileptic encephalopathy beginning in infancy). The anticonvulsant activity of phenytoin and diazepam have been potentiated by THC. Cannabis use, however, may occasionally precipitate convulsions.
- Trials in 1980s indicated the antiemetic effects of cannabis in nausea from multiple causes, including control of nausea and vomiting associated with chemotherapy for cancer. THC in low doses appears to improve the efficacy of other antiemetic drugs if given together.
- AIDS / HIV - cannabis can control the nausea and vomiting caused by medications used in treatment.
- Studies have shown mild to moderate analgesic properties of THC cannabis products, particularly CB1 receptor agonists. Possible indications are neuropathic pain due to multiple sclerosis, damage of the brachial plexus and HIV infection, pain in rheumatoid arthritis, cancer pain, headache, menstrual pain, chronic bowel inflammation and neuralgias. Combination with opioids is possible.
- A 2015 systematic review of efficacy in chronic pain in nine studies demonstrated a 30% or more reduction in pain when compared to placebo (Whiting et al).
- Cannabis has been shown to decrease intraocular pressure and could prevent blindness in people with glaucoma.
- There are some positive anecdotal reports of therapeutic response to cannabis in Tourette's syndrome, dystonia and tardive dyskinesia.
- Small trials of THC, nabilone and cannabis have shown a beneficial effect, particularly subjective, on spasticity caused by multiple sclerosis or spinal cord injury. This is likely to be related to the high density of cannabinoid receptors in the brain areas controlling movement. Among other positively influenced symptoms were pain, paraesthesia, and modest dose related improvements in dystonia, tremor and ataxia. In some studies improved bladder control was observed.
- Animal studies have shown that marijuana extracts may help kill certain cancer cells and reduce the size of others. Research in mice showed that treatment with purified extracts of THC and CBD, when used with radiation, increased the cancer-killing effects of the radiation (Scott, 2014).
- Anti-inflammatory and relaxant effects of cannabis may be responsible for anecdotal improvements in patients with difficulty taking in food / nourishment (appetite or nausea and vomiting problems), inadequate absorption of nutrients, elimination problems (constipation, diarrhoea, irritable bowel) and / or cancer developing anywhere along the GI tract (Crohn's disease, Ulcerative Colitis, Irritable Bowel Syndrome). Cannabis does appear to be ineffective in anorexia nervosa.
- Dronabinol treatment in 11 patients with Alzheimer's disease resulted in substantial weight gains and declines in disturbed behaviour with no serious side effects observed.
- Cell culture and animal studies have established cannabinoids as immunomodulators and is likely to be multi-faceted.

- According to historical and modern case reports cannabis can combat withdrawal in dependency on benzodiazepines, opiates and alcohol. Both the reduction of physical withdrawal symptoms and stress connected with discontinuance of drug abuse may play a role in perceived benefits.
- There are case reports that claim improvement of mood in depression, which has the greatest self-reported benefit, as well as case reports claiming benefit of cannabinoids in sleep disorders, anxiety disorders, bipolar disorders, and dysthymia. This evidence, however, is not robust.

The Dutch Health authorities developed a list of indications based on the outcome of an extensive review of the scientific literature. Currently, there is sufficient reason to assume that medicinal cannabis can help in cases of:

- pain and muscle spasms or cramps associated with multiple sclerosis or spinal cord damage;
- chronic neuropathic pain (mainly pain associated with the nervous system, e.g. caused by a damaged nerve, phantom pain, facial neuralgia or chronic pain which remains after the recovery from shingles);
- nausea, loss of appetite, weight loss, and debilitation due to cancer or AIDS;
- nausea and vomiting associated with chemotherapy or radiotherapy used in the treatment of cancer, hepatitis C or HIV infection and AIDS;
- Gilles de la Tourette syndrome;
- therapy-resistant glaucoma.

In Australia, the Victorian Law Reform Commission, Medicinal Cannabis Issues Paper (March 2015) identified the following list based on evidence:

- Muscle spasticity and other symptoms of multiple sclerosis
- Chemotherapy-induced nausea and vomiting
- Epilepsy and severe seizures
- HIV and AIDS-related symptoms
- Chronic pain
- Arthritis.

Condition	Number of Studies	Strength of Evidence	Conclusion
Nausea & vomiting	3 RCTs	Low	THC or THC/CBD > placebo
Weight gain in HIV & AIDS	1 RCT	Low	THC > placebo
Spasticity in MS / paraplegia	14 RCTs	Moderate	THC/CBD > placebo
Depression	3 RCTs	Low	Placebo > THC/CBD
Anxiety	1 RCT	Low	CBD > placebo
Sleep	12 RCTs	Low	THC or THC/CBD > placebo
Psychosis	1 RCT	Low	CBD = amisulpiride
Tourette's syndrome	1 RCT	Low	THC > placebo
Glaucoma	1 RCT	Low	THC = CBD = placebo
Epilepsy	Not completed	N/A	CBD

*Taken from Systematic Review of Cannabinoids – Whiting et al. JAMA June 2015*

The reason for this limited list of indications is that the efficacy of medicinal cannabis use for other medical conditions has not yet been properly studied in convincing clinical trials and is subject to change based on new studies.

According to Cochrane, Whiting 2015 and the 2017 US National Academy of Science:

- there is moderate efficacy evidence for nausea and vomiting and analgesia (especially neuropathic pain in MS).
- there is weak efficacy evidence for the treatment of wasting.
- there is limited published evidence for epilepsy.
- there is limited OBJECTIVE evidence for spasticity in MS, but evidence as better than placebo on SUBJECTIVE measures
- there is limited / insufficient evidence in irritable bowel syndrome, Parkinsons disease, Huntington's chorea, anxiety, PTSD and depression.
- there is some weak evidence for CBD-based preparations in schizophrenia.

The evidence differs across the various products; for instance, Dronabinol (nausea & vomiting / appetite); Nabilone (appetite stimulation); nabiximols (Sativex) for spasticity in MS. The last group in the cannabidiol-based preparations (Epidiolex).

However, there are no specific limitations on the conditions for which medicinal cannabis can be prescribed for. Each application from a prescribing doctor will be considered on its merits.

Proponents argue that controlled trials of medicinal cannabis indicate that frequencies of both side effects and dependence are low. Those who oppose the use of medicinal cannabis focus on the lack of evidence, the lack of provenance, inconsistency of dosage, and concern about side effects, including psychosis.

The acute side effects of cannabis include vomiting, impaired coordination and performance, anxiety, suicidal ideation and psychotic symptoms, as well as impaired ability to drive.

Chronic cannabis use is associated with a number of negative health and social effects including increased risk of respiratory diseases associated with smoking, cancer, mood disorders, exacerbation of psychotic disorders in vulnerable people, decreased memory and learning abilities and decreased motivation in areas such as study, work and concentration. The side effects of cannabis when used for medicinal purposes are not well understood.

There is growing evidence that occasional cannabis use by adolescents is associated with greater risk of amotivation, reduced academic performance, lower educational attainment and potentially school dropout. Some adolescents go on to develop addiction. Evidence strongly suggests that heavy cannabis use in adolescence is an independent risk factor for schizophrenia and other psychotic disorders.

#### **Access and Administration:**

Prior to medicinal cannabis becoming readily available there are several issues that need to be resolved. The production and supply of medicinal cannabis should not differ from other botanical medicines. Governance for regulation / registration, and good manufacturing practice (GMP) needs to be in place.

In other countries a range of pharmaceutical-grade products have been made by extracting compounds from cannabis plants. These manufactured products better fit the usual definition of medicines. This is because they are produced so that their composition of active ingredients and purity is standardised, and they can be taken in measured doses, so their likely effects are known.

Questions that still need to be answered include whether in Australia and New Zealand the plant will be grown for the base or will it be synthetic? If it is to be grown, where will this be to ensure consistency and stability?

Other issues include whether scripts should be written or should patients be able to self-titrate; which drug / chemical / combination will be available; and what route(s) of administration, dose and frequency will be available.

As medicinal cannabis will not be listed on the Pharmaceutical Benefits Scheme (PBS), the cost of obtaining medicinal cannabis could amount to thousands of dollars per month. There are difficulties in importing medicinal cannabis products from overseas because of limited supply and legal constraints in those countries.

The product can be imported from a legal supply source overseas according to the *Customs (Prohibited Imports) Regulations 1956*, or in the future produced lawfully under an amended *Narcotics Drug Act 1967*. Despite changes to legislation in 2016, supplies of medicinal cannabis are not expected to be available until early 2017 at the earliest.

In February 2014, Tasman Health Cannabinoids proposed trials of cultivation and processing of medicinal cannabis in Tasmania in conjunction with the University of Tasmania; approved in principle by the Labor Health Minister but subsequently rejected by the incoming Liberal Health Minister. The company then was granted a licence by the Norfolk Island Government to produce medical cannabis, but that licence was overturned by the island's Administrator.

The most common modes of administering botanical cannabis is by transpulmonary, peri-oral, or oral transmucosal routes. Smoking does not deliver an accurate dosage and is not acceptable to many patients, nor is it medically acceptable; however it may be of benefit to certain patients with a short life expectancy or as an expedient self-medication treatment. Vaporisation in an electrically heated vaporiser produces comparable results and is preferable.



Vaporising cannabis:

- Similar to 'e-cigarettes' - vaporising heats cannabis at lower temperature than 'smoking'.
- Higher bioavailability
- No side stream smoke (fewer concerns re: passive smoking)
- Peak THC effects: typically 15-90 min after dose, psychoactive effects for 2-3 hours

Factors that affect drug toxicity / benefit that need to be adjusted for:

- Target symptoms
- Route of administration
- t<sub>1/2</sub>, clearance
- Age, gender, presence of other diseases
- Obesity
- Known / unknown drug AND food interactions
- Patient side effects - tolerability
- Surrogates of efficacy or toxicity
- Drug supply / chemistry

Potential and relative contraindications include:

- Hypersensitivity
- Severe unstable cardiopulmonary disease (CB1 increases the risk of myocardial infarction, especially in the first hour post dose)
- Personal or family history of schizophrenia
- <25 years (due to relative neuroplasticity)
- Severe liver and renal dysfunction
- Heavy drug dependence or prescription of other psychoactive medications.

## LEGISLATION

### Australia:

According to the *Therapeutic Goods Act 1989 (Cwlth)*, the *Narcotic Drugs Act 1967 (Cwlth)* cannabis is a prohibited substance. However, in February 2016 the *Narcotic Drugs Act* was amended to establish a national licensing and permit scheme for lawful use. In August 2016, the Poisons and Therapeutic Goods Amendment (Designated Non-ARTG Products) Regulation (under the Poisons and Therapeutic Goods Act 1966) took effect. The TGA rescheduled all botanical cannabis products and all botanically-derived extracts, when prepared and packed for therapeutic use as Schedule 8. This came into force on 1 November 2016. This now allows for doctors to apply to the health authority for approval to prescribe cannabis-based products that are not on the Australian Register of Therapeutic Goods, in appropriate circumstances.

The Therapeutic Goods Administration (TGA) has approved three cannabis products classified as Schedule 8 (controlled drugs). With restrictions, these drugs can be used in states / territories: nabiximols (e.g. Sativex) for multiple sclerosis; dronabinol and nabilone for therapeutic purposes.

There are three TGA pathways to access medicinal cannabis:

1. Special Access Scheme (A or B)
2. Authorised Prescriber
3. Clinical Trial under CTN / CTX

State government approval to prescribe Schedule 8 drug.

The use of cannabis is not a first line therapy and all other options must have to have been trialled. The 'prescribing' process, as in other states / territories, is a dual step process requiring both TGA and state approval. TGA requires demographic data as well as diagnosis and target symptom, with a clinical justification for a specific product, the administration monitoring details. Information about the dose, form, active ingredients, shelf-life and storage conditions as well as manufacturer-supplier details.

The NSW Government introduced clinical trials in 2014 in patients with drug-resistant and uncontrollable epilepsy: CBD in paediatric epilepsy (NSW, QLD, Victoria) and adult focal epilepsy (Victoria, NSW, QLD).

Other trials include THC (vaporised and oral) in palliative care in NSW; oral THC:CBD in NSW for chemotherapy-induced nausea and vomiting (CINV); cannabis dependence with nabiximols as substitution treatment (NSW) and safety in driving (NSW).

A national working party is to decide the initial list of specialists; however areas are likely to be paediatric neurology, oncology and palliative care medicine. Approved hospital and dispensing pharmacies may also be specified.

Single-patient and patient-class prescriber pathways are available under the legislation. The patient-class pathway may state a class of specialist doctors that have as-of-right authority to prescribe specific medicinal cannabis products for patients suffering a specific range of conditions, without any need for additional approval.

A range of new offences will be covered in the provisions of any monitoring, investigation and enforcement framework; for instance it is an offence to perform a regulated activity (e.g. prescribing, possessing, obtaining or manufacturing medicinal cannabis) without authorisation.

### Victoria

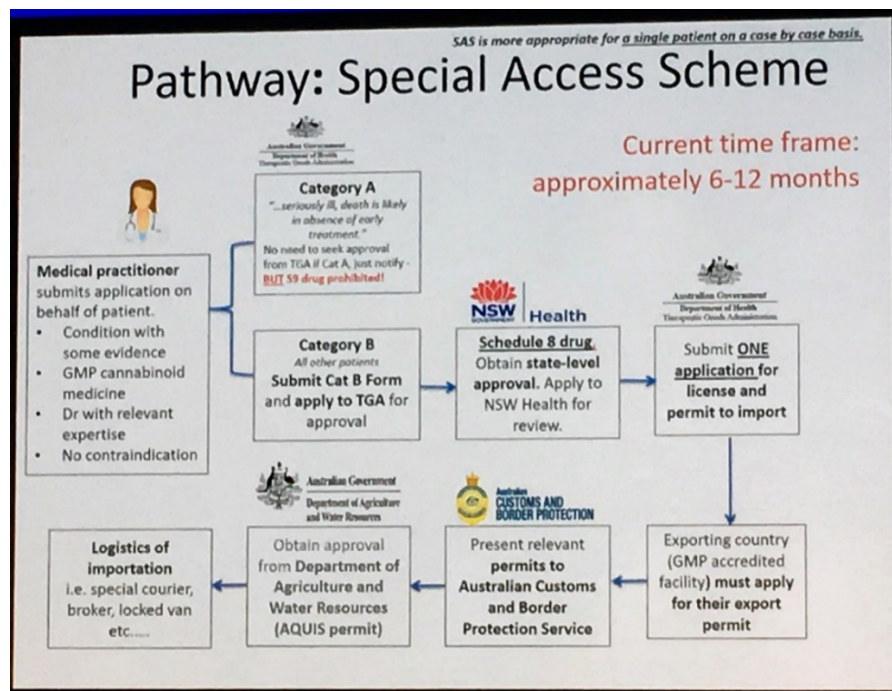
The Victorian Parliament became the first Australian state to legalise medicinal cannabis when it passed the *Access to Medicinal Cannabis Act 2016* on 12 April 2016. This now enables access to locally manufactured medicinal cannabis products for a defined group of patients in exceptional circumstances. Children with severe epilepsy will be able to access legal medicinal cannabis products from early 2017.

It is expected that the Office of Medicinal Cannabis will be established within the Department of Health and Human Services which will be responsible for all clinical and manufacturing aspects of the medicinal cannabis framework. An Independent Medical Advisory Committee will provide advice to the Victorian Government on the types of medicinal cannabis products that should be available to Victorian patients, and the expansion of eligibility to include other patient groups.

### New South Wales

In May 2013, a New South Wales parliamentary committee comprising members of five political parties unanimously recommended making medicinal cannabis available for selected conditions. New South Wales (NSW) started a Terminal Illness Cannabis Scheme in late 2014. The scheme allows NSW residents aged 18 years and over who have a terminal illness to register to use natural cannabis. The scheme, now called the Medicinal Cannabis Compassionate Use Scheme, provides guidelines for NSW police officers so as not to charge people on the scheme using cannabis or cannabis products to help their symptoms, or carers who help them.

In July 2016, the New South Wales Government secured a licence from the Federal Government to grow cannabis for medical use in Australia. This is the first licence approved by the Federal Government since legislation changed earlier in 2016.



(source: International Medicine in Addictions 2017: Nlinteris)

### Western Australia

Cannabis remains a prohibited Schedule 9 substance in WA, making it illegal to cultivate, possess, use, sell or supply cannabis. The *Misuse of Drugs Act 1981* is in place to prevent the misuse of certain drugs and plants such as cannabis.

WA Health will set up an 'expert advisory council', to which doctors must apply, as well as the Federal Therapeutic Goods Administration, before prescribing new cannabis drugs from early next year.

### Queensland

Cannabis was a prohibited substance under the *Health (Drugs and Poisons) Regulation 1996* and it is an offence to produce, possess and supply cannabis without authorisation, justification or lawful excuse under the *Drugs Misuse Act 1986*. In December 2015, the Queensland Government amended the Regulation to allow the use of cannabis for clinical trials and where the TGA has approved an individual accessing these products, under special authority.

The Public Health (Medicinal Cannabis) Act 2016 was passed in October 2016. Under this legislation medicinal cannabis will only be approved:

- if the patient has already tried the conventional treatments available and these have failed; AND
- the doctor provides evidence that medicinal cannabis is effective for the particular condition or symptoms.

### South Australia

South Australia adopted the national scheduling changes from 1 November 2016, when medicinal cannabis products became in the same class as medicines such as morphine. Medicinal cannabis products will be prescription only medicines, with only authorised medical practitioners able to prescribe medicinal cannabis. All other types of cannabis remain prohibited.

The *Controlled Substances Act 1984 (SA)* and the *Controlled Substances (Poisons) Regulations 2011 (SA)* regulate the sale, supply, administration and possession of prescription drugs.

### **New Zealand**

The Minister or Ministry of Health has the power to authorise the medicinal use of cannabis products, as long as the application is put forward by a medical specialist on behalf of the patient. There have been few applications and ministerial approval has been granted for only a small number of patients. The cannabis-based drug *Sativex®* oromucosal spray was gazetted for use in 2011 in New Zealand.

Medsafe (the government's medicines regulatory agency) approved *Sativex®* for use as an add-on treatment for symptom improvement in patients with moderate to severe spasticity due to multiple sclerosis who have not responded adequately to other anti-spasticity medication and who demonstrate clinically significant improvement in spasticity related symptoms during an initial trial of therapy.

Using cannabis or cannabis-based products as medicine without the proper approval of the Minister or Ministry of Health is illegal in New Zealand. As part of an election promise in New Zealand Labour have promised to legalise the prescription of medicinal cannabis for people with chronic pain or terminal conditions.

<b>Drug</b>	<b>Suggested medical use</b>
<b>Sativex®</b> (GW Pharmaceuticals) A mouth spray made from natural extracts of the cannabis plant. Contains THC and CBD (cannabidiol)	Treating neuropathic pain and muscle stiffness from MS; analgesia for adults with advanced cancer
<b>Dronabinol / Marinol®</b> (Unimed Pharmaceuticals) Contains artificial THC	Treating nausea and vomiting from cancer treatment; appetite stimulant for AIDS patients; painkiller for nerve pain from MS
<b>Nabilone / Cesamet®</b> (Valeant Pharmaceuticals International) Contains an artificial drug like THC	Treating nausea and vomiting from cancer treatment
<b>Canasol</b> (Medi-Grace Pharmaceuticals Ltd.) (only approved in Jamaica) A cannabis plant-based solution	Glaucoma treatment
<b>Bedrocan®</b> (Bedrocan BV) Medicinal grade natural full-bud cannabis plant material	All the above conditions and to treat Tourette syndrome
<b>Epidiolex</b> (new cannabis-based medicine)	Showing some promising results for difficult to treat childhood epilepsy conditions Dravet syndrome and Lennox-Gastaut syndrome

(adapted from NZ Drug Foundation)

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## 4.0 Instructions to the Role Player

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

You are Jack Flynn, a 36-year-old man with bipolar mood disorder. You have been married to Grace for 8 years and do not have any children. You work as a carpenter in your own business which has been going well over the last few years. Grace works part-time as a secretary at a local real estate agent.

The main purpose of your visit is to persuade the psychiatrist that you want to change medication to medicinal cannabis. You have been following all the media hype and have been reading bits and pieces on the subject. On the internet, you have seen that medicinal cannabis has been used in people with mood disorders and you want to try it.

If you are asked: you started smoking cigarettes when you were 17 years old, and you regularly smoked cannabis in your early 20's. You very occasionally smoke cannabis now. You do not believe cannabis has any negative impact on your mental illness, and have not been aware of any link between smoking and worsening of symptoms.

Your friends think it is a great idea to switch, especially as you have kind of tested cannabis already by smoking weed. Your wife's boss told you about his mother who lives in California: she is having chemotherapy and feels really terrible, and she has been prescribed medicinal cannabis to help her feel better. If asked, in what way she feels better: it helps reduce severe nausea and pain.

About your mental illness:

If you are asked about the history of your illness: you were diagnosed with bipolar mood disorder when you were 22 years old after you were admitted to an acute inpatient unit because you were '*out of control*'. Over a number of weeks you had become more and more irritable and elevated in mood, and started to believe you had a special mission for God. At the time, you had been setting up our own business which was very stressful. You had so much energy, had found you didn't need to sleep and felt really great within yourself. Since then you have had two further admissions in 2010 and 2013 – both for recurrence of these kind of manic symptoms.

Each admission was for more than three weeks long, and it took at least another 6-8 weeks to get the business back on track. There was a cost: to your business reputation as you were picked up by the police on worksites on the last two admissions; and to your family financial stability.

Your bipolar disorder has been stable for about 2 years, and you have not needed an admission for three years.

Reasons for stopping medication:

Your current medication is quetiapine and lithium (see doses in section 4.7 below). You have taken them for many years and have become worried about 12kg of weight gain, and you have also read that lithium can '*wreck your kidneys*'.

If asked what would a relapse of your illness cost you at this stage of your life: your business is stable and you have a regular contract with a large house & land package firm, and without it your finances would be much more unstable. Your wife has said that she is scared about you getting ill again after what happened last time when you spent a lot of money on multiple credit cards, and it took the last three years to get sorted out.

If asked about your daily schedule / any routine of eating & exercise: you get up at 6am most days and take breakfast with you to the work site, coffee and a snack; lunch is whatever the local café has, and you get home around 5pm; you do not do much regular exercise since you stopped playing football and cricket after your last admission.

### 4.2 How to play the role:

You are a casually dressed man, usually with an easy-going manner. You are keen to talk with the doctor about stopping your current medications. You want to do this for several reasons; you have been well for a few years, but you have put on at least 12 kg since you have been on these medications.

You have heard increasing media about medicinal cannabis being legal for use, and want it prescribed for your own use. You used to smoke cannabis regularly when you were younger, and liked the way it made you feel. So you do not see why you shouldn't be able to get the legal cannabis now as you do not think that is will be dangerous for you.

You are adamant you want to change, and will not be talked out of this easily. You expect the candidate to explain all the legal and clinical aspects related to access to medicinal cannabis.

#### 4.3 Opening statement:

*'Doc, I am keen to change to my medication.'*

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

The candidate should try to engage you in a discussion to better understand why you want to stop your medications and switch to medicinal cannabis. They are expected to provide you with the current evidence that is available that does not support the use of cannabis in bipolar disorder, and explain the conditions under which medicinal cannabis has good evidence to be prescribed.

If the candidate flatly refuses to even consider this as an option or is unable to provide you with any information about its approved use then you can respond in an irritated manner, and threaten to grow your own and smoke it anyway.

#### 4.5 Responses you MUST make:

*'I want you to prescribe medicinal cannabis for me instead of my current meds.'*

*'I know that doctors can prescribe medicinal cannabis – so why won't you?'*

*'So what kind of patients can get cannabis legally?'*

*'Maybe I can now just grow my own cannabis or someone can grow it for me.'*

#### 4.6 Responses you MIGHT make:

*'I know that cannabis can be prescribed legally now.'*

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

Lithium carbonate 500 milligrams twice a day (your last blood level done on 29 March was the same as before – 0.6)

Quetiapine-XR 400 milligrams at night (KWET-I-APEEN)

## STATION 4 – MARKING DOMAINS

### The main assessment aims are:

- To demonstrate the ability to take a brief history to confirm that the patient’s mood symptoms are stable and that there is no reason to change medication.
- To demonstrate an awareness of the indications for medicinal cannabis and its role in the current clinical environment.
- To demonstrate the ability to provide advice and negotiate reconsideration of medicinal cannabis.

### 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.

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

conducting a detailed but targeted assessment; obtaining a history relevant to the patient’s circumstances with appropriate depth and breadth; history taking is hypothesis-driven; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; clarifying important positive and negative features.

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

- Identify that the patient’s bipolar disorder is stable
- Elicit weight gain as the major driver for desire to change treatment.

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

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

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

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

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

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

#### 3.0 COLLABORATOR

#### 3.4 Did the candidate demonstrate an appropriately skilled approach to patient? (Proportionate value - 25%)

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

recognises complexity of liaison; competently manages the interview; actively seeks to evaluate the influence of any local and regional advocacy groups who may be recommending use in bipolar disorder.

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

demonstrating respect; listening to differing views, identifying appropriate techniques to enhance engagement; maintaining an effective working alliance.

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

- Clearly advise the patient that medicinal cannabis is not indicated for bipolar 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 or 1):**

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

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

any errors or omissions adversely impact on a collaborative relationship; being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

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

**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 - 25%)**

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

clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; easily collaborates with the patient to develop an understanding about the pros and cons of biological and psychological treatment options.

**Achieves the Standard by:**

demonstrating ability to: communicate a more appropriate treatment plan; advise the risk of relapse with change of medication; clearly outline options and recommendations; work around patient treatment goals, and negotiate targeted outcomes; reasonably establish that the patient understands and agrees with a treatment approach.

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

- a. Recommend options for management of weight gain.

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

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

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

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

description of the management plan lacks structure; difficulty tailoring treatment to the patient's specific circumstances.

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

**7.0 PROFESSIONAL**

**7.2 Did the candidate demonstrate an adequate knowledge of legislation / regulatory requirements? (Proportionate value - 25%)**

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

readily articulates any gaps in their knowledge, offers to follow up on questions they cannot answer; addresses role and reliability of media / Internet.

**Achieves the Standard by:**

demonstrating the capacity to: apply relevant legislation / regulation; show integrity, honesty and compassion; distinguish between legal and illegal behaviours.

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

- a. Explain the most evidence-based indications for medicinal cannabis that are likely to meet legislative requirements
- b. Identify that it is still illegal for the patient to grow cannabis in Australia.

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

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

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

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

does not demonstrate adequate knowledge of the legislation; does not sufficiently warn the patient of legal risks.

<b>7.2. Category: COMPLIANCE &amp; INTEGRITY</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**GLOBAL PROFICIENCY RATING**

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

In this station the candidate is expected to describe the differences between clinical audit and a research study, and then explain considerations, including the role of ethics committees, when undertaking research. The candidate is also expected to discuss the ethical principles related to an observational research project.

**1.1 The main assessment aims are:**

- To explain the key differences between clinical audit and research.
- To describe the main considerations, including cultural issues, when planning an observational study.
- To discuss the ethical principles related to observational research.

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

- Explain that research is generally designed to test a hypothesis while clinical audit is aimed to measure performance against a standard.
- Identify that ethics committees review research proposals to protect participant rights.
- Include cultural consideration and consultation in the planning stage of this research.
- Specify the importance of the ethical principles of autonomy and informed consent in research.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (research)
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Scholar, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Scholar (Research), Professional (Ethics)

**References:**

- Australian Code for the Responsible Conduct of Research (the Code) 2007 NHMRC.
- Gillon, R (1994). "Medical ethics: four principles plus attention to scope". *British Medical Journal* 309 (184). doi:10.1136/bmj.309.6948.184.
- National Health and Medical Research Council Act 1992, Australian Government.
- National Statement on Ethical Conduct in Human Research (2007) (updated 2013) (the National Statement) issued by NHMRC.
- National Safety and Quality Health Service standards September 2012: Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney. 978-1-921983-04-7.
- COREC (2005), Differentiating Audit, Service Evaluation and Research. [www.corec.org.uk/recs/guidance/guidance.htm](http://www.corec.org.uk/recs/guidance/guidance.htm).
- National Ethics Advisory Committee. 2012. Ethical Guidelines for Observational Studies: Observational research, audits and related activities. Revised edition. Wellington: Ministry of Health.

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Pen for candidate.
- Nametag for examiner "Dr Robertson"
- Timer and batteries for examiner.

## 2.0 Instructions to Candidate

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

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

In this **VIVA**, You are working as a junior consultant psychiatrist in a community mental health centre.

You recently completed a clinical audit on how the metabolic syndrome is being monitored in patients with schizophrenia in your centre. You noted many of the indigenous people with schizophrenia have hyperglycaemia.

Your registrar, Dr Robertson, approaches you to be his scholarly project supervisor. Dr Robertson wants to test the hypothesis that indigenous people with schizophrenia have a higher rate of hyperglycaemia than non-indigenous people with schizophrenia. He is planning to observe the routinely collected laboratory data prospectively as part of the metabolic syndrome monitoring programme in your centre. He also hopes to publish the findings in a peer-reviewed journal primarily focussing on the indigenous aspect.

Your tasks are to:

- Explain to Dr Robertson the key differences between clinical audit and research study.
- Describe the main considerations when planning and preparing for this research study.
- Apply the key ethical principles related to this research study.

**The examiner will play the role of Dr Robertson.**

**You are not required to describe the process for getting College approval for scholarly project.**

**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.

### 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 and **no** time prompts in this station.
- 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 VIVA station, your role is to:

Observe and listen to the responses provided to the station tasks and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

There is no opening statement or any prompts.

Specifically, the tasks that the candidate has been asked to perform are described below:

##### The FIRST TASK is:

Explain to Dr Robertson the key differences between clinical audit and research study.

##### The SECOND TASK is:

Describe the main considerations when planning and preparing for this research study.

##### The THIRD TASK is:

Apply the ethical principles related to this research study.

### 3.2 Background information for examiners

The aims of this station are to describe the differences between clinical audit and research study. The candidate is also expected to discuss the ethical principles related to observational research.

In order to achieve this station the candidate **MUST**:

- Explain that research is designed to test a hypothesis while clinical audit is aimed to measure performance against a standard.
- Identify that ethics committees review research proposals to protect participant rights.
- Include cultural consideration and consultation in the planning stage of this research.
- Specify the importance of the ethical principles of autonomy and informed consent in research.

A surpassing candidate may consider the role of researchers in a study where an adverse outcome such as hyperglycaemia is likely to be encountered in the observation period, relationship with clinicians to address the adverse outcome, obtaining informed consent from people with schizophrenia who are vulnerable and their capacity may be compromised due to the presence of cognitive symptoms, and seeking mentoring and / or support from a senior colleague with research experience.

#### Research versus Clinical Audit

The candidate should be able to describe some of the key differences between research and clinical audit within the context of this station.

RESEARCH	CLINICAL AUDIT
The attempt to derive generalisable new knowledge including studies that aim to generate hypotheses as well as studies that aim to test them.	Designed and conducted to produce information to inform delivery of best care.
Quantitative research – designed to test a hypothesis.	Designed to answer the question: "Does this service reach a predetermined standard?"
Addresses clearly defined questions, aims and objectives.	Measures against a standard.
Needs a statistically valid sample size.	Does not necessarily need a statistically valid sample size.
Extensive statistical analysis is required.	Basic statistical analysis usually suffices.
Usually involves collecting data that are additional to those for routine care but may include data collected routinely. May involve treatments, samples or investigations additional to routine care.	Usually involves analysis of existing data but may include administration of simple interview or questionnaire.

No built-in mechanism to require action on findings.	Clear responsibility to act on findings through development of an action plan.
Findings can have a wide influence on clinical practice.	Findings usually only influence practice within the area evaluated.
Always requires ethics committee approval.	Does not usually require ethics approval.
Expectation that research findings are published.	Without ethics approval, audit results are not generally eligible for publication.

### Important aspects of research planning

When considering their research plan, the candidate can discuss the type of study design, management of research bias, study power, timeframes to obtain ethics approval, publication goals (e.g. journal to submit to, mentioning publication in the ethics application and informed consent), rights and authorship (e.g. order of authors, substantial participation in the project), governance, leadership, support, having access to resources (e.g. time, data, and quality managers / statisticians), any opportunity costs, and utilisation / dissemination of the findings.

### Research application and governance

Human research is described as research conducted with or about people, their data or tissues. Although there is no generally agreed definition, human research can generally be understood to include the involvement of people through:

- participation in surveys, interviews or focus groups
- undergoing psychological, physiological or medical testing or treatment
- being observed by researchers
- access to people's personal documents or other material by researchers
- the collection and use of individuals' body organs, tissues, fluids, etc.
- access to people's information, in individually identifiable, re-identifiable or non-identifiable form, as part of an existing published or unpublished source or database.

All human research activities involving patients and / or staff must undergo ethical review and monitoring by a Human Research Ethics Committee (HREC). This review and monitoring is conducted in accordance with the relevant national human research legislation (e.g. The National Statement on Ethical Conduct in Human Research (2007) in Australia; Human Research Council in New Zealand).

### Ethics Committees

Ethics committees review research proposals to ensure that they are ethically acceptable and undertaken in accordance with relevant standards and guidelines. The underlying goals of ethics committees are to:

- protect patient rights;
- encourage shared decision making between patients (or substitute decision maker) and clinicians;
- promote fair policies and procedures that optimise the likelihood of achieving good, patient-centred outcomes;
- enhance the ethical environment for health professionals within healthcare organisations.

Ethics committees have become increasingly interested in protecting the rights of participants who may not be patients; e.g. carers / support persons, staff, other key stakeholders.

Some ethics committees, particularly those affiliated with academic institutions and large healthcare systems, have expanded their traditional functions to address both clinical and organisational ethical issues. Ethics programs may include:

- integrating ethics throughout the healthcare organisation from the bedside to the executive level;
- ensuring that systems and processes contribute to, and do not interfere with ethical practice;
- promoting ethical leadership behaviours: explaining values that underlie decisions, stressing the importance of ethics and promoting transparency in decision making.

Ethics committee members can also assist in resolving ethical conflicts and answering ethical questions through the provision of advice and consultation.

The requirement for ethical review of human research can be determined by the level of risk to participants and the category of research. All research considered to be greater than 'low risk' or including vulnerable participants or sensitive issues should have a formal and comprehensive review by a fully constituted Human Research Ethics Committee (HREC).

Researchers must be aware of the effects research activities may have on participants and whether their participation in the project may lead to any harm, discomfort and / or inconvenience:

- 'Harm' to research participants may include physical harms (injury, illness, pain); psychological harms (feelings of worthlessness, distress, guilt, anger or fear related, for example, to disclosure of sensitive or embarrassing information, or learning about a genetic possibility of developing an untreatable disease); devaluation of personal worth (being humiliated, manipulated or in other ways treated disrespectfully or unjustly); social harms (damage to social networks or relationships with others; discrimination in access to benefits, services, employment or insurance; social stigmatisation; and findings of previously unknown paternity status); economic harms (discovery and prosecution of criminal conduct).
- 'Low risk research' describes research where the only foreseeable risk to participants is not more than one of 'discomfort', which can include minor side-effects of medication, the discomforts related to measuring blood pressure or doing exercise, or anxiety introduced by being interviewed. 'Inconvenience' may include such activities as filling in a form or participating in a street or phone survey, or simply giving up time to participate in research.
- Research into human genetics, pregnant women / human foetus, human stem cells, people highly dependent on medical care, people with intellectual or cognitive disability or severe mental illness usually require review by a full committee.

### **Cultural aspects of research planning**

The Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) has created the Guidelines for Ethical Research in Australian Indigenous Studies (GERAIS) to ensure that research with and about Aboriginal and Torres Strait Islander peoples follows a process of meaningful engagement and reciprocity between the researcher and the individuals and / or communities involved in the research. The GERAIS has 14 principles:

- Principle 1 - Recognition of the diversity and uniqueness of peoples, as well as of individuals, is essential.
- Principle 2 - The rights of Indigenous peoples to self-determination must be recognised.
- Principle 3 - The rights of Indigenous peoples to their intangible heritage must be recognised.
- Principle 4 - Rights in the traditional knowledge and traditional cultural expressions of Indigenous peoples must be respected, protected and maintained.
- Principle 5 - Indigenous knowledge, practices and innovations must be respected, protected and maintained.
- Principle 6 - Consultation, negotiation and free, prior and informed consent are the foundations for research with or about Indigenous peoples.
- Principle 7 - Responsibility for consultation and negotiation is ongoing.
- Principle 8 - Consultation and negotiation should achieve mutual understanding about the proposed research.
- Principle 9 - Negotiation should result in a formal agreement for the conduct of a research project.
- Principle 10 - Indigenous people have the right to full participation appropriate to their skills and experiences in research projects and processes.
- Principle 11 - Indigenous people involved in research, or who may be affected by research, should benefit from, and not be disadvantaged by, the research project.
- Principle 12 - Research outcomes should include specific results that respond to the needs and interests of Indigenous people.
- Principle 13 - Plans should be agreed for managing use of, and access to, research results.
- Principle 14 - Research projects should include appropriate mechanisms and procedures for reporting on ethical aspects of the research and complying with these guidelines.

Consultation with Māori is an integral part of research planning and ethics application when involving indigenous people in New Zealand. There should be due recognition of Māori as the tāngata whenua and indigenous people of Aotearoa New Zealand. He Korowai Oranga: Māori Health Strategy specifies that 'The Government is committed to fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi' (Minister of Health and Associate Minister of Health 2002, p 2). This commitment should be respected by all researchers and, when applicable, should be reflected in the design and conduct of observational studies. Relevant principles that apply include:

- Partnership: working together with iwi, hapū, whānau and Māori communities to ensure Māori individual and collective rights are respected and protected in order to achieve health gain
- Participation: involving Māori in the design, governance, management, implementation and analysis of research, particularly research involving Māori
- Protection: actively protecting Māori individual and collective rights, and Māori data, cultural concepts, norms, practices and language in the research process.

Issues relating to Māori cultural and ethical values should be addressed in discussion with Māori concerned, including appropriate whānau, hapū or iwi. He Korowai Oranga states: 'Comprehensive, high-quality Māori health research and information is necessary to inform the Government and to assist whānau, hapū and iwi to determine and provide for their own health priorities' (Minister of Health and Associate Minister of Health 2002, p 23).

### **Ethical Principles for Consideration**

When considering research, there are basic medical ethical principles underlying any decision that the candidate should demonstrate knowledge of. Tom Beauchamp and James Childress proposed a framework incorporating the "four principles" approach in their textbook (Principles of biomedical ethics):

- Respect for autonomy - the patient has the right to refuse or choose their treatment (Voluntas aegroti suprema lex).
- Beneficence - a practitioner should act in the best interest of the patient (Salus aegroti suprema lex).
- Non-maleficence - "first, do no harm" (primum non nocere).
- Justice - the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality) (Iustitia).

The following considerations are important to the ethics of observational studies. The application and weighting of these considerations will vary depending on the nature and specific circumstances of the observational study in question.

- Respect for people, and for their rights, incorporates at least two fundamental principles:
  - Autonomy, which requires that people who are capable of deliberation about their personal goals should be treated with respect for their capacity for self-determination.
  - Protection of people with impaired or diminished autonomy, which requires that people who are dependent or vulnerable be afforded security against harm.
- Informed consent
  - Researchers should obtain the prior informed consent of study participants. Informed consent has two basic components:
    - a) The decision is informed by adequate understanding of any information that is relevant to that decision.
    - b) The decision is voluntary, and is therefore free from undue influence such as manipulation or coercion.
  - Information about the purpose of the study should be as specific as possible without compromising the validity of the study.
  - When specific information cannot be provided at the outset, the researcher should offer to provide results to participants.
  - When researchers collect information directly from individuals, or seek their consent to access records, they should inform them that supplying information is voluntary.
  - The right of any person to decline to take part in a study or to withdraw from the study at any time must always be explained and respected. This includes the right to decline to answer all or any questions in a questionnaire.

- Justice
  - Justice requires that, within a population, there is a fair distribution of the benefits and burdens of participation in a study, and for any participant, a balance of burdens and benefits.
  - Accordingly, a researcher must:
    - a) avoid imposing on particular groups an unfair burden of participation in research; for example, vulnerable members of communities should not bear disproportionate burdens of studies from which other members of the community are intended to benefit
    - b) design studies so the inclusion and exclusion conditions for participants are fair
    - c) not discriminate in the selection and recruitment of participants by including or excluding them on the grounds of ethnicity, age, sex, disability or religious or spiritual beliefs, except when such exclusion or inclusion is essential to the purpose of the study.
- Beneficence and non-maleficence
  - The risks of a study should be reasonable in the light of the expected benefits.
  - Researchers should consider the features of a proposed study in the light of ethical considerations, and satisfactorily resolve ethical issues raised by the study. Not all ethical considerations weigh equally. A study may be assessed as ethically justifiable even if a usual ethical expectation, such as confidentiality of data, has not been comprehensively met, provided the potential benefits clearly outweigh the risks and the researchers can minimise the risks.
  - A proportionate approach should be taken: the greater the risk of harm from the study, the greater should be the care in addressing the ethical issues raised.
  - Above the threshold of minimal risk, a study warrants greater provision for the protection of participants. A study is within the range of minimal risk if potential participants can reasonably be expected to regard the probability and magnitude of possible harms from participation in the study as no greater than those encountered in those aspects of everyday life that relate to the study (for example, a clinical consultation with a health care provider).

The potential harms associated with observational studies are generally less than with experimental studies, as no intrusive intervention takes place and participants are less likely to be in a dependent relationship with the researcher. Depending on the method used (whether previously collected information is used or new information is collected) potential harms in observational studies could include breaches of confidentiality.

- Integrity
 

A researcher's commitment to the advancement of knowledge implies a duty to conduct honest and thoughtful inquiry and rigorous analysis, and to be accountable for her or his activities.
- Conflict of interest
 

Researchers should identify to co-researchers, sponsors, employers, participants and, where applicable, ethics committees any perceived, potential or actual conflict of interest he or she might have in relation to any others who are involved with the study. Such conflicts of interest can compromise the design or conduct of a study or the reliability of its results, thereby exposing study participants or others to needless risk or inconvenience.

As appropriate to the circumstances, any conflict of interest should be minimised.



### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

**STATION 5 – MARKING DOMAINS**

The main assessment aims are:

- To explain the key differences between clinical audit and research.
- To describe the main considerations, including cultural issues, when planning an observational study.
- To discuss the ethical principles related to observational research.

Level of Observed Competence:

**6.0 SCHOLAR**

**6.2 Did the candidate appropriately demonstrate understanding of the key differences between clinical audit and research study? (Proportionate value – 30%)**

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

demonstrates a sophisticated understanding of the differences between clinical audit and research; incorporates the concept of compliance and monitoring versus generation of novel information.

**Achieves the Standard by:**

demonstrating the capacity to differentiate between clinical audit and research; generalisability of findings, sample size, statistical analysis, use of existing data, act on findings, influence on clinical practice.

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

- Explain that research is generally designed to test a hypothesis while clinical audit is aimed to measure performance against a standard.

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

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

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

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

demonstrates limited understanding of uniqueness of research; unable to adequately explain differences between research practice and audit.

<b>6.2. Category: RESEARCH</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**6.2 Did the candidate appropriately demonstrate understanding of the main considerations when planning a research study? (Proportionate value – 30%)**

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

comprehensively considers all aspects of research planning; seeking mentoring from senior colleague to allow reflective practice; reflecting on the role of researchers in a study where an adverse outcome such as hyperglycaemia is likely to be encountered in the observation period and relationship with clinicians to address the adverse outcome.

**Achieves the Standard by:**

demonstrating the capacity to: identify key requirements governing human and health services research; type of study design, management of research bias, study power; timeframes to obtain ethics approval; publication goals, rights and authorship; governance, leadership, support; having access to resources (e.g. time, data, and quality managers / statisticians); any opportunity costs; utilisation / dissemination of the findings.

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

- Identify that ethics committees review research proposals to protect participant rights
- Include cultural consideration and consultation in the planning stage of this research.

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

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

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

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

limited understanding of factors related to research good clinical practice; unable to adequately explain ethical research practice and governance.

<b>6.2. Category: RESEARCH</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**7.0 PROFESSIONAL**

**7.1 Did the candidate appropriately discuss the ethical principles associated with research? (Proportionate value – 40%)**

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

able to provide a sophisticated argument for or against research activities based on sound ethical principles; incorporates relevant ethical theories; understands intellectual property aspects of research;

**Achieves the Standard by:**

demonstrating the capacity to articulate: beneficence, non-maleficence, justice, discrimination, integrity, conflict of interest, potential harm of breaches of confidentiality, protection of people with impaired or diminished autonomy; obtaining informed consent from vulnerable people who may have compromised capacity in the presence of cognitive symptoms.

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

a. Specify the importance of the ethical principles of autonomy and informed consent in research.

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

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

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

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

does not appear to be aware of or adhere to accepted medical ethical principles.

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

**GLOBAL PROFICIENCY RATING**

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

The aim of the station is to assess the candidate's ability to provide advice to a midwife who is concerned about a patient who has a history of Anorexia Nervosa who is due to deliver her second child at a regional hospital where the midwife works.

**1.1 The main assessment aims are:**

- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the late antenatal period.
- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the early post-natal period.

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

- Identify reasons why there is an increased risk of relapse of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that symptoms of Anorexia Nervosa may be masked by pregnancy.
- Recommend the need for increased monitoring of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that there is an increased risk of relapse of symptoms of Anorexia Nervosa in the post-natal period.
- Describe how the symptoms of anorexia nervosa may impact perceptions of health in both mother and baby in the postnatal period.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:** Other Disorders (eating disorder)
- **Area of Practice:** Consultation Liaison
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Formulation – Communication; Management – Initial Plan; Management – Long-term, Preventative)

**References:**

- Eating Disorders and Obesity, Second Edition: A Comprehensive Handbook, edited by Christopher G. Fairburn DM FMedSci FRCPsych, Kelly D. Brownell PhD, 2002 Guilford Press.
- Abraham, M.D (1999) Disordered Eating and Pregnancy. Eating Disorders Review. Vol 10, Number 1. Accessed [http://eatingdisordersreview.com/nl/nl\\_edr\\_10\\_1\\_1.html](http://eatingdisordersreview.com/nl/nl_edr_10_1_1.html)
- National eating disorders collaboration "Pregnancy and eating disorders: a professional's guide to assessment and referral" nedc.com 2015

**1.4 Station requirements:**

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

## 2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in a consultation liaison service at the metropolitan hospital with a tertiary referral maternity service attached.

You have been contacted by a midwife who works in a regional hospital connected with your hospital that provides maternity services. She has been attending a training session at your hospital.

The midwife is asking for advice about a patient with a history of Anorexia Nervosa now in remission who has been referred by her GP for delivery at her local hospital. She does not have much specific information about the patient and would like some general information and advice, including management strategies that may be employed to support a person who has a history of Anorexia Nervosa in the late antenatal period and early postnatal period.

Your tasks are to:

- Describe the major risks and management strategies associated with Anorexia Nervosa in the late antenatal period to the midwife.
- Describe the major risks and management strategies associated with Anorexia Nervosa in the early postnatal period to the midwife.

**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 simulated health professional.

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

### At conclusion of examination:

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

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

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

### 3.0 Instructions to Examiner

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

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

When the candidate enters the room briefly check ID number.

There is no opening statement and there are no prompts.

The role player opens with the following statement:

***'Thank you so much for making time to see me, I'm hoping to get some advice about a pregnant woman who has been referred to me.'***

#### 3.2 Background information for examiners

The aims of this station are to examine the ability of the candidates to provide advice about the risks and management of Anorexia Nervosa through the peripartum period. The midwife is concerned about a patient who has a history of Anorexia Nervosa who is due to deliver her second child at a regional hospital where the midwife works. The candidates are to engage with a midwife and demonstrate effective collegial engagement.

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

- Identify reasons why there is an increased risk of relapse of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that symptoms of Anorexia Nervosa may be masked by pregnancy.
- Recommend the need for increased monitoring of symptoms of Anorexia Nervosa in the antenatal period.
- Explain that there is an increased risk of relapse of symptoms of Anorexia Nervosa in the post-natal period.
- Describe how the symptoms of anorexia nervosa may impact perceptions of health in both mother and baby in the postnatal period.

A surpassing candidate may present a systematic and comprehensive approach that identifies biological, psychological and social risks, and synthesises this to describe dynamic, static and environmental risk factors. The management of these risks would be presented in a way that identifies all important bio-psycho-social strategies structured into immediate, short and medium term plans.

According to the DSM-5 criteria, to be diagnosed as having Anorexia Nervosa a person must display:

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

#### **Subtypes:**

Restricting type

Binge-eating / purging type

According to the ICD-10 criteria, for a definite diagnosis of Anorexia Nervosa, all the following are required:

- Body weight is maintained at least 15% below that expected (either lost or never achieved), or Body Mass Index (BMI) is 17.5 or less. Pre-pubertal patients may show failure to make the expected weight gain during the period of growth.
- The weight loss is self-induced by avoidance of 'fattening foods' and one or more of the following: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and / or diuretics.
- There is body-image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.
- There is endocrine disorder, manifesting in women as loss of periods (amenorrhoea) and in men as a loss of sexual interest and potency.

The following is a summary from the *"Pregnancy and eating disorders: a professional's guide to assessment and referral"* nedc.com 2015. [Acknowledgments to the National eating disorders collaboration who approved use of this information for examination purposes.]

Eating disorders occur in a significant number of pregnant and post-natal women, and the outcomes can be dangerous for both mother and baby. An eating disorder can develop as a result of a pregnancy (and subsequent changes in body shape and weight during pregnancy) or it can develop / exist prior to the pregnancy, with the pregnancy further complicating eating disorder symptoms and impacting health. These symptoms and body dissatisfaction can remain once the baby is born. A mother's expectations of her post-natal body and of the time it 'should take' to return to her pre-pregnancy size and shape may be unrealistic. When it comes to pregnancy and childbirth, there is no 'normal' in terms of expectations to 'return to' or 'become' a particular size or shape before, during or after the pregnancy and early motherhood period. The health and nutrition of the mother and her baby is paramount and women should be encouraged to embrace any changes to their body as natural and healthy. Women who place emphasis on avoiding weight gain or a changing body shape during pregnancy and / or focus on intensive exercise in the early months following childbirth place themselves and their babies at additional health risks.

These risks include:

- antenatal and postnatal depression and anxiety
- impaired foetal development and antenatal complications
- premature births
- lower birth weights and birth defects
- hyperemesis (excessive vomiting)
- gestational diabetes
- unplanned caesareans
- increased risk of miscarriages
- breast milk supply complications due to nutritional deficiencies in the mother
- increased risks of nutritional deficiency for the baby when transitioning from breast or bottle feeding to introducing solids.

### **Recognising signs and symptoms**

In expectant mothers, eating disorder signs and symptoms can manifest as normal symptoms of the pregnancy (e.g. tiredness) or they can be disguised by other expected ailments associated with pregnancy (e.g. signs of vomiting may be mistaken for morning sickness rather than self-induced purging). Health professionals assessing a pregnant or postnatal woman should be aware of signs and symptoms in the context of eating disorders where they could be seen as not in the usual range associated with pregnancy or postnatal periods or are particularly severe. In general, common eating disorder presentations can be psychological, physical and behavioural:

#### **Psychological**

- Concern, distress or preoccupation with weight gain, even when weight is within the expected range.
- Dissatisfaction with body shape, even despite your discussions with them about expecting normal body shape changes with stages of pregnancy.
- Negative or unusual attitudes towards food and / or eating (see below).
- Negative attitudes towards the unborn baby.
- Depression, anxiety about pregnancy and anxiety about caring for their baby.

#### **Physical & Medical**

- Severe weight loss or low weight in relation to stage of pregnancy.
- Severe weight gain or excessive weight in relation to stage of pregnancy.
- Fainting, dizziness, headaches.
- Shortness of breath, fatigue.
- History of menstrual disturbances.
- Previous infertility or related problems.
- Gastrointestinal problems.
- Low bone density.



## Behavioural

- Indications of food intake restriction.
- Signs of repeated, self-induced vomiting.
- Restriction of certain foods not advised by a clinician.
- Avoidance of meals or changes in eating behaviour (e.g. refusing to eat with others).
- Evidence of substance / medication abuse in order to maintain body weight.
- Insomnia or disturbed sleeping patterns.
- Self-harming or suicidal behaviour (in which case emergency treatment will be vital).
- Excessive or distorted exercise patterns or signs of distress when exercising is not possible.

## Signs and complications

- Little or no weight loss (in the case of binge-eating disorder for example) or weight gain (in the case of anorexia nervosa for example) over the course of the pregnancy, despite a growing foetus.
- Problems with foetal growth and development.
- Gestational diabetes.
- Respiratory problems.
- Miscarriage.
- Premature labour / preterm.
- Complications during labour.
- Unplanned caesarean.
- Low birth weight.
- Stillbirth or foetal death.
- Postnatal depression.
- Measurable health indicators.

## Postnatal and early childhood specific signs include:

- A history of eating disorders prior to pregnancy or during pregnancy.
- Postnatal depression.
- Rapid, otherwise unexplained postnatal weight loss or weight gain.
- Negative feelings towards the baby or to becoming a mother.
- Anxiety about baby's appearance, e.g. overly referring to the baby as 'chubby'.
- A strong focus on pre-baby shape and / or returning to body shape-inspired exercise soon after childbirth.
- Compulsive / obsessive breast-feeding (can be associated with a desire to lose weight quickly).
- Difficulty maintaining or loss of milk supply.
- Signs associated with purge activities such as signs of excessive vomiting (bad breath, eroding teeth), laxative abuse, calluses on knuckles (from forced purging).
- Irregular weight gain in the infant.
- Signs of under or over feeding in the infant.
- Signs of malnutrition or under-nutrition in the mother and infant.
- Measurable health indicators.

## Physical assessment

- General physical state (well vs. unwell).
- Vital signs including temperature, lying and standing blood pressure and pulse.
- Alertness vs. somnolence / sleepiness.
- Height and weight history, and weight / height proportion – preconception, during pregnancy and postnatal.
- Menstruation pattern / history.
- Hydration (tongue, lips, sunken eyes, skin).
- Signs of vomiting (ketones on breath, bad breath, eroded teeth).
- Fundal measurements according to individual's expected progression of foetal growth (in pregnancy).

- Deep irregular sighing; breathing seen in ketoacidosis.
- Peripheral circulation (limbs, extremities) and cold peripheries.
- Physical changes, such as swelling in cheeks, jaw, ankles; calluses on knuckles; abdomen scaphoid.
- Electrolyte disturbances (thirst, dizziness, fluid retention, swelling, weakness / lethargy, muscle twitches).
- Alkaline urinary pH.

### **Management during pregnancy**

If an eating disorder is detected in a woman who is already pregnant, a high-risk management approach will need to be adopted throughout the perinatal period. You should:

- Refer to an eating disorder specialist and / or mental health professional or mental health team.
- Discuss notifying additional antenatal services of the eating disorder with the patient.
- Work with the patient's additional medical team, such as an obstetrician regarding risks and encourage the patient to undertake regular monitoring of foetus and development.
- Educate on the importance of good nutrition and foetal development.
- With patient's permission where possible, engage family members or carer to provide support and help.
- Refer to a hospital or emergency room if the mother's or baby's life may be at risk.

### **Management after birth**

Clinicians involved in postpartum care should aim to:

- Assess parenting skills and the mother's relationship with infant in general.
- Provide advice and guidance to improve coping strategies if the mother is stressed or struggling.
- Increase self-esteem and confidence in mothers / parents.
- Provide breastfeeding support.
- Be aware of possible relapse if a prior eating disorder was present.
- Assess whether attitudes towards food and / or eating have changed.
- Assess whether the mother's attitude or feelings about her own body weight and shape have changed.
- Look for signs of postnatal depression or anxiety.
- Monitor infant growth, development and weight gain.
- Be aware of any negative emotions towards the infant.
- Be aware of anxious or avoidant attachment patterns.

If you suspect the mother may be at risk of developing an eating disorder or if you feel she may already be engaging in disordered eating, you can:

- Refer to an eating disorder specialist and / or mental health professional.
- Provide nutritional advice and emphasise the importance of nutrition for growing babies.
- Notify the assigned paediatrician, obstetrician, nurse or anyone else involved in the child's care.
- Refer to a hospital or emergency room if the mother's or baby's life may be at risk.
- Communicate the issue to another family member or carer who can provide additional support and help (e.g. husband, parent, sister, friend).

### **Management and ongoing care**

- Create a management plan and provide ongoing reviews of eating disorder issues.
- Regularly review the health and condition of both mother and baby.
- Communicate regularly with other specialists and clinicians who may be involved in treating the patient for the eating disorder or providing care for the pregnancy (e.g. obstetricians, midwives, psychologists, early childhood nurses).
- Become familiar with the specific risks and / or complications associated with the particular health problem or eating disorder e.g. social isolation, family support, risks commonly associated with generalised postnatal depression.

Update other treating clinicians with relevant information and details throughout the course of the pregnancy so that they are informed when the time comes to deliver the baby or provide other forms of 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

- 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## 4.0 Instructions to the Role Player

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

Your name is Mary Jenkins, and you have been practising as a midwife at the Armadale health services for the last three years. You are in Perth for a hospital training day, and have asked to speak to one of the psychiatrists for some advice about a referral you have received from a GP, Dr Robbins, who works in a small rural town.

You are concerned about how to manage a patient, Tiffany Banks, who has a history of Anorexia Nervosa and is due to deliver her second child at the regional hospital where you work. You have arranged to speak to a psychiatrist in Perth today while you are here doing some training.

You would like advice about the management strategies that may be used to support a person with a history of Anorexia Nervosa in the late antenatal and early postnatal period. As you have never looked after a woman with Anorexia Nervosa you are hoping that the psychiatrist will describe the risks that Tiffany may face in the later stages of her pregnancy, and then after the birth. You are then expecting to hear how to manage these risks.

#### What you know about the patient

The referral you have received is for a 26-year-old patient, Tiffany Banks, whom the GP has been managing for a long time. She is pregnant with her second child. The patient has had Anorexia Nervosa since late adolescence which settled, and has caused her limited problems (in remission) since her early 20's. She is currently still in remission and the pregnancy has been uncomplicated so far.

Tiffany is due to deliver in the next 6-8 weeks, and the GP has referred her to your midwifery group for delivery at the hospital where you work in order to connect her into the local maternity services to ensure close observation. He has requested an extended stay at the maternity ward due to her history of Anorexia Nervosa. She has refused an offer of a referral to the tertiary maternity hospital in Perth as she does not want to be too far away from her family. The GP has discussed the patient with the obstetric medical staff who have accepted the referral.

There is no psychiatric service to provide advice and support to the maternity services where you work, and there is only limited psychiatric support from the local mental health team and currently your hospital is relying on locum psychiatrists. When you contacted the local psychiatric services, they suggested you contact the consultation-liaison psychiatrist in Perth to get specialist advice.

The GP did not elaborate on the details of Tiffany's mental health history, and you have limited information about her at the moment. While you are in Perth you want to get general advice about the risks that may be associated with Anorexia Nervosa during the late stages of pregnancy, and in the early period after delivery (postnatal) as you have no experience as midwife of managing a woman with Anorexia Nervosa before.

The GP had explained that Tiffany has a 5-year-old daughter, Amy, and a supportive husband, Bob. They live remotely running the local shop.

You have been working as a midwife for 5 years but have limited experience with patients that have psychiatric histories. You intend to ring the GP after your conversation with the psychiatrist to get more detailed information from him.

#### About your work area

Armadale Health Service provides a range of services including emergency services, a midwifery group practice, some general medical and surgical services, and general inpatient and community mental health. Community midwives provide shared antenatal care with local GPs where possible, including visiting and outreach services to expectant women throughout the area. Women can plan their birth to enhance the safety and wellbeing of their babies. Mental health in the community is provided in a 'shared-care' approach between GPs, mental health services and nurse practitioners.

#### 4.2 How to play the role:

You are casually but professionally attired as you have just attended an education session for work. You are a young and keen midwife who presents herself in a professional manner. You are interested to learn as much as you can to assist you to provide the best care that you can to Tiffany.

You are anxious (and a bit embarrassed) about managing a woman with Anorexia as you have no experience. You are a bit anxious about the situation but cooperative and accepting of any advice given. You will be able to use the information provided by the candidate to get further information from the GP.

#### 4.3 Opening statement:

***'Thank you so much for making time to see me, I'm hoping to get some advice about a pregnant woman who has been referred to me.'***

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

The candidate is expected to enquire about the patient and what you know about the patient. Your concerns are about a patient who has Anorexia Nervosa who is due to deliver in your hospital, you do not know much about the condition, and would like advice about the risks in pregnancy and in the weeks after delivery (postpartum period), and how these may be managed.

The candidates are to engage with the midwife and demonstrate effective collegial engagement.

The candidate should do most of the talking, and should recognise that your knowledge of psychiatry is limited; so should not use a high level of technical terminology.

#### 4.5 Responses you MUST make:

***'I only have limited information and would like general advice at this stage.'***

***'What are the critical things for me to watch out for before and after the birth.'***

***'Why would that happen?' (when the candidate explains the possible risks).'***

#### 4.6 Responses you MIGHT make:

Anticipated Question: If the candidate uses highly technical language.

Scripted Response: ***'Sorry, would you mind explaining that again?'***

Anticipated Question: If the candidate does not provide practical details for management.

Scripted Response: ***'So what do I have to do / look out for?'***

Anticipated Question: What psychiatric services are available in your hospital?

Scripted Response: ***'We only have access to the limited adult mental health services.'***

Anticipated Question: If asked about your knowledge of psychiatry.

Scripted Response: ***'I am really sorry but I don't know too much about psychiatry.'***

Anticipated question: What resources do you have available.

Scripted response: ***'We have access to a multidisciplinary team for obstetric care.'***

Anticipated question: Do you have access to a paediatrician?

Scripted response: ***'Yes, we have someone who visits once a week.'***

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

Nil

**STATION 6 – MARKING DOMAINS**

**The main assessment aims are:**

- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the late antenatal period.
- Assess the candidate's ability to provide advice about the risks and management of Anorexia Nervosa in the early post-natal period.

**Level of Observed Competence:**

**1.0 MEDICAL EXPERT**

**1.12 Did the candidate communicate the likely antenatal findings to the midwife sensitively, appropriately and accurately? (Proportionate value - 20%)**

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

communicates risks in a sophisticated manner that considers risk across biological, psychological and social domains using a structured approach that considers immediate, short, medium and long term risks; monitors physical and psychological status; interprets findings in a resource effective and ethical manner demonstrated by enquiring about available resources.

**Achieves the Standard by:**

recommending thorough assessment of physical status that takes into account the symptoms of Anorexia Nervosa, and assessment of current mental state and recent psychiatric history; correctly communicating risks with appropriate detail; outlining monitoring strategies to identify risks; reflecting on any limitations and value of examination / investigations.

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

- Identify reasons why there is an increased risk of relapse of symptoms of Anorexia Nervosa in the antenatal period
- Explain that symptoms of Anorexia Nervosa may be masked by pregnancy.

**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. Must identify increased risk of relapse of Anorexia Nervosa and how symptoms may be masked by pregnancy.

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

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

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

does not synthesise risk factors in a cohesive manner, incorrectly recommends even routine / standard range of monitoring for risks.

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

**1.13 Did the candidate formulate and describe a relevant initial management plan for the antenatal period? (Proportionate value - 30%)**

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

provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan; acknowledges the risk of relapse and the plan clearly considers possible masking of symptoms and how this can be addressed through assessment and monitoring.

**Achieves the Standard by:**

demonstrating the ability to prioritise and implement evidence based care; recommending plans for risk management including of relapse; considering inpatient / community treatment environment; recommending specific treatments that include biological, psychological and social interventions; engaging safely and skilfully appropriate treatment resources; identifying potential barriers; recognising the importance to a multidisciplinary approach as far as possible; recognising the need for consultation and referral.

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

- Recommend the need for increased monitoring of symptoms of Anorexia Nervosa in the antenatal period.

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

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

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

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

errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan does not tailored to patient's immediate needs or circumstances; fail to acknowledge the increased risk of relapse AND fail to identify the need for increased monitoring.

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

**1.12 Did the candidate communicate the likely postpartum risks to the midwife sensitively, appropriately and accurately? (Proportionate value - 20%)**

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

communicates risks in a sophisticated manner; considers risk across biological, psychological and social domains using a structured approach that considers immediate, short, medium and long term risks; monitors physical and psychological status of both mother and baby; interprets findings in a resource effective and ethical manner demonstrated by enquiring about available resources.

**Achieves the Standard by:**

recommending thorough assessment in postpartum period that takes into account the risks of Anorexia Nervosa relapse; explaining how symptoms of Anorexia Nervosa may impact on mother and baby; assessing mental state and recent psychiatric history; correctly communicating risks with appropriate detail; outlining monitoring strategies to identify risks; reflecting on any limitations and value of examination / investigations.

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

- a. Explain that there is an increased risk of relapse of symptoms of Anorexia Nervosa in the postnatal period.

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

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

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

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

does not synthesise risk factors in a cohesive manner, incorrectly recommends even routine / standard range of monitoring for risks.

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

**1.16 Did the candidate formulate an appropriate longer term management plan, including preventative treatment and referral to other specialists? (Proportionate value - 30%)**

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

overall plan is sophisticated, tailored yet comprehensive; recognises the limitations of their role in effective treatment; recognises the important role of the father and other supports in the postpartum period.

**Achieves the Standard by:**

demonstrating ability to prioritise and implement evidence based care including need for acute and ongoing monitoring of the physical status of both mother and baby; acknowledging the increased risk of relapse psychiatric status; giving priority to continuity of care and inclusion of long-term outcomes; demonstrating awareness of possible complications of illness and available interventions / monitoring; acknowledging appropriately realistic possibility of treatment failure due to available resources; elaborating discharge arrangements.

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

- a. Describe how the symptoms of anorexia nervosa may impact perceptions of health in both mother and baby in the postnatal period.

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

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

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

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

errors or omissions will adversely affect outcomes; failure to acknowledge an increased risk of relapse of symptoms of Anorexia Nervosa in the mother in the postnatal period, and that these symptoms may impact on both mother and baby; candidate has difficulty with most of the skills above.

<b>1.16. Category: MANAGEMENT - Long-term, Preventative</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

## GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

In this station the candidate is asked to assess a 23-year-old woman, Zoe Sandford. Her employer has asked her to undertake a psychiatric assessment because of difficulties in the work place. She has symptoms in keeping with a schizotypal personality disorder with a preferred differential diagnosis of schizoid personality disorder.

**1.1 The main assessment aims are:**

- To engage a young woman with ego-syntonic personality disorder symptoms.
- To assess Cluster A personality disorders.
- To arrive at a diagnosis of schizotypal personality disorder and substantiate this diagnosis with the findings elicited.
- To identify the most likely differential diagnoses as schizoid personality disorder and paranoid personality disorder or attenuated psychosis syndrome.

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

- Engage the patient adequately in order to elicit phenomenology.
- Establish an enduring pattern of social and interpersonal deficits along with lack of desire for close relationships that began in early life.
- Demonstrate skills in eliciting at least five of the symptoms associated with schizotypal personality disorder.
- Justify a diagnosis of schizotypal personality disorder.
- Offer a differential diagnosis of schizoid personality disorder.

**1.3 Station covers the:**

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

**References:**

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder 5th Edition. 2013. Washington DC.
- Bernstein, DP., Cohen, P., Velez, CN., et al. Prevalence and stability of the DSM-III-R personality disorders in a community-based survey of adolescents. *Am J Psychiatry*. 1993; 150:1237-1243.
- International Classification of Diseases-10th Edition, World Health Organization, 1992. Geneva.
- Kendler K. Diagnostic approaches to schizotypal personality disorder: A historical perspective. *Schizophrenia Bulletin*. 1985; 11(4): 538-553.
- Pulay, AJ., Stinson, FS., Dawson, DA., Prevalence, correlates disability and comorbidity of DSM-IV Schizotypal personality disorder. *Primary Care Companion to Journal of Clinical Psychiatry*. 2009; 11(2):53-67.
- Schultze-Lutter F., Michel C., Ruhrmann S. Prevalence and clinical significance of *DSM-5*-Attenuated Psychosis Syndrome in adolescents and young adults in the general population: The Bern Epidemiological At-Risk (BEAR) Study. *Schizophrenia Bulletin*. 2014; 40 (6): 1499-508.
- Tsuang M., van Os J., Tandon, R. Attenuated Psychosis Syndrome in DSM-5. *Schizophrenia research*. 2013; 150 (1): 31-35. Widiger TA (Editor). *Oxford handbook of personality disorders*. 2012. Oxford University Press. New York.

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female, early 20's, neatly groomed and somewhat conservatively dressed.
- Pen for candidate.
- Timer and batteries for examiners.



## 2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in an adult community mental health clinic.

Zoe Sandford is a 23-year-old single woman who has presented to the Community clinic in which you work because her employer has asked for her to have a psychiatric assessment and 'sort out her problems'. She has no previous psychiatric history but has a family history of schizophrenia.

She has worked as a data entry operator for the past two years. Her boss says she has longstanding difficulty relating to the rest of the team and has 'some unconventional views'. Although she is high functioning and competent at her job, she mostly remains aloof with a 'cold character'.

Your tasks are to:

- Conduct an assessment of her presenting symptoms.
- Present and justify the likely diagnosis **to the examiner**
- Present and explain the differential diagnoses you would consider **to the examiner**.

You are not required to take a medical history or perform a physical examination.

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

## 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 of the scripted prompt you are to give at **six (6) minutes** if the candidate has not commenced the second task.
- 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 **six (6) minutes**, as indicated by the timer, if the candidate has not already begun the second task, provide the following prompt:  
***'Please proceed to the second task.'***
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

### At conclusion of examination:

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

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

- You are to state the following:  
***'Are you satisfied you have completed the 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 don't know why my boss thinks there is a problem. I do my work perfectly well.'***

If the candidate has not commenced the second task by **six (6) minutes**, please provide the following prompt:

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

#### 3.2 Background information for examiners

##### Detailed Assessment Aims

In this station the candidate is to engage a patient who does not believe she has a mental health problem. They are expected to conduct a brief targeted psychiatric assessment of symptoms related to Cluster A personality disorders and present the diagnosis of schizotypal disorder followed by appropriate differential diagnoses to the examiner.

The patient has been sent for a psychiatric assessment because of problems at the workplace. As there is a family history of schizophrenia the candidate is to identify symptoms associated with schizoid and schizotypal personality disorders. The candidate is expected to elicit these findings and use them to support a preferred diagnosis of schizotypal personality disorder. The candidate can consider differential diagnoses of schizoid personality disorder, paranoid personality disorder and attenuated psychosis syndrome (DSM-5) or early phase of psychosis. The candidate's questioning should briefly exclude other disorders, namely a full-blown psychotic and mood disorder, social anxiety disorders and substance abuse.

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

- Engage the patient adequately in order to elicit phenomenology
- Establish an enduring pattern of social and interpersonal deficits along with lack of desire for close relationships that began in early life.
- Explore at least five of the symptoms associated with schizotypal personality disorder.
- Justify a diagnosis of schizotypal personality disorder.
- Offer a differential diagnosis of schizoid personality disorder.

The patient in this scenario has personality disorder, which is ego-syntonic, and in denial of any psychiatric symptoms. In order to engage a patient who is in denial, the candidate may utilise a number of approaches: listen to the patient's concerns at workplace; acknowledge the patient's experience of the first psychiatric consultation; point out the concerns raised by employer; demonstrate empathy; employ smooth transitions to explore various domains of psychiatric history and paraphrasing.

The candidates are not expected to take a medical or developmental history. They are not asked to perform physical or formal cognitive examinations.

The patient has several symptoms indicative of schizotypal personality disorder, which is the first diagnostic consideration. Some of the symptoms are suggestive of schizoid personality disorder, which is another cluster A personality disorder. Considering that the patient has suspiciousness of her employer, strange beliefs and family history of schizophrenia, it is also appropriate to consider a differential diagnosis of paranoid personality disorder or an attenuated psychosis syndrome.

Candidates are expected consider the following features when formulating the diagnosis: blunted inappropriate affect; vague and circumstantial speech; magical thinking; oddities and eccentricities in thoughts and behaviour; family history of schizophrenia as a significant history; enduring nature of symptoms with an onset in childhood; and significant impairment on quality of life (from pre-occupation with plastics) and work relationships (from reduced interactions).

A better candidate will be able to identify factors that could challenge further assessment and management (for example, poor social network; difficulty with follow-up etc.); genetic factors (genetically linked to schizophrenia) and phenotypic variation etc.

**Schizotypal Personality Disorder** is a serious and highly disabling condition that has a lifetime prevalence of 1.8 to 3.9% (Pulay, et al 2009; Bernstein, et al 1993) in adolescent and adult population respectively. The essence of schizotypal disorder is a perpetual pattern of social and interpersonal deficit marked by reduced capacity for intimate relationships and eccentricities.

Historically one of the factors that formed the concept of schizotypal disorder is a set of symptoms, though in attenuated form, which were regarded as the fundamental symptoms of schizophrenia. Abnormalities of personality traits were identified in the family members of patients with schizophrenia, and Kraepelin and Bleuler described them as qualitatively similar to the symptoms (arrested form of schizophrenia) in patients and quantitatively sub-threshold for the disease. This is relevant in this patient as Zoe has family history of schizophrenia.

Magical thinking is a symptom found in schizotypal disorder. It is a belief in causations through mechanisms that are invalid under reasoning and ordinary circumstances. Candidates must identify these features, as they are evident in Zoe. They may take the opportunity to explain what symptoms represent magical thinking. In the Mental State Examination blunted affect must be identified as an important component of both schizoid and schizotypal disorder. The candidate may identify circumstantiality.

Impairment from symptoms is an essential criterion for any disorder. In this particular patient, there is significant impairment on her functions (from pre-occupation with plastics, counting numbers and work place function). Therefore, for a successful outcome candidates must present this as an important finding.

#### DSM-5 diagnostic criteria for schizotypal personality disorder

- A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for close relationships, as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1. Ideas of reference (excluding delusions of reference).
  2. Odd beliefs or magical thinking that influences behaviour and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).
  3. Unusual perceptual experiences, including bodily illusions.
  4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, over-elaborate, or stereotyped).
  5. Suspiciousness or paranoid ideation.
  6. Inappropriate or constricted affect.
  7. Behaviour or appearance that is odd, eccentric, or peculiar.
  8. Lack of close friends or confidants other than first-degree relatives.
  9. Social anxiety that tends to be associated with paranoid fears rather than negative judgments about self.
- B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

ICD-10 placed schizotypal disorder along with schizophrenia (F21), not under personality disorders. The symptom criteria are similar to that of DSM-5. The differences are inclusion of obsessive ruminations without inner resistance, often with dysmorphophobic, sexual or aggressive contents and occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations, and delusion-like ideas, usually occurring without external provocation. According to ICD-10 schizotypal disorder may evolve into schizophrenia.

**Schizoid Personality Disorder**, with its main trait of aloofness, is less closely connected to the schizophrenia spectrum than schizotypal personality disorder. Patients with this disorder seldom seek psychiatric treatment. Many patients with schizoid personality disorder function reasonably well in the community.

DSM-5 diagnostic criteria for schizoid personality disorder

- A. A persistent pattern of disinterest from social interactions and a limited variety of expression of emotions in close personal settings, starting in early adulthood and there in an array of contexts, as shown by at least four (or more) of the subsequent:
1. Neither wants nor likes close relationships, counting being part of a family
  2. Almost constantly picks introverted activities
  3. Has little if any, thought in engaging in any sexual experiences
  4. Seldom derives pleasure from any activities
  5. Has no close friends other than immediate relatives
  6. Appears apathetic to the admiration or disapproval of others
  7. Shows emotional coldness, detachment, or flattened affectivity.
- B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

In ICD-10, as in DSM-5, schizoid personality disorder is classified under personality disorder. The symptom criteria are similar with addition of the following symptoms:

1. Excessive preoccupation with fantasy and introspection
2. Marked insensitivity to prevailing social norms and conventions.

**Paranoid Personality Disorder** has suspiciousness, mistrustfulness and frank misreading of the meanings and intentions of others dominating the clinical picture. When confronted about false beliefs the person may react with anger.

DSM-5 diagnostic criteria for schizoid personality disorder

- A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
  2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
  3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
  4. Reads hidden demeaning or threatening meanings into benign remarks or events
  5. Persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
  6. Perceives attacks on his or her character or reputation that are not apparent to others, and is quick to react angrily or to counterattack
  7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.
- B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiological effects of a general medical condition.

ICD-10 included the following symptoms as well:

1. Excessive sensitiveness to setbacks and rebuffs,
2. Tendency to experience excessive self-importance, manifest in a persistent self-referential attitude.

**Attenuated psychosis syndrome** has been included in DSM-5 as 'conditions for further study' in an attempt to define a syndrome characterised by sub-threshold psychotic symptoms (in severity or duration), and was associated with a very significant increase in the risk of development of a full-fledged psychotic disorder. A vast majority of individuals who go on to develop schizophrenia or other psychotic disorder exhibit a range of psychiatric symptoms in the period prior to their initial psychotic episode. During this period, many such individuals experience decline in their academic-occupational and other aspects of social functioning. The prevalence of individuals with attenuated psychotic syndrome in the general population is around 0.3 percent.

#### DSM-5 diagnostic criteria for attenuated psychosis syndrome

A. At least one of the following symptoms is present but attenuated; contact with reality remains intact.

1. Delusions.
2. Hallucinations, perceptual disorders.
3. Disorganised speech.

B. Criterion A symptoms:

1. Have occurred at least once (1) a week for one (1) month.
2. Appeared or worsened in the past year.
3. Are distressing or incapacitating enough to cause the person or a loved one to seek help.
4. The symptoms cannot be explained by another diagnosis, nor by substance abuse.

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## 4.0 Instructions to the Role Player

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

You are Zoe Sandford a 23-year-old single woman who has come to the community mental health clinic because your boss told you to.

#### Reason for presentation:

In your current job, as a data operator, there was a change of supervisor two months ago and the new boss, Jane, thinks you have a problem relating to the rest of the team and wants you to '*sort out your problems*'. You don't know what she is talking about and don't think you have a problem. You are quite comfortable with your work and think you do it as well as you ever have. You accept that you don't talk to the other people much but you answer any questions they ask. You find Jane very intrusive and she puts you on edge. You just want her to leave you alone to get on with your job.

Jane seems to have something against you, but you are unsure about this. Your evidence for this is that she has made you come to this appointment. You have no idea what agenda she has or what you need to do to make things better. You hope this doctor will just say you are normal (of which you have no doubt), and this will mean Jane will leave you alone. You cannot describe any further about what Jane has got against you. You simply '*don't know*'.

#### About your beliefs:

You do admit to day dreaming a lot (not at work!), and think that the human brain is capable of all sorts of things we don't understand. You believe in Extra Sensory Perception (ESP) and astrology. The latter you think is part of the complexity of how the moon and tides are connected. Number '9' is special to you in some situations, for instance 9 seconds between two consecutive vehicles on the road means something bad for your family. You believe if you count to an even number then that will prevent bad outcomes to your family and bring them fortunes. If the candidates ask if you are sure or convinced about the bad outcome of 9 seconds; you are not '*100% definite*'.

You also believe that plastic materials are bad as they contaminate the earth, and therefore you avoid brushing with a plastic toothbrush (you have a metal one, but they are hard to find at most stores), and any item that is brought or packed in a plastic bag. You somehow manage things without plastic materials although you sometimes miss a meal if you don't get food items not packed in plastic container, but you don't want to change your behaviour or ideas, which have been present for years.

#### Your work history:

You did a science degree at university. You work as a data entry operator in a large company where you have worked for two years. You have had two previous jobs, both of which you left because you didn't like the work environment. There were no major interpersonal issues but you didn't like your bosses whom you saw as intrusive.

#### Your social life:

You have been a loner from childhood. This is not because of your anxiety of how you may be judged by others or feelings of embarrassment. You don't care about such things. At school you were always the last to be picked for teams, and you only ever had one or two friends. This never bothered you. If asked were you close to your friends, you are a bit perplexed and not sure what this means. They were nice people. You sometimes see one of the people you went to University with but not often, and this doesn't strike you as unusual. You experience no pleasure in social activities. You are indifferent to praise and critical comments from others.

You do not have any specific fear of seeing people, although social situations sometimes make you uneasy (such as Jane badgering you at work), but you don't think they make you anxious and you don't specifically avoid them.

You don't go to parties because no one asks you, and you don't enjoy them particularly. You'd rather read or watch TV. The last '*party*' you went to was with your parents to a cousin's 21st birthday six months ago. This went '*fine*'. They had a really good spicy food dip and you got the recipe.

You are not in a relationship and have never had a boyfriend. You think you are heterosexual but don't think having a partner is a priority. You just get on with your job. You don't ask others for any help. You haven't thought about getting married or whether you want children.

Your past psychiatric history and other mental health symptoms:

- You have no past psychiatric history. Your only family history is a maternal grandmother who was diagnosed with schizophrenia. She died long ago.
- You do not have odd, false, unshakable ideas or experience hearing of voices or seeing things that other people do not.
- You do hold a suspicion that people may take undue advantage of you at any time and you are vigilant against people, although you don't generally think people are after you, following you, or trying to harm you.

If the candidate asks you whether you have repetitive, intrusive thoughts (called obsessions): you can describe your beliefs about the number '9'. But this is just your belief. You don't want to elaborate or talk about it any further.

You don't believe that you are monitored or messages are sent to you from unknown sources (including from outer space or other planets). You do not worry about your safety. There is no strange experience of your thoughts or actions being controlled by others or obscure forces, neither that your thoughts are known to others. You do not have unusual experience of hearing voices while alone.

You never had any significant mood symptoms; low, depressed or high and elevated. You were never suicidal. You do not drink alcohol or use any other recreational substances.

#### Background history in case you are asked:

You are an only child. Your father was fifty years old when you were born, and your mother was forty. You think you might have been born a bit premature, and think you spent a week in ICU after you were born but you don't know why. You also had meningitis and were in hospital for a few weeks when you were about three years old. Otherwise your early childhood was conservative but unremarkable.

Academically you were always average, better at maths and science and not very good at English, and you hated anything that required group work or role-plays.

Both your parents are now retired. Previously your dad worked as an accountant, and mom was a librarian. You still live with them and you get on well. Your family are not big socialites, and you (and they) rarely go out. You have dinner together and you help your mother cook.

You have three cats you are very fond of; their names are Mitsy, Fluffy and Max. You read a lot of science fiction and fantasy. You like vampire and Star Wars movies, novels and watching TV.

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

Normal neat appearance, formally dressed but **quite aloof without much eye contact and blunted emotional expression**.

You do not believe there is a problem but will answer questions readily although responses must be **vague and long-winded**. Answer all questions with little emotions. Don't be animated, keep your emotions dull - you are emotionally restricted.

If the candidates ask you about your views or ideas then you **MUST** outline your belief in astrology, ESP, connectedness between moon and tides, and / or your view against plastic materials.

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

***'I don't know why my boss thinks there is a problem. I do my work perfectly well.'***

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

The candidate needs to establish what kind of a personality disorder you have. They may ask about relationships and work history (answer as above), as well as thoughts or attempts of self-harm, social anxiety and drug and alcohol dependence issues, of which you have none.

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

***'I am not "mad"; I just have my own view of the world.'***

***'I am wary that people may take undue advantage of me.'***

***'I don't see why I should change my ideas.'***

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

Any other unexpected questions, you may say:

***'I don't know' or 'That is not important to me.'***

If the candidate uses the term "magical thinking":

***'What is magical thinking?'***

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

None



**STATION 7 – MARKING DOMAINS**

**The main assessment aims are:**

- To engage a young woman with ego-syntonic personality disorder symptoms.
- To assess Cluster A personality disorders.
- To arrive at a diagnosis of schizotypal personality disorder and substantiate this diagnosis with the findings elicited.
- To identify the most likely differential diagnoses as schizoid personality disorder and paranoid personality disorder or attenuated psychosis syndrome.

**Level of Observed Competence:**

**2.0. COMMUNICATOR**

**2.1 Did the candidate demonstrate an appropriate professional approach to gather information from the patient? (Proportionate value - 10%)**

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

clearly achieves the standard overall with a superior performance in a number of areas: generates a sophisticated understanding of complexity; engages the patient at a superior level, e.g. employing transitions, paraphrasing etc; demonstrates sensitivity for employer engagement and discusses the need for a medical certificate for taking time off work.

**Achieves the Standard by:**

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the client taking regard of culture, gender, etc.; listening to patient’s concerns at workplace; effectively managing the patient’s denial of psychiatric problems; respecting and discussing confidentiality issues.

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

- a. Engage the patient adequately in order to elicit phenomenology.

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

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

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

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

errors or omissions materially adversely impact on alliance; inadequately reflects on relevance of information obtained; being critical of patient’s views and ideas.

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

**1.0 MEDICAL EXPERT**

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

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

clearly achieves the overall standard with a superior performance in a range of areas; explores obsessional symptoms; addresses need for precipitated consultation; demonstrates effective prioritisation of questions.

**Achieves the Standard by:**

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient’s circumstances with appropriate depth and breadth; demonstrating ability to prioritise; eliciting the key issues like enduring pattern of social and interpersonal deficits along with lack of desire for close relationships; completing a relevant risk assessment; clarifying important positive / negative features; assessing for typical and atypical features including the ego-syntonic nature.

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

- a. Establish an enduring pattern of social and interpersonal deficits along with lack of desire for close relationships that began in early life
- b. Demonstrate skills in eliciting at least five of the symptoms associated with schizotypal personality disorder.

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

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

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

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

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history related to relevant personality disorders; does not explore other major psychiatric disorders; no attempt to screen the ideas of self-harm or harm to others.

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

**1.9 Did candidate describe and individualise relevant diagnosis? (Proportionate value - 30%)**

**Surpasses the Standard if:**

provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; outlines variation in classification of schizotypal disorder between ICD 10 and DSM-5.

**Achieves the Standard by:**

identifying and succinctly summarising important aspects of the history, observation and examination; synthesising information using a biopsychosocial framework; integrating psychiatric and sociological information; developing hypotheses to make sense of the patient's predicament; commenting on missing or unexpected data; accurately linking formulated elements to their diagnostic statement; analysing vulnerability and resilience factors.

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

- a. Justify a diagnosis of schizotypal personality disorder.

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

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

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

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

significant deficiencies including inability to synthesise information obtained; failure to question veracity where this is important; providing an inadequate formulation or diagnostic statement; misinterprets findings as suggestive of psychosis or delusional disorder.

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

**1.9 Did candidate describe and individualise relevant differential diagnosis? (Proportionate value - 30%)**

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

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems; sophisticated understanding of similarities of symptoms of schizotypal disorder and schizoid personality disorders to the fundamental symptoms of schizophrenia.

**Achieves the Standard by:**

demonstrating capacity to integrate available information in order to formulate a differential diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for differential diagnoses (e.g. preference for solitary life, absence of pleasure in activities, indifference to praise or criticism); knowledge about evolving concepts about diagnostic classification (e.g. attenuated psychosis syndrome); adequate prioritisation of conditions relevant to the obtained history and findings; considering paranoid personality disorder or attenuated psychosis syndrome or early phase of psychosis.

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

- a. Offer a differential diagnosis of schizoid personality disorder.

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

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

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

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

inaccurate or inadequate considerations of differential diagnosis; errors or omissions are significant and do materially adversely affect conclusions; attempts to normalise presentation.

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

## GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

The candidate is expected to discuss the efficacy and rationale for prescribing clozapine with a concerned parent of a patient with treatment resistant schizophrenia. The patient's father is concerned about the potential side effects, and the candidate is expected to explain monitoring options and provide a description of specific interventions to prevent and manage specific side effects.

**1.1 The main assessment aims are to:**

- Assess the candidate's ability to demonstrate knowledge of the indications and efficacy of clozapine over other antipsychotics.
- Assess how the candidate explains the management of potential life-threatening and the common, but less severe, side effects of clozapine.
- Assess whether the candidate communicates with a relative in a professional, empathetic manner.

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

- Refer to evidence-based guidelines for clozapine prescribing e.g. RANZCP or other recognised guidelines (e.g. NICE).
- Recommend accurate monitoring for cardiac side effects with ECG, echocardiogram, troponin and CRP.
- Describe options for addressing constipation.
- Mention appropriate interventions for prevention of diabetes.
- Effectively communicate an accurate risk / benefit analysis of clozapine treatment whilst empathetically engaging with an anxious parent.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Management – Therapy; Assessment – Investigations, Selection; Management – Long-term Preventative), Communicator (Patient Communication – To Patient / Family / Carer)

**References:**

- Agid O et al. An algorithm-based approach to first-episode schizophrenia: response rates over 3 prospective antipsychotic trials with a retrospective data analysis. *J Clin Psychiatry* 2011; 72:1439-1444
- De Fazio P et al. Rare and very rare adverse effects of clozapine. *Neuropsychiatric Disease and Treatment* 2015;11 1995–2003
- Layland, JJ, Liew D Prior DL. Clozapine-induced cardiotoxicity: a clinical update. *Med J Aus* 2009;190(4): 190-192
- Lewis SW et al. Randomised controlled trial of effect of prescription of clozapine versus other second-generation antipsychotic drugs in resistant schizophrenia. *Schizophr Bull* 2006; 32:715-723
- McEvoy JP et al. Effectiveness of clozapine versus olanzapine, quetiapine and risperidone in patients with chronic schizophrenia who did not respond to prior antipsychotic treatment. *Am J Psychiatry* 2006; 163:600-610
- Mohan I, Wendelborn K. Constipation associated with clozapine: need for closer monitoring. *Australasian Psychiatry*. 2016 Feb;24(1):97
- NICE guidelines, Psychosis and schizophrenia in adults: prevention and management. Clinical guideline. Published: 12 February 2014. ([nice.org.uk/guidance/cg178](http://nice.org.uk/guidance/cg178))

- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Australian & New Zealand Journal of Psychiatry 2016, Vol. 50(5) 410 –472
- The Maudsley, prescribing guidelines in psychiatry, 12th edition (2015)
- Youssef DL et al. Incidence and risk factors for clozapine-induced myocarditis and cardiomyopathy at a regional mental health service in Australia. Australasian Psychiatry 2016;24(2):176-180

#### 1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: well-dressed man in 50s-60s.
- 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 a junior consultant psychiatrist covering a colleague in an acute general adult mental health service, and have been asked to see Harold Stokes, the father of an inpatient, Michael.

Michael, aged 29, was diagnosed with schizophrenia 3 years ago. He thought that his university had installed a device in his ear to control him and so left his course. He also stopped looking after himself and became very socially withdrawn. He still lives with his parents.

He has undertaken adequate trials of oral olanzapine and risperidone, and haloperidol depot. Despite being compliant with treatment, he continues to experience both positive and negative symptoms, which significantly impact on his day-to-day function.

His usual doctor has already discussed clozapine with Michael and he is keen to proceed. However, his father has raised questions about its safety. As a result, Michael asked his father to speak with a doctor to address his concerns and has given his consent for this discussion.

### Your tasks are to:

- Explain the rationale for the recommendation of clozapine rather than any other antipsychotic for Michael.
- Describe the screening for possible cardiac events and their management if they occur.
- Briefly outline preventative management of other non-haematological serious adverse effects of clozapine.

**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 parent.

### 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 for any scripted prompt you are to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated parent 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've heard that clozapine has got lots of serious side effects. Why are you going to give it to Michael?'***

#### 3.2 Background information for examiners

In this station the candidates are expected to engage the father of a young man with chronic schizophrenia whose illness meets the criteria for treatment resistance. They must demonstrate that they are aware of the indications for and efficacy of clozapine over other antipsychotics to justify the decision to trial the drug. The candidate is to outline the major tests for cardiac monitoring.

The candidate should then explain the management of the main potential life-threatening and the most common, but less severe, side effects of clozapine as well as aim to reassure the father as to what specific cardiac monitoring will be put in place. The candidate is specifically instructed not to comment on the haematological side effects (agranulocytosis and neutropenia) in order to test their knowledge of the management of other side effects.

The candidate must complete these tasks while communicating with the father in a professional, empathetic manner.

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

- Refer to evidence-based guidelines for clozapine prescribing e.g. RANZCP or other recognised guidelines (e.g. NICE).
- Recommend accurate monitoring for cardiac side effects with ECG, echocardiogram, troponin and CRP.
- Describe options for addressing constipation.
- Mention appropriate interventions for prevention of diabetes.
- Effectively communicate an accurate risk / benefit analysis of clozapine treatment whilst empathetically engaging with an anxious parent.

A surpassing candidate may cite relevant recent publications to support their explanations, may focus more on how life-threatening side effects can be monitored and managed. They may also show a more empathic approach when dealing with a concerned, anxious parent.

The evidence suggests that, in patients whose symptoms have not responded adequately to sequential trials of 2 or more antipsychotic drugs, clozapine is the most effective treatment. Some suggest that olanzapine should be one of the two drugs used before clozapine (Lewis, 2006).

Clozapine Monitoring Systems: Prior to first dose, the patient must be registered for the clozapine monitoring service. WCC and differential, LFTs, RBG, lipids, troponin and CRP blood tests, and ECG are required. An echocardiogram needs to be performed within the first 6 months.

Clozapine is generally commenced according to standardised protocols: Clozapine dosage is gradually increased, starting at 12.5mg per day and increasing in 25mg-50mg steps over 2-3 weeks to 300mg. Thereafter it can be increased in 50mg-100mg weekly steps. Treatment is usually commenced as an inpatient, but can be done in the community if adequate monitoring is possible. Daily blood pressure, pulse, respiration rate and temperature recordings are required in the initial 2-3 weeks.

Preventative management options for the most serious (potentially life-threatening) side effects of clozapine are:

<p>Agranulocytosis. Risk is in the region of 1 in 10,000 patients exposed.</p>	<p>Well managed by the approved Australia and NZ monitoring system, i.e. weekly FBC for 18 weeks then 4-weekly (monitoring systems differ slightly across the world). Individual risk factors for developing neutropenia and agranulocytosis are different and although the addition of lithium can raise WCC, its use is still somewhat controversial in preventing true clozapine-induced agranulocytosis.</p>
<p>Thromboembolism. Possible risk between 1 in 2000 to 1 in 6000 patients exposed. Other antipsychotics also increase risk.</p>	<p>Managed by maintaining adequate hydration and exercise.</p>
<p>Myocarditis. Seems to occur most in first 6-8 weeks, but can occur at any time. Australian studies show higher risk (up to 1%) compared to USA (1 in 67,000). Unknown reasons for differences.</p>	<p>Monitor for symptoms including hypotension, tachycardia, fever, flu-like symptoms, fatigue, dyspnoea and chest pain. ECG shows ST depression; echocardiograph shows enlarged heart (value of regular / routine echocardiographs questionable). Blood tests show eosinophilia, raised CRP and troponin 1. Risk increased if dose rapidly increased, if patient is older and if sodium valproate co-prescribed.</p> <p>If it is suspected, urgent referral to a physician, immediate cessation of treatment is indicated. Provision of supportive care. May require intensive haemodynamic support with inotropic agents initially then consideration of LV residual dysfunction.</p>
<p>Cardiomyopathy. Tends to occur later (average 9 months), but can occur at any time. Suspect if any signs of heart failure.</p>	<p>ECG changes reported are also non-specific and include sinus tachycardia, T-wave inversion, prolonged QTc, and ST flattening / depression.</p> <p>Value of regular / routine echocardiograph is questionable.</p> <p>If it is suspected, urgent referral to a physician and immediate cessation of treatment is indicated. May require treatment with established heart failure medical therapies to slow the progression of the disease.</p>
<p>Constipation. Clozapine-Induced Gastrointestinal Hypomotility (CIGH) is very common (up to 60%), and causes more deaths than blood dyscrasias, but receives little attention. Most common in the first 4 months of treatment. Probable link with higher doses (average daily dose in those patients who have died was 535mg). Anticholinergics increase risk.</p>	<p>Monitor bowel function and recommend increased fibre and water intake, plus exercise. Possible use of polyethylene glycol (Movicol) / lactulose. Refer early to physician if signs of obstruction. May need surgical intervention.</p>
<p>Seizures. Risk increases with plasma clozapine level.</p>	<p>Some suggest prophylactic anticonvulsants if dose above 500mg/day or blood level above 500mcg/l.</p> <p>Bear in mind the effect on driving licence if a seizure occurs.</p>



Less serious or acute, but other important and common side effects include:

- Sedation
- Hypersalivation
- Weight gain
- Hyperlipidaemia
- Hyperglycaemia
- Hypotension
- Hypertension
- Tachycardia
- Fever
- Nausea
- Nocturnal enuresis
- Gastro oesophageal reflux disease (GORD)

Mean triglyceride levels increase by 10% over 5 years. Cholesterol levels also increase. The risk of diabetes seems higher with clozapine than other second generation antipsychotics. Therefore, metabolic monitoring is essential, with dietary advice, regular exercise, smoking cessation and consideration of lipid-lowering drugs and metformin.

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## 4.0 Instructions to the Role Player

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

You are Harold Stokes, a 55-year-old lawyer. You live with your wife, Judith, and 29-year-old son Michael.

You are attending an appointment with the psychiatrist at the request of your son, as he wants to start a new medication called CLOZAPINE, which you are not sure you agree with.

Michael was diagnosed with schizophrenia 3 years ago, and came back to live with you shortly afterwards. He is your only child. Michael was academically gifted and had gone to university to study engineering, but midway through the second year, had a 'breakdown' and was admitted to the local psychiatric hospital under the mental health act. This was a very traumatic time for you and your wife.

You need to be convinced that the 'significant risks' you have heard about for Michael taking clozapine are outweighed by the potential improvement in his mental wellbeing and day-to-day functioning. You want him to be able to live independently and not be permanently disabled and reliant on you and your wife.

You accept that Michael is capable of making the decision about taking clozapine himself, but want to be knowledgeable enough about the pros and cons of treatment to be able to discuss it further with Michael so that you can all be sure it is the best treatment for him.

Your concerns about clozapine:

You have read that clozapine is the 'gold standard' antipsychotic but you don't know why. What you do know is that it can have life-threatening side effects. You have heard and read of some, but are not sure how commonly these things occur; they include:

- effects on your heart
- causing fits (seizures)
- really bad constipation
- High risk of weight gain leading to diabetes
- dramatically lowering the white blood-cells in your blood which usually fight disease; leaving you more susceptible to serious infections. Dr West, the usual treating psychiatrist has explained this problem to you in detail and even though this is a worrying side effect, you think you have a reasonable understanding of it and so want to discuss the other problems that you have read about.

You are worried because you know there have been deaths linked to clozapine, and want to have the risks clearly explained. You also want to know how Michael will be monitored so that if any of these side effects occur, they can be detected early and 'something can be done'. You want to know what will happen if any of the 'bad' side effects occur to ensure Michael doesn't suffer any irreversible medical problems.

You are also aware that on top of these very serious sudden events that might happen, clozapine can also cause other side effects. These include weight gain, raised cholesterol and blood sugar, which in a young man like Michael could in the longer term increase the chances of him developing diabetes, and having a heart attack or a stroke. He is not doing much exercise either so the risk of weight gain will be higher.

Michael's symptoms:

At the time he became unwell, Michael had been seen mumbling to himself, and had been complaining that the university had secretly drugged him and inserted a communication device into his ear so that they could control him. He had attempted to cut the device out of his ear, which had led to him needing stitches. He had also become very withdrawn, spending most of his time in his room. His self-care had markedly worsened, and he hadn't been washing or changing his clothes, and had only eaten convenience foods. To your knowledge, Michael hadn't used any illicit drugs, and he does not smoke or drink alcohol.

Treatment for Michael's symptoms:

During that admission Michael was started on the antipsychotic medication OLANZAPINE, and had been discharged after about 3 weeks. He had returned home with you to recuperate, and had hoped to return to his studies, but this did not happen. Despite regularly taking the olanzapine 20mg in a wafer form (he allowed you to watch him take it), he remained convinced the device had been inserted into his ear and that he was being controlled by people at the university. He continued olanzapine for 8 months, but complained of feeling tired on it and gained around 10kg. His doctor did some blood tests, and you were told they were all good.

His psychiatrist, Dr West, eventually changed him over to another medication, called HALDOL which was given by injection every 4 weeks, but all this seemed to do was make Michael feel 'dull' and made him very stiff, 'like a robot'. Michael didn't like the injection either and started to resist taking it, so after 4 months it was stopped and he was started on a third medication (tablet) called RISPERIDONE, which he took 4mg per day.

Michael has no problems taking RISPERIDONE and has remained on it for nearly 2 years. It seems to dampen down some of his concerns about the device and being followed or controlled, but you still hear him talking to himself at times and he remains socially isolated and unmotivated. He hasn't been able to go back to university and he hasn't been able to attend any employment training. He is receiving a disability pension. The only enjoyment he seems to get is driving his car so that he can go fishing. He seems to tolerate the medication quite well and does not complain of any side effects that you are aware of.

Because of the ongoing low grade symptoms, Michael was admitted to hospital last week following an outpatient meeting with his psychiatrist who recommended he should now consider taking another medication called clozapine instead of risperidone. Michael really wants to try this medication and is about to start the new treatment.

You have heard that there are risks in taking clozapine and this has made you concerned about Michael's decision. You want to discuss these with the psychiatrist. Michael is happy for the doctor to discuss his care with you and has made an appointment for you to meet. You are aware that the candidate is not the usual treating doctor, therefore, they will not know all of the details in his background.

#### 4.2 How to play the role:

You are well dressed in a business suit or at least shirt and tie. You are very confident, standing to firmly shake the candidate's hand as they enter the room. Maintain eye contact throughout the meeting. You should not be overly aggressive in your style of interaction, but make the candidate aware that you are trying to act in the best interests of Michael and want to be as clear as you can be about the risks involved in him taking clozapine as well as the potential benefits. The candidate should provide you with the information about management of the side effects with little prompting.

You appreciate that the candidate is not Michael's usual treating doctor, and will not be aware of all the details of Michael's background. Your main focus is to understand clozapine treatment in more detail.

As the doctor begins to explain the potential side effects of clozapine, you become increasingly concerned about how well Michael will be monitored and what will happen if any of these bad things occurs. As the list of side effects gets longer, you will need more reassurance that the positives of clozapine treatment are likely to exceed the negatives.

#### 4.3 Opening statement:

*'I've heard that clozapine has got lots of serious side effects. Why are you going to give it to Michael?'*

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

A clear explanation of the evidence for clozapine being 'the best' antipsychotic, but also a clear and succinct summary of the most serious and the most common side effects, how Michael will be monitored to detect if these are occurring and what will happen if any of them do occur.

Despite the long list of potentially serious side effects, clozapine is likely to be the best treatment option to allow Michael to control his symptoms and improve his day-to-day function, therefore increasing the chance of him becoming more independent in the future.

You should also expect the candidate to be open with you and empathise with you regarding the difficulties Michael's illness may have caused over the last 3 years.

#### 4.5 Responses you MUST make:

*'He doesn't eat well – so what happens if he gets constipated?'*

*'Can you guarantee that this medicine will not kill my son?'*

*'But what about the risk of diabetes?'*

#### 4.6 Responses you MIGHT make:

*'I realise you don't know Michael very well, but I really want to understand more about clozapine.'*

As the list of side effects gets longer, you become more anxious and might say:

*'Wow! With all these side effects, why does anyone get treated with clozapine?'*

If the candidate starts talking about changes to the blood, or white cell counts, say:

*'That's the one thing that the other doctor explained really well to me. We need not talk about it.'*

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

- OLANZAPINE (also known as Zyprexa) 20mg a day – he took this for 8 months
- HALDOL (haloperidol decanoate), a long-acting antipsychotic injection, 100mg every 4 weeks – he took this for 4 months
- RISPERIDONE (also known as Risperdal) 4mg a day – he has been taking this for nearly 2 years.

## STATION 8 – MARKING DOMAINS

### The main assessment aims are:

- Assess the candidate's ability to demonstrate knowledge of the indications and efficacy of clozapine over other antipsychotics.
- Assess how the candidate explains the management of potential life-threatening and the common, but less severe, side effects of clozapine.
- Assess how the candidate communicates with a relative in a professional, empathetic manner.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.14 Did the candidate demonstrate an adequate knowledge and application of the efficacy of clozapine in treatment of resistant schizophrenia? (Proportionate value - 25%)

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

includes a clear understanding of levels of evidence to support treatment recommendation; identifies the role of other health professionals; outlines the importance of family support for successful outcomes.

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

demonstrating the understanding of treatment with clozapine; identifying specific treatment outcomes and prognosis – on both positive and negative symptoms, including appropriate selection, benefits / risks, initiation practices, dosages; stating the need for adherence, and importance of specific monitoring while on treatment.

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

- Refer to evidence-based guidelines for clozapine prescribing e.g. RANZCP or other recognised guidelines (e.g. NICE).

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

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

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

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

errors or omissions impact adversely on patient care; plan lacks structure and/or is inaccurate; unable to accurately identify evidence based rationales for treatment.

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

#### 1.8 Did the candidate make an appropriate choice of investigations to screen for cardiac functioning and complications? (Proportionate value - 25%)

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

considers the resource impact of choices; identifies any difficulties with access to investigations chosen; identifying potential limitations of investigations.

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

prioritising and selecting the optimal range of tests; justifying selection of monitoring and diagnostic procedures and investigations; demonstrating consideration of cost-benefit reasoning; seeking guidance or advice for complex or less familiar clinical problems.

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

- Recommend monitoring for cardiac side effects with ECG, echocardiogram, troponin 1 and CRP.

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

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

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

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

incorrectly chooses even routine / standard range of investigations; unable to prioritise relevant investigations.

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

**1.16 Did the candidate formulate an appropriate longer term management plan, including preventative management of other side effects? (Proportionate value - 35%)**

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

overall plan is tailored yet comprehensive; incorporates sophisticated plans for monitoring for the emergence of side effects.

**Achieves the Standard by:**

demonstrating awareness of major possible complications of treatment and available interventions/monitoring; demonstrating the ability to prioritise and implement evidence based interventions; demonstrating awareness of incident reducing / ameliorating effects of specific treatments; covering the preventative management of potential acute life-threatening side effects like seizures; acknowledging appropriately realistic possibility of treatment failure.

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

- a. Describe options for addressing constipation
- b. Mention appropriate interventions for prevention of diabetes.

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

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

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

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

errors or omissions will adversely affect outcomes; candidate has difficulty with most of the skills above.

1.16. Category: MANAGEMENT – Long-term, Preventative	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

**2.0 COMMUNICATOR**

**2.1 Did the candidate demonstrate an appropriate professional approach to gauging the concerns and providing information to Michael’s father? (Proportionate value - 15%)**

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

generates a superior understanding of the complexity of the father’s concerns; effectively tailors interactions to maintain rapport within the therapeutic environment.

**Achieves the Standard by:**

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of Michael’s father; providing education; communicating plans and discussing acceptability; effectively managing challenging communications; containing conflictual interactions; recognising confidentiality and bias; sensitively considering barriers to implementation.

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

- a. Effectively communicate an accurate risk/benefit analysis of clozapine treatment whilst empathetically engaging with an anxious parent.

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

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

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

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

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

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

## GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

In this station the candidate is expected to demonstrate an awareness of lithium pharmacokinetics and of the problematic interactions between lithium and angiotensin converting enzyme (ACE) inhibitors including an angiotensin II receptor antagonist candesartan, and then incorporate this into the management of Mrs Harris, a 74-year old woman with bipolar affective disorder and hypertension.

**1.1 The main assessment aims are to:**

- Demonstrate understanding of the pharmacokinetics of lithium in terms of absorption, excretion and effects on organ systems, leading to safe prescribing practices.
- Discuss the areas to address when making a decision to change medications.
- Provide education to a general practitioner whose decision-making may place a patient at risk due to limited knowledge regarding the use of lithium.

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

- Explain that lithium is excreted essentially unchanged through the kidneys.
- Explain the impact of angiotensin II receptor antagonist on lithium levels.
- Identify the importance of a risk-benefit evaluation of continuation or cessation of lithium.
- Contact the GP to explain that the co-prescription of lithium and candesartan can cause serious problems and should be avoided.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Old Age Psychiatry
- **CanMEDS Domains:** Scholar, Medical Expert, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Scholar (Application of Knowledge), Medical Expert (Management – Therapy; Management – Initial Plan), Collaborator (Teamwork)

**References:**

- Finley PR. Drug Interactions with Lithium: An Update. Clin Pharmacokinet 2016 Aug; 55(8):925-41.
- Juurlink et al. (2004) Drug-Induced Lithium Toxicity in the Elderly: A Population-Based Study. Journal of the American Geriatric Society 2004: 794–798.
- Kanowski S, Müller-Oerlinghausen B, 1973. Need for additional medication in outpatients during 3 years of prophylactic lithium treatment. In: Ban TA, Boissier JR, Gessa GJ, et al., editors. Proceedings of the VIIIth CINP Congress, Copenhagen, 1972. Amsterdam: North Holland Publishing Company, 1973: 105-8.
- Malhi, GS., Darryl Bassett, D., Philip Boyce, P., Bryant, R., Fitzgerald, PB., Fritz, K., Hopwood, M., Lyndon, B., Mulder, R., Murray, G., Porter, R., Singh, AB. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Australian and New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1-185.
- Müller-Oerlinghausen B. Drug Interactions with Lithium A Guide for Clinicians. CNS drugs. 1999; 11(1):41-48.
- Saddock BJ et al (Editors). Kaplan & Sadock's Comprehensive Textbook of Psychiatry. Ninth Edn. Wolters Kluwer. Lippincott Williams & Wilkins. 2009. Philadelphia. PA. USA.
- Schou M. Clinically significant lithium interactions. Review and recommendations. Eur J Psychiatry 1987; 1:42-7.
- Shine, B., McKnight, R., Leaver, L., Geddes, J. Long-term effects of lithium on renal, thyroid, and parathyroid function: a retrospective analysis of laboratory data. Lancet 2015 386: 461-468.
- Zwanzger P, Marcuse A, Boerner RJ, Walther A, Rupprecht R. Lithium intoxication after administration of AT1 blockers. J Clin Psychiatry 2001 Mar;62(3):208-9

**1.4 Station requirements:**

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

## 2.0 Instructions to Candidate

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

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

You are working as a junior consultant psychiatrist in an outpatient Mental Health Clinic for Older Persons.

You are preparing to review Mrs Harris, 74-year-old woman with long-standing bipolar affective disorder in remission. Her recent serum lithium level is 0.7mmol/l and renal function within normal limits.

She has been taking lithium for the last five years and she has tolerated this well, with all regular monitored blood results being within normal limits. She complies with all aspects of lithium treatment. Prior to this, her bipolar affective disorder was not well managed with multiple hospital admissions usually under the Mental Health Act.

Mrs Harris has a new General Practitioner, Dr Green, who wrote to you last week to ask that you stop her lithium as he is concerned that she will develop hypothyroidism or go into renal failure if lithium is continued for longer than five years.

He has also informed you that Mrs Harris has recently been diagnosed with hypertension, and he has just started her on the angiotensin II receptor antagonist candesartan cilexetil.

Your tasks are to explain to the examiner:

- the pharmacokinetic profile of lithium including its absorption, distribution, metabolism and excretion.
- clinically important drug interactions and potential complications of lithium with reference to this scenario.
- important factors that may influence your decision regarding whether to change medications for Mrs Harris.
- the key issues to communicate to Dr Green.

**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.

### During examination:

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

### At conclusion of examination:

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

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

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



### 3.0 Instructions to Examiner

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

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

When the candidate enters the room briefly check ID number.

There is no opening statement or any prompts.

This is a VIVA station. The candidate is to explain to the examiner:

- the pharmacokinetic profile of lithium including its absorption, distribution, metabolism and excretion.
- clinically important drug interactions in this scenario.
- important factors that may influence your decision regarding whether to change medications for Mrs Harris.
- the key issues to communicate to Dr Green.

#### 3.2 Background information for examiners

In this station the candidates are to demonstrate knowledge of safe prescribing practices by applying the pharmacokinetics of lithium, in particular the renal effects, to this scenario. The candidate is expected to be able to demonstrate an awareness of the toxic interactions between lithium and ACE inhibitors, and to incorporate this into the management of an elderly woman with bipolar affective disorder and hypertension.

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

- Explain that lithium is excreted essentially unchanged through the kidneys.
- Explain the impact of angiotensin II receptor antagonist on lithium levels.
- Identify the importance of a risk-benefit evaluation of continuation or cessation of lithium.
- Contact the GP to explain that the co-prescription of lithium and candesartan can cause serious problems and should be avoided.

#### Management of the long-term side effects of lithium

The first step is to look at the possibility of reducing / stopping the lithium as sometimes renal or thyroid function can spontaneously improve. If this does not occur or reduction and stoppage is not possible, increased monitoring is indicated. In the case of renal impairment, liaison with a nephrologist is indicated to identify any other factors that may be promoting renal impairment. In the case of hypothyroidism, thyroid replacement is indicated. Such factors should be minimised and increased renal monitoring undertaken.

#### Deciding whether to stop lithium

The candidate needs to explain any decisions regarding changing medication.

A risk-benefit assessment would indicate that Mrs Harris's bipolar disorder may deteriorate if she were to stop lithium particularly because many of her admissions have been under the Mental Health Act, so there is a degree of risk when she becomes unwell.

Whilst there is no right or wrong answer to this part of the question, good candidates will be able to explain how they have arrived at their decision as to whether to stop Mrs Harris' lithium (including risk, efficacy of previous treatments) and if they are to continue lithium, how they will educate the GP or if they are to stop lithium, how they will manage this.

#### The co-prescription of the angiotensin II receptor antagonist candesartan cilexetil

The candidate should identify that they need to communicate with the GP about ceasing candesartan while Mrs Harris is still taking lithium; preferably before they meet with Mrs Harris so a cohesive plan can be presented to her without causing alarm.

Options are to temporarily stop or reduce the dose of lithium, or consider an alternative antihypertensive. If the angiotensin II receptor antagonist candesartan cilexetil is prescribed, it will be necessary to monitor the lithium levels more often.

They are expected to outline what they would say to the GP, including explaining the clinical risks of stopping lithium, and why the prescription of the angiotensin II receptor antagonist candesartan is unsafe for this patient.

## Background to this station

Lithium is commonly used for the treatment of unipolar and bipolar affective disorder. According to the RANZCP guidelines for mood disorders, there is evidence from randomised controlled trials for the effectiveness of lithium as an augmenting agent in depression. Lithium is widely supported for use, and is found to be more effective than placebo in augmentation of TCAs, SSRIs and other antidepressants. For bipolar disorders, lithium is shown to be the most effective mood stabiliser, which may also reduce suicide risk but has important side effects with long-term use.

Lithium's low therapeutic index and significant toxicity raise serious considerations in its use. Elderly patients are at a particularly high risk of lithium toxicity because of altered pharmacokinetics, polypharmacy, renal impairment, and proneness to medication induced confusion.

Polypharmacy is also a common occurrence in patients with co-morbidities and increased age. Several doctors may be independently caring for the same patient, and communication among them is imperative to ensure safe polypharmacy. There are a number of conditions that can lead to polypharmacy where lithium is one of the medications: insomnia, agitation, psychotic symptoms, physical co-morbidities, use of contraceptive pills and self-medication. Studies showed that more than 50% of patients taking lithium are prescribed additional medications at some point, and reports of pharmacokinetic interactions between lithium and other medications are uncommon.

Three major drug classes have been identified as potential precipitants of lithium toxicity:

- Diuretics that promote renal sodium excretion;
- The antihypertensive class of angiotensin II receptor antagonist, which reduce glomerular perfusion pressure and can enhance the tubular reabsorption of lithium;
- Nonsteroidal anti-inflammatory drugs (NSAIDs) that inhibit renal prostaglandin synthesis.

### Pharmacokinetics:

Pharmacokinetics refers to the movement of drug into, through and out of the body; including the time course of its absorption, bioavailability, distribution, metabolism, and excretion (how the person affects the drug). It differs from pharmacodynamics which is the study of the biochemical and physiologic effects of a drug (how a drug affects a person). Both together influence dosing, benefit, and adverse effects.

Lithium ions are almost completely absorbed from the gastrointestinal tract, complete absorption occurring after about 8 hours. Peak plasma concentrations occur after about 2-4 hours of ingestion. Lithium initially distributes into extracellular fluid and then to most other tissues. The final volume of distribution equals that of total body water. Lithium slowly enters cerebrospinal fluid achieving a steady state 40% of the plasma concentration. Elimination occurs via the kidneys but lithium can also be detected in sweat and saliva. Lithium is able to cross the placenta and is excreted in breast milk.

The elimination half-life of lithium is 18-24 hours, but can be longer in elderly patients. Except for a very small fraction that is excreted through sweat and other body fluids, the excretion of lithium is through kidneys. Unlike many other psychotropic drugs, lithium is neither metabolised nor protein bound in the body. Excretion of lithium is linked with sodium excretion. Lithium is known to inhibit its own excretion and clearance of lithium dramatically declines with increasing serum levels of lithium.

### Lithium and renal function:

Lithium is completely filtered at the glomerulus and the majority of the filtered load is reabsorbed by the proximal tubule. Significant quantities are also absorbed in the loop of Henle and the early distal nephron. Up to 90% of the filtered load is reabsorbed by the nephron, 60% in the proximal tubule, and the remainder in the thick ascending limb of the loop of Henle, the connecting tubule, and the cortical collecting duct. Lithium can substitute for sodium in several sodium channels, particularly the sodium-hydrogen exchanger in the proximal tubule, the exchanger in the thick ascending limb of the loop of Henle, and the epithelial channel of the cortical collecting tubule.

Acute lithium nephrotoxicity is evidenced by volume depletion, reduced alertness and the potential for cardiovascular collapse. The most common chronic complication is nephrogenic diabetes insipidus where the kidneys cannot respond to anti-diuretic hormone (ADH), the chemical messenger that controls fluid balance. This results in polyuria secondary to a deficit in urine concentrating ability, excessive thirst and polydipsia.

After 10-20 years of treatment, some patients develop lithium-induced interstitial nephropathy which, in small proportion of patients may lead to end-stage renal disease. Lithium-induced hypercalcemia and nephrotic syndrome are rare complications of lithium therapy. In patients on long-term lithium therapy periodic monitoring of kidney function by measuring serum creatinine concentration and glomerular filtration rate is necessary.

## Interactions:

As an alkali metal and monovalent cation, lithium is not biotransformed or highly protein-bound but is excreted unchanged by the kidneys. Therefore, any drug that has the potential to reduce renal function may lead to accumulation of lithium. Drugs with nephrotoxic potential should generally be avoided in patients who are receiving lithium.

Drug-drug interactions may contribute to altered lithium serum concentrations and decreased efficacy or increased toxicity. In particular, drugs that affect sodium or water balance may result in interactions with lithium.

In one study 10,615 elderly patients treated continuously with lithium for a total of 26,866 patient years of therapy were identified. The mean age of the cohort was 72, 62% were women. During the 10-year study period, 413 patients were admitted to the hospital with lithium toxicity. These patients were, on average, about 2 years older than the rest of the cohort and were marginally more likely to be women (66%). Patients admitted with lithium toxicity spent a total of 7,885 days (median 11; interquartile range 6–23 days) in the hospital. Sixty-one (15%) were treated in a critical care unit, 13 (3%) underwent dialysis, and 19 (5%) died before discharge. Of the 413 elderly patients admitted with lithium toxicity, many had received prescriptions for a potential interacting medication during the preceding month. After adjustment for potential confounders, the use of diuretics (particularly loop diuretics) and angiotensin II receptor antagonist in the preceding month was associated with a modest increase in the risk of admission for lithium toxicity. In new users of these agents, the risk of toxicity was considerably higher. Patients newly treated with loop diuretics were nearly six times more likely to be hospitalised, and those started on angiotensin II receptor antagonist were four times more likely to be hospitalised.

In no analysis was the use of thiazide diuretics or NSAIDs associated with a significantly greater risk of hospitalisation for lithium toxicity, even in new users of these agents. As expected, no association was found between topical corticosteroid use and lithium toxicity. Sensitivity analyses employing various definitions of the discontinuation date, individual observation period, and covariate exposure interval yielded uniformly consistent results. Approximately 2.4% of all hospitalisations for lithium toxicity in this cohort could be ascribed to new use of a loop diuretic in the preceding 28 days, and about 3.0% of such admissions could be ascribed to new use of an angiotensin II receptor antagonist.

Candesartan is prescribed in patients treated for hypertension where an agent acting on the renin-angiotensin system (RAS) is considered to be clinically indicated. The active ingredient is candesartan cilexetil. Candesartan is an angiotensin II receptor blocker / antagonist (ARB / AIIIRA) used to treat hypertension as monotherapy or in combination with other medications. It is also indicated in congestive cardiac failure in addition to angiotensin II receptor antagonist or when angiotensin II receptor antagonist cannot be used.

Candesartan is contraindicated in people with allergy to the drug; in pregnancy; in severe liver disease or biliary obstruction; diabetes or kidney problems, and including in people taking direct renin inhibitors (e.g. hemifumarate); angioedema, including that caused by other angiotensin II receptor antagonist (e.g. lisinopril).

In some patients, such as those with liver problems, kidney problems, dehydration, or those who recently have lost body fluids, e.g. through vomiting or diarrhoea or by using water tablets, a lower starting dose should be prescribed. Electrolyte problems (e.g. high blood potassium levels, low blood sodium levels) or a low-salt (sodium) diet also place people at risk when taking candesartan.

Medications that interact with candesartan therefore include:

- Lithium because the risk of its side effects may be increased by candesartan
- Diuretics (e.g. frusemide, hydrochlorothiazide) because the risk of hypotension may be increased
- Potassium-sparing diuretics (e.g. spironolactone, triamterene) or potassium supplements because the increased risk of hyperkalaemia
- Other angiotensin II receptor antagonist (e.g. lisinopril) or aliskiren because the risk of certain side effects (e.g. kidney problems, high blood potassium levels, low blood pressure) may be increased
- Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g. celecoxib, ibuprofen, indomethacin) because they may decrease candesartan's effectiveness and the risk of serious kidney problems may be increased.

Lithium and candesartan may interact and cause serious side effects because candesartan can slow down the elimination of lithium. This can lead to increased lithium blood levels. If taken in combination, patients may experience typical signs of toxicity; new or worsened tremors, fatigue, muscle weakness, confusion, slurred speech, vomiting, diarrhea, loss of appetite, blurred vision, trouble walking, ringing in the ears, seizures, dizziness, or heart palpitations.

### Incidence of long term side effects of lithium and their management:

In a paper published in the Lancet in 2015, the authors completed a retrospective analysis of laboratory data from Oxford University Hospitals National Health Service Trust (Oxfordshire, UK) investigating the incidence of renal, thyroid, and parathyroid dysfunction in patients (aged  $\geq 18$  years) who had at least two creatinine, thyrotropin, calcium, glycosylated haemoglobin, or lithium measurements between Oct 1, 1982, and March 31, 2014, compared with controls who had not had lithium measurements taken. They used survival analysis and Cox regression to estimate the hazard ratio (HR) for each event with lithium use, age, sex, and diabetes as covariates.

Adjusting for age, sex, and diabetes, presence of lithium in serum was associated with an increased risk of stage three chronic kidney disease (HR 1.93, 95% CI 1.76–2.12;  $p < 0.0001$ ), hypothyroidism (2.31, 2.05–2.60;  $p < 0.0001$ ), and raised total serum calcium concentration (1.43, 1.21–1.69;  $p < 0.0001$ ), but not with hyperthyroidism (1.22, 0.96–1.55;  $p = 0.1010$ ) or raised adjusted calcium concentration (1.08, 0.88–1.34;  $p = 0.4602$ ). Women were at greater risk of development of renal and thyroid disorders than were men, with younger women at higher risk than older women. The adverse effects occurred early in treatment (HR  $< 1$  for length of treatment with lithium). Higher than median lithium concentrations were associated with increased risk of all adverse outcomes.

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## STATION 9 – MARKING DOMAINS

### The main assessment aims are to:

- Demonstrate understanding of the pharmacokinetics of lithium in terms of absorption, excretion and effects on organ systems leading to safe prescribing practices.
- Discuss the areas to address when making a decision to change medications.
- Provide education to a general practitioner whose decision-making may place a patient at risk due to limited knowledge regarding the use of lithium.

### 6.0 SCHOLAR

#### 6.4 Did the candidate prioritise and apply appropriate and accurate knowledge about pharmacokinetic profile of lithium based on available literature / research / clinical experience? (Proportionate value - 30%)

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

discusses major strengths and limitations of available evidence; recognises the impact of specific presentations, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

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

identifying key aspects of the available literature; providing a detailed and comprehensive description of the absorption, distribution, metabolism and excretion profile of lithium; describing the relevant applicability of theory to the scenario; mentioning that it is not protein bound nor metabolised (distributed in water containing tissues).

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

- Explain that lithium is excreted essentially unchanged through the kidneys.

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

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

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

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

unable to demonstrate adequate knowledge of the literature / evidence relevant to the scenario; inaccurately identifies or applies literature / evidence; provides a basic explanation of lithium's indications and side effects but little regarding absorption or excretion.

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

### 1.0 MEDICAL EXPERT

#### 1.14 Did the candidate demonstrate an adequate knowledge and application of clinically important complications and drug interactions of lithium? (Proportionate value - 30%)

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

includes a clear understanding of levels of evidence to support known treatment interactions.

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

explaining the renal and thyroid complications of lithium; identifying specific treatment outcomes and prognosis; demonstrating an understanding of lithium's major drug interactions, for instance NSAIDs or diuretics; medication choice, dosing and monitoring.

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

- Explain impact of angiotensin II receptor antagonist on lithium levels.

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

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

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

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

errors or omissions impact adversely on patient care; unable to identify major drug interactions; neglects to explain renal or thyroid complications; does not tailor responses to the patient's circumstances.

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

**1.13 Did the candidate formulate and describe a relevant initial management plan in relation to the request to stop lithium? (Proportionate value - 30%)**

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

provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan.

**Achieves the Standard by:**

demonstrating the ability to prioritise and implement evidence based acute care; identifying medication options; linking relevant investigations with assessment of physical condition, considering patient preference; recognising of their role in effective treatment; discussing the importance of ascertaining prior response to medications; identification of potential timeframes for communications and managing barriers.

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

- a. Identify the importance of a risk-benefit evaluation of continuation or cessation of lithium.

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

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

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

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

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

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

**3.0 COLLABORATOR**

**3.2 Did the candidate appropriately involve the GP in developing a management plan? (Proportionate value - 10%)**

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

takes a leadership role in treatment planning; effectively negotiates complex aspects of care; provides a clear explanation of why the requested medication is contraindicated; recognises the risk of causing patient alarm.

**Achieves the Standard by:**

suitably engaging the general practitioner; communicating proposed recommendations clearly and with good judgment; expressing views and expectations candidly and respectfully; taking appropriate and effective leadership to ensure positive patient outcomes; dealing effectively with potential disagreement.

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

- a. Contact the GP to explain that the co-prescription of lithium and candesartan can cause serious problems and should be avoided.

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

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

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

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

candidate allows the request for medication; errors impact adversely on the finalised plan.

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

**GLOBAL PROFICIENCY RATING**

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

This station tests the candidate's knowledge about signs of chronic alcoholism, and their ability to carry out a focussed physical examination in a man who has a long-standing history of alcohol dependence.

**1.1 The main assessment aims are:**

- To assess the candidate's knowledge of signs of chronic alcoholism.
- To assess the candidate's ability to conduct a focussed physical examination – general and systemic.
- To assess the candidate's ability to accurately communicate the examination findings to the examiner.

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

- Assess hands / arms for at least 3 signs (e.g. tremors, generalised small muscle wasting, Dupuytren's contracture, palmar erythema, nail pallor, clubbing, koilonychia).
- Undertake at least 2 nervous system tests (e.g. peripheral neuropathy, proximal myopathy, gait, other cerebellar signs).
- Demonstrate specific neurological signs (e.g. abnormal gait, proximal myopathy signs, lack of coordination and cerebellar signs).
- Explain positive findings of being unkempt, restlessness, with hand tremors.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Medical Disorders in Psychiatry
- **Area of Practice:** Addictions
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Physical - Selection, Physical - Technique, Examination Accuracy)

**References:**

- Kaplan and Sadock's Comprehensive Textbook of Psychiatry
- David, AS., Fleminger, S., et al. Lishman's Organic Psychiatry; a textbook of neuropsychiatry. 4th Edition. Wiley-Blackwell. 2009
- Clinical Examination- A systematic guide to physical diagnosis- Nicholas J Talley and Simon O'Connor

**1.4 Station requirements:**

- Standard consulting room; all physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male aged mid-30s; scruffily and casually dressed in long / board shorts and open shoes / thongs – wearing a short-sleeved shirt that is either buttoned or easy to remove.
- Pen for candidate.
- Timer and batteries for examiners.

## 2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in community mental health team.

You are reviewing Mr Ryan Smith, a 35-year-old man who has been under the care of community mental health services for over 6 months. He has a history of depression on a background of chronic alcohol dependence. The team has been closely monitoring the adequate treatment of depression as Ryan tends to be non-compliant.

Ryan has a long history of alcohol use starting from the age of 14 years. He currently drinks up to 12 standard drinks per day thus the comorbid diagnosis of alcohol dependence. He presents today for an assessment for signs of chronic alcoholism as the major focus of the appointment.

Your tasks are to:

- Conduct a focussed physical examination on Ryan with regard to alcohol dependence.
- Provide a running commentary to the examiner as to the purpose of each step of your examination and findings.

You are **not** required to take a history or initiate a treatment plan.

**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 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.

There are no prompts.

The role player opens with:

***'Hi Doc, like I said before - I am losing strength in my hands and legs. I think it's the antidepressants.'***

If the candidate attempts to examine the role player's lower abdomen or groin area you are to advise them to stop:

***'You are not required to undertake examination of lower abdomen or groin area.'***

#### 3.2 Background information for examiners

The aims of this station are to assess the candidate's knowledge of signs of chronic alcoholism, and demonstrate their skill in undertaking a physical examination whilst providing a commentary to the examiner as to the purpose and expected findings in the context of chronic alcohol dependence.

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

- Assess hands / arms for at least 3 signs (e.g. tremors, generalised small muscle wasting, Dupuytren's contracture, palmar erythema, nail pallor, clubbing, koilonychia).
- Undertake at least 2 nervous system tests (e.g. peripheral neuropathy, proximal myopathy, gait, other cerebellar signs).
- Demonstrate specific neurological signs (e.g. abnormal gait, proximal myopathy signs, lack of coordination and cerebellar signs).
- Explain positive findings of being unkempt, restlessness, with hand tremors.

Alcoholism is a chronic and progressive illness; the early symptoms are generally behavioural and not physical. The majority of medical problems typically appear in the late, chronic stage of the illness and has the potential to cause serious physical harm to any and all of the body systems. The appearance of medical complications are secondary to the primary nature of alcoholism.

**General physical examination in alcoholism: the candidate can choose to undertake any of the following assessments / tests.**

It is important that the candidate prioritise the assessment related to the loss of strength in his limbs. Assessment for signs related to these symptoms should be the main focus of their assessment as well as a review of associated signs.

A comprehensive examination for complications of alcohol dependence would generally include a wide range of signs. However, given the history provided the candidate must focus on neurological and hepatic signs after a review of general appearance.

Key features to be identified are positive findings of being unkempt, restlessness, hand tremors, with abnormal gait (wide based gait to balance), proximal myopathy signs (difficulty to stand from sitting position with arms crossed), lack of coordination, and cerebellar signs (abnormal finger-nose test / shin-heel test).

### General examination

- General appearance – often unkempt.
- Excitability or agitation or restlessness - often as a symptom of withdrawal or associated with lack of sleep (alcohol can cause a disturbance in REM sleep).
- Bruising (easy bruising).
- Sweating.
- Respiratory rate – often tachypnoea (possibly due to symptoms of ARDS) – normal respiratory rate 12-20 breaths per minute.
- Rosacea, seborrheic dermatitis (itchy, red, dry skin) – secondary to vitamin B deficiency or poor hygiene.
- Muscle wasting due to improper nourishment can result in acute pain in these areas: proximal muscles, extremities, pelvic and shoulder girdle, muscles of the thoracic cage.

### Examination of hand / arm

- Hand tremor – generally as part of withdrawal.
- General small muscle wasting.
- Pulse (irregular pulse during later stages).
- General signs of malnutrition.
- Nicotine stains (frequent comorbidity with smoking).
- Palmar erythema (reddening of the skin on palmar aspect of the hand – thenar and hypothenar eminence).
- Clubbing (bulbous fusiform enlargement of the distal portion of a digit probably related to alcoholic cirrhosis) – *have the patient place both forefinger nails together and look between them for small diamond space (Schamroth's sign). In clubbing the space is obliterated, and the angle between the nail plate and the skin overlying the proximal part of distal phalanx is more than 160 degrees.*
- Dupuytren's contracture (thickening and shortening of the palmar fascia that results in clawed fingers) - *tabletop test: can the patient put their hand flat on a tabletop or other flat surface.*
- Asterixis / Hepatic flap (secondary to metabolic encephalopathy found in advanced liver disease – *ask the patient to hold arms straight with hyper extended hands.*
- Koilonychia (spoon nails) – non-specific sign of hypochromic anaemia, especially iron-deficiency anaemia.
- Lower limb oedema.

### Examination of eyes

- Pallor.
- Icterus - yellowish discoloration of the skin, eyes and mucus membranes as a sign of jaundice.
- Nystagmus (rapid, repetitive, involuntary eye movements which often result in reduced vision and depth perception and can affect balance and coordination) - *using index finger or a small fixation target, the clinician observes the nystagmus in all positions of gaze, while asking the patient to comment on any visual symptoms as the eyes move, and identifying the angle which patients describe limits to their vision.*

### Examination of face and mouth

- Feter hepaticas ('breath of dead' or faecal breath) - found in chronic liver disease and portal hypertension where portosystemic shunting allows thiols / mercaptans to pass directly into the lungs.
- Sialadenosis (asymptomatic, bilateral enlargement of the parotid glands) secondary to increased stickiness of saliva, causing blockage of salivary ducts.

### **As the major complaint is neurological, the candidate must undertake a neurological examination.**

### Neurological examination

- **Peripheral neuropathy** secondary to vitamin B deficiency – *check for strength: check finger flexion by asking patient to curl their fingers into yours and try to prevent you from straightening their fingers; flexion / extension and abduction / adduction at different joints – sensation: by checking pinprick and vibration and reflexes (upper and lower limb); proximal myopathy – by asking the patient to stand from sitting position with arms crossed.*

- **Test for coordination**

- Rapidly alternating movement evaluation – *ask the patient to place their hands on their thighs and then rapidly turn their hands over and lift them off their thigh. Repeat it rapidly for 10 seconds – Dysdiadokinesia (inability to perform rapidly alternating movements due to cerebellar lesions).*
- Point to point movement evaluation:
  - *Finger-nose test – ask the patient to alternatively touch their nose and the examiner's (candidate's) finger as quickly as possible;*
  - *Heel-shin – ask the patient to touch the heel of one foot to the opposite knee, and then to drag their heel in a straight line all the way down the front of their shin and back up again.*
- **Gait** – ataxia secondary to peripheral neuropathy presenting as loss of balance and coordination, which occurs and results in the characteristic of the 'wide based gait' in order to keep balance. It generally develops over chronic use, as a result of vitamin B deficiency.
  - *Ask the patient to walk across the room under observation (gross gait abnormalities to be noted).*
  - *Ask the patient to walk heel to toe across the room (abnormality - tandem gait), then toes only (best way to test early foot plantar flexion weakness), and finally heels only (best way to test foot dorsiflexion weakness). Also note the amount of arm swinging.*
  - *Observe patient rising from sitting position, note gait abnormalities.*

#### Examination of Abdomen

- Ascites (*wave-like action of the abdominal cavity when tapped, as well as the skin tone appearing paper thin and glistening*).
- Scratch marks.
- Caput medusa (Palm tree sign) – appearance of distended and engorged superficial epigastric veins, which are seen radiating from the umbilicus across the abdomen as a sign of portal hypertension.
- Umbilicus – everted / inverted (high venous pressure in the vessels around the umbilicus).
- Hepato- and splenomegaly (non-palpable liver).
- Testicular atrophy (candidate will not examine lower abdomen and groin area).

#### Examination of the chest

- Loss of body hair.
- Gynaecomastia.
- Spider naevi / angiomas (commonly in exposed areas, including the face, neck, upper trunk, and arms) – often in clusters when associated with liver disease.
- Tachycardia - associated with palpitations.
- Heart sounds (auscultation).

A minimum requirement is:

- Observe for smell of alcohol, unkempt nature, poor self-care signs.
- Specific peripheral signs, for instance, finger nails (e.g. nail bed pallor / clubbing), skin and muscle changes, tremors / abnormal movements, signs of jaundice.
- Centralised assessment of abdomen and screening for cardiothoracic signs as well as non-peripheral skin changes.
- Neurological assessment to address presenting complaints.

A surpassing candidate may demonstrate high levels of competence in that they will be able to identify the most important features to assess in the timeframe provided. Not only the accuracy but also the relevance of each part of the examination will be clear to the examiner.

## Explanation of the signs and symptoms found in alcoholism:

A key organ that is affected by chronic heavy alcohol use is the liver. The major actions of the liver include manufacture of blood proteins that aid in clotting, oxygen transport, and immune system function; storage of excess nutrients and return of some of the nutrients to the bloodstream; manufacture of bile, needed to assist in digestion; assistance in storage of glucose in the form of glycogen; removal of harmful substances in the bloodstream, including drugs and alcohol; breakdown of saturated fat and production of cholesterol. Signs of liver disease will be associated with impairment of these functions.

Multiple symptoms that present in alcoholism are related to impairment of the liver function in response to the toxic effects of alcohol on hepatocytes which leads to its inflammation. Chronic high levels of use cause ongoing inflammation leading to scarring (fibrosis; nodular regeneration). Alcohol-induced liver disease is a spectrum of disorders: fatty liver; alcoholic hepatitis through to liver cirrhosis.

Alcoholic liver disease is a leading cause of alcohol-related death and contributes to a significant percent of total burden of liver disease. Early symptoms include fatigue and malaise; loss of appetite and weight loss, nausea and abdominal pain, and spider naevi.

Overall, symptoms of alcoholic liver disease vary but sufferer can present with mood changes, agitation and confusion, headaches and light-headedness. Hepatitis associated with inflammation presents with fever, nausea and vomiting, and fatigue. As the damaged liver cannot remove the residue of bilirubin it builds up, and is deposited in the skin and the whites of eyes causing jaundice.

Sequelae of a failing liver in cirrhosis include ascites, impaired clotting factors production causing bleeding disorders, portal hypertension and hepatic encephalopathy. Other symptoms include significant weight loss (or gain), bloody or melena stools, epistaxis and bleeding gums, chest pain, erythema of hands and feet, and jaundice.

Bruising is linked to changes in the ability for blood clotting in the context of alcoholic liver disease, and excessive bleeding and bruising can be of concern if the person is involved in a serious accident / trauma.

Alcohol dependence increases levels of oestrogen and reduces testosterone, contributing to testicular atrophy, erectile dysfunction and gynaecomastia in men (and infertility in women).

Alcohol can increase triglycerides and increases risks for hypertension, heart failure and stroke. The high caloric intake within alcohol increases risk of obesity which worsens cardiac risk.

Severe alcohol dependence is also associated with osteoporosis, muscular deterioration, skin sores and itching.

Alcohol has a range of actions on the nervous system. Direct dose-related depressant effects on nutritional defects can lead to peripheral neuropathy, Wernicke's encephalopathy, cerebellar degeneration, and Korsakoff's syndrome.

Alcohol alters brain function by affecting the balance between inhibitory and excitatory neurotransmitters (NT). Short term use increases inhibitory NT and suppresses excitatory NT; thus, having a depressant effect: slowed slurred speech and movements while increasing pleasurable feelings. Longer term use leads to decreased inhibitory NT activity and increasing excitatory NT levels which leads to tolerance and addiction.

Thiamine, folate, niacin, vitamins B6 and B12, and vitamin E are all needed for proper nerve function. In alcoholism vitamin deficiencies are common, particularly vitamin B. Wernicke-Korsakoff syndrome is a serious consequence of thiamine (vitamin B1) deficiency. Wernicke's presents with serious malnutrition, ocular abnormalities, severe loss of balance / ataxia, peripheral neuropathy, confusion and memory loss, and can eventually result in death.

Nutritional deficiencies, often thiamine deficiency, that are common in alcoholic patients, are commonly complicating factors in the development of this neuropathy. Vitamin B12 deficiency can lead to peripheral neuropathy which causes pain, tingling and other abnormalities of the limbs.

Primary axonal sensorimotor peripheral polyneuropathy is found in people with a history of chronic heavy alcohol consumption. Symptoms usually manifest initially in the distal lower extremities. Sensory symptoms (e.g. numbness, paresthesias, dysesthesias (abnormal unpleasant sensations which can occur in the absence of stimulus of felt when touched), allodynia (pain resulting from a stimulus, as a light touch of the skin, which would not normally provoke pain), and loss of vibration and position sense usually develop prior to motor symptoms (e.g. weakness). However, patients may present with both motor and sensory symptoms at initial presentation.

If autonomic nerves are affected, signs and symptoms might include heat intolerance and altered sweating, bowel, bladder or digestive problems or changes in blood pressure, causing dizziness or light-headedness.

Folate deficiencies can cause severe anaemia. Additionally, in the gastrointestinal tract, impaired digestion causing dyspepsia, violent vomiting can lead to oesophagitis, upper GI tears and bleeding; increase risk for ulcers; and inflamed oesophageal varices. Alcohol causes an increased rate of food propulsion through the small intestine which results in malabsorption in the remainder of the small intestine.

Abdominal pain can be caused by inflammation of liver, stomach or colon or pancreatitis. Stomach cramps and right upper quadrant pain are often associated with an enlarged fatty liver or alcoholic hepatitis. Alcohol also has a direct toxic effect on the pancreas, causing changes in the secretions of the pancreas. Increased secretion of digestive juices can produce pancreatic irritation and damage. It is postulated that alcohol induces an increase in protein concentration in pancreatic juice which precipitates and clogs the ducts of the organ.

Sweating, especially night sweats, can be related to drinking alcohol as it causes tachycardia and vasodilatation, which can trigger sweating. Alcohol withdrawal or alcohol intolerance could also lead to night sweats. Heat intolerance is a symptom associated with peripheral neuropathy.

Long-term alcohol abuse can lead to cardiomyopathy and can lead to congestive cardiac failure, with associated symptoms of fatigue and shortness of breath. Signs of cardiomyopathy are cardiomegaly, valvular murmurs, evidence of pulmonary congestion, raised jugular venous pressure, and pedal oedema. Clubbing is caused by alcohol cardiomyopathy, resulting in poor circulation to extremities.

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## 4.0 Instructions to the Role Player

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

You are Ryan Smith, a 35-year-old, single, unemployed man who has been living in a caravan park for the last few years.

The mental health service diagnosed you with depression and commenced on antidepressant treatment 6 months ago.

You have been dependent on alcohol for many years. You started drinking alcohol at the age of 14 years, and currently drink around 10-12 mid strength beer (Carlton Mid stubbies) on daily basis. You have never really had a period of time without drinking since 14 years.

The key features you have to describe to the candidate are:

- You have noticed losing strength in your arm and legs for months.
- Your abdomen feels distended and uncomfortable under your right ribs – but it is not painful.
- You are worried about these physical signs.

You will be trained to present the following signs for the candidate to test:

- Being unkempt.
- Slight restlessness.
- Hand tremors.
- Abnormal gait – walk with wide based gait to balance.
- Proximal myopathy signs – difficulty to stand from sitting position with arms crossed.
- Lack of coordination – cerebellar signs – abnormal finger-nose test / shin-heel test.

### 4.2 How to play the role:

You are dressed casually in long / board shorts and open shoes / thongs. PLEASE wear a short-sleeved shirt that is either buttoned or easy to remove as the candidate should ask to examine your chest and abdomen.

The candidate will conduct physical examination and in doing so, is likely to check parts of your face, your limbs and your stomach.

If at any stage the candidate causes you pain or unnecessary discomfort, please let them know. As long as the candidate does not hurt you, you will cooperate with the examination.

If the candidate attempts to examine your lower abdomen or groin area the examiner will advise them to stop.

### 4.3 Opening statement:

***'Hi Doc, like I said before - I am losing strength in my hands and legs. I think it's the antidepressants.'***

### 4.4 What to expect from the candidate:

The candidate should introduce themselves. They are expected to advise you of what they are going to do, may seek your permission to conduct a physical examination – general examination of different areas of your body which would involve your chest, heart, abdomen and nervous system. As they do this, the candidate is expected to provide a running commentary to the examiner about what they are doing.

The candidate may clarify a very limited history from you that mainly focusses on alcohol use and related issues.

#### 4.5 Responses you MUST make:

Anticipated Question: If asked to clarify current or past alcohol use.

Scripted Response: ***'I have been drinking at least a 6 pack, but more than 10 beers on most days for all my life.'***

Anticipated Question: If asked about other features in your history or any risks (e.g. past medical complications or drinking including admissions, risks of harm to others or yourself).

Scripted Response: ***'No'***.

#### 4.6 Responses you MIGHT make:

If the candidate tries to take a fuller history from you:

Scripted Response: ***'I thought that you said you were going to examine my body?'***

If asked to clarify your medication:

Scripted Response: ***'I'm still taking Sertraline 200 milligrams in the morning.'***

The candidate is not expected to take a history from you, however, if you are asked about these symptoms:

- Loss of appetite and weight loss – ***'not really'***.
- Nausea and abdominal pain – ***'occasionally'***.
- Feeling tired and generally run down – ***'yes'***.
- Headaches and light-headedness – ***'occasionally'***.
- Feelings of confusion and agitation – ***'no'***.
- Increased bruising – ***'sometimes'***.
- Nose bleeds or bleeding gums – ***'no'***.

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

Antidepressant - SERTRALINE 200 milligrams in the morning.



## STATION 10 – MARKING DOMAINS

### The main assessment aims are:

- To assess the candidate's knowledge of signs of chronic alcoholism.
- To assess the candidate's ability to conduct a focussed physical examination – general and systemic.
- To assess the candidate's ability to accurately communicate the examination findings to the examiner.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.4 Did the candidate carry out an appropriately focussed and relevant examination as per examiner's instructions? (Proportionate value - 35%)

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

conducts a thorough systemic examination from periphery to general systemic; includes examination for signs like malnutrition, alcohol on breath, nicotine stains on fingers.

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

focussing on general and systemic examination, attention to privacy for physical examination; covering all essential aspects including general unkempt nature; assessing head and neck (jaundice, nystagmus, +/- fetor hepaticus), chest (spider naevi, cardiac murmurs), abdomen (ascites, hepatomegaly, +/-caput medusa,) and specific neurological signs.

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

- Assess hands / arms for at least 3 signs (e.g. tremors, generalised small muscle wasting, Dupuytren's contracture, palmar erythema, nail pallor, clubbing, koilonychia)
- Undertake at least 2 nervous system tests (e.g. peripheral neuropathy, proximal myopathy, gait, other cerebellar signs).

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

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

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

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

candidate does not attempt neurological and abdominal examination, significant deficiencies in organisation; errors or omissions do adversely impact on the examination outcome.

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

#### 1.5 Did the candidate demonstrate adequate technique in the selected examination(s)? (Proportionate value - 35%)

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

overall examination technique is accurate and well organised; performs a detailed and comprehensive assessment.

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

competently applying adequate technique in examining periphery (hands / arm), head and neck, chest examination, abdominal and nervous examination.

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

- Demonstrate specific neurological signs (e.g. abnormal gait, proximal myopathy signs, lack of coordination and cerebellar signs).

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

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

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

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

incorrect technique is utilised; incorrect conclusions are drawn.

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

1.6 Did the candidate describe the expected physical findings accurately as per the examiner's details for this case and communicate with the examiner? (Proportionate value - 30%)

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

appropriate overall elicitation and explanation of expected physical findings.

**Achieves the Standard by:**

accurately explaining main physical tests undertaken; correctly identifying and interpreting important positive and negative physical findings; including alcoholic breath, general examination, peripheral, hepatic and cardiovascular signs.

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

a. Explain positive findings of being unkempt, restlessness, with hand tremors.

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

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

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

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

incorrectly interprets even routine / standard range of tests; errors, omissions of findings affect conclusions; candidate does not elicit any findings, does not communicate findings to the examiner.

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

## GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

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

This is a history taking and diagnostic station. The candidate is expected to take a brief history from a mother whose 17-year-old son, Chris, is spending excessive time playing games on the internet. The candidate is then expected to explain a diagnosis of Internet Addiction / Internet Gaming Disorder to the mother, and to outline long term comorbidities and complications to the examiner. The candidate is not expected to provide management options.

**1.1 The main assessment aims are to:**

- Take a brief relevant history to diagnose an Internet Addiction in a teenager and explain this to a mother.
- Consider longer term comorbidities and complications associated with Internet Addiction / Internet Gaming Disorder.

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

- Elicit behavioural addiction features of salience and tolerance.
- Sensitively respond to the mother's concerns.
- Outline key criteria for a formulation of Internet Addiction / Internet Gaming Disorder.
- Exclude mood or anxiety disorder.
- Explain at least two common physical health issues (headaches, weight gain, disturbances in sleep, carpal tunnel syndrome, blurred or strained vision).

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders (substance-related and addictive disorders)
- **Area of Practice:** Addictions
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Formulation – Communication), Communicator (Patient Communication – To Patient / Family / Carer; Synthesis)

**References:**

- Alavi, S.S., Ferdosi, M., Jannatifard, F., Eslami, M., Alaghemandan, H., Setare, M. Behavioral Addiction versus Substance Addiction: Correspondence of Psychiatric and Psychological Views. *Int J Prev Med.* 2012 Apr; 3(4): 290–294
- Beard KW. Internet Addiction: a review of current assessment techniques and potential assessment questions. *CyberPsychology and Behavior.* 2005 Feb; 8(1): 7-14
- Brown RI. Some contributions of the study of gambling to the study of other addictions. Gambling behavior and problem gambling. Reno, NV: University of Nevada; 1993
- Cash, H., Rae, C. D., Steel A.H., Winkle, A. Internet Addiction: A Brief Summary of Research and Practice. *Current Psychiatry Reviews,* 2012, 8, 292-298
- Christakis, D.A.C. Internet Addiction: a 21st century epidemic? *BMC Medicine* 2010, 8:61
- Demetrovics, Z., Szeredi, B., Rózsa S. The three-factor model of Internet Addiction: the development of the Problematic Internet Use Questionnaire. *Behav Res Methods,* 2008 May;40(2):563-74
- Fu, King-wa, Chan, W. S. C., Wong, P. W. C., Yip, Paul S. F. Internet Addiction: prevalence, discriminant validity and correlates among adolescents in Hong Kong. *British Journal of Psychiatry,* 2010; 196, 486–492. doi: 10.1192/bjp.bp.109.075002
- Goodman A. Addiction: definition and implications. *Br J Addict.* 1990;85:1403–8. [[PubMed](#)]
- Griffiths M. Nicotine, tobacco and addiction. *Nature.* 1996;384:18. [[PubMed](#)]

- Kuss, DJ. Internet Gaming Addiction: current perspectives. *Psychology Research and Behavior Management* 2013; 3:6 125-137
- Lu, D.W., Wang, J.W., Huang, A.C. Differentiation of Internet addiction risk level based on autonomic nervous responses: The Internet-addiction hypothesis of autonomic activity. *Cyberpsychology, Behavior and Social Networking* 2010; 13:371-378
- Young, K.S. Internet addiction: the emergence of a new clinical disorder. *University of Pittsburgh at Bradford, Published in CyberPsychology and Behavior, Vol. 1 No. 3., pages 237-244*

**1.4 Station requirements:**

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

## 2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in an office based private practice.

At the request of his mother, the GP has referred Chris, a 17-year-old university student, to you. She is concerned that he spends too much time in his room on the computer and has been isolating himself; she is also worried about what it is doing to his health.

Chris has not come to the appointment but told his mother, Joanne, if she was so worried she should come instead.

Your tasks are to:

- Take a brief collateral history about Chris from his mother.
- Explain the most likely explanation to the mother.
- Present the longer term comorbidities and physical complications most commonly associated with your preferred explanation **to the examiner**.

**You are not expected to discuss management options.**

If you have not commenced the final task by **six (6) minutes** you will receive a time prompt.

## 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 of the cue / time for the scripted prompt you are to give at **six (6) minutes**.
- 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 apologise for my son not attending, I am really worried about him.'***

If the candidate has not commenced the final task by **six (6) minutes** - this is your specific prompt:

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

#### 3.2 Background information for examiners

The aims of this station are to test the candidate's ability to take a focussed history of Internet Addiction from a teenager's mother.

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

- Elicit behavioural addiction features of salience and tolerance.
- Sensitively respond to the mother's concerns.
- Outline key criteria for a formulation of Internet Addiction / Internet Gaming Disorder.
- Exclude mood or anxiety disorder.
- Explain at least two common physical health issues (headaches, weight gain, disturbances in sleep, carpal tunnel syndrome, blurred or strained vision).

A surpassing candidate may demonstrate:

- Clear understanding of Internet Addiction and elicit supportive collateral history that demonstrates this knowledge.

#### Behavioural Addiction

Several experts such as Brown have argued that the concept of addiction is meaningful, and that it should not be restricted to the ingestion of substances. The six criteria of Brown can be summarised as follows:

1. Salience: Domination of a person's life by the activity.
2. Euphoria: A 'buzz' or a 'high' is derived from the activity.
3. Tolerance: The activity has to be undertaken to a progressively greater extent to achieve the same 'buzz'.
4. Withdrawal Symptoms: Cessation of the activity leads to the occurrence of unpleasant emotions or physical effects.
5. Conflict: The activity leads to conflict with others or self-conflict.
6. Relapse and Reinstatement: Resumption of the activity with the same vigour subsequent to attempts to abstain, negative life consequences, and negligence of job, educational or career opportunities.

#### Diagnostic Criteria of Behavioural Addiction - Griffiths (1996)

- A. Salience: When the particular activity becomes the most important activity in people's lives and dominates their thinking (preoccupations and cognitive distortions).
- B. Mood modification: A consequence (such as an arousing 'buzz' or 'high' or a feeling of escape) of engaging in the particular activity; can be seen as a coping strategy.
- C. Tolerance: Increasing amounts of the particular activity are required to achieve satisfaction.
- D. Withdrawal symptoms: Unpleasant feeling states (such as moodiness or irritability) and / or physical effects.
- E. Conflict: Interpersonal conflicts between addicts and those around them or intrapsychic conflict within the addicted individual.
- F. Relapse: The tendency to revert to earlier pattern of the particular activity after a period of abstinence or control over the addictive behaviour.

Goodman (1990):

- A. Recurrent failure to resist impulses to engage in a specified behaviour.
- B. Increasing sense of tension immediately prior to initiating the behaviour.
- C. Pleasure or relief at the time of engaging in the behaviour.
- D. A feeling of lack of control while engaging in the behaviour.
- E. At least 5 of the following 9 criteria:
  - Frequent preoccupation with the behaviour or with activity that is preparatory to the behaviour
  - Frequent engaging in the behaviour to a greater extent or over a longer period than intended
  - Repeated efforts to reduce control or stop the behaviour
  - A great deal of time spent in activities necessary for the behaviour or recovering from its effects
  - Frequent engaging in the behaviour when expected to fulfil occupational, academic, domestic or social obligations
  - Important social, occupational or recreational activities given up or reduced because of the behaviour
  - Continuation of the behaviour despite knowledge of having a persistent or recurrent social, financial, psychological or physical problem that is caused or exacerbated by the behaviour
  - Tolerance: need to increase the intensity or frequency of the behaviour in the desired effect or diminished effect with continued behaviour of the same intensity
  - Restlessness or irritability if unable to engage in the behaviour.
- F. Some symptoms of the disturbances have persisted for at least 1 month, or have occurred repeatedly over a longer period of time.

So, from the psychological and psychiatric viewpoint, behavioural addictions include a collection of disorders, such as anxiety, mood disorders especially depression, obsessive thoughts, withdrawal and isolation, disturbances in social relationships, school problems such as educational failure and lack of interest in doing homework, occupational or interpersonal difficulties, isolation and negligence of friends and family or personal responsibilities, and mental or physical restlessness.

In instances when the individual reduces or stops a specific behaviour, excessive fatigue, lifestyle changes, significantly reduced physical activity, deprivation and changes in sleep patterns, impatience, sexual deviations, violence, eating disorder and withdrawal symptoms ensue.

### Internet Addiction

Some online users were becoming addicted to the internet in a similar manner to becoming addicted to drugs or alcohol, and this can result in academic, social, and occupational impairment. Both the International Classification of Disease-10 (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis referenced as being most alike to misuse of the internet was Pathological Gambling. In the absence of formal diagnostic criteria, most researchers extrapolate from one compulsive non-pharmacologically addictive behaviour to another. Key components of addiction have been identified including preoccupation with the behaviour; repeated unsuccessful attempts to reduce use; mood disturbances related to reduction attempts; greater usage than anticipated or desired; jeopardising employment, relationships or education; or lying about usage.

By using Pathological Gambling as a model, addictive internet use could be defined as an impulse-control disorder that does not involve an intoxicant. Problematic internet use has also been called compulsive internet use, internet overuse, problematic computer use, pathological computer use, problematic internet use, online addiction or Internet Addiction Disorder. In the DSM-5, Internet Gaming Disorder is the latest term to describe this problem where it is classified as a 'Condition for Further Study'.

The number of people playing online gaming is growing each year. Games are generally described as MMORPG (massively multiplayer online role-playing games) and MMO (massively multiplayer online) types; playing in a fantasy world with others or by yourself respectively. Cash et al report on surveys in the United States and Europe that have indicated prevalence rates between 1.5 and 8.2%. It is thought that 95% of Australian children / youth are playing computer games at least one hour per day. In youth 13-17 years it is thought that about 20% feel anxious or uncomfortable when not on the internet and internet addictive problems are worse in girls, possibly due to the impact of social media. Internet addictive problems are being found increasingly in adults.



A common attribute appears to be the realisation of activities through the internet. Consideration has been given to the importance of separating out the subcategories of internet use disorder (such as online gaming, gambling, shopping, pornography addiction, etc.). Excessive screen time is also common to all the problems, whether video gaming, social networking, or downloading, gambling and shopping online.

Excessive internet use can gradually lead to neglect of professional and social relations and duties, with increasing risk of occurrence of somatic problems.

Studies focussing on the physiological basis of this disorder have shown a stronger blood volume pulse and respiratory response, and weaker peripheral temperature reactions of the high-risk internet users, which indicates that the sympathetic nervous system is heavily activated in these individuals (Lu et al. 2010).

Some studies have identified four symptom dimensions: obsessive-compulsiveness, depression, anxiety and emotional sensitivity, and hostility.

The following psychological symptoms are typical of online addiction / Internet Gaming Disorder:

- Feelings of guilt
- Anxiety
- Low mood
- Suicidal ideation
- Agitation
- Euphoric feelings when in front of the computer
- Unable to keep schedules
- No sense of time
- Social isolation
- Defensiveness
- Avoidance of school / work
- Dishonesty

Comorbid psychiatric disorder is common, e.g. attention deficit disorder, depression, insomnia or social phobia.

Physical complications of online addiction / Internet Gaming Disorder that are characteristic of someone who uses the computer for extended periods of time include:

- Backache
- Headaches
- Weight gain or loss
- Disturbances in sleep
- Carpal tunnel syndrome
- Blurred or strained vision
- Vitamin D deficiency and osteoporosis

There have been a variety of assessment tools used in evaluation. Young's Internet Addiction Test, the Problematic Internet Use Questionnaire (PIUQ) developed by Demetrovics, Szeredi, and Pozsa and the Compulsive Internet Use Scale (CIUS) are all examples of instruments to assess for this disorder.

Beard's review of assessment techniques recommends that five of the following diagnostic criteria are required for a diagnosis of Internet Addiction:

1. Is preoccupied with the internet (thinks about previous online activity or anticipate next online session);
2. Needs to use the internet with increased amounts of time in order to achieve satisfaction;
3. Has made unsuccessful efforts to control, cut back, or stop internet use;
4. Is restless, moody, depressed, or irritable when attempting to cut down or stop internet use;
5. Has stayed online longer than originally intended. Additionally, at least one of the following must be present:
6. Has jeopardised or risked the loss of a significant relationship, job, educational or career opportunity because of the internet;
7. Has lied to family members, therapist, or others to conceal the extent of involvement with the internet;
8. Uses the internet as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression).

## Diagnostic Classificatory Models

There is no formal diagnosis of Internet Gaming Disorder, however the proposed diagnostic criteria for DSM-5 Internet Gaming Disorder include:

Repetitive use of internet-based games, often with other players, that leads to significant issues with functioning. Five of the following criteria must be met within one year:

1. Preoccupation or obsession with internet games.
2. Withdrawal symptoms when not playing internet games.
3. A build-up of tolerance – more time needs to be spent playing the games.
4. The person has tried to stop or curb playing internet games, but has failed to do so.
5. The person has had a loss of interest in other life activities, such as hobbies.
6. A person has had continued overuse of internet games even with the knowledge of how much they impact a person's life.
7. The person lied to others about his or her internet game usage.
8. The person uses internet games to relieve anxiety or guilt – it is a way to escape.
9. The person has lost or put at risk an opportunity or relationships because of internet games.

The closest in ICD-10 is Pathological Gambling:

### Clinical Information

- A disorder characterised by a preoccupation with gambling, and the excitement that gambling with increasing risk provides. Pathological gamblers are unable to cut back on their gambling, despite the fact that it may lead them to lie, steal, or lose a significant relationship, job, or educational opportunity.
- Many people enjoy gambling, whether it's betting on a horse or playing poker on the internet. Most people who gamble don't have a problem, but some lose control of their gambling. Signs of problem gambling include:
  - always thinking about gambling
  - lying about gambling
  - spending work or family time gambling
  - feeling bad after you gamble, but not quitting
  - gambling with money you need for other things.

### 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

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

## 4.0 Instructions to the Role Player

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

You are Joanne, mother of Chris a 17-year-old university student (studying graphic design). You are worried about how much time he spends on the computer, and you have come to the appointment because you want to find out what you can do to help him.

You are apologetic for Chris not attending - he feels there is nothing wrong with himself, and does not need to see anyone. Not wanting to come is also in keeping with Chris spending hours in his room and refusing to come out for usual family activities.

#### About Chris' internet use:

He is spending at least 4 hours every day, and 7-10 hours or more a day on weekends. You are worried about him as he has failed last semester. During semester breaks it gets worse as he is alone in the house while you are away at work. He spends very little time on his course work, and if he is not on the computer he spends his time watching television. Chris calls himself as 'sci-fi mad', and spends 'hours and hours' taking part in online discussion groups as well as online games.

You have been studying up on excessive internet use, and think Chris is playing both MMORPG and MMO types of games. You don't really understand what these mean and don't want to ask him in case he gets upset with you.

#### About Chris' activities:

His use of the internet seemed to worsen when he got his own computer. Over a 2-year period he has upgraded his computer 11 times. At the same time, his general behaviour worsened: he started to refuse to do his normal household chores when requested, was generally awkward and difficult, and provoked confrontational situations.

Chris has difficulty limiting or controlling the time on and offline. If he's not connected - even for a short length of time, he worries that he no longer knows 'what is going on'. At your request Chris has tried to quit the internet, he once gave up for 3 days, but the pressure to log back on proved too great and he dismissed your concerns.

Chris' use of the internet causes irregular sleeping patterns. It doesn't bother him that he has become nocturnal in order to use the internet when the internet charges are low. Occasionally he oversleeps and misses university because of his computer usage.

Chris does not really have any friends, and any acquaintances he has are limited to his friends online. In the past he has had difficulty in making friends, difficulty in coping with teasing for being a bit awkward and minor bullying (usually of a verbal nature). You have encouraged him to make real friends but he is happy with his 'real friends' on the internet. You feel he views his computer as a 'friend' and, therefore, tends to spend much of his time on the machine.

#### Concerns associated with Chris' behaviour:

You believe Chris suffers from inferiority complex and lack of confidence when dealing with his peers. Consequently, he easily gets upset. You feel that much of his lack of confidence stems from the fact that Chris is content to spend his time in his room to the exclusion of others in external world. You see the problem as 'a self-induced Catch-22 situation' in that he will never make friends whilst he spends time alone, but the action of spending time alone reduces his ability to deal with other people.

Chris' own view is that he does not have a problem with his computer use, and that he does not spend too much time on the computer. He feels that the internet has improved his level of knowledge, and intends to enter an internet-related field of employment. He spends a lot of time gaming and believes this is the future of sports.

If you are asked about Chris' physical health, you are to provide the following information to specific questioning: Chris has stopped playing footie and does not do any real activity. He does not leave the house apart from school. He tends to sit and has to be coerced to eat when on his computer, and has lost a lot of weight in the past few months. He is already complaining of backache and blurry vision. He sometimes complains about his wrist being painful. You are worried that he is likely to suffer from long term physical problems.

#### Chris' mental wellbeing:

You do not think he is depressed in that he doesn't complain of feeling sad, and when he does engage with you he does not look down. He will only eat if you persist with him as he enjoys being on his computer. You do not believe that he has any thoughts of harming himself, and he does not get hostile towards you when you try to encourage him to do other things.

He does not appear to be anxious, fearful or tense. He has not really ever been an anxious kind of person.

If asked you haven't heard him talking to himself and don't think he is 'mad'. He does not take any drugs or alcohol that you are aware of. You don't think Chris has any other issues like gambling, or any recurrent intrusive obsessive thoughts.

Family and personal situation:

If asked by the candidate, you separated from his father, Mike, when Chris was 3 years old. He is an only child and the two of you live together. Chris never had close school friends and was always shy. He is a smart boy and did well at school until he got into computers and the internet. He experienced some minor bullying at school but there was never any abuse in the home. He finished school and commenced university last year. He has told you he can have a career in gaming.

**4.2 How to play the role:**

You are a smartly dressed 38-year-old woman. You are an anxious mother trying to get help for your son. You come across as generally anxious but trying to be friendly and co-operative. Your speech is initially quite hesitant because of your anxiety, but depending on how the candidate speaks to you these feelings of anxiety can settle.

**4.3 Opening statement:**

*'I apologise for my son not attending, I am really worried about him.'*

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

The candidate is expected to take a focussed history regarding your son's use of computer and internet, the candidate is also expected to ask questions regarding other symptoms like mood or other addictions as well as his behaviours and his personal history.

The candidate is expected to give you an understanding of your son's addiction, not just provide you with a diagnostic label.

The candidate is then expected to explain long terms physical and mental health complications to the examiner.

**4.5 Responses you MUST make:**

*'I am worried about how much time he spends on his computer; it is like it is all he cares about.'*

*'I am worried about Chris' physical health.'*

*'So what is wrong with Chris?'*

**4.6 Responses you MIGHT make:**

*'Are you saying Chris has is mentally ill?'*

*'Could this be something else?'*

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

Nil

**STATION 11 – MARKING DOMAINS**

The main assessment aims are to:

- Take a brief relevant history to diagnose an Internet Addiction in a teenager and explain this to a mother.
- Consider longer term comorbidities and complications associated with Internet Addiction / Internet Gaming Disorder.

**Level of Observed Competence:**

**1.0 MEDICAL EXPERT**

**1.2 Did the candidate take appropriately detailed and focussed collateral history related to presentation? (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; includes all significant elements for a diagnosis and associated comorbidities.

**Achieves the Standard by:**

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient’s addictive problems and circumstances with appropriate depth and breadth; assessing for withdrawal symptoms, conflict, relapse and reinstatement (history taking is hypothesis-driven); integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues related to symptoms, functioning and behaviour; completing a risk assessment relevant to the individual case; clarifying important positive and negative features including bullying and isolation; assessing for typical and atypical features.

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

- Elicit behavioural addiction features of salience and tolerance.

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

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

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

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

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

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

**2.0 COMMUNICATOR**

**2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from the mother? (Proportionate value - 10%)**

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

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

**Achieves the Standard by:**

demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the client taking regard of culture, gender, ethnicity etc.; accommodating minor inappropriateness in the mother’s behaviour; containing conflict or behavioural abnormalities; recognising confidentiality and bias.

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

- Sensitively respond to the mother’s 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 or 1):**

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

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

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

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

**2.5 Did the candidate demonstrate effective communication skills appropriate to the explanation of diagnosis to the mother? (Proportionate value - 25%)**

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

integrates information in a manner that can effectively be utilised by the mother; provides succinct and professional information.

**Achieves the Standard by:**

providing accurate and structured verbal feedback; prioritising and synthesising information; explaining that international diagnostic classificatory systems do not clearly define Internet Addiction; identifying psychological vulnerabilities leading to addiction; excluding other disorders like OCD and personality vulnerabilities; adapting communication style to the setting; using language so as to enhance understanding by the mother; demonstrating discernment in selection of content.

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

- Outline key criteria for a formulation of Internet Addiction / Internet Gaming Disorder
- Exclude mood or anxiety disorder.

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

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

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

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

provides inaccurate or inadequate diagnostic formulation; any errors or omissions impact on the accuracy of information provided.

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

**1.0 MEDICAL EXPERT**

**1.12 Did the candidate accurately communicate the longer term health complications to the examiner? (Proportionate value - 30%)**

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

clearly achieves the overall standard with a superior performance in a range of areas; communicates findings in a sophisticated manner; demonstrates understanding of key risk factors leading to comorbidities.

**Achieves the Standard by:**

including most or all correct elements; explaining the long term issues of chronic physical conditions like osteoporosis and metabolic disorders; demonstrating knowledge of common mental health comorbidities like anxiety, agoraphobia and depression.

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

- Explain at least two common physical health issues (headaches, weight gain, disturbances in sleep, carpal tunnel syndrome, blurred or strained vision).

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

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

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

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

does not synthesise information in a cohesive manner, incorrectly interprets even routine / standard range of investigations.

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

## GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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