Committee for Examinations
Objective Structured Clinical Examination

Station 9
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:
In this station the candidate is working in a forensic service and utilises this case as an example to teach the junior doctor an outline of risk assessment, then develop a management plan that takes into account the risk factors and the ethical issues involved in the situation.

1.1 The main assessment aims are to:
- Teach a junior doctor about assessing risk of future violent behaviour incorporating static and dynamic factors.
- Formulate a management plan taking into account the risk factors of future violence.
- Consider the ethical issues pertaining to breach of confidentiality in the context of future risk.

1.2 The candidate MUST demonstrate the following to achieve the required standard:
- Use the scenario to describe dynamic and static risks.
- Consider use of the mental health act and the appropriate treatment setting.
- Prioritise substance use management and compliance strategies in the management plan.
- Explain the duty to protect potential victims.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Psychotic Disorders
- **Area of Practice:**
  Forensic Psychiatry
- **CanMEDS Domains of:**
  Medical Expert, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment, Management), Professional (Ethics)

References:

- Dolan, M, Doyle, M. (2000) Violence risk prediction: *Clinical and actuarial measures and the role of the Psychopathy Checklist.* British Journal of Psychiatry 177:303-311
- McSherry, B. (2004) *Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour. Trends and Issues in Crime and Criminal Justice.* Australian Institute of Criminology No. 281;1-6.
- Felthous, AR. (2006) *Warning a Potential Victim of a Person's Dangerousness: Clinician's Duty or Victim's Right?* Journal of the American Academy of Psychiatry Law September;34:3 338-348
- Sadoff, RL. (2011) *Ethical Issues in Forensic Psychiatry: Minimizing Harm.* John Wiley and Sons Ltd.
- Mendelson, D., Mendelson, G. (1991) *Tarasoff down under: the psychiatrist's duty to warn in Australia.* The Journal of Psychiatry and Law/Spring-Summer; 33-61.
- RANZCP Code of Ethics (2010).
- Volavka, J. (2013) *Violence in Schizophrenia and Bipolar Disorder.* Psychiatria Danubina Vol. 25, No.1,pp 24-33.

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'.
- Role player – examiner will role-play the junior doctor.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

This is a VIVA station.

The examiner will play the role of the junior doctor.

You are working as a junior consultant in Forensic Psychiatry. You have just assessed Eric, who has schizophrenia with a history of violence and significant alcohol and stimulant use. Eric lives in the community and has been non-compliant with his depot antipsychotic medication. His delusions involve being a secret agent to combat terrorism. He just described hearing the Prime Minister say, "*The country is on alert*." In the past week, he was seen to be monitoring movement around Parliament House and 'interrogating' people. He has made specific threats about killing a prominent member of the community, whom he believes is aiding the terrorists.

The **FIRST TASK** is:

"Using the above case vignette, conduct a teaching session with your junior doctor about assessment of risk of future violence."

The examiner will present you with the second task at five (5) minutes.

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:
  - Duplicate copy of 'Instructions to Candidate'.
  - Paper, pen.
  - Water and tissues are available for candidate use.
- Ensure you have your Second Question to read out and then you will give it to the candidate.
- Ensure you have additional copies of the Second Question in case the candidate inadvertently takes the paper with them from the room, or they have written on it or it needs to be changed for some reason.

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 **five (5) minutes**
- DO NOT redirect or prompt the candidate unless scripted.
- If the candidate asks you for information or clarification say:
  "Your information is in front of you – you are to do the best you can".
- At **five (5) minutes**, as indicated by the timer, hand the second task to the candidate and say:
  "Please proceed to the second task."
  The ***SECOND TASK*** is:
  Please outline your management plan to reduce the risk of future violence, and outline the ethical considerations within your plan.
- 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 first task (i.e. before 5 minutes):

- You are to state the following:
  "Are you satisfied you have completed the first task?
  If so, do you want to proceed to the second task?"
- If yes, handover the second task to the candidate and say the following:
  "Please proceed to the second task and you can return to the first task at a later time."

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**.**

In this station, you are playing the role of the junior doctor. You can use your own given name if asked by the candidate. There is no further prompt or script for you after delivering the second task.

The candidate has the First Task from the 'Instructions to Candidate'.

FIRST TASK:

"Using the above case vignette, conduct a teaching session with your junior doctor about assessment of risk of future violence."

At five (5) minutes, hand the ***SECOND TASK*** to the candidate and say:

"Please proceed to the second task."

The ***SECOND TASK*** is:

"Please outline your management plan to reduce the risk of future violence, and outline the ethical considerations within your plan."

If the candidate has completed the first task before five minutes - you are to state the following:

"Are you satisfied you have completed the first task?
If so, do you want to proceed to the second task?"

If yes, handover the second task to the candidate and say the following:

"Please proceed to the second task and you can return to the first task at a later time."

There are no other prompts for this station.

3.2 Background information for examiners

This is a short viva station that examines the core skills of risk assessment in Forensic Psychiatry, with better candidates likely to consider in detail the ethical aspects of confidentiality in the forensic setting. This station is concerned with the competencies of Medical Expert and Professional, rather than emphasising the communicator role to the junior doctor. Medical Expert in this scenario relates to the ability to explain risk assessment and the development of a management plan that contains the risk. The Professional competency is interested in the candidate appropriately adhering to principles of ethical conduct and practice.

The candidate is expected to describe some of the principles of risk assessment. The risk assessment as pertains to this forensic scenario must consider the risk of future violent behaviour, specifically dynamic and static risk factors. There are specific structured risk assessment tools used in the forensic setting that assist in determining future risk of violence that better candidate may present. To justify level of risk candidates should recommend or mention use of a specific risk assessment tool.

The candidate must then include management, aspects of which include:

- Disease management – specifically substance use management and compliance strategies for reducing risk of future violence.
- Actions to contain risk – mental health act status, setting of treatment (inpatient / community).
- Need for consultation / escalation to their superiors due to the nature and possible imminence of the risk.

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

- Use the scenario to describe dynamic and static risks.
- Describe the limitations of risk assessment.
- Consider use of the mental health act and the appropriate treatment setting.
- Prioritise substance use management and compliance strategies in the management plan.
- Explain the duty to protect the potential victim.

A "**surpassing"** candidate may also discuss:

- The complexity of violence risk assessment, evidence of its limitations (meta analyses of various instruments show an effect size of ~0.5 (Cohen's d), showing moderate to good efficacy, but far from the certainty levels expected by sections of the society).
- The content matter and properties of one of the instruments in detail.
- How PCL-R appears to have better predictive validity for 'violent recidivism'.
- Issues related to confidentiality in a more sophisticated way, including legal precedents in the US (Tarasoff v Regents of The University of California).
- The relevance of the RANZCP Code of Ethics in situations exemplified by the case vignette.
- Having to weigh up the potential consequences of a breach of confidentiality to ensure safety of third party; such as breach of contract, breach of confidence, legal claim for negligence as well as professional disciplinary action. If they do not breach confidentiality, there may be increased risk to the patient or others.

Assessment of possible future risk of violence

- Some of the principles of risk assessment for future violence are:
  - Violence risk prediction is an inexact science, which has led to the development of systematic structured protocols to assist in the assessment of the risk of violent behaviours.
  - Violence prediction will never be entirely accurate; given violence is a complex concept.
  - Risk assessment is necessary when considering involuntary commitment of those diagnosed with mental illness.
  - In forensic psychiatry risk assessment is important when considering an accused person of offending or re-offending.
  - Obtaining all the available information, including information from various collateral sources, enhances the validity of assessment and improves management.
  - Both ethics and law hold that confidentiality is relative not absolute.

- Assessment of risk of violence is done using the conventional classification of 'static' and 'dynamic' factors, including:
  - **Static factors** (pre-existing vulnerabilities) are enduring unchangeable characteristics linked to the offending behaviour.
    - Male gender.
    - Single, never married.
    - Young age / under 25 years of age at first violent incident.
    - Conduct disorder / antisocial personality disorder / traits.
    - Major mental illness.
    - History of previous violence / sexual offence – best predictor of future violence is past violence.
    - Criminal history; history of imprisonment.
    - History of substance abuse.
    - Childhood abuse, neglect, or harsh inconsistent parenting.
    - Lifestyle instability.
    - Employment problems.
    - Relationship instability.
  - **Dynamic factors** (tend to change and moderate static risk factors) are acute rapidly changing changeable characteristics; may indicate that a re-offense will occur within a short period of time
    - Negative attitudes such as anger and hostility.
    - Suspiciousness, irritability, impulsivity.
    - Lack of insight.
    - Intoxication / withdrawal – exposure to substances.
    - Cognitions supporting violence.
    - Carries weapon / access to firearm.
    - Recent threats or other aggressive actions / thoughts.
    - Victim availability.
    - Intimacy deficits.
    - Collapse of social supports.
    - At risk of sexually abusing others.
    - Unresponsive to treatment.
    - Noncompliance with remediation attempts.
    - Stress.
    - Symptoms of mental illness related to risk include active symptoms, poor compliance with medication and treatment, poor engagement with treatment services.
    - Elevated mood state.
    - Psychotic symptoms - command hallucinations, threat-control-override and misidentification symptoms, morbid jealousy.

Structured risk assessment instruments:

A combination of clinical and actuarial (historical risk factors) approaches increasingly used in settings where there is the possibility of serious violence or offending behaviours. There is good evidence that these instruments have reasonable predictive validity when assessing the risk of violent behaviours.

Some of the commonly used instruments to assess risk of violent behaviours are:

1. Hare Psychopathy Checklist Revised (PCL-R) is a 20-item rating scale with semi-structured interview and collateral information. It has shown to be a relatively good predictor of violence across diverse populations.

2. Historical Clinical Risk (HCR-20) is a 20-item rating scale with 10 historical variables (static-past documented), 5 clinical variables (dynamic-present observed), and 5 risk management factors (speculative-future projected).

3. Violent Risk Appraisal Guide (VRAG) is a 12-item actuarial scale used to predict risk of violence within a specific time frame following release in violent, mentally disordered offenders.

The HCR-20 has 20 items: (History, Clinical and Risk parameters)

- 10 items concerning the patient's history.
- 5 items related to clinical factors.
- 5 items that deal with risk management.
- Total score range from 0 – 40.

The HCR-20 scores each item as 0, 1, or 2, depending on how closely the patient matches the described characteristic. The higher the score, the higher the likelihood of violence in the coming months. The scores on the subscales will assist the clinician in formulating an appropriate intervention plan to contain the risks.

Items from the Historical, Clinical, and Risk Management (HCR-20)

Historical items ***History of problems with…***	**Clinical items** ***Recent problems with…***	**Risk Management items** ***Future problems with…***
H1 Violence *Previous violence*	C1 Insight ▪ Mental Disorder *Lack of insight* ▪ Violence risk ▪ Need for treatment	R1 Professional services and plans *Plans lack feasibility*
H2 Other antisocial behaviour *Young age at first incident*	C2 Violent ideation or intent *Negative attitudes*	R2 Living situation *Exposure to destabilisers*
H3 Relationships *Relationship instability*	C3 Symptoms of major mental disorder	R3 Personal support *Lack of personal support*
H4 Employment *Employment problems*	C4 Instability *Impulsivity*	R4 Treatment or supervision response ▪ Compliance *Noncompliance with remediation attempts* ▪ Responsiveness
H5 Substance use *Substance use problems*	C5 Treatment or supervision response *Unresponsive to treatment*	R5 Stress or coping
H6 Major mental disorder		
H7 Personality disorder *Psychopathy*		
H8 Traumatic experiences *Early maladjustment*		
H9 Violent Attitudes		
H10 Treatment or supervision response *Prior supervision failure*		
Score each item 0, 1, or 2, depending on how closely the patient matches the described characteristic. For example, when scoring item C3 (active symptoms of major mental illness), a patient gets 0 for "no active symptoms," 1 for "possible / less serious active symptoms," or 2 for "definite / serious active symptoms." An individual can receive a total HCR-20 score of 0 to 40. The higher the score, the higher likelihood of violence in the coming months.		
Source: Reprinted with permission from Webster CD, Douglas KS, Eaves D, Hart SD. HCR-20: *assessing risk for violence, version 2.* Burnaby, British Columbia, Canada: Simon Fraser University, Mental Health, Law, and Policy Institute; 1997 & adjusted from HCR-20, Version 3 (2013)		

Formulate a management plan that reduces the risk of future violence:

The candidate must use the case vignette and then elaborate further in their discussion about risk assessment and risk management. They should take into account the spectrum of risk considerations dependent on the profile of the patient (e.g. a patient who has means opposed to one who does not).

- Attempt to modify "dynamic risk factors' by:
  - Thorough clinical assessment – presents high risk of harm to others.
  - Assertive management of mental illness – treating and monitoring active symptoms of mental illness.
  - Use of Mental Health Act or other appropriate legislation.

- Decide on the best setting for treatment – inpatient, secure facility / high dependence unit.
- Request input from local Forensic services, including Forensic Risk Assessment.
- Professional service plans – consider types of "leave" processes to monitor adjustment, and compliance. Reduction in intensity of monitoring to commence only after adequate clinical response.
- Ensure adequate supervision in the community.
- Consider legislated restrictions in the community, if appropriate – liaising with other agencies effectively.
- Aim to improve insight – motivational interviewing, therapeutic alliance, stages of change model; compliance with treatment.
- Identify stressors, aim to reduce occurrence of likely stressors and improve coping.
- Management of substance abuse, including motivational counselling, prophylactic medications.
- Enhance compliance through compliance therapy / adherence therapy.
- Treatment of symptom resistance and responsiveness - consider clozapine in treatment resistant psychosis, mood stabilisers, ECT, etc.
- Change negative / antisocial attitudes through cognitive behavioural approaches.
- Manage emotions / behavioural instability such as use of dialectical behaviour therapy.
- Collaborate with family, friends and other associates. Encourage personal support and limit / discourage antisocial support and influences.
- Increase opportunities for prosocial support – vocational, recreational.
- Social skills training.
- Living situation – consider optimising environment to reduce violence and improve opportunities for monitoring; limit exposure to destabilisers and monitor for exposure such as substances, explore and restrict access to weapons, victims.
- Notify the intended victim about the statement made by the patient, as soon as possible.
- Notify the police about the patient's statements.
- Consult the Medical Director and Hospital Lawyers prior to these actions.

Ethical aspects:

It is now generally accepted that psychiatrists have a duty to warn an identifiable victim of a patient's serious threat of harm. The legal precedent was the Tarasoff v. Regents of the University of California decision of the Supreme Court of California in 1976.

The ethical dimension of psychiatry provides a system of moral principles, rules and standards governing the practice of psychiatry and professional conduct. The Code of Ethics includes the principle of confidentiality – psychiatrists shall strive to maintain confidentiality of patients and their families. Confidentiality is at the core of the doctor-patient relationship, involving a 'holding in trust' process and shall not be undermined.

Principle 4.3 of the RANZCP Code of Ethics states that a breach of confidentiality may be justified on rare occasions in order to promote the best interests and safety of the patient or of other people. Psychiatrists may have a duty to inform the intended victim(s) and / or relevant authorities. Principle 4.4 states the clinical information may need to be shared with colleagues in order to provide best possible care (annotation 3.9 being mindful of the constraints of confidentiality, psychiatrists shall provide relevant clinical information when the care of a patient is transferred to a colleague or institution).

The patient should be informed of the general limits of confidentiality. Where the patient is unable to understand the concept of confidentiality and its limits, substitute consent may be required. The Code of Ethics serves to guide ethical conduct and is a benchmark of satisfactory ethical behaviour in the practice of psychiatry as this is interpreted in Australia and New Zealand. Since the Code is a public document, it may be referred to in a court of law or in other statutory contexts.

Do psychiatrists have a duty to protect potential victims of their patients' violence?

The general policy is to promote public safety over privacy concerns in certain circumstances. It involves issues of predicting violence, breaching confidentiality, defensive practices and insurance implications that can be overcome by this duty of care. There is a risk that the actions of a third party can be imposed on a psychiatrist if there is a failure to prevent harm caused by someone else. In psychiatric patients they at times are not deemed morally responsible for their actions due to insanity. Psychiatrists must be seen to have appropriately used medication, therapy and compulsory detention to reduce the risk of violence.

The psychiatrist or mental health professional must, pursuant to the standards of their profession determine, if the patient presents a serious danger of violence to another, thereby incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of the duty to protect and the duty to warn may require the therapist to take one or more various steps, depending on the nature of the case. It holds that the obligation is to use reasonable care to protect the intended victim against danger. It may call the psychiatrist to warn the intended victim or others likely to apprise the victims of that danger, to notify the police or take whatever steps are reasonably necessary under the circumstances, including determining if there is a past history of violence, any thoughts about seriously harming another person / group, symptom management, deteriorating mental illness, and patients' ability to control their violent impulses. Further steps can be warning the potential victim(s), informing mental health services of the threat, notifying police, use of Mental Health Act, professional supervision and so on. Code of Ethics for psychiatrists entails the duty to warn and protect.

3.3 The Standard Required

In order to:

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

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

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including 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:

- Teach a junior doctor about assessing risk of future violent behaviour incorporating static and dynamic factors.
- Formulate a management plan taking into account the risk factors of future violence.
- Consider the ethical issues pertaining to breach of confidentiality in the context of future risk.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate adequately present a detailed description of the process of risk assessment? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of areas; demonstrates depth in their knowledge regarding the complexity of assessment of violence risk and the difficulties with accuracy and the implications for the treatment of psychiatric patients; accurately describes details of more than one risk assessment tool; defines assessment of violence using actuarial techniques.

Achieves the Standard by:
considering the information from the vignette relevant to a risk assessment linked to the patient's problems and circumstances with appropriate depth and breadth; exploring the key issues; clarifying from the vignette the important positive and negative features; outlining any typical and atypical features; providing details about application of risk assessment tools; synthesising static and dynamic factors with information provided about the patient.

To score 3 or above the candidate **MUST**:
a. demonstrate awareness of static and dynamic risk factors.

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

Does Not Achieve the Standard (scores 0) if:
demonstrates significant deficiencies including omissions adversely impact on the obtained content; substantial omissions in history considered.

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.13 Did the candidate formulate and describe a relevant management plan to the junior doctor? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* provides a sophisticated link between the plan and key issues identified; effectively explains decision-making in terms of the risk components in the scenario; clearly addresses difficulties in the application of the plan; clearly advocates organisational risk mitigation.

Achieves the Standard by:
being able to prioritise and implement a plan that takes into account and mitigates the risk, considering the relevant static and dynamic factors; recommending medication optimisation and other specific treatments; safe, realistic time frames / risk assessment / review plan; multidisciplinary framework for implementing the plan; skilful engagement of appropriate resources / support; communication with necessary others; identification of potential barriers; consideration of the ethical issues in the development of the management plan; recognition of the need for consultation / supervision / escalation.

To score 3 or above the candidate **MUST**:
a. consider use of the Mental Health Act and the appropriate treatment setting.
b. prioritise substance use management and compliance strategies in the treatment plan.

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

Below the Standard (scores 2 or 1) if:
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 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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* seamlessly incorporates the principles of ethical conduct and practice; good knowledge of professional Code of Ethics; balances the aspects of static and dynamic risk factors for violence with the ethical considerations.

Achieves the Standard by:
demonstrating capacity to: identify and adhere to professional standards of practice in accordance with College Code of Ethics and institutional guidelines; applying ethical principles to resolve conflicting priorities; utilising ethical decision-making strategies to manage the impact on patient care; recognising the importance and limitations of obtaining consent and keeping confidentiality; justifying breach of confidentiality in order to promote safety of the patient or other people; addressing duty to inform intended victim(s) and / or relevant authorities; sharing of clinical information with colleagues in order to provide best possible care.

To score 3 or above the candidate **MUST**:
a. explain the duty to protect the potential victim.

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

Does Not Achieve the Standard (scores 0) if:
errors or omissions will impact adversely on patient care; does not take into account principles of ethical conduct and practice; lacks structure or is inaccurate.

7.1. Category: ETHICS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	**Definite Pass**	**Marginal Performance**	**Definite Fail**