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1.0 Descriptive summary of station

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

1.1 The main assessment aims are to:

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

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

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

1.3 Station covers the:

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

References

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

1.4 Station requirements:

- Standard consulting room.
- Writing paper and pen.
- Four chairs (examiners x 1, candidate x 1, observer x 1, actor x 1).
- Role player: Male in early 20s.
- Laminated copy of 'Instructions to Candidate'.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

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

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

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

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

She is now being offered day patient treatment.

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

Your tasks are to:

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

You will not receive any time prompts.

Station 6 - Operation Summary

Prior to examination:

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

During examination:

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

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

You have no opening statement.

The role player opens with the following statement:

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

3.2 Background information for examiners

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

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

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

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

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

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

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

General principles of treatment for all eating disorders include:

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

Treatment priorities for AN are as follows:

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

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

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

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

Outpatient treatment should involve a multidisciplinary approach including:

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

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

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

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

Body mass index (BMI)

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

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

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

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

Underweight: < 18.5

Normal weight: 18.5 - 24.9

Overweight: 25 - 29.9

Obese: ≥ 30

Medical monitoring should include weekly:

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

After 6 months of amenorrhoea and every second year:

- Bone density

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

DSM 5 Criteria for Anorexia Nervosa

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

Specify whether:

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

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

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

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

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

3.3 The Standard Required

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

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

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

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

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

4.0 Instructions to the Role Player

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

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

About Megan, your mother's history

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

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

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

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

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

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

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

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

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

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

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

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

About you and your family

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

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

4.2 How to play the role:

You are smartly dressed.

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

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

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

4.4 What to expect from the candidate:

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

4.5 Responses you MUST make:

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

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

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

4.6 Responses you MIGHT make:

If the candidate does not explain what BMI is.

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

If the candidate hasn't talked about outpatient therapies.

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

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

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

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

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

4.7 Medication and dosage that you need to remember:

Nil

STATION 6 – MARKING DOMAINS

The main assessment aims are to:

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

Level of Observed Competence:

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

- Correctly interpret Megan's current BMI.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

- Clearly outline that physical deterioration leads to admission.

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2):

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

Below the Standard (scores 1):

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

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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