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1.0 Descriptive summary of station:

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

1.1 The main assessment aims are to:

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

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

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

1.3 Station covers the:

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

References:

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

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Male 30's casually dressed.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are about to assess Justin who has been referred by his GP with this accompanying letter:

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

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

*Dr Fred Masters
General Practitioner*

Your tasks are to:

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

You will not receive any time prompts.

Station 5 - Operation Summary

Prior to examination:

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

During examination:

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

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

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

3.2 Background information for examiners

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

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

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

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

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

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

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

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

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

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

DSM-5: Somatic Symptom Disorder

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

Specifiers

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

ICD 10 F45.1 Undifferentiated Somatoform Disorder

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

ICD10 G89.4 Chronic Pain Syndrome

Chronic pain associated with significant psychosocial dysfunction.

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

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

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

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

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

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

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

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

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

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

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

3.3 The Standard Required

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

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

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

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

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

4.0 Instructions to the Role Player

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

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

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

History of your back pain

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

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

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

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

Other symptoms you may be asked about

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

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

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

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

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

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

About your work

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

About your childhood

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

Physical and mental health history

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

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

4.2 How to play the role:

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

4.3 Opening statement:

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

4.4 What to expect from the candidate:

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

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

4.5 Responses you MUST make:

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

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

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

4.6 Responses you MIGHT make:

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

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

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

4.7 Medication and dosage that you need to remember

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

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

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

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

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas including asking about history of trauma, indicators of previous personality functioning, any history of prescription of pain modifying medications, history of previous pain experiences and responses; recognises the significance of history from supports.

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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