

1.0 Descriptive summary of station:

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

1.1 The main assessment aims are:

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

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

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

1.3 Station covers the:

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

References:

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

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- No role player as VIVA station.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

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

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

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

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

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

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

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

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

Your tasks are to:

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

You will not receive any time prompts.

Station 2 - Operation Summary

Prior to examination:

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

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, check the candidate ID number on entry.
- There are no prompts so you may elect not to use a timer.
- DO NOT redirect or prompt the candidate.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can'.
- At **fifteen (15) minutes**, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

This is a VIVA station. There are no prompts or questions to ask.

If asked by the candidate, your response is:

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

3.2 Background information for examiners

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

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

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

A surpassing candidate may:

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

Definitions

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

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

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

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

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

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

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

Phenomenology of Grief

Manifestations of grief reflect the individual's:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Application to this scenario:

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

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

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

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

The candidate should outline possible steps in management:

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

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

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

3.3 The Standard Required

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

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

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

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

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

STATION 2 – MARKING DOMAINS

The main assessment aims are:

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

Level of Observed Competence:

6.0 SCHOLAR

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2 or 1):

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

Does Not Achieve the Standard (scores 0) if:

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

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

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

- Prioritise a grief process over a formal psychiatric disorder.

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

Below the Standard (scores 2 or 1):

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

Does Not Achieve the Standard (scores 0) if:

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

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

3.0 COLLABORATOR

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2 or 1):

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

Does Not Achieve the Standard (scores 0) if:

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

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

2.0 COMMUNICATOR

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

Surpasses the Standard (scores 5) if:

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

Achieves the Standard by:

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

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

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

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

Below the Standard (scores 2 or 1):

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

Does Not Achieve the Standard (scores 0) if:

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

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

GLOBAL PROFICIENCY RATING

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

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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