

Committee for Examinations  
Objective Structured Clinical Examination  
Station 5  
Perth September 2019



CONTENT	PAGE
Overview <ul style="list-style-type: none"><li>- Descriptive summary of station</li><li>- Main assessment aims</li><li>- 'MUSTs' to achieve the required standard</li><li>- Station coverage</li><li>- Station requirements</li></ul>	2
Instructions to Candidate	3
Station Operation Summary	4
Instructions to Examiner <ul style="list-style-type: none"><li>- Your role</li><li>- Background information for examiners</li><li>- The Standard Required</li></ul>	5 5-8 9
Instructions to Role Player	10-12
Marking Domains	13-14

# Committee for Examinations Objective Structured Clinical Examination

Station 5  
Perth September 2019



## 1.0 Descriptive summary of station:

The station examines the complexity of managing a situation in which a mentally unwell man has come to visit his son, Eric, who is currently admitted to an inpatient psychiatric ward. The family member, his father Max, is presenting in a hypomanic state. The candidate engages Max, determines key features of hypomania in the mental state examination, and presents the findings to the Examiner along with their diagnosis. The candidate must then discuss ethical issues in the case, and duty of care to Max who is not their patient, but whose behaviour is impacting the inpatient psychiatric unit and the patient.

## 1.1 The main assessment aims are to:

- Evaluate how the candidate manages an interview with the family member, Max.
- Attribute accurate phenomenology to make a diagnosis of hypomania using a diagnostic system.
- Discuss ethical considerations raised by Max's presentation.

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

- Effectively de-escalate the initial presentation.
- Elaborate on the phenomenology of hypomania with at least three signs of hypomania.
- Justify why the presentation is more likely hypomania than mania in their diagnostic formulation.
- Elaborate on at least two of the following issues: beneficence, non-maleficence, duty of care, autonomy towards a person who is not their patient.

## 1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Mental State Examination; Diagnosis), Communicator (Patient Communication – To Patient), Professional (Ethics)

### References:

- American Psychiatric Association. (2013) *Diagnostic and statistical manual of mental disorders*, 5th ed. (DSM-5). Washington, DC: American Psychiatric Publishing.
- Legal Aid Queensland (2015-2019) Duty of Care. Available at: <http://www.legalaid.qld.gov.au/Find-legal-information/Personal-rights-and-safety/Injury-loss-and-compensation/Negligence-duty-of-care-and-loss> (accessed 04 April 2019).
- Malhi GS, Bassett D, Boyce P, Bryant R, Fitzgerald PB, Fritz K, Hopwood M, Lyndon B, Mulder R, Murray G, Porter, Singh AB (2015) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Australian and New Zealand Journal of Psychiatry* Vol.49 (12): 1-185.
- RTK Ethics in Psychiatry. Available at: <https://www.slideshare.net/mentalist/ethics-in-psychiatry> (accessed 04 April 2019).
- World Health Organisation ICD 10 Chapter V Mental and behavioural disorders (F00-F99) Mood [affective] disorders (F30-F39). Available at: <http://apps.who.int/classifications/apps/icd/icd10online2003/fr-icd.htm?gf30.htm> (accessed 04 April 2019).

## 1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Anglo-Australian male, 50 to 60 years old.
- Pen for candidate.
- Timer and batteries for examiners.

## 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 inpatient psychiatric unit. The nurse in charge of the unit is concerned by Max Coombs' behaviour, and has asked you to talk to him.

Max is the father of one of your adult patients, Eric Coombs. Eric was admitted two weeks ago with mania, following a relapse of his bipolar disorder. His mental state has improved considerably since his admission, and you have no acute concerns about him. Eric is happy for you to meet his father, and this is the first time you are meeting Max.

Before you go into the ward, you can hear loud laughter and talking. When you enter the ward, you see Max, who is talking and laughing loudly, as he is shown into the interview room by nursing staff. There are no other medical staff present on the unit at this time.

Your tasks are to:

- Talk with Max to clarify why the nurse is concerned about him.
- Present Max's mental state examination findings, and justify possible differential diagnoses **to the examiner**.
- Present ethical considerations that arise in this situation **to the examiner**.

## Station 5 - Operation Summary

### Prior to examination:

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

### During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE there are no cues / time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the role player 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.

There are no prompts for you to give.

The role player must talk or laugh as the bell sounds at the end of the reading time.

The role player opens with the following statement:

***'Wow doc, I seem to be the only sane person in here.'***

#### **3.2 Background information for examiners**

In this station, the candidate is expected to deal with the uncommon, but complex scenario in which a mentally unwell man has come to visit his son who is an inpatient psychiatric ward. The father is presenting in a hypomanic state which the candidate must elicit through interview.

The candidate is then expected to accurately present the phenomenology in the mental state examination findings to the Examiner along with their diagnosis of hypomania.

Finally, the candidate must discuss ethical issues arising from the situation, and how to address any duty of care to Max, who is not their patient, but whose behaviour is impacting the inpatient psychiatric unit and the index patient.

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

- Effectively de-escalate the initial presentation.
- Elaborate on the phenomenology of hypomania with at least three signs of hypomania.
- Justify why the presentation is more likely hypomania than mania in their diagnostic formulation.
- Elaborate on at least two of the following issues: beneficence, non-maleficence, duty of care, autonomy towards a person who is not their patient.

A surpassing candidate may:

Give a comprehensive discussion of the ethical considerations of having a family member who presents to visit the patient, and is found to be mentally unwell, what needs to be considered as an appropriate approach, and how these impact on the candidate's approach to Max, and his son Eric who is the candidate's current patient.

#### **Information for the Examiners**

This station examines how a candidate deals with the complicated situation of a family member visiting an inpatient unit and presenting as mentally unwell:

The father exhibits the phenomenology for hypomania of persistent mood elevation, increased energy and activity, marked feelings of wellbeing, increased sociability, talkativeness, over-familiarity, increased sexual energy, decreased need for sleep, which has not caused severe disruption to work or social rejection. It is an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

The candidate is to consider what is the best approach to this situation. They may discuss the implications for Eric of his father's behaviour on the inpatient unit, the impact on other patients and their visitors on the ward, and the staff reaction. They may reflect on how best the staff could address the behaviour of an overtly unwell man who has no insight into being unwell, and the implications for the psychiatrist requested to address Max and the situation. An alternate consideration they may discuss could be to determine if this man is unwell or is the nurse unit manager and the nurses over reacting, possibly as a result of an unconscious or conscious bias against the patient. The candidate will likely raise the consideration if Max is unwell, is it physical or mental illness, is it drug, or alcohol related and also give consideration to personality issues.

They should determine that Max is hypomanic, with a genetic vulnerability to bipolar affective disorder. They may consider a conflict of interest as Eric is their patient. But there are times when there are few options, and the same clinician must treat family members. A management plan is not required in this station.

At this point, the candidate is not obliged to act immediately regarding admission and treatment as Max is hypomanic. It would be appropriate to ask for consent to ring his GP and inform of his illness.

### **Differential diagnoses**

There is no evidence given for dementia or delirium; other organic illness; or psychotic illness. There is evidence of a mood disorder. There is no evidence for substance misuse. Personality factors may be taken into consideration as to whether there is any influence on the presentation.

### **Diagnosis**

#### **Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders: criteria for bipolar disorders (BD):**

- Presence or history of mania / hypomania is the defining element of bipolar disorders and distinguishes them from depressive disorders.
- An individual is diagnosed with BD I if they have experienced a full manic episode.
- One manic episode is sufficient to qualify for the diagnosis, but most individuals will also have experienced one or more major depressive episodes, which often precede the onset of mania.
- BD II is diagnosed if an individual has experienced both an episode of major depression and hypomania in their lifetime but has never had a manic episode.
- The phases and stages of bipolar disorder are associated with varying degrees of functional impairment.

### **DSM-5 Hypomania Criteria**

A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behaviour, and have been present to a significant degree:

1. inflated self-esteem or grandiosity
  2. decreased need for sleep (e.g., feels rested after only three hours of sleep)
  3. more talkative than usual or pressure to keep talking
  4. flight of ideas or subjective experience that thoughts are racing
  5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
  6. increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation
  7. excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
  - The disturbance in mood and the change in functioning are observable by others.
  - The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalisation. If there are psychotic features, the episode is, by definition, manic.
  - The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).
  - Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative or a bipolar diathesis.

## **ICD-10 Criteria for Bipolar**

- F31 Bipolar Affective Disorder
- F30 Manic Episode
- F30.0 Hypomania

## **Mood [affective] disorders (F30-F39)**

Disorders in which fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity.

F30	<b>Manic episode</b> All the subdivisions of this category should be used only for a single episode. Hypomanic or manic episodes in individuals who have had one or more previous affective episodes (depressive, hypomanic, manic, or mixed) should be coded as bipolar affective disorder (F31.-). <b>Includes:</b> bipolar disorder, single manic episode
F30.0	<b>Hypomania</b> A disorder characterised by a persistent mild elevation of mood, increased energy and activity, and usually marked feelings of wellbeing and both physical and mental efficiency. Increased sociability, talkativeness, over-familiarity, increased sexual energy, and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit, and boorish behaviour may take the place of the more usual euphoric sociability. The disturbances of mood and behaviour are not accompanied by hallucinations or delusions.
F31	<b>Bipolar affective disorder</b> A disorder characterised by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classified as bipolar. <b>Includes:</b> manic-depressive: <ul style="list-style-type: none"> <li>• illness</li> <li>• psychosis</li> <li>• reaction</li> </ul> <b>Excludes:</b> bipolar disorder, single manic episode ( <a href="#">F30.-</a> ) cyclothymia ( <a href="#">F34.0</a> )
F31.0	<b>Bipolar affective disorder, current episode hypomanic</b> The patient is currently hypomanic, and has had at least one other affective episode (hypomanic, manic, depressive, or mixed) in the past.

## **Ethical considerations**

Medical ethics comprises four basic principles of health care ethics when evaluating the merits and difficulties of medical treatments. Ideally, for a medical practice to be considered 'ethical', it must respect all four of these principles: autonomy, beneficence, non-maleficence and justice. Including duty of care, confidentiality and informed consent makes the process more complete.

### **Beneficence**

This requires being bound with the intent of doing good for the patient. It demands that health care providers develop and maintain skills and knowledge, continually update training, consider individual circumstances of all patients, and strive for net benefit. Psychiatric patients may not necessarily consider themselves to be ill, and this has impact on beneficence. If requiring more intensive approach it may need to occur against their will. These considerations come under the principle of beneficence.

In respect of beneficence, the candidate is bound with the intention to do good for Max. They should consider the individual circumstances of Max and Eric. Max does not necessarily consider himself to be ill. However, he is hypomanic, which means in respect of beneficence and good psychiatric practice, he does not require admission to an inpatient psychiatric unit. But as he is disruptive on the unit, this has a negative impact on his beneficence and that of Eric, his son. Considering the obligation to do good, the candidate may seek to explore Max's beliefs and history. Bringing Max's attention to the impact of his behaviour on Eric is reasonable to explore. All these considerations come under the principle of beneficence.

## **Non-maleficence**

This requires to do no harm to the patient involved or others in society. To operate under the assumption to do no harm or at least minimising harm by pursuing the greater good. However, because of the nature of the treatment, the emotional state of the patient may be impacted negatively. The aim for each patient is that their wishes are respected, and the aim of treatment is towards an early restoration of the functioning of the individual.

In respect of non-maleficence, the candidate is aware for Max, the intention is to do no harm to him. To operate under the assumption to do no harm or at least minimising harm by pursuing the greater good. However, because of the nature of the interview and assessment, Max's emotional state may be impacted negatively. The aim for Max is that his wishes are respected, and the aim of the interview with the candidate is to establish if Max is at risk of harm from his elevated mood and unusual behaviour. It is established he has hypomania rather than mania, so does not currently require the candidate to be coercive towards an early restoration of the functioning of Max. These considerations come under the principle of non-maleficence.

## **Duty of Care**

The principle of duty of care is an obligation to avoid acts or omissions, which could be reasonably foreseen to injure or harm other people. This means that you must anticipate risks for your clients, and take care to prevent them coming to harm. The law says we all have a duty of care to take reasonable care not to cause foreseeable harm to other people or their property. This is also known as the law of negligence.

The candidate may discuss the obligation to avoid acts or omissions, which could result in injury or harm to Max. His presence on the ward is a risk to his reputation and potential risk of harm. His behaviour may cause his son shame and embarrassment. The potential counter-transference from the staff, and co-clients and their families and friends, may impact adversely on his son. The risk of further harm due to deterioration in mental state may be considered. The aim would be to reduce his risk to self and others due to his hypomanic state. All these considerations come under the principle of duty of care.

## **Autonomy**

Requires that the patient have autonomy of thought, intention, and action when making decisions regarding health care treatments. Therefore, the decision-making process must be free of coercion or coaxing. For a patient to make a fully informed decision, they must understand all risks and benefits of their illness, potential treatments and the likelihood of success. Given the complexity of treatment and diagnosis, it is difficult to expect patients to be operating under fully-informed consent.

The candidate may discuss the obligation to maintain Max's autonomy, and ability to make his own decisions in respect of his health and wellbeing.

## **Confidentiality**

Anything learned during the professional relationship should not be revealed to others without the consent of the patient. There are specific incidences when confidentiality may be breached as risk usually outweighs confidentiality.

## **Informed Consent**

This covers the information to be provided, competence of the patient to comprehend the information provided and freedom to choose. The consent can be withdrawn whenever the patient wishes. There are specific incidences when informed consent may be breached.

## **Competence**

Refers to the ability to understand the nature and severity of presenting problems, and the need for suggested therapeutic help and its limitations, the ability to demonstrate comprehension of the information given, and the ability to make judgement based on this information.

## **Justice**

The idea that the burdens and benefits of treatments must be distributed equally among all groups in society. This requires that treatments uphold the spirit of existing laws and are fair to all involved. The health care provider must consider four main areas when evaluating justice: fair distribution of scarce resources, competing needs, rights and obligations, and potential conflicts with established legislation.

### 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 Max Coombs, a 58-year-old Anglo-Australian man. You are a widower and live in your own home, independently in the small coastal town of Albany with your adult son, Eric.

You have come to visit Eric, who is in an acute mental health unit. Eric was admitted two weeks ago with a relapse of his bipolar (manic depressive) illness. He is getting better now, and you had planned to talk with the psychiatrist about how things were going towards discharge.

##### Recent history

In general, people who meet you and people who know you have always described you as energetic and eccentric. You reckon they mean you are different, of course cleverer than most, obviously richer than most and you have been quite successful.

One month ago, you started to worry about your finances. The accountant said there were no problems, but you couldn't seem to get the thought out of your mind. You checked and re-checked all the businesses, and it seemed all was well. Then Eric got sick, and you stayed up with him, because he kept leaving the house, and going down to the marina to check the boats. You told him it was okay, but he wouldn't listen to you. During this time, you had an altercation with Eric, trying to stop him going out. You had to call the police and Eric was taken to hospital. In the end, you had very poor sleep over four nights.

After that you couldn't settle and couldn't sleep. You noticed that you didn't need sleep, and you didn't need feel hungry. You felt wonderful, you felt powerful and energetic.

Your children are worried about you, including Eric. You spoke to him just now, and he said you weren't right, '**the silly boy**'. What nonsense, of course you are fabulous. Eric has tried to suggest that you are unwell, even now that you are visiting him on the psychiatry ward. That has amused you, and now these nice nurses and doctors want to talk to you.

If asked what you are doing with your time: you can still function reasonably at work. Lately you have noticed that your thoughts are racing, but you seem to be coping okay. You have noticed ideas have started flowing so beautifully in you; and you knew you had to write a book. You had to do your autobiography, because your life is so fascinating. You would only be able to sit to write for about a few hours, over the past three weeks you can't sit still – there is too much to do.

You met a woman, others would describe as a '**lady of the night**', but you know Priscilla is your soul mate. You have been visiting her regularly, and even proposed marriage to her. She has said '**no, you silly old coot!**'

You have been thinking about buying a new car, because your suggestion to buy a boat as a new financial investment was not met with support from the family. You just saw a great boat in Fiji when you visited your sister. You wanted to go back, and you wanted to buy it. The car would be an upgrade for the one you have, so you are thinking about that now. But your kids, your accountant and lawyer did not think it was good business sense. You did get into an argument with your lawyer about it, but you are glad you have such caring people around you. After seeing the lawyer, you decided to come and see your boy, Eric, so drove to the hospital.

In the last few days, you have been feeling happier than usual. If asked, you admit that you have more energy to do all the things you have been planning to do, people have been saying you seem happier, and more energetic than usual. You feel there's nothing wrong with you, you feel you have never been better. You are enjoying meeting new people wherever you go. You can't help it if you are so popular suddenly.

The other day, when you were driving you have to admit you were a bit distracted, but you stopped the car, so you could have a rest – no harm done.

## Past History

You do recall in your late teens having a period of six months when you felt depressed. Your mood was low, and your parents took you to see the GP. You were started on an antidepressant, you can't remember the name, but after three days you felt '**really good**'. Then after two weeks, you became so happy and high, you weren't sleeping, you couldn't focus at school, you forgot to go to school because you had so many projects on the go, you spent all your time doing them, you forgot to eat or to sleep. In the end, your parents called for help. You were admitted to a psychiatric unit, and later you were told you had been manic. They told you that you were very sick, but you didn't feel sick, you felt wonderful. In hospital, they gave you a medication called LITHIUM and after three weeks, you felt like your normal self. Since then, you have had periods of fluctuations in your mood, but never like that time.

You have never required further admission to a psychiatric unit. You stopped the medication years ago, maybe three months after they gave it to you. You do not believe you have a mental illness, and in fact you feel wonderful, full of life and you simply live life passionately. Why clinicians must label it as an illness irritates you. You think your son should exercise more, and he will stay well.

You have never heard voices or seen things that others do not. You know you are special, but do not have any special powers or special connection with God. You love Priscilla and are not interested in other women, and have not been having indiscriminate relationships or an abnormally high sexual drive. You have been wanting to buy a few things as described above, but have been reluctantly talked out of this by your children or lawyer. You have never been in trouble with the law. You have never been in physical fights.

You do not remember much of the time when you were depressed, but you can say with confidence that you were not suicidal at the time, and you have never attempted self-harm or had a desire to die.

You have never smoked cigarettes, or cannabis, or used any other illicit substances. You have enjoyed alcohol, and there have been times when you have drunk too much, but it has never caused any problems for you. You are fit and healthy, and have no physical illnesses.

## Family History:

As far as you know, your father, sister and brother all have Bipolar Disorder ('**bipolar**'). Your eldest son, Paul, has no mental health problems. Your daughter is overly emotional, but does not have Bipolar Disorder or require medication, other than occasional sleeping tablets when she has trouble sleeping. Your son, Eric, developed Bipolar Disorder when he was 25 years old. When he is well, he works for you. Eric has had both depressive and manic episodes, and you have tried to support him as best you can. You know that he is in hospital now for mania. You know you are nothing like any of the others, in fact, you are simply too busy to be bothered with being unwell.

## Personal History

You were born and bred in Albany, Western Australia.

Your wife, Nancy, died 10 years ago from an asthma attack. You have missed her greatly since.

You own two businesses, and your three children work with you (Paul 38, Rose 36, and Eric 34 years old respectively). Your first business is your cattle farm which brings in a steady return. You have a Whale Watching tour business with two large boats. Recently, you have found that the stress of running two relatively successful busy enterprises difficult.

### 4.2 How to play the role:

You are feeling happy, and you are brightly dressed in a suit and hat. You initially laugh and move your head, lean in closer to the candidate and then back again into your seat, smiling at the candidate and waiting for them to speak. You continue to be loud at times and laughing at times, talking quicker at times, using your hands in gestures to emphasise what you are saying. You are enjoying talking with the doctor.

You can talk on a range of topics in no particular sequence, talk about the weather, the drive, the clothes you are wearing, the colour of your clothes, how great you are feeling, how energetic and healthy you are, probably healthier than the candidate. You are relaxed and happy, and enjoying the interview.

You let the candidate interrupt you and answer the questions as best you can, from the information provided. But you don't really link any of the information to you being elevated in mood, you just feel 'happy'.

#### **4.3 Opening statement:**

**'Wow doc, I seem to be the only sane person in here.'**

#### **4.4 What to expect from the candidate:**

The candidate should engage you in respectful conversation, with a focus on trying to engage with you to try to understand how things are going for you, and not follow your tangents of conversation. They are expected to try and take a history of your life in summary to look for details of bipolar disorder, drug use, and other relevant history.

The candidate is then expected to talk to the examiner about how they will manage the situation you are in.

#### **4.5 Responses you MUST make:**

**'I feel amazing – check me out.'** (*hit upper arms and do pose, lean forward and smile at the candidate*)

**'There's nothing wrong with me, doc'** (*lean forward and look into the candidate's eyes but NOT in a threatening manner*)

**'I'm just here to see my boy.'**

#### **4.6 Responses you MIGHT make:**

If the candidate asks about any thoughts of harm to self (suicidal or self-harm) or others (homicidal)?

*Scripted Response:*      **'No, never.'**

If the candidate asks about low mood or depression?

*Scripted Response:*      **'No, there's nothing wrong with me, I'm great.'**

If the candidate asks if you would consider taking medication?

*Scripted Response:*      **'No, there's nothing wrong with me, I'm great.'**

If the candidate asks if you are willing to come into hospital?

*Scripted Response:*      **'No, there's nothing wrong with me, I'm great.'**

If the candidate asks you questions you do not have answers for:

*Scripted Response:*      **'That doesn't matter.'**  
**'I don't know.'**

#### **4.7 Medication and dosage that you need to remember:**

None.

## STATION 5 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate how the candidate manages an interview with the family member, Max.
- Apply accurate phenomenology to make a diagnosis of hypomania using a diagnostic system.
- Discuss ethical considerations raised by Max's presentation.

**Level of Observed Competence:**

### 2.0 COMMUNICATOR

#### 2.1 Did the candidate demonstrate an appropriate professional approach to gathering information on Max? (Proportionate value - 15%)

**Surpasses the Standard (scores 5) if:**

able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment.

**Achieves the Standard by:**

demonstrating empathy and 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, mental illness, etc.; providing education; communicating plans and discussing acceptability; effectively managing challenging communications; containing conflict or behavioural abnormalities; recognising confidentiality and bias.

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

- Effectively de-escalate the initial presentation.

**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 materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

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

2.1. Category: PATIENT COMMUNICATION - To Patient	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

#### 1.3 Did the candidate demonstrate adequate proficiency in undertaking a mental state examination for hypomania? (Proportionate value - 25%)

**Surpasses the Standard (scores 5) if:**

able to conduct mental state examination relevant to the patient's problems and circumstances; it is conducted / presented at a sophisticated level.

**Achieves the Standard by:**

demonstrating capacity to: conduct and present an accurate mental state examination for hypomania; assess key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; decide on the importance of a cognitive assessment; present succinctly with accurate use of phenomenological terms; include appropriate positive and negative findings. Hypomania: mild elevation in mood, increased energy, increased activity, marked feelings of wellbeing, talkativeness, overfamiliarity, increased sexual energy, decreased need for sleep, lack of insight.

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

- Elaborate on the phenomenology of hypomania with at least three signs of hypomania.

**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 and / or presentation.

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

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

**1.9 Did candidate formulate and describe the relevant diagnosis / differential diagnosis? (Proportionate value - 20%)**

**Surpasses the Standard (scores 5) if:**

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; adequate prioritising of conditions relevant to the obtained history and findings; identifying relevant predisposing, precipitating, perpetuating and protective factors; aiming to exclude coexisting physical illness, substance use, personality factors.

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

- a. Justify why the presentation is more likely hypomania than mania in their diagnostic formulation.

**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 or inadequate diagnostic formulation; errors or omissions are significant and do materially 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"/>

**7.0 PROFESSIONAL**

**7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value - 40%)**

**Surpasses the Standard (scores 5) if:**

comprehensively considers all major aspects of ethical conduct and practice.

**Achieves the Standard by:**

demonstrating the capacity to: identify and adhere to professional standards of practice in accordance with College Code of Conduct / Code of Ethics and institutional guidelines; integrate ethical practice into the clinical setting; apply ethical principles to resolve conflicting priorities; utilise ethical decision-making strategies to manage the impact on professional practice / patient care; maintain appropriate personal / interpersonal boundaries; recognise the importance and limitations of obtaining consent and keeping confidentiality.

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

- a. Elaborate on at least two of the following issues: beneficence, non-maleficence, duty of care, autonomy towards a person who is not their patient.

**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; did not appear aware of or adhere to accepted medical ethical principles.

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

7.1. Category: ETHICS	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
---------------------------	---------------	----------------------	---------------