

1.0 Descriptive summary of station:

In this station the candidate is to assess a 40-year-old Indian woman's complaints of multiple aches and pains. The aim is to sensitively explore the history taking into account the underlying cultural issues in order to clarify the diagnosis of depression and offer treatment.

1.1 The main assessment aims are to:

- Explore a depressive history in a manner that sensitively identifies underlying cultural issues in the patient.
- Synthesise the obtained information and explain to the patient the diagnosis and management strategies.
- Explore psychosocial history to identify role of in-laws and husband in her level of stress, and assess the candidate's ability to deal with patient's resistance to accept antidepressant treatment.

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

- Explore physical symptoms to support or refute clinical depression.
- Identify that the patient is dependent on husband's permission to accept treatment.
- Demonstrate recognition of the role the in-laws play in her level of stress and acceptance of treatment.
- Diagnose major depressive disorder as the preferred diagnosis.
- Incorporate the patient's preference of traditional treatment into the management plan.
- Approach the patient's resistance to accept treatment in a sensitive manner.

1.3 Station covers the:

- RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of: Mood Disorders, Other Skills (Culture)
- Area of Practice: Adult Psychiatry
- CanMEDS Domains: Medical Expert, Communicator
- RANZCP 2012 Fellowship Program Learning Outcomes: Medical Expert (Assessment – Data Gathering Content; Diagnosis; Management – Treatment Contract), Communicator (Cultural Diversity)

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1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: 40-year-old woman of Indian background; casually but neatly dressed.
- 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.

You are working as a junior consultant psychiatrist in a clinic in a community setting.

You are about to see Simran, a 40-year-old Indian woman referred by her local GP Dr Keogh. She has come to your clinic with a referral letter:

Dear Colleague:

Thank you for seeing Simran for an opinion regarding her complaints of multiple aches and pains. Simran has been seeing me for the last few months. She has been coming in quite frequently requesting treatment for pain in multiple areas of her body including headaches, back pain, neck pain and abdominal pains which appear to fluctuate. There has been no relief with analgesics. I have completed a range of blood tests including Vit D, B12, FBC, TFT and an abdomen ultrasound which have been normal.

These aches and pains have resulted in Simran spending extended periods in bed. She struggles with household tasks and has been withdrawing from family activities.

I believe that Simran has been experiencing depression and have offered her antidepressants which she has repeatedly declined. She has finally agreed to see you, after a lot of negotiation.

Thank you for your opinion regarding diagnosis and treatment.

Your tasks are to:

- Conduct a focussed and relevant psychiatric assessment with Simran.
- Based on your identified issues, explain your diagnosis and differential diagnoses to Simran.
- Discuss treatment options with Simran.

You will not receive any time prompts.

Station 1 - 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 and co-examiner.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE of the cue / 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 **fifteen (15) 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 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.

There are no scripted prompts.

The role player opens with the following statement:

'You are only a mental doctor; I don't know how you are supposed to help me with my aches and pains.'

3.2 Background information for examiners

The candidate is expected to take a focussed history presenting with multiple physical aches and pains from a 40-year-old married Indian woman. They are required to identify and consider the impact of her cultural background on how she copes with changing family dynamics in order to clarify the diagnosis of depression. They are further required to offer treatment to the patient and deal effectively with the patient's resistance to accept treatment.

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

- Explore physical symptoms to support or refute clinical depression.
- Identify that the patient is dependent on husband's permission to accept treatment.
- Demonstrate recognition of the role the in-laws play in her level of stress and acceptance of treatment
- Diagnose major depressive disorder as the preferred diagnosis.
- Incorporate the patient's preference of traditional treatment into the management plan.
- Approach the patient's resistance to accept treatment in a sensitive manner.

To be able to justify the diagnosis of clinical depression, the candidate should be able to establish the criteria for clinical depression according to either the DSM or ICD.

A surpassing candidate may recognise the significance of the family role and identify aches and pains as "cultural idioms of distress", and incorporate this when carefully addressing the patient's resistance to accept treatment in a very sensitive manner.

DSM-5 Diagnostic Criteria for Major Depression

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. (**Note:** Do not include symptoms that are clearly attributable to another medical condition.)
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
 2. Markedly diminished interest or pleasure in all (or almost all) activities most of the day, nearly every day (as indicated by either subjective account or observation).
 3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
 4. Insomnia or hypersomnia nearly every day.
 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or another medical condition.
- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode. **(Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.)

ICD-10 Criteria for Depression

The depressive episode should last for at least 2 weeks.

- G2. There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode at any time in the individual's life.
- G3. Most commonly used exclusion clause. The episode is not attributable to psychoactive substance use or to any organic mental disorder.

Somatic syndrome - some depressive symptoms are widely regarded as having special clinical significance and are called 'somatic'. (Terms such as biological, vital, melancholic, or endogenomorphic are used for this syndrome in other classification.)

A fifth character may be used to specify the presence or absence of the somatic syndrome. To qualify for the somatic syndrome, four of the following symptoms should be present:

1. marked loss of interest or pleasure in activities that are normally pleasurable;
2. lack of emotional reactions to events or activities that normally produce an emotional response;
3. waking in the morning 2 hours or more before the usual time;
4. depression worse in the morning;
5. objective evidence of marked psychomotor retardation or agitation (remarked on or reported by other people);
6. marked loss of appetite;
7. weight loss (5% or more of body weight in the past month);
8. marked loss of libido.

In the ICD-10 clinical descriptions and diagnostic guidelines, the presence or absence of the somatic syndrome is not specified for severe depressive episode, since it is presumed to be present in most cases.

F32.0 Mild Depressive Episode

- A. The general criteria for depressive episode must be met.
- B. At least two of the following three symptoms must be present:
 1. depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks;
 2. loss of interest or pleasure in activities that are normally pleasurable;
 3. decreased energy or increased fatigability.

- C. An additional symptom (or symptoms) from the following list should be present, to give a total of at least four:
1. loss of confidence and self-esteem;
 2. unreasonable feelings of self-reproach or excessive and inappropriate guilt;
 3. recurrent thoughts of death or suicide, or any suicidal behaviour;
 4. complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation;
 5. change in psychomotor activity, with agitation or retardation (either subjective or objective);
 6. sleep disturbance of any type;
 7. change in appetite (decrease or increase) with corresponding weight change.

A fifth character may be used to specify the presence or absence of the 'somatic syndrome':

F32.00 Without somatic syndrome; F32.01 With somatic syndrome.

F32.1 Moderate Depressive Episode

1. The general criteria for depressive episode must be met.
2. At least two of the three symptoms listed for mild depression, criterion B, must be present.
3. Additional symptoms from mild depression, criterion C, must be present, to give a total of at least six.

A fifth character may be used to specify the presence or absence of the 'somatic syndrome':

F32.10 Without somatic syndrome; F32.11 With somatic syndrome.

Cultural aspects relevant to the case

Cultural factors influence and shape the experience and expression of perceived distress. The personal impact and the significance of symptoms are evident in the patient's narrative that elaborates meaning and causation regarding culturally shaped ideas about the body in sickness and health. Bodily pains in patients are based in the context of their local worlds.

From a cultural perspective, epidemiological surveys of patients attending primary health care facilities in developing countries have indicated that as many as one-fifth to one-third of them have depressive illness as a primary or secondary reason for seeking care (Desjarlais et al., 1995). Despite their frequency, depressive disorders are less likely than many other health problems to be recognised and treated by clinicians even in Western cultures (Eisenberg, 1992).

Unfortunately, in routine medical encounters the social dimensions of the suffering body are often conceptualised as disconnected events within the individual's biological body. Depressive experience is interpreted through somatisation to be a less stigmatising and therefore more tolerable condition.

In the DSM-IV it was recognised that in some cultures depression may present with somatic complaints, such as headaches, gastrointestinal disturbances and unexplained pains, these must be distinguished from somatic presentations of depressive illness, symptoms of which include loss of appetite, constipation, weight loss, loss of libido, and insomnia.

Cross cultural epidemiological studies suggest that somatisation of depression is a common phenomenon in non-Western societies. In India, researchers have also emphasised the somatic presentation of depressive illness in psychiatric settings. It has been consistently observed that patients with depression in India have more somatic symptoms than their counterparts in the West (Teja et al., 1971). Raguram et al. (2000) tried to examine how patients in India actually understand and construct the experience of depression, and tried to explore the many ways in which they act in response to their distress.

In a study of depressed Chinese patients coming for treatment in general practice, Cheung et al. noted that an overwhelming majority of them complained primarily of somatic symptoms. Cheung suggested that Chinese patients suppress or disguise their deep feelings owing to fear of the powerful social stigma that attaches to mental illness in their culture.

In a study of epilepsy-related stigma, Kleinman et al. pointed out that there could be several factors operating in the affected people including reduced self-esteem and power, ostracism affecting marital prospects and marital life, and fears about disclosure.

Kleinman, based on research in China, concluded: "Depressive affect is socially and culturally unsanctioned and therefore suppressed. Somatisation is sanctioned and expressed, and it carries both cultural cachet and social efficacy."

A study conducted by Raguram et al. (2001), found a positive relationship between the severity of depressive symptoms and the scores on a stigma scale demonstrated that higher levels of depression were experienced as more stigmatising. They found that symptom expression was governed by the perceived stigma attached to psychological problems.

In India, patients report somatic symptoms spontaneously, but report psychological symptoms upon being probed (Raguram et al. 2001; Jadhav et al. 2001).

The social meaning of somatic symptoms is less distressing because they closely approximate experiences that everyone has from time to time. Depressive symptoms, on the other hand, are considered to be private and even dangerous. Like in the Kleinman study above, symptoms are experienced as socially disadvantageous; they might interfere with marriage, diminish social status and compromise the self-esteem required to perform effectively in society.

It is imperative that clinicians attend not only to questions of diagnosis and clinical formulation according to professional concepts, but also to the experience and meaning of their patients' problems. Raguram et al. (2001) comment that a culturally sensitive enquiry helps in the development of treatment strategies that are congruent with the cultural concepts and needs of patients.

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.

4.0 Instructions to the Role Player

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

You are Simran, a 40-year-old married mother of two young daughters (Hema and Deepti, aged 10 and 8 years respectively). Your parents-in-law currently live with you and your family.

Reason for referral:

You have been referred to a community mental health centre by your GP Dr Keogh. Since last year or so, you have started getting increasing aches and pains. Plus, you have started to feel dull and dreary, and increasingly worried about the strain you are putting on your family.

Kinds of symptoms you have been experiencing:

You have been suffering with multiple aches and pains, and have experienced headaches quite often. These headaches mostly feel like a '*band around your head*', which is dull, continuous and in the forehead region.

In relation to the headache you do **not** experience:

- changes in your eyesight or sensitivity to light
- any change in the headache with change in posture
- any nausea or vomiting
- headaches on a daily basis, but they are very common almost every other day.

You have also experienced abdominal pains, spread all over your abdomen, which are not associated with any nausea, vomiting or diarrhoea. You have also intermittently experienced aches in your arms and legs which mostly come and go without any reason.

You had similar problems with aches and pains around eight years ago, when your parents were having ongoing conflict related to some financial difficulties. However, the symptoms disappeared on their own after the financial crisis resolved.

If asked:

Sleep and energy levels: In the last 6-7 months, you have started to have interrupted sleep, and feel worried and tense about how to get through each day. You often find that you wake up in the middle of the night and are unable to get to sleep again, lying awake for half an hour to an hour. This has been happening up to 1-3 times in the night. You do not feel refreshed when you get up in the morning. Over the two or three months you have started to feel more exhausted and tired during the day. However, you are still able to cook, clean and manage the household tasks everyday.

Socialising and enjoyment: You used to be described by your friends as '*happy-go-lucky*' and had a good group of friends while in India, but after moving to Perth, have felt socially isolated. You are now unable to enjoy things, particularly playing with your children, as you have in the past. You used to enjoy watching TV, and had started making friends with other parents through your kids' school. You are now really worried that you are losing the excitement and zest about living in Australia, and have started wishing you could go back to your parents in India.

Appetite and weight: You are generally eating as before, but you do not enjoy food as much, but eat because you have to. You haven't lost any weight.

Sexual function: If asked, you do not enjoy sex with Rajiv any more. However, though not interested, you feel the need to give in to Rajiv's desire for sex.

You feel bad about being unable to fulfil your duties as a wife and mother and feel guilty about your failure at times. However you do not think that you are a bad person or deserve to be punished. You do not feel hopeless but do feel somewhat helpless in your current situation.

You and your family:

You have been married for 15 years - through an arranged marriage to Rajiv in Amritsar when you were 25 years old. You only met him a couple of times before the wedding. However, the marriage was acceptable to you as it was the norm within your peer group and culture. Rajiv had studied a Diploma in Engineering in India and migrated to Australia along with your children in early 2011. You are trained as a primary school teacher.

While you had been very excited and optimistic about this move to Perth, things did not go as well as you had hoped. Your husband struggled initially in getting a job based on his Indian qualifications, and ended up driving a taxi to support the family for a few months. He then completed a Diploma in IT and finally got a stable job in the last year. However, financially the income does not seem quite enough to take care of the needs of your growing family.

You are worried and anxious about meeting the needs of the family, development of the children, financial situation and what would it entail to be able to start working as a teacher in the Australia.

Over the last few months your husband has been suggesting that you start looking for a job to assist in the financial situation. You are quite reticent to start looking for jobs as you do not know whether your qualification will be recognised, and what examinations would you have to take to get recognised as equivalent as a qualified teacher in the Australian system.

Moreover, your husband's parents also moved over from India six months ago to live with you. They are frail and elderly, and this has placed additional pressure on you to attend to their day-to-day needs as well as health needs. Your husband wishes that you all live together as a "joint family". You feel very ambivalent about this, as while this may have been the norm in India, you feel that you have changed as a person after living in Australia for the last six years, and now would struggle to fit into this 'traditional' system again.

More and more you have been feeling that you have a right to be more independent, and have reservations about this arrangement which you feel would impact on your finances as well as your time with your husband and children. You also see that in Australia it is not automatically expected that you should be living with your parents, and you feel that while it is important to have a good relationship with them, you see it is going to be difficult to live with them on an ongoing basis.

However, you find it difficult to explain your feelings to Rajiv as you feel he is very traditional in his thinking and would not understand your point of view. Moreover, you feel that Rajiv does not really understand all the household responsibilities you have to bear as he works long hours, and even when home, does not really help around the house. This has also caused increasing conflict between you both. Rajiv sees it as your 'duty' but you feel that he needs to chip in to help at home as well as trying to meet his parents' needs.

You had been toying with the idea of not pursuing teaching career but to do a diploma in beauty therapy that can set you up to earn quickly and give you more flexible working hours. While Rajiv was initially supportive, now he feels you should follow his parent's wishes and this idea is not liked by your in-laws. This has been very upsetting to you as you feel you should have the right to make these choices individually rather than always listen to them.

You have recently started experiencing increased conflict with your husband in relation to his choices about your career. You are also finding it difficult to deal with increasing demands from your in-laws since they started living with all of you. You do not get any 'down time' and believed that they interfere with how you spend time with your two gorgeous little daughters. You also feel that your husband would like to have a son, but you do not wish to have any more children.

You have followed Hinduism as a religion, and you have always been taught to take care of parents and their needs, and that it is your duty to take care of them and agree with what your husband says. You are therefore conflicted with the values that you have been taught and seen while growing up, and with what emotions and thoughts that you are experiencing now. You have become more stressed since Rajiv's parents arrived from India, and at times you view them as quite demanding but do your best to take care of their needs.

If you are asked about your personal history:

Your birth and early development has been unremarkable. You are the eldest of three siblings, all of whom still live in India. Your youngest brother has just joined the family business. Your middle sister has recently divorced because of some issues which you are unclear about.

Your parents live in Amritsar, and your memories of your childhood are of your parents arguing over financial issues. You were closer to your mother who took care of your needs as a child. You remember her as being quite unwell for long periods of time, and recall that she used to cry in pain and repeatedly visited doctors, but are not aware if she was diagnosed with a specific illness.

Looking back on those times, it appeared that going to all those doctors provided little benefit. With this in mind, and in light of the fact that your GP has not been able to help you with your pains, you are not convinced that Western medicine can really help you. When you were in India, you recall your relatives suggesting Ayurvedic treatment for ailments. You are more interested in searching for traditional methods to manage pain and help your body to relax like yoga, massage and Ayurveda.

You qualified as a school teacher in India, and had been working as a primary school teacher for three years before getting married. However, you have not thought of exploring work opportunities after coming to Australia as you have been taking care of your children because you could not afford after school care or child care.

Psychiatric history and symptoms:

You have never been diagnosed as having depression and you do not feel depressed. You have never attempted or thought about suicide, but at times do wonder if your family may be better off without you given that you are not getting well.

You have never experienced a high / elevated mood (mania). You do not suffer from chronic feelings of anxiety.

You do not think you have ever had a psychotic episode – if asked, you can ask the candidate to explain what they mean by the word ‘psychosis’. You have never heard voices or seen things that other people do not, you do not get messages from the TV that are directed specifically at you, you do not think anyone is trying to harm you. You do not believe that your symptoms are due to any part of your body rotting or that you have a terrible illness.

You have never drunk alcohol or used illegal drugs.

You have a family history of your mother experiencing similar symptoms - aches and pains and feeling tired, unable to work, not enjoying life as much but carrying on. Your mother has never visited a psychiatrist or taken any antidepressants. Your mother continues to suffer from aches and pains, and continues to not be able to meet her duties to a level that she would like to.

4.2 How to play the role:

You are a casually but neatly dressed Indian woman who is anxious about seeing a psychiatrist. You come across as being worried and a bit sad, and find it difficult to cheer up during the interview. However, you deny being depressed although you do acknowledge some extent of sadness, even though you have many symptoms of depression (as described earlier).

If the candidate asks you about family factors / concerns, you hesitate to bring up the issues that are occurring at home. However, if the candidate sensitively explores the issues with you, you can bring them up.

If asked, you are willing to talk about your ambitions, how you would want to be more independent and that you do not want the situation at your family of origin to be repeated.

You quite hesitatingly accept any help being offered but wonder how your husband is going to view it. You feel ashamed and stigmatised to having been referred to a Psychiatrist, and unsure whether antidepressants is the right choice for you.

4.3 Opening statement:

‘You are only a mental doctor; I don’t know how you are supposed to help me with my aches and pains.’

4.4 What to expect from the candidate:

The candidate should ask you a series of questions about why you have been referred, about your aches and pains and your personal background. The candidate is then expected to describe what they think you are suffering from and in a sensitive, empathic manner, explain how he / she can assist in understanding your aches and pains, and make treatment recommendations.

4.5 Responses you MUST make:

‘These days I feel so dull and dreary.’

‘I would prefer to try traditional options first like Ayurveda, yoga or massage.’

‘At times worried about my husband’s reactions as to how I am coping.’

‘I’m not sure my husband will agree to me taking medication.’

4.6 Responses you MIGHT make:

Anticipated Question: If asked about how supportive your husband is.

Scripted Response: ***'I can see my husband really getting frustrated with me. He is supportive in his own typical way.'***

Anticipated Question: If asked about your in-laws.

Scripted Response: ***'I am finding it quite difficult to get used to how they want us to live.'***

Anticipated Question: If asked whether you feel depressed

Scripted Response ***'I do not know what you mean by that, I feel dull and dreary.'***

4.7 Medication and dosage that you need to remember:

You are not on any medicines at present.

You took paracetamol and ibuprofen previously for you pain but did not find them helpful.

You have not had and do not want any stronger pain medicine.

STATION 1 – MARKING DOMAINS

The main assessment aims are:

- Explore a depressive history in a manner that sensitively identifies underlying cultural issues in the patient.
- Synthesise the obtained information and explain to the patient the diagnosis and management strategies.
- Explore psychosocial history to identify role of in-laws and husband in her level of stress, and assess the candidate's ability to deal with patient's resistance to accept antidepressant treatment.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 15%)

Surpasses the Standard if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; taking hypothesis-driven history; integrating key sociocultural issues relevant to the assessment; eliciting the key issues; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features; assessing for typical and atypical features.

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

- Explore physical symptoms to support or refute clinical depression.

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:

omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <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

2.4 Did the candidate demonstrate a culturally sensitive approach to patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

demonstrates a sophisticated and knowledgeable approach to cultural aspects of patient engagement; successfully negotiate inclusion of husband and in-laws in the treatment plan.

Achieves the Standard by:

recognising and incorporating cultural expectations in the assessment; adapting assessment and management to the specific cultural needs; considering whether to use cultural health workers; identifying a range of culturally relevant issues for the patient.

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

- Identify that the patient is dependent on husband's permission to accept treatment
- Demonstrate recognition of the role the in-laws play in her level of stress and acceptance of treatment.

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:

ignores sociocultural aspects of the scenario; insensitive / dismissive approach to cultural issues of the patient; is rude or trivialises the patient's needs.

2.4. Category: CULTURAL DIVERSITY	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"/>	

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment particularly with regard to cultural context.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a differential diagnosis; demonstrating detailed understanding of diagnostic systems for diagnosis and differential diagnosis; adequately prioritising of conditions relevant to the obtained history and findings; identifying relevant predisposing, precipitating perpetuating and protective factors; communicating in appropriate language and detail, and according to good clinical judgment. Considers adjustment disorder, somatisation disorder and possible physical illnesses such as hypothyroidism

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

- a. Diagnose a major depressive disorder as the preferred diagnosis.

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:

inaccurate or inadequate diagnostic formulation; errors or omissions are significant and materially adversely affect conclusions.

1.9. Category: DIAGNOSIS	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"/>	

1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; incorporates individual vulnerabilities and resilience factors into a carefully tailored plan.

Achieves the Standard by:

demonstrating the ability to: communicate a culturally acceptable treatment plan; clearly explain indications for treatment, range of options, and recommendations; attempt to work within patient treatment goals, including suitable consideration of patient preferences for alternative interventions like yoga/massage; encourage inclusion of the husband in treatment planning; reasonably establish that the patient understands the treatment recommendations; adequately inform of treatment risks / benefits, including potential adverse outcomes; employ a psychologically informed approach.

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

- a. Incorporate the patient's preferences of traditional treatment into the management plan
- b. Approach the patient's resistance to accept treatment in a sensitive manner.

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:

description of the management plan lacks structure; inaccuracies or errors about specific therapies impact adversely on patient care; difficulty tailoring treatment to the patient's specific circumstances.

1.15. Category: MANAGEMENT - Treatment Contract	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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