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REGISTRARS

Mastering your Fellowship

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Abstract

The series, "Mastering your Fellowship", provides examples of the question format encountered in the FCFP(SA) examination. The series aims to help family medicine registrars and their supervisors prepare for this examination. Model answers are available online.

Keywords: FCFP(SA) examination, family medicine registrars

Introduction

This section in the *South African Family Practice* journal is aimed at helping registrars prepare for the FCFP (SA) Final Part A examination (Fellowship of the College of Family Physicians) and will provide examples of the question formats encountered in the written examination: Multiple Choice Question (MCQ) in the form of Single Best Answer (SBA - Type A) and/or Extended Matching Question (EMQ – Type R); Modified Essay Question (MEQ)/Short Answer Question (SAQ), questions based on the Critical Reading of a journal (evidence-based medicine) and an example of an Objectively Structured Clinical Examination (OSCE) question. Each of these question types is presented based on the College of Family Physicians blueprint and the key learning outcomes of the FCFP programme. The MCQs will be based on the ten clinical domains of family medicine, the MEQs will be aligned with the five national unit standards and the critical reading section will include evidence-based medicine and primary care research methods.

This month's edition is based on unit standard 1 (critically appraising quantitative research) unit standard 2 (evaluate and manage a patient according to the bio-psycho-social approach) and unit standard 3 (facilitate the health and quality of life of the family and community). The theme for this edition is Mental Health

We suggest that you attempt answering the questions (by yourself or with peers/supervisors), before finding the model answers online: http://www.safpj.co.za/

Please visit the Colleges of Medicine website for guidelines on the Fellowship examination:
https://www.cmsa.co.za/view_exam.aspx?QualificationID=9

We are keen to hear about how this series is assisting registrars and their supervisors in preparing for the FCFP (SA) examination. Please email us your feedback and suggestions.

1. MCQ (multiple choice question: single best answer)

A 32-year-old patient who is a known mental healthcare user defaulted treatment and is brought in with insomnia and increased activity which has disturbed the neighbours. You establish that she defaulted treatment 6 months ago. She is cooperative, talks rapidly, has an elevated mood, an expansive affect, auditory hallucinations and shows poor insight and judgement. She has no other medical problems and denies abusing substances. The most appropriate drug management of this patient is:

a. Haloperidol and lorazepam
b. Haloperidol and valproate
c. Risperidone and lamotrigine
d. Risperidone and lorazepam
e. Risperidone and valproate

Short answer:

e. The constellation of symptoms in this patient suggests a diagnosis of bipolar mood disorder with acute symptoms of mania. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has the following criteria for a Bipolar I disorder:
   i. One or more manic or mixed episodes
   ii. Distinct period of abnormally and persistently elevated, expansive, or irritable mood, and increased goal-directed activity or energy lasting ≥ 1 week (any duration if hospitalized), present most of the day, nearly every day
   iii. During the mood disturbance and increased energy or activity, ≥ 3 (or 4 if irritable mood only) of the following: inflated self-esteem, decreased need for sleep, pressured speech, racing thoughts or flight of ideas, distractibility, increased activity and excess pleasurable or risky activity
   iv. Marked impairment not due to a substance or medical condition
   v. In addition, these symptoms:

a. Do not meet criteria for a mixed episode
b. Cause functional impairment, necessitate hospitalization, or there are psychotic features
c. Are not related to substance misuse
d. Are not due to a general medical condition
e. Are not caused by somatic antidepressant therapy

Such patients often present to the emergency centre for treatment and it is important for family physicians to have a working knowledge of managing an acutely manic patient. This patient has defaulted treatment but in those patients on antidepressants it is important to scale down these and eventually stop them. The acute episode may require lorazepam as adjunctive treatment in a patient with aggression or disruptive behaviour. Additional treatment options include electroconvulsive treatment in patients not responding to treatment.

Combination therapy has proven to be superior to monotherapy. The recommended drug treatment for the acute manic episode is an atypical antipsychotic (risperidone) and a mood stabiliser (valproate). Other anti-epileptic (mood stabilisers) have been found to not be effective for acute mania. An alternative to valproate is lithium which although highly effective requires close monitoring for side effects. One needs to review the maintenance drug options once the acute manic episode is controlled.

There are various tools that one may consider using to assist with assessment, monitoring and measuring treatment responses such as the Bipolar Inventory of Symptoms Scale. These clinical tools should ideally be printed and available in the medical wards/emergency centre.

One would assume that the baseline history and investigations have been done on this patient, so it is important to review the clinical notes and obtain good collateral history. If the investigations have not been performed one would need to do these at this juncture (see SASOP guidelines below).

Psycho-education and family-focused therapy have been found to be effective adjuncts in preventing relapses.

Further reading:

1. South African Department of Health. Hospital Level Standard Treatment Guidelines and Essential Medicines List. Pretoria: National Department of Health 2015. EML App available from:
Android: https://play.google.com/store/apps/details?id=omp.guidance.phc&hl=af
iTunes: https://itunes.apple.com/za/app/eml-clinical-guide/id990809414?mt=8

2. Colin F. Bipolar disorder: The South African Society of Psychiatrists (SASOP) treatment guidelines for psychiatric disorders. South African Journal of Psychiatry. 1 Jan 2013;19(3):164-71.

3. Naidoo M. Management of a patient with psychosis or mania. In Mash B (Ed). Handbook of Family Medicine. 4th ed. Cape Town: Oxford University Press; 2017. pp. 327-330.

2. SAQ (short answer question): The family physician's role as a community advocate

You work as a family physician appointed at a rural district hospital and are tasked with overseeing mental health care for the entire district. You have noticed that patients are repeatedly re-admitted with poorly controlled schizophrenia.

(Total 20 marks)

2.1 What might be reasons for these re-admissions? (6)

2.2. How would you determine the prevalence of schizophrenia in this district? (2)

2.3 Describe in some detail how you could make use of the ward-based outreach team (WBOT) to help reduce the re-admissions for these patients in this community? (8)

2.4 Identify four other potential or existing stakeholder groups that may help to reduce the re-admissions and explain what their specific contribution may be. (4)

Suggested answers:

2.1 What might be reasons for these re-admissions? (6)

Poor social or family support; homelessness; poor adherence to medication; poor understanding of their illness; use of alternative or traditional healers; ongoing substance abuse; undiagnosed medical condition.

2.2 How would you determine the prevalence of schizophrenia in this district? (2)

National data, household survey, detailed community survey, district office data, any information collected by the WBOTs. Divide the number of known patients with schizophrenia by the number of people residing in the district (1 mark each for any 2 examples above).

2.3 Describe in some detail how you could make use of the ward-based outreach team's (WBOT) to help reduce the re-admissions for these patients in this community?(8)

See page 339 in the new edition of the Handbook of Family Medicine. List the points applied to the current scenario (1 mark for each concept described up to total of 8).

i. Ensure capacity in WBOTs by adding additional members with mental health expertise. (1)
ii. Ensure that the team leader (nurse coordinator) understands what is expected; ensure that the roles of the CHW in respect of mental health care are clear. (1)
iii. Decentralisation of care, care in the community – would depend on adequate support structures in the home/community, access to clinics, adequate mental health care services at clinic level /close to home. (1)
iv. Ensure that the team has access to ongoing clinical guidance and training on mental health/psychosis. (1)
v. Ensure that the household registration and individual assessment forms include mental health problems; and adjust the health information system to include mental health data. (1)
vi. Patients can be referred to the WBOT for follow-up by CHWs on discharge. (1)
vii. Provide adherence support, to enable more social or

family support, to explain more about the illness to the patient or family. (1)

viii. Discuss use of traditional or alternative healers (suspicion around diagnosis – culture, thought to be chosen ones as traditional healers, etc.). (1)

ix. Refer to other resources in the community. Ensure that the database of community resources includes organizations working with mental health. (1)

x. Refer the patient back early if there are problems. (1)

xi. Nature of schizophrenia is to have poor insight into the disease, and therefore high risk for default. Often self-medicate/concomitant substance abuse is a risk for defaulting medication and worsening the disease process. (1)

xii. Medication issues – side effects, and rather use intra-muscular injections of longer acting formulations to address risk for defaulting treatment, also address the perception that medications may blunt effect/dull patient, especially in the presence of positive symptoms, and therefore leads to default. (1)

2.4 Identify four other potential or existing stakeholder groups that may help to reduce the re-admissions and explain what their specific contribution may be. (4)

Community psychiatric nurse may be able to keep a record of consultations and pick up when patients miss appointments.

NGOs working with mental health in the community may identify patients who are at risk of a relapse.

Peer support groups may identify early symptoms of relapse and refer appropriately.

SANCA/ NA/AA groups may help flag patients in need of assistance.
(Any 4 substantiated points)

Further reading:

- Van Deventer C. Approach to an aggressive patient. In Mash B (Ed). Handbook of Family Medicine. 4th ed. Cape Town: Oxford University Press; 2017. p.146.
- Marcus T, Hugo J. Community-orientated primary care. In Mash B (Ed). Handbook of Family Medicine. 4th ed. Cape Town: Oxford University Press; 2017. pp. 334-359 (COPC cycle on page 339).

3. Critical appraisal of quantitative research

Read the accompanying article carefully and then answer the following questions (total 35 marks). As far as possible use your own words. Do not copy out chunks from the article. Be guided by the allocation of marks with respect to the length of your responses.

Breet E, Bantjes J, Lewis I. Chronic substance use and self-harm in a primary health care setting. African Journal of Primary Health Care & Family Medicine. 2018;10(1):9.

Obtainable from: https://phcfm.org/index.php/phcfm/article/view/1544.

3.1 What research question did the authors attempt to answer in this study? (2 marks)

3.2 Considering the introduction section in this paper, identify two sentences/phrases that best reflect the authors' justification for the social and scientific value of the study (more than one correct answer possible). (2 marks)

3.3 How did the authors justify their choice of study design? Please elaborate. (3 marks).

3.4 Appraise the authors' description of the study setting? (5 marks)

3.5 Were study participants sampled in an appropriate way for this study design? (4 marks)

3.6 Was the exposure measured in a valid and reliable way? (4 marks)

3.7 Were confounding factors identified and were strategies to deal with confounding factors stated? (4 marks)

3.8 Were valid methods used for the identification of suicidal intent? (3 marks)

3.9 Critically review this excerpt from the article below. Your answer will be evaluated not for being right or wrong, but for the strength of your critique. (4 marks)

> The finding that not all patients who present to the ED following self-harm receive a psychiatric assessment or referral is consistent with international practices.[30] Likewise, a smaller proportion of CSU patients, compared to other patients, received a psychiatric assessment. The lack of psychiatric assessment is worrying given that a greater proportion of CSU patients compared to other self-harm patients reported a history of self-harm. The lack of a psychiatric assessment is a lost opportunity for intervention or for putting these patients in contact with substance abuse treatment facilities such as arranging referrals to specialist alcohol and drug treatment services. Integrating a psychiatric assessment within primary care could be an important component of preventing repetition of self-harm by ensuring that adequate treatment strategies are followed; psychiatric assessments also provide an opportunity to refer self-harm patients to available mental health services.[31,48]

3.10 Discuss the value of the study findings for your own practice using the READER outline. (4 marks)

(Total: 35 marks)

Suggested answers

3.1 What research question did the authors attempt to answer in this study? (2 marks)

The authors set out to describe the epidemiology of chronic substance use (CSU) and self-harm for the South African primary health care setting. They aimed to compare the two groups of self-harm patients, those with and those without the variable of interest, CSU. Data on additional variables were also collected to compare the two groups, namely the demographic characteristics, method of self-harm, suicidal intent, history of self-harm, referral for hospital admission, and whether or not a referral for a psychiatric assessment was received.

3.2 Considering the introduction section in this paper, identify two sentences/phrases that best reflect the authors' justification for the social and scientific value of the study (more than one correct answer possible). (2 marks)

Each study should have a starting point, from which the rationale for the research is further explained and/or elaborated on. A few key sentences are available to motivate for the social and scientific value of this research, notably:

- "No studies have explored the epidemiology of CSU and self-harm, or the implications for primary health care in SA."
- "Knowledge of the epidemiology of CSU and self-harm in primary health care settings and emergency departments (EDs) has the potential to contribute to improved service delivery and suicide prevention in primary health care settings."
- "Though substance use is a growing public health problem in LMICs, there are no published data on the risk for self-harm among those with CSU in SA."
- "A better understanding of the epidemiology of CSU and self-harm is a first step in better understanding how to organise care for these patients, provide early detection and deliver effective interventions for this vulnerable population."

3.3 How did the authors justify their choice of study design? Please elaborate. (3 marks)

The authors do not justify their choice of study design. The authors used the term "cohort study" in the methods section (under study design, setting and sampling). The reader has to deduct that this choice of study design is linked with the study aim of comparing two groups of self-harm patients (with and without CSU). No explicit justification is provided in the text, however. The authors mentioned that they wished to understand the epidemiology of self-harm with CSU. A cohort study design is used to investigate the causes of disease and to establish links between risk factors and health outcomes. Therefore, the choice of a cohort study design is appropriate here, as the authors wished to study any potential link between CSU and self-harm. Usually, a prospective cohort study commences with the participants being free of the outcomes of interest at the beginning of the study. This cohort study is retrospective in nature, as the outcome of interest (CSU) is already present at the time of the study onset/recruitment.

3.4 Appraise the authors' description of the study setting? (5 marks)

The authors provided a very brief description of the study setting: the emergency department (ED) of "a large public hospital in an urban city with a catchment area of 1.5 million people". The reference cited (nr 38: Medical inpatient mortality at Groote Schuur Hospital, Cape Town, South Africa, 2002–2009) suggests that the hospital in question is in fact a tertiary academic hospital. This setting does not link well with the authors' desire to study the link between self-harm and CSU within the South African primary health care setting. The urban tertiary setting is typically more equipped compared to rural primary care settings, especially in terms of mental health human resources. The illness profile of this tertiary health care setting differs from that of the primary health care setting, as patients' conditions are better differentiated and more complex in nature, requiring more specialised and resource-intensive care. Therefore, the study setting appears to be a significant limitation and the findings need to be interpreted with caution, especially when trying to make inferences to the primary health care setting.

A more in-depth description of the study setting, and justification for using an ED based at a tertiary hospital, would have been useful. For example, one does not know the ratio of referred vs. self-presentation patients. Furthermore, some more detail on the prevalence of substance use, mental health illnesses and other socio-economic demographics of the catchment population (target population) would have been desirable, especially for interpreting the potential value of the study findings for different settings, such as rural district hospital EDs.

3.5 Were study participants sampled in an appropriate way for this study design? (4 marks)

For a cohort study, the two groups selected for comparison should be as similar as possible in all characteristics except for their exposure status (exposure to the risk factor under investigation: CSU for this study). The authors should provide clear inclusion and exclusion criteria that they developed prior to recruitment of the study participants.

In this study, data were collected from 270 consecutive self-harm patients presenting to the ED of the hospital between 16 June 2014 and 29 March 2015. Therefore, the authors did not employ a sampling method, but rather recruited all potential patients with self-harm. The authors applied exclusion criteria: missing files/incomplete records (17 patients), previous inclusion during the study period during a prior presentation (9 patients), leaving the hospital before data capture (1 patient) and patient death as a result of their injuries (5 patients). Therefore, 238 out of 270 patient data sets were included in the analysis (88% of data sets collected).

In terms of the similarity between the two groups, the sampling method only allowed for determining exposure to the risk factor of CSU retrospectively, once data has been extracted and validated by the experienced psychiatric nurse. Therefore, the data collection method did not allow for ensuring that the two groups are a similar as possible in all characteristics except for their exposure to CSU. However, the study participants were recruited from the same population (self-harm patients presenting from the same drainage area to the same ED).

3.6 Was the exposure measured in a valid and reliable way? (4 marks)

Both self-harm and CSU were defined in the introduction section. The methods section provides more detail on the measures.

It is essential to clearly describe the method of measurement of exposure, in terms of validity and reliability. Assessing validity requires that a 'gold standard' is available to which the measure can be compared. The validity of exposure measurement usually relates to whether a current measure is appropriate or whether a measure of past exposure is needed. Reliability refers to the processes included in an epidemiological study to check repeatability of measurements of the exposures. (These usually include intra-observer reliability and inter-observer reliability.)

The clinical features of self-harm were captured from the clinical records (valid and reliable).

However, in this study, the key measure of interest, CSU, was self-reported. This introduces potential bias. The authors cite local and international evidence that self-report measures of substance use should be viewed as both valid and reliable. Understandably, this limitation was acknowledged at the end of the discussion section, and the authors recommend that future studies will be strengthened by including more objective measures of substance use (substance use biomarkers).

3.7 Were confounding factors identified and were strategies to deal with confounding factors stated? (4 marks)

The authors intended to investigate the link between CSU and self-harm. This is a complex phenomenon, with a number of potential confounding variables. The authors included potential confounders by collecting data on the participants' demographic details (gender, age, race, relationship status, whether or not they had dependents, completed level of education, employment status and socio-economic status, SES), time and day of presentation to the ED, level of suicidal intent and history of self-harm.

After descriptive statistics and simple bivariate analyses to study the association between CSU and self-harm, logistic regression analysis was used to determine the relationship between CSU and the confounding variables: gender, age, SES, having dependents or not, history of self-harm, impulsive self-harm, method of self-harm, level of suicidal intent, psychiatric referral, and referral for secondary or tertiary care.

From the above information, it is safe to state that the authors did identify suitable confounding factors and employed statistical measures (logistic regression analysis) to deal with the confounders. One must admit, however, that it is not always possible to collect data on all potential confounders, and this study design may have been improved by reviewing its sampling method (for example, by matching or stratifying participants according to their gender, relationship status or socio-economic status).

Additional information (not part of model answer): Confounding has occurred where the estimated intervention exposure effect is biased by the presence of some difference between the comparison groups (apart from the exposure investigated/of interest). Typical confounders include baseline characteristics, prognostic factors, or concomitant exposures (e.g. smoking). A confounder is a difference between the comparison groups and it influences the direction of the study results. A high quality study at the level of cohort design will identify the potential confounders and measure them (where possible). This is difficult for studies where behavioural, attitudinal or lifestyle factors may impact on the results. Strategies to deal with effects of confounding factors may be dealt within the study design or in data analysis. By matching or stratifying sampling of participants, effects of confounding factors can be adjusted for. When dealing with adjustment in data analysis, assess the statistics used in the study. Most will be some form of multivariate regression analysis to account for the confounding factors measured. Look out for a description of statistical methods as regression methods such as logistic regression are usually employed to deal with confounding factors/variables of interest.

3.8 Were valid methods used for the identification of suicidal intent? (3 marks)

A 12-item Pierce Suicidal Intent Scale (PSIS) was used to measure suicidal intent among patients. The authors did not justify their choice for this scale (how does it compare with other instruments used to measure suicidal intent), nor did they specify whether this instrument has been validated for the study context. A brief description on how to interpret the PSIS findings is provided: 11 is used as a cut-off point, which dichotomises the interpretation between low to moderate, and severe suicidal intent. It is unclear if the original developer of the tool or the researchers have determined that the tool's continuous data should be used a categorical variable instead (the reference nr 41 is from 1977 and was published in a British journal; in addition to being dated, the study cited may not be relevant to this study's context). Practically, it would be difficult to understand how someone with a score of 11 has a lower suicidal intent than a person with a score of 12. Therefore, more information on this method of identifying suicidal intent should have been provided to aid the reader when considering the validity of the instrument for this study population. Interestingly, more than half (57.3%) of the CSU patients did not receive a suicidal intent assessment, even though this is part of the routine care of self-harm patients in this setting (39.6% of the non-CSU participants' PSIS findings were unknown). These percentages represent a significant paucity of data for this measure, which may reflect on the clinical uptake of the instrument by the treating team.

3.9 Critically review this excerpt from the article below. Your answer will be evaluated not for being right or wrong, but for the strength of your critique. (4 marks)

A key aspect of appraising a research article is to evaluate if the authors' conclusions are indeed based on the study's findings. This excerpt describes the finding that self-harm patients do not seem to receive formal psychiatric

assessment or referral. Furthermore, self-harm patients with CSU in this cohort study appear to have even less access to such dedicated or specialised services. Table 3 shows the descriptive and bivariate analyses for this clinical variable, "received a psychiatric assessment".

There are several potential pitfalls to support this statement by the authors based on the findings. Firstly, the data on this variable was collected from the patient records that contained information recorded by the ED doctors. The authors do not specify what is understood as sufficient information to justify a "yes" for this variable (validity and reliability of the assessment). Furthermore, the association of an odds ratio of 8:1 from the bivariate analysis (chi-square analysis) did not remain significant when controlling for confounders in the logistic regression analysis (Table 2). The confounders included in the model included gender, age, SES and suicidal intent. It is interesting that other confounders such as method or impulsivity of self-harm were not included. These are likely linked to the suicidal intent assessment tool (unfortunately, the detail of the PSIS instrument's questions were not provided in the article).

Referral patterns is a complex phenomenon and may require further unpacking. ED doctors are typically overworked and this setting may predispose to reflexive curative approaches to self-harm, without considering to address the underlying predisposing factors such as CSU. The issue of access and care coordination within the local health system needs to be considered as well: how many mental health professionals are available and accessible with a 24-hour, 7-day ED service? Is there a local protocol in place which encourages referral? How supportive is the management? What are the bed-capacity issues and flow management requirements for a busy ED service linked to a tertiary, urban hospital with service pressures? What is the interface between the tertiary hospital's ED and its primary health care facilities and community based services in its drainage area?

3.10 Discuss the value of the study findings for your own practice using the READER outline. (4 marks)

The READER format may be used to answer this question:

- Relevance to family medicine and primary care?
- Education – does it challenge existing knowledge or thinking?
- Applicability – are the results applicable to my practice?
- Discrimination – is the study scientifically valid enough?
- Evaluation – given the above, how would I score or evaluate the usefulness of this study to my practice?
- Reaction – what will I do with the study findings?

The answer may be seen as a subjective response, but should be one that demonstrates a reflection on the possible changes within the student's practice within the South African public health care system. It is acceptable for the student to suggest how his/her practice might change, within other scenarios after graduation (e.g. general private practice).

A model answer could be written from the perspective of the family physician employed in the district health system: this study is relevant, may change practice, especially in primary care contexts with a similar setting compared to the study setting. The study highlights the need for screening for CSU in patients presenting with self-harm. The findings support the need for a more integrated service model aimed at supporting all self-harm patients (and especially patients with underlying CSU issues). Such an integrated service model should look at the interface between the emergency/curative components of the local health service and the mental health preventative/promotive/rehabilitative services. The study may be discussed with the local management team and used as basis for improving the local health service to ensure better care coordination and appropriate access to specialised mental health services.

Further reading:

- Mash B, Ogunbanjo GA. African primary care research: quantitative analysis and presentation of results. African Journal of Primary Health Care & Family Medicine. 2014;6(1):1-5.
- Pather M. Evidence-based family medicine. In Mash B (Ed). Handbook of Family Medicine (4th ed). Cape Town: Oxford University Press; 2017. pp. 430-53.
- Greenhalgh T. How to read a paper: the basics of evidence-based medicine. John Wiley & Sons; 2014.
- Glasziou PP, Del Mar C, Salisbury J. Evidence-based practice workbook (2nd ed). Blackwell Publishing; 2007.
- Joannabriggs.org. Critical Appraisal Tools - JBI. 2018 [Accessed on 24 Dec 2018]. Available at: http://joannabriggs.org/research/critical-appraisal-tools.html

4. OSCE scenario: Mental Health

Objective of station:

This station tests the candidate's ability to

1. Do a mental state examination.
2. Perform a mental health risk assessment on an in-patient.
3. Develop an appropriate management plan for a mental health client.

Type of station

Focussed consultation

Equipment list:

1. Table and two chairs for office consultation
2. Male simulated patient (young adult)

Instructions for candidate

History / context

You are doing the ward round in the 72-hour observation unit of the district hospital. This young man was admitted with manic psychosis two days ago. His family reported that he had spent all his money on clothes and shoes, and had given it all away at the taxi rank. Collateral from work colleagues also describes similar behaviour.

He is currently on risperidone 2 mg orally at night and lorazepam 2 mg orally/intra-muscular as required. This was started on admission. No prior history of note.

Please conduct a focussed consultation to:

1. Do a mental state examination.
2. Do a mental health risk assessment and develop a management plan.

Instructions for the examiner

OBJECTIVES: This station tests the candidate's ability to:

1. Do a mental state examination.
2. Perform a mental health risk assessment.
3. Develop an appropriate management plan for a mental health client.

This is an integrated consultation station in which the candidate has 15 minutes.

Familiarize yourself with the Assessor guidelines which details the required responses expected from the candidate.

No marks are allocated. In the mark sheet, tick off one of the three responses for each of the competencies listed. Make sure you are clear on what the criteria are for judging a candidate's competence in each area.

This station is 16 minutes long. The candidate has 15 minutes, then you have 1 minute between candidates to complete the mark sheet and prepare the station. Please switch off your cellphone.
Please **do not** prompt the student.
Please ensure that the station remains tidy and is reset between candidates.

Further reading:

- Baumann SE. Psychiatry and Primary Health Care. Juta; 1998. pp. 51-9
- Naidoo M. Management of a patient with psychosis or mania. In Mash B (Ed). Handbook of Family Medicine. 4th ed. Cape Town: Oxford University Press; 2017. pp. 327-30.
- Zabow T. How to manage a patient under the Mental Health Care Act. In Mash B, Blitz J (Ed). South African Family Practice Manual. 3rd ed. Pretoria: Van Schaik Publishers; 2015. pp. 190-7.
- EML, Hospital level. 4th ed. Dept of Health; 2015. pp. 15.4-15.7

Marking template for consultation station

Exam number of candidate:			
Competencies	**Candidate's rating**		
	Not competent	**Competent**	**Good**
1. Gathering information: history Comments:			
2. Gathering information: mental state exam Comments:			
3. Clinical judgement: assessment and explanation Comments:			
4. Explaining and planning: evidence-based interventions Comments:			
Comments:			
Examiner's name:	**Examiner's signature:**		

Guidance for assessors

This assessment defines competency as the ability to complete a task in a safe and effective manner. The examiner as an expert uses his/her judgement to categorise the candidate's performance. Examiners must be well versed with the case, and the content matter.

1. **Gathering information:** the candidate gathers sufficient information to understand context of current consultation. The 'good' candidate has a structured and efficient approach, displaying respect and empathy in communication style.
2. **Gathering information - mental state examination:** the competent candidate gathers sufficient information to detect underlying ongoing mental health pathology. The 'good' candidate has a comprehensive and logical approach, detecting ongoing pathology and includes any other risk factors. Elicits information sensitively, respecting the dignity of the patient.
3. **Clinical judgement – risk assessment:** the competent candidate identifies that this client is at risk of ongoing psychosis: grandiose delusions, poor insight and judgement.
4. **Clinical judgement – evidence-based interventions:** the competent candidate continues with the admission, and anti-psychotic medication, involving the multi-disciplinary team. The 'good' candidate develops a plan in collaboration with the patient, family and multi-disciplinary team, with proactive forward planning and appropriate referral to specialised psychiatric services.

Role play – Instructions for actors

You are a 23-year old man. You have been admitted to hospital – brought by the police two days ago. Your speech is normal.

Appearance: untidy, dressed in hospital attire, with name tag. Slightly dazed.

Opening statement

"I'm here because the police brought me. I don't know why they brought me. Doctor, I need to go home, because this place can make me sick!"

History

Open responses:

- You don't know why you are here – you think it is your family trying to control you.
- You feel a little tired because of the medication they've given.
- You are unmarried, and focussed on your work.
- You are a call centre agent, which you enjoy. It is a step to bigger and better things.

Closed responses:

- **You do not use drugs or alcohol.**
- **Mood:** You feel happy, but you must get home, as you have tasks to complete ***– if asked, just say that you have many secret projects that will change the world. You can't really talk about it.***
- **Thoughts:** your thoughts are your own. Some people have tried to control you, but you have developed ways to protect yourself against this – ***if asked: people have tried to steal your secrets.***
- **Cognitive:** ***able to answer all questions correctly.***
- **Insight into illness:** you actually have nothing wrong – this admission was due to your family's interference. You are destined for great things, that's why you have to be discharged and get back to work. ***If asked: The reason you gave your clothes away was to alleviate poverty – you are starting a movement that will change the world!***
- **Judgement:** you must continue the projects you started as the work is not yet done – the world will become a better place as a result of this work.

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