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1.0 Descriptive summary of station:

The candidate is to assess Matthew, a 26-year old university student who has an established diagnosis of obsessive-compulsive disorder and has been on treatment for the past year. He has been referred by his GP for an assessment of the emergence of what the GP believes are psychotic symptoms. The candidate is to conduct a mental state examination to facilitate symptom clarification and then present the findings including the likely diagnosis to the examiner.

1.1 The main assessment aims are to

- Conduct a tailored mental state examination, including differentiating between psychotic symptoms and obsessive-compulsive symptoms based on form, content and insight.
- Differentiate between delusions and obsessions in the mental state examination, and present a preferred diagnosis and differential diagnoses.

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

- Elicit at least three (3) features of obsessions and compulsions e.g. repetitive, intrusive, ego dystonic, time consuming, behaviours designed to reduce anxiety.
- Identify the delusional belief related to being charged by the police for a misdemeanour.
- Justify the possibility of OCD with poor insight or with delusion.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Core Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis), Scholar (Teaching and Presenting)

References:

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- Michael Y, Hwang MD, Sung-Wan Kim MD, PhD, Sun Young Yum MD, Lewis A Opier MD, PhD: Management of Schizophrenia with Obsessive Compulsive features. Psychiatric Clinics of North America 2009- 12-01, Volume 32, Issue 4, Pages 835-851
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- Spitzer M, Sigmund D. The phenomenology of Obsessive Compulsive Disorder. Int Rev Psychiatry 1997; 9: 7-14

1.4 Station requirements:

- Standard consulting room
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Young male in mid-20's who is casually dressed, polite and cooperative.
- 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 private practice.

You are about to see Matthew Pinkerton, a 26-year-old man. His General Practitioner (GP) is concerned about the emergence of recent symptoms, and so has referred him for an assessment. Matthew has previously been diagnosed with obsessive-compulsive disorder one year ago, and has been reasonably stable on Fluoxetine 80 mg daily.

Your tasks are to:

- Conduct a mental state examination that addresses the GP's concerns.
- Present your mental state examination and elaborate on the key findings **to the examiner**.
- Justify the most likely diagnosis and differential diagnosis **to the examiner**.

You are not required to complete a detailed cognitive assessment.

You will not receive any time prompts.

Station 9 - Operation Summary

Prior to examination:

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

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there is no cue / time for any scripted prompt you are to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **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:

'Hello, I've been referred to you, but I am not sure how you can help me.'

3.2 Background information for examiners

In this station the candidate is expected to identify that this patient has now developed a new fixed belief that is delusional in nature on a background of an established diagnosis of OCD. The candidate is expected to identify the differences in phenomenology between the pre-existing obsessive-compulsive symptoms, and the recent development of a delusion. They are then to explore the associated impaired insight regarding this new belief which points to a possible diagnosis of OCD with poor insight / delusions.

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

- Elicit at least three (3) features of obsessions and compulsions e.g. repetitive, intrusive, ego dystonic, time consuming, behaviours designed to reduce anxiety.
- Identify the delusional belief related to being charged by the police for a misdemeanour.
- Justify the possibility of OCD with poor insight or with delusion.

A surpassing candidate may present both positive and negative findings in a well-structured, sophisticated manner and identify the limitations of diagnostic classification systems in guiding treatment.

Obsessive-Compulsive Disorder (OCD) and Delusional Disorders (DD) have been recognised with increased frequency in recent years, and the propensity of some OCD subjects to become delusional has become a focus of interest.

There has been re-emergence of 19th century proposals that the two conditions may be linked. Obsessionality in the context of a paranoid disorder was taken to indicate that obsessions could be prodromal for schizophrenia. However, obsessionality is not seen in this way now. Rasmussen and Eisen reported that 67 of 475 OCD patients had psychotic symptoms like delusions, hallucinations and thought disorder. They divided their 'psychotic' 'obsessionals into four groups:

- those meeting criteria for both OCD and schizophrenia.
- OCD and schizotypal personality with magical thinking.
- OCD and DD.
- OCD without insight.

The obsessive and compulsive (OC) phenomena observed in patients with psychotic disorder are similar to those of the traditional neurotic obsessive-compulsive disorder. These phenomena include contamination, sexual, somatic, religious, aggressive, and somatic themes with or without accompanying compulsions and intrusiveness. Many early clinicians considered such OC phenomena as a prodrome or an integral part of psychotic illness, and some considered the presence of OC symptoms in schizophrenia a predictor of better clinical outcome. However, such diagnostic practice remained controversial until the 1980s as the presence of OC symptoms in schizophrenia contradicted the diagnostic convention. This was based on distinguishing three unique, nonoverlapping diagnostic categories in mental illness: namely, neurotic as opposed to psychotic disorders, with borderline personality organisation emerging to define those individuals who fell between this dichotomy.

In the 1980s a more descriptive and less psychoanalytically driven nosology emerged, which led to various terms such as 'malignant OCD', 'psychotic OCD', and 'schizo-obsessive compulsive disorder' to describe coexisting OC symptoms in schizophrenia. However, in clinical practice the presence of OC symptoms were frequently overlooked and therefore not treated.

The epidemiological and clinical evidence for the interface and overlap between OC phenomena and certain neuropsychiatric disorders has been well established. Neuropsychiatric disorders often associated with OCD include Tourette syndrome, autism, Sydenham chorea, trichotillomania, body dysmorphic disorder, hypochondriasis, and dissociative and eating disorders. During the course of illness, these patients often show an overlap of overvalued ideations and delusional manifestations. Epidemiological studies have also indicated that the risk of psychosis is greater in patients with OCD than in the general population.

Emerging evidence suggests more than one pathogenesis in OC schizophrenia. The OC symptoms in patients with schizophrenia may clinically present as:

- A prodrome in schizophrenic illness – they precede the onset of schizophrenia and may resolve or attenuate after the onset of psychosis.
- A coexisting independent disorder presenting before the onset of psychotic symptoms - may persist or worsen regardless of progress of the schizophrenic illness as an independent disorder. Patients in this category may have previously met the criteria for OCD, and subsequently develop psychosis in the course of chronic and often treatment-refractory illness that currently meets the criteria for schizophrenia. Patients in this category exhibit variable degrees of insight and resistance regarding their OC symptoms during the course of illness. Patients in this group often have a worse clinical course and outcome than patients with non-OC schizophrenia
- Part of active psychotic illness - in some patients, OC symptoms develops as a part of an active psychotic process that emerges along with acute psychosis and usually resolves with the overall improvement in psychosis. Patients in this group have an unequivocal diagnosis of schizophrenia, with little or no insight into their OC symptoms.
- Obsessive ruminations during recovery or the remission phase - as the psychotic symptoms improve, the OCS may become attenuated and present as obsessive rumination or obsessive doubt, which may resolve with further improvement. Patients in this group show varying degrees of insight and resistance regarding their obsessions and show little difference in clinical course and prognosis compared with non-OC schizophrenia patients
- De novo OC symptoms associated with second generation antipsychotic treatment - emergence (de novo) or exacerbation of OCS following treatment with second generation antipsychotics that possess a potent anti-serotonergic receptor profile has challenged clinicians in recent years. This group includes clozapine, olanzapine, risperidone, quetiapine, aripiprazole, and ziprasidone. In particular, clozapine has been most commonly associated with the emergence of de novo OCS.

Due to the diverse nature of clinical presentation and presence of multiple pathogeneses, it is important to be familiar with the varying presentations of OCS in schizophrenia, as each pathogenesis may require a specific treatment intervention. Ascertaining pathogenesis during a single cross-sectional evaluation can often be difficult. OC schizophrenia therefore, may require multiple and longitudinal assessments to ascertain its pathogenesis and formulate treatment strategy.

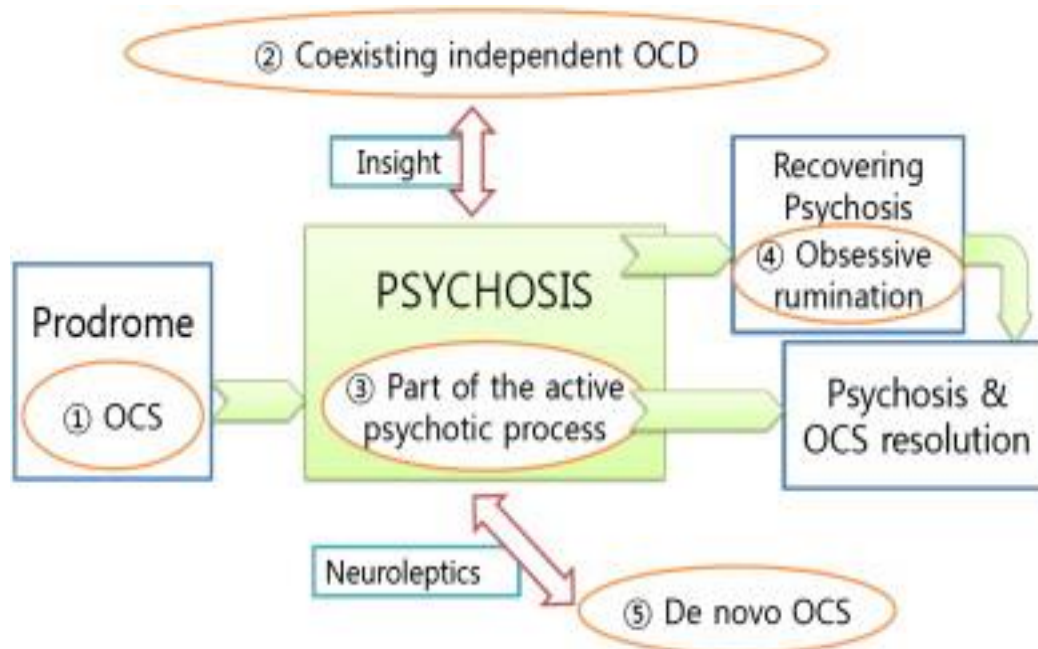


Fig. 1 Pathogenesis of obsessive-compulsive symptoms (OCS) in schizophrenia. OCD, obsessive-compulsive disorder (from Rasmussen and Eisen).

OCD was previously identified by the American Psychiatric Association as an anxiety disorder but is now a separate diagnosis with its own chapter, 'Obsessive-Compulsive and Related Disorders' in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

DSM-5 Diagnostic Criteria for Obsessive-Compulsive Disorder (300.3)

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralise them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviours or mental acts.

- B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalised anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualised eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

Specify if:

With good or fair insight: The individual recognises that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight / delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

Tic-related: The individual has a current or past history of a tic disorder.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Association.

According to the ICD-10: Obsessive-compulsive disorder F42-

Clinical Information

- A disorder characterised by the presence of persistent and recurrent irrational thoughts (obsessions), resulting in marked anxiety and repetitive excessive behaviours (compulsions) as a way to try to decrease that anxiety.
- An anxiety disorder characterised by recurrent, persistent obsessions or compulsions. Obsessions are the intrusive ideas, thoughts, or images that are experienced as senseless or repugnant. Compulsions are repetitive and seemingly purposeful behaviour which the individual generally recognises as senseless and from which the individual does not derive pleasure although it may provide a release from tension.
- An anxiety disorder in which a person has intrusive ideas, thoughts, or images that occur repeatedly, and in which he or she feels driven to perform certain behaviours over and over again. For example, a person may worry all the time about germs and so will wash his or her hands over and over again. Having an obsessive-compulsive disorder may cause a person to have trouble carrying out daily activities.

- Anxiety disorder characterised by recurrent, persistent obsessions or compulsions: obsessions are the intrusive ideas, thoughts, or images that are experienced as senseless or repugnant; compulsions are repetitive and seemingly purposeful behaviour which the individual generally recognises as senseless and from which the individual does not derive pleasure although it may provide a release from tension.
- Disorder characterised by recurrent obsessions or compulsions that may interfere with the individual's daily functioning or serve as a source of distress.
- Obsessive-compulsive disorder (OCD) is classified as a type of anxiety disorder in ICD-10. ... Examples of obsessions are a fear of germs or a fear of being hurt. Compulsions include washing your hands, counting, checking on things or cleaning. ... It tends to run in families. The symptoms often begin in children or teens. Treatments that combine medication and therapy are often effective.

Codes

- F42 Obsessive-compulsive disorder
 - F42.2 Mixed obsessional thoughts and acts
 - F42.3 Hoarding disorder
 - F42.4 Excoriation (skin-picking) disorder
 - F42.8 Other obsessive-compulsive disorder
 - F42.9 Obsessive-compulsive disorder, unspecified

Type 2 Excludes

- obsessive-compulsive personality (disorder) (F60.5)
- obsessive-compulsive symptoms occurring in depression (F32-F33)
- obsessive-compulsive symptoms occurring in schizophrenia (F20.-)

3.3 The Standard Required

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

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

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

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

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 Matthew Pinkerton, a 26-year-old single man, living with your parents. You are a university student and have completed three semesters of a four-year commerce degree. You are now in your fourth semester.

A psychiatrist you saw for a one-off appointment around a year ago diagnosed you with a disorder called Obsessive-Compulsive Disorder or OCD. OCD is a mental health disorder that affects people of all ages and walks of life, and occurs when a person gets caught in a cycle of obsessions and compulsions.

Obsessions are unwanted, intrusive thoughts, images or urges that trigger intensely distressing feelings.

Compulsions are behaviours an individual engages in to attempt to get rid of the obsessions and / or decrease his or her distress.

You had been struggling with obsessive-compulsive symptoms since you were 20 years old, but these were not very troubling until a year ago. You have been taking Fluoxetine 80mg every morning with generally good effect. You have no side effects from this medicine.

However, your symptoms have recently got worse and your GP was quite concerned about how to manage them.

Current symptoms:

About 2 months ago you travelled to Wellington with your parents for a family holiday. Since returning you have been feeling uneasy while driving your car. In particular, you find yourself looking in the rear-view mirror repeatedly to make sure you have not hit something or someone. You have this constant doubt that you could have hit a pedestrian, and you keep looking for a police car following you and listen out for sirens of emergency vehicles. You have often retraced your route to check that you have not hit someone or something. When you get these thoughts your driving time is greatly lengthened, and you end up missing classes. You often involve your parents by insisting that they come along with you, and be on the lookout to ensure you have not hit anyone and seek their reassurance - even driving back with them checking the route taken. Over the last four weeks you have found yourself being constantly worried that the police are going to lay charges for hitting a pedestrian, and not stopping to help out. You have started scanning the environment for police officers and vehicles. It feels like this thought has taken over your life to the extent of affecting your sleep and remaining anxious all through the day, which is worse whenever you hear emergency vehicles.

Background to your symptoms:

You noticed that you were spending a lot of time checking the door – as to whether it was locked properly and would have to keep on doing until you felt sure. This would take a lot of time and would delay you in reaching university in time. This would involve the lock on your front door. Although you knew that you had locked the door, you were not able to rid the thought in your mind and would keep doubting that the door had been locked. There have been many occasions when you decided that you will not check the door more than couple of times, however that made you feel quite uncomfortable and anxious that you could not stick to your decision. You can spend up to 2-3 hours each day checking the doors. This has resulted in you missing your classes at times as well as going out with mates.

The checking behaviour has reduced significantly over the last year after starting treatment, and is now sufficiently under control.

Along with the door checking, you also have repeated doubts about germs on the toilet seat. You would worry about catching some illness and then spreading it to others. These doubts make you repeatedly check the toilet seat and repeatedly clean it with wipes until you feel 'just right'. This has resulted in you spending lot of time in the toilet but also avoiding public toilets, as well as spending a lot of money on cleaning agents on a weekly basis. These obsessions and compulsions have been more manageable in the last few months.

The following information is not to be provided unless the candidate specifically attempts to explore details of the new symptom described above.

You are getting more convinced that the police have you under surveillance for this accident that you are yet to discover. You keep seeing similar looking people around you in uni and on the streets, and you know that these are plain clothes detectives. It is possible that they have your home under surveillance from a neighbouring property. Your parents are getting concerned that you are getting paranoid by the day. You seem to be quite certain that you will be arrested and will rot in prison for this misdemeanour, and believe that this news is also going to be published in the newspapers shortly. Your day-to-day functioning has been significantly affected.

You are able to distinguish between these concerns and the other obsessive-compulsive symptoms. With the other checking behaviour, you are aware that you would feel compelled to check and that by doing so the anxiety would reduce. However, no amount of checking makes these new concerns go away and so you do not think this is part of your OCD.

If asked, you do not:

- hear voices, see things that others can't see, or experience any other strange smells, tastes or sensations.
- think that people are talking about you or any other people want to hurt you.
- think that people can read your thoughts or insert their thoughts into your mind. Your thoughts are under your own control.
- experience any depressive symptoms like low mood or lack of pleasure.
- have tic movements or Tourette's disorder.
- have any other anxiety disorder symptoms like panic attacks or social anxiety.
- have any repeated thoughts or worries about your body shape.
- give excessive attention to detail, or hoard things.

You do not use drugs or alcohol.

No one in your family has any mental health problems.

You have never been hospitalised.

You have never been suicidal or attempted harm yourself.

You do not feel the need to attack or hurt anyone to keep yourself or your family safe.

Your personal history:

You are the only child of loving parents, both of whom are accountants.

You have no bad memories from your childhood.

You have always been neat and meticulous as a child, but did not have intrusive thoughts until you were 20 years old.

You are an average student.

After you left school you took a break from studies for 4 years to travel (mainly around New Zealand and Australia) and work. You have mostly worked in retail and have held down jobs, and were often complimented on your neatness.

4.2 How to play the role:

Young 26-year-old Caucasian man, reasonably groomed and dressed. Appearing anxious, preoccupied. Initially you are hesitant in your speech though you warm up within a minute.

4.3 Opening statement:

'Hello, I've been referred to you, but I am not sure how you can help me.'

4.4 What to expect from the candidate:

The candidate is expected to talk with you about your symptoms mainly focussing on clarifying obsessions and compulsions. They may also ask you a range of questions related to delusions, psychotic symptoms, and how strongly you believe what is happening to you. The candidate will then speak to the examiner about their findings and provide justification for their opinion.

4.5 Responses you MUST make:

'Can you do something about the police?'

'I don't want to go to jail.'

'Do you believe me when I say this is really happening?'

4.6 Responses you MIGHT make:

If asked whether you have actually been charged for anything by the police.

Scripted Response: *'No, but they will come for me soon.'*

If asked whether you take your medicines regularly.

Scripted Response: *'I have never skipped a single dose.'*

4.7 Medication and dosage that you need to remember:

Fluoxetine 80mg every morning.

You have no side effects from your medicines.

You have not been on any other medicines.

You have not received any psychological treatments for your illness and are not interested in these.

STATION 9 – MARKING DOMAINS

The main assessment aims are to:

- Conduct a tailored mental state examination, including differentiating between psychotic symptoms and obsessive-compulsive symptoms based on form, content and insight.
- Differentiate between delusions and obsessions in the mental state examination, and present a preferred diagnosis and differential diagnoses.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate undertake appropriately detailed and focussed Mental State Examination? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

the candidate is clearly able to distinguish between obsessions and delusions; demonstrates accurate prioritisation and achieves the overall standard with a superior performance.

Achieves the Standard by:

demonstrating capacity to conduct a thorough, organised and accurate mental state examination; assessing key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; adequately exploring psychotic symptoms; testing quality of beliefs in order to elicit delusional intensity.

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

- Elicit at least three (3) features of obsessions and compulsions e.g. repetitive, intrusive, ego dystonic, time consuming, behaviours designed to reduce anxiety.

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; significant deficiencies in technique, organisation, accuracy; does not explore obsessions and compulsions, and their features at all.

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

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

6.0 SCHOLAR

6.3 Did the candidate demonstrate an appropriately skilled approach to presenting Mental State Examination and pertinent findings? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

the candidate presents both positive and negative findings on a well-structured, sophisticated manner with good prioritisation; systematically highlights the pertinent findings.

Achieves the Standard by:

presenting the key elements of a comprehensive mental state assessment; presenting a thorough, organised and accurate mental state examination; including key aspects of MSE; characterising the level of insight related to different aspects of symptoms, including poor insight for delusional beliefs.

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

- Identify the delusional belief related to being charged by the police for a misdemeanour.

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.

Below the Standard (scores 2 or 1):

scores 1 if the candidate does not qualify the insight and does not justify it; does not apply any structure to their presentation; misses major aspects of the MSE; does not comment on presence of obsessive and compulsive phenomena; assesses insight to be good.

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

| 6.3. Category: TEACHING & PRESENTING | 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"/> |

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:

the candidate demonstrates a superior performance, appropriately identifies the limitations of diagnostic classification systems to guide treatment.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; adequately prioritising of conditions relevant to the obtained history and findings, providing appropriate and accurate level of detail; considering a prodrome of schizophrenia or the presence of two independent illnesses; providing diagnoses for exclusion; excluding the role of personality or possible substance misuse.

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

- a. Justify the possibility of OCD with poor insight or with delusion.

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; inaccurate diagnoses and differential diagnoses; errors or omissions in justification are significant and adversely affect conclusions.

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

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

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 |
|----------------------------------|----------------------|-----------------------------|----------------------|