JOHANNESBURG OFFICE
EXAMINATIONS & CREDENTIALS

C M S A
The Colleges of Medicine of South Africa NPC
Nonprofit Company (Reg No.1955/000003/08)
Nonprofit Organisation (Reg. No. 009-874 NPO)
Vat No. 4210273191
27 Rhodes Avenue, PARKTOWN WEST, 2193
Tel: +27 11 726 7037; Fax: +27 11 726 4036
Website: www.cmsa.co.za
General: Academic.Registrar@cmsa.co.za

August 2023

R E G U L A T I O N S

FOR ADMISSION TO THE FELLOWSHIP OF

THE COLLEGE OF PSYCHIATRISTS OF SOUTH AFRICA

FC Psych(SA)

1.0 COMPONENTS

1. The examination comprises Part I and Part II: Part II must be passed within 36 months of **completing** registrar training time (defined as 48 months). In exceptional circumstances, candidates who do not successfully complete the Part II examination within this period may motivate on the basis of c*ontinued active involvement* in their department's academic programme, and with support from their HOD, to the College of Psychiatrists for a **once off extension** to sit the examination once only. If a candidate passes the written component of the Part II examination but fails the clinical/OSCE/OSPE/practical component, they will be permitted to redo the clinical/OSCE/OSPE/practical component only at the next set of examinations without having to rewrite the written component.

   Should the candidate be unsuccessful in the once-off attempt to pass the Part II, the candidate is required to repeat the four years of training and submit a new portfolio of learning in the latest format. A research report or publication from the first period of training is acceptable; it is a recommendation that the portfolio of learning be accompanied by a research report or publication based on the research conducted as part of the MMED.

2.0 PURPOSE OF ASSESSMENT

This qualification forms part of a process to accredit medical practitioners, as specialists in Psychiatry. The Health Professions Council of South Africa (HPCSA) stipulates training requirements, including a minimum period of experiential learning. It is usual for the examination to be taken and passed prior to the completion of the required period of supervised learning specified by the HPCSA. The aim of this qualification is to meet the needs for formal examination certification, as well as to set standards, nationally, for such a qualification.

3.0 ADMISSION TO THE EXAMINATION (read in conjunction with the Instructions)

3.1 Part I/Primary

For admission to Part I of the examination the candidate must:

3.1.1 hold a post-internship qualification to practise medicine and have full registration with the Health Professions Council of South Africa (i.e. must have completed 1 year of community service post-internship)

3.1.2 the CMSA Senate, through its Examination and Credentials Committee, will review all applications for admission to the examination.

3.2 Part II/Final (to be read in conjunction with the Instructions)

For admission to Part II the candidate must present evidence of:

3.2.1 Having passed the Part I examination, or Part I of an accredited MMed (Psychiatry) degree

3.2.2…/

3.2.2 Having not less than 3 years satisfactory fulltime experience as the holder of a clinical appointment or registrar post acceptable to the CMSA Senate or its Examinations and Credentials Committee. Registrar training can only commence after completion of (i) an internship (2 years) and (ii) community service (1 year). Training must be under the direction of approved departments of psychiatry, and must be supervised throughout

3.2.3 Having completed a minimum of 33 of the 48 months of training prior to the examination date

3.2.4 Having submitted to the CMSA a letter from the Head of Department confirming acceptance of the Portfolio of Learning. The Portfolio must be retained in the required Department for 3 years as it may be subject to an audit

3.2.4 Having supervised experience in a community psychiatric service for a full-time period of not less than 3 months, or the equivalent of 3 months in total.

3.2.5 Having supervised experience in a child psychiatric unit or child guidance unit recognised for the purpose by the CMSA for a full-time period of not less than 3 months, or equivalent

3.2.6 Having spent at least one year working on the staff in an approved psychiatric hospital.

3.2.7 Supervised experience and training, as defined in the blueprints (Appendix C) and the Portfolio of Learning in the fields of neuropsychiatry, psychotherapy[1], emergency and crisis care, the care of the geriatric patient, alcohol and substance abuse/dependence, intellectual disability, and forensic psychiatry at institutions recognised for the purpose by the CMSA. If facilities are not available, alternative arrangements which provide equivalent experience can be submitted in advance for approval by the CMSA Senate or its Examinations and Credentials Committee

[1] *With specific reference to psychotherapy – there is a required format in the Portfolio of Learning for recording of supervised training which must be completed and signed off by the relevant supervisor/s and Head of Department as evidence of training. In addition, the specific requirements for psychotherapy training are detailed in Section 2 of the Portfolio of Learning content "FC Psych(SA) Portfolio" available on the CMSA website.*

3.2.8 Research Experience to the satisfaction of the Head of Department. While a completed MMED research output is a university requirement, as well as an HPCSA requirement for specialist registration, candidates are advised that research knowledge and skills will be examined in both the written and oral examinations. Having completed the research project prior to attempting the examination will therefore be advantageous.

3.2.9 Supervised experience in administering courses of electroconvulsive therapy. At minimum, one full course of ECT for a patient, with a minimum involvement with 3-5 patients' treatment. A set of reflection notes should be included for each patient as detailed in the portfolio of learning. Covid restrictions may have negatively impacted on ECT treatment experience and this will be taken into consideration for relevant training periods: candidates who were unable to fulfil the minimum ECT training requirements must submit a motivation from the HOD

Registrars are to note that these requirements are the MINIMUM necessary to be eligible for the national exit examination. Universities and departments retain the right to stipulate additional training and assessment requirements according to their university MMED policies.

3.3 On application to the CMSA Senate, exemption may be granted from part of the examination or certain requirements for those who present evidence of acceptable training and/or examination in one of the Colleges with which there is a formal agreement or reciprocity.

3.4 The CMSA may accept from registrars part-time training of up to 50% of the training required for admission to the examination, provided the candidate submits evidence of prior approval by the Health Professions Council of South Africa of a part-time training programme acceptable for specialist registration.

4.0 FORMAT OF THE EXAMINATION

The Part I examination is a written examination. The Part II examination comprises two sections: a written component and a clinical component. For the Part II examination, the written component must be passed in order to enter the clinical examination.

4.1 **PART I: Formative and Summative Assessments**

4.1.1 Formative assessments: there are no formal requirements for this.

4.1.2 Summative assessments: FC Psych (SA) Part I Final examinations

- The examination will comprise **TWO** digital written papers
- The 2 papers will be in short answer format and may include single best answers (SBAs), multiple choice questions (MCQs), extended matching questions (EMQs) and very short answer questions, with each paper consisting of 100 questions.
- Paper 1: Clinical Neurosciences (Neuro-anatomy and Psychopharmacology 50 questions, Neurophysiology and Genetics-50 questions)
- Paper 2: Introduction to Psychiatry-50 questions and Psychology/Behavioural Sciences-50 questions
- Each paper will be of three (3) hours duration
- A pass mark for each paper will be determined by standard setting using the Angoff method
- Negative marking will not be applied
- Each paper must be individually passed
- Both written papers will be offered for each semester i.e. twice per annum
- Candidates will need to write both papers in one examination sitting and pass both papers. No carry-over will be possible.
- The examination will be administered electronically on the Speedwell System for which computer literacy is essential.

4.2 **CONDUCT OF THE PART II EXAMINATION**

To qualify for entry to the Part II examination, a candidate must have achieved a passing grade in Part 1 as described by the rules in 4.1 above

4.3 **COMPONENTS AND WEIGHTINGS FOR FC PSYCH(SA) PART II EXAMINATION**

4.3.1 **WRITTEN:**

- **The** examination will comprise **TWO** digital written papers
- The 2 papers will be in **SBA format** with each paper consisting of **75-100** SBA questions. It is possible that multiple choice questions (MCQs), extended matching questions (EMQs) and very short answer questions will be included
- Both papers will include content from the entire content blueprint
- Each paper will be of three (3) hours duration
- An overall pass mark for both papers combined will be determined by standard setting using the Angoff method
- Negative marking will not be applied
- Both written papers will be offered for each semester i.e. twice per annum
- Both papers must be written in one sitting of the examination
- Both papers must be written in each sitting of the examination
- The examination will be administered electronically on the Speedwell System for which computer literacy is essential.

Criteria for passing the written component and entry to the oral and clinical examination

An overall pass has to be obtained for both papers combined.

4.3.2 **CLINICAL: 70% of final mark**

The clinical component comprises a 12 station OSCE, constituted as follows:

1. Nine stations each of 20-minute duration covering content in general and special psychiatry (neuropsychiatry, child and adolescent, forensic, addiction, consultation-liason etc).
2. A single long case examination that will contribute marks to the equivalent of 3 OSCE stations
3. All examinations are currently conducted online.
4. All stations carry an equal weighting of marks.
5. The OSCE must be passed with a minimum of ≥50%

4.3.3…/

4.3.3 Criteria for passing the Part II examination:
Passing the written component of the examination as defined above AND passing the OSCE (≥50%).

4.3.4 Criteria for failing the Part II examination:
Failing the written component as defined above OR a failure (<50%) in the OSCE

4.4 Candidates who achieve the required marks in the written component of the examination but who fail the oral examinations will be exempt from the written component of the next examination session. Such exemption applies to one sitting only and must be exercised in the following semester.

5.0 ADMISSION AS A FELLOW

5.1 Only candidates who have completed training in a CMSA recognised registrar post may be awarded a fellowship if successful in the examination.

5.2 **Candidates who have written the examination as a prerequisite from the HPCSA for inclusion on the specialist register are not eligible to be awarded a Fellowship but will be sent a letter confirming their success in the examinations**

All other candidates will be asked to sign a declaration as below:

I, the undersigned, …… do solemnly and sincerely declare

that while a member of the CMSA I will at all times do all within my power to promote the objects of the CMSA and uphold the dignity of the CMSA and its members

that I will observe the provisions of the Memorandum and Articles of Association, By-laws, Regulations and Code of Ethics of the CMSA as in force from time to time

that I will obey every lawful summons issued by order of the Senate of the said CMSA, having no reasonable excuse to the contrary

and I make this solemn declaration faithfully promising to adhere to its terms

Signed at ……..……. this …… day of

…….. 20 ……..

Signature ……

Witness ……
(who must be a Founder, Associate Founder, Fellow, Member, Diplomate or Commissioner of Oaths)

5.3 A two-thirds majority of members of the Senate of the CMSA present at the relevant meeting shall be necessary for the award to any candidate of a Fellowship

5.4 A Fellow shall be entitled to the appropriate form of certificate under the seal of the CMSA

5.5 In the event of a candidate not being awarded the Fellowship (after having passed the examination) the examination fee shall be refunded in full excluding HPCSA candidates who are not entitled to a Fellowship.

5.6 The first annual subscription is due one year after registration (statements are rendered annually)

A P P E N D I X A

PART I BLUEPRINT

1.0 GUIDELINES TO THE SYLLABUS FOR THE FC PSYCH(SA) PART I

This document is meant as a *guide to core FC Psych (SA) Part I topics* which candidates can expect to be assessed on. It is not all- inclusive, and is not intended to be prescriptive. As the topics overlap and interface with each other, the number of questions per topic in the examination will not be exactly as listed. A knowledge of key clinical syndromes associated with the topics outlined is expected.

2.0. RECOMMENDED READING LIST FOR PART I

It is suggested that exam candidates source the most recent editions of the recommended reading list provided. This list represents basic requirements and is not intended to limit the scope of reading

NEUROANATOMY

- Waxman S.G. (2020). Clinical Neuro-Anatomy (29th Ed.). McGraw-Hill/Lange.

NEUROPHYSIOLOGY

- Carpenter RHS. & Reddi B. (2012). Neurophysiology: A Conceptual Approach (5th Ed.). Hodder Arnold.

PSYCHOPHARMACOLOGY & NEUROCHEMISTRY

- Stahl S. (2021). Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Application. (5th Ed.). Cambridge

BEHAVIOURAL SCIENCES

- Swartz L., de la Rey C., Duncan N., Townsend L. & O'Neill V. (2016). Psychology: An Introduction. (4th Ed.). Oxford University Press.
- Naidu T. & Ramlall, S. (2016). Talk therapy toolkit: Theory and practice of counselling and psychotherapy. Van Schaik.

INTRODUCTION TO PSYCHIATRY

- Burns J. & Roos L. (2016). Textbook of Psychiatry for Southern Africa. (2nd Ed.). Oxford University Press.
- American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders – 5th Ed. (DSM-5). American Psychiatric Association.

ADDITIONAL READING

- Higgins ES, George MS. Neuroscience of clinical psychiatry: the pathophysiology of behaviour and mental illness. Lippincott Williams & Wilkins; 2013.
- Arciniegas DB, Anderson CA, Filley CM, editors. Behavioral neurology & neuropsychiatry. Cambridge University Press; 2013 Jan 24.

3.0…/

3.0. FC PSYCH(SA) PART I CURRICULUM CONTENT BLUEPRINTS

MODULE	Domain	Topics
NEURO-ANATOMY	**Developmental neuroanatomy**	Basic embryology & histology of neural structures
		Neurodevelopmental factors in psychiatric disorders
		Neuroplasticity
	Autonomic Nervous System	Gross anatomy
		Functional areas and tracts
	Skull & coverings of the CNS	Cranial osteology, especially anterior, middle & posterior fossae
		Cranial meninges
	Spinal cord	Gross anatomy
		Spinal tracts
		Mediation in sensory and motor systems
	Ventricular system & CSF	Topographical anatomy
		CSF circulation
	Blood supply of the CNS	Arterial supply and venous drainage
	Brainstem & reticular formation	Gross anatomy
		Blood supply
		Functional areas and tracts
	Cranial nerves	Cranial nerve anatomy and nuclei
	Cerebellum	Gross anatomy
		Blood supply
		Tracts, nuclei and connections
	Diencephalon	Topographical anatomy
		Functional organization
		Nuclear groups & connections
	Cortex	Gross anatomy of grey & white matter
		Blood supply
		Functional areas, tracts & connections
		Cortico-subcortical pathways
	Corpus striatum	Topographical anatomy & components
		Functional organization
		Connections and functions
	Limbic system	Topographical anatomy & components
		Functional organization
		Connections and functions

NEUROPHYSIOLOGY…/

MODULE	Domain	Topics
NEURO-PHYSIOLOGY	**Neuronal signaling**	Action potentiation
		Key transporters, receptors, enzymes & ion channels
		Synaptic transmission
		Messenger systems
	Neuro-biochemistry	Key neurotransmission systems including: monoamines; acetylcholine; amino acids; histamine; neuroactive peptides; neuromodulators
		Related pathophysiology & neuropharmacology
	Hormones and the brain	Basic principles of Hypothalamic-Pituitary-Adrenal/Thyroid/Gonadal axes
		Appetite; sexual response cycle
		Other important neuroendocrine systems e.g. neuropeptides; neuro-steroids; growth hormone; prolactin
		Clinical applications e.g. depression; stress; eating disorders
	Neuroplasticity and learning	Principles of neurogenesis
	Higher functions	Arousal, sleep & chronobiology
	Higher functions Applied electrophysiology	Attention; learning & memory; language; cognition; hemispheric & higher cortical functions; motivation & behaviour.
		Frontal subcortical circuits (especially frontal & pre-frontal circuitry)
		Basic electro-encephalography
	Neuroscience of major psychiatric syndromes & disorders	Schizophrenia; depression; bipolar disorder; anxiety; anger & aggression; memory & Alzheimer's disease; pain; pleasure & addiction
GENETICS	**Introduction to genetics**	Basic principles of psychiatric genetics
		Patterns of inheritance
		Genetic variants
		Population genetics
		Epigenetics
		Pharmacogenetics

MODULE	Domain	Topics
PSYCHO-PHARMACOLOGY	**General principles**	General principles of psychopharmacology: pharmacokinetics & pharmacodynamics
		Clinical principles of prescribing
		Special treatment considerations
		Adverse effects & their treatment
		Common drug interactions
	Specific classes of medication	Antipsychotics
		Antidepressants & mood stabilizers
		Sedatives, hypnotics & anxiolytics
		Pain & its treatment
		Sleep disorders and their treatment
		Attention deficit hyperactivity disorder and its treatment
		Neurocognitive disorders & their treatment
		Substances of abuse; treatment of addictions
		Eating, movement & sexual disorders, and their respective treatments

MODULE	Domain	Topics
BEHAVIOURAL SCIENCES	**Personality**	Key approaches to personality theory (including psychoanalytic, life span, behaviourist, trait, humanistic, cognitive, social learning)
		Assessment of personality
		Cultural aspects of personality
	Intelligence	Theories & components of intelligence
		Measurement of intelligence
		Cultural aspects of intelligence
	Attention	Theories of attention
		Attentional systems
	Learning and Memory	Classical and operant conditioning
		Social learning theory
		Application to therapeutic interventions
		Information processing
		Alternative approaches to learning and memory
	Motivation and	Theories of motivation and emotion
	Thinking	Thinking: representation and approaches
		Cognitive domains
		Neuropsychological assessment of cognition
	Developmental Psychology	Developmental theories, including cognitive, social, moral, emotional developmental theory
		Developmental assessment, including assessment of intellect
		Assessment of neurocognitive function in adults
	Psychotherapy & Counselling	Basic competencies and skills in counselling & psychotherapy
		Theoretical basis of core therapeutic approaches
		Supportive psychotherapy
		Crisis & trauma counselling
		Cognitive behavioural therapy
		Psychodynamic therapy
		Group therapy
		Dialectical behavior therapy
		Family therapy
		Ethical aspects of psychotherapy
	Psychometrics	The indications, uses and interpretation of psychometric tests; intelligence (verbal and nonverbal tests), personality; scales that assist in diagnosing and determining severity of disorders (e.g. SCID, Hamilton, YBOC scales)

.

MODULE	Domain	Topics
	Phenomenology	Definitions of psychiatric and psychological symptoms and terms
	Nosology	Classification Systems: The principles of classification systems and a critical review and comparison of the ICD and DSM
	Psychiatric Emergencies	Assessment & management of key psychiatric emergencies (listed
		Self-harm & suicide
		Aggression & violence
		Trauma
		Catatonia
		Delirium
		Acute dystonia
		Serotonin syndrome
		Neuroleptic malignant syndrome
		Lithium toxicity
	Mental Health Law	The Mental Health Care Act & Regulations
		Relevant sections of other legislation e.g. Child Care Act; Sterilization Act; Prevention & Treatment of Substance Abuse Act; Criminal Procedure Act
	Public Mental Health	Basic principles of community based mental health care
		Key public mental health policies and practices, especially in the SA context
	Research Methodology & Statistics	Basic epidemiological principles in psychiatry
		Measures of morbidity & risk
		Types of research study & design
		Case definition, identification; sampling methods
		Qualitative methods
		Principles of evidence-based medicine
		Types of data
		Reliability & validity
		Types of error & bias
		Probability & risk
		Incidence & prevalence
		Descriptive statistics, including measures of central tendency &
		Basic analytic statistics, including tests of significance; confidence intervals; key parametric and non-parametric tests; tests for
		Principles of meta-analyses
		Principles of qualitative analyses
	Ethics	Basic principles of psychiatric ethics, including autonomy, beneficence, non-maleficence & justice
		Confidentiality, privacy and privilege
		Informed consent
		Dual agency
		Human rights & stigma
	Socio-cultural psychiatry	Transcultural perspectives in psychiatry, especially in the South
		Presentations of distress & disorder; cultural syndromes
		Religion & spirituality in psychiatry
		Psychosocial determinants of mental disorder

A P P E N D I X B

CERTIFICATE OF TRAINING – FC PSYCH(SA)

The certificate of training must be submitted on application to write the FC Psych(SA) Parts II examinations. All sections must be signed off by the supervising Psychiatrist and the Head of Department

NAME: ……..……..…….

INSTITUTION: ……...…….

REGISTRAR TIME: ……...…….

DATE STARTED: ……....…….

JOHANNESBURG
August 2023

A P P E N D I X C:
PART II BLUEPRINT

1.0 GUIDELINES TO THE SYLLABUS FOR THE FC PSYCH(SA) PART II

1.1 PSYCHIATRY

The aim of the examination in Psychiatry is to determine that the candidate is able to treat or deal effectively with all the common clinical problems of psychiatry at a specialist level without supervision. The candidate should also have a broad knowledge of medicine and paediatrics relevant to psychiatry

1.2 In addition to topics covered in the core Part 2 curriculum, trainees are expected to have knowledge of advances in physiology applicable to psychiatry. The recommended learning resources for the part II examinations are collated in the Part I **and** Part II reading lists, including coverage of reviews, relevant policies, guidelines and seminal articles from the journals recommended below.

Recommended
JAMA Psychiatry
World Psychiatry
Am J Psychiatry
Br J Psychiatry
J Clinical Psychiatry
Lancet Psychiatry
J Am Acad Child Adolesc Psychiatry
SAJP

Additional
SAMJ
N Eng J Med
The Lancet
BMJ

NB. Candidates are expected to consult relevant and current local and international journals, policies and guidelines as appropriate. (Please also check if a newer version of the listed textbook has become available.)

1.2. **RECOMMENDED**	1.3 **ADDITIONAL REFERENCES THAT MAY BE CONSULTED**
1.2.1 General Psychiatry • American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th Ed Text Revision, American Psychiatric Publishing, 2022 • Sadock, B.J., Sadock, V.A et al. Kaplan & Sadock's Synopsis of Psychiatry: Behavioural Sciences, Clinical Psychiatry, 12th Ed, Lippincott, Williams and Wilkins, 2022	**1.3.1 General Psychiatry** • Sadock, B.J., Sadock, V.A. et al, Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 10th Ed, Lippincott, Williams and Wilkins, 2017
1.2.2 Neuropsychiatry and Consultation-Liaison Psychiatry: • Lishman, W.A. Organic Psychiatry: The Psychological Consequences of Cerebral Disorders, 3rd Ed, Blackwell Science,1998	**1.3.2 Neuropsychiatry and Consultation-Liaison Psychiatry:** • Yudofsky, S.C. & Hales, R.E. The American Psychiatry Press Textbook of Neuropsychiatry and Behavioural Neurosciences, 5th Ed, American Psychiatric Press, 2007 • Hodges, J.R. Cognitive assessment for clinicians, 3rd Ed, Oxford University Press, 2017

1.2.3…/

1.2.3 Child/Adolescent Psychiatry • The IACAPAP textbook of child and adolescent mental health-free download	**1.3.3 Child/Adolescent Psychiatry** • Barker, P. Basic Child Psychiatry, 7th Ed, Wiley-Blackwell, 2004 • Martin, A., & Volkmar, F. Lewis's, Child and Adolescent Psychiatry: A Comprehensive Textbook. 4th ed. Philadelphia; Lippincott • Turk, J., Graham, P. et al, Child and Adolescent Psychiatry: A Developmental Approach, 4th Ed, Oxford University Press, 2007
1.2.4 Psychopharmacology • Stahl, S.M. Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications, 4th Ed, Cambridge University Press, 2013 • Taylor, D., Paton C. et al, The Maudsley Prescribing Guidelines in Psychiatry, 12th Ed, Wiley-Blackwell, 2015 • South African Guidelines (e.g. SASOP and DOH)	**1.3.4 Psychopharmacology** • Labbate, L.A., Fava, M. et al, Handbook of Psychiatric Drug Therapy, 6th Ed, Lippincott, Williams and Wilkins, 2009
1.2.5 Forensic Psychiatry and Ethics • Kaliski, S. Psycholegal Assessment in South Africa1st Ed, Oxford University Press, 2006 • Mental Health Care Act, No 17 and regulations, 2002 • Moodley K. Medical Ethics, Law and Human Rights: A South African Perspective, 1st Ed, Van Schaik Publishers, 2011	**1.3.5 Forensic Psychiatry and Ethics** • Bluglass, R. & Bowden, P. Principles and Practice of Forensic Psychiatry,1st Ed, Churchill Livingstone, 1990
1.2.6 Geriatric Psychiatry • Dening, T & Thomas A. Oxford Textbook of Old Age Psychiatry. 2nd ed. Oxford University Press 2013.	**1.3.6 Geriatric Psychiatry** • Copeland, J.R.M., Abou-Saleh, M.T. et al, Principles and Practice of Geriatric Psychiatry, 2nd Ed, Wiley, 2002 • Jocoby, R. & Oppenheimer, C. Psychiatry in the Elderly, 3rd Ed, Oxford University Press, 2002.
1.2.7 Addiction Psychiatry • Ruiz P, Strain E. Substance Abuse: A Comprehensive Textbook 5th edition, Lippincott Williams & Wilkins, 2011.	**1.3.7 Addiction Psychiatry** • Galanter M, et al. The American Psychiatric Publishing Textbook of Substance abuse Treatment 5th edition, American Psychiatric Publishing, 2015. • Ries RD, Fiellin DA, Miller SC, Saitz R. Principles of Addiction Medicine 5th Edition. Lippincott Williams & Wilkins, 2011.
1.2.8 Psychotherapy • Gabbard, G.O., Beck, J.S. et al, Oxford Textbook of Psychotherapy, 1st Ed, Oxford	**1.3.8 Psychotherapy** • Beitman, B.D., Blinder, B.J. et al, Integrating pharmacotherapy and psychotherapy, 1st Ed, American Psychiatric Publishing, 1991 • Beck, J.S. Cognitive therapy: Basics and beyond, 1st Ed, The Guilford Press, 1995 • Hawton, K., Salkovskis, P.M. et al, Cognitive behaviour Therapy for Psychiatric Problems: A Practical Guide, 1st Ed, Oxford University Press, 1989 • Miller, W.R. & Rollnick, S. Motivational Interviewing: Helping People Change (Applications of Motivational interviewing), 3rd Ed, Guilford Press, 2012

A P P E N D I X D

PORTFOLIO OF LEARNING

https://www.cmsa.co.za/view_exam.aspx?QualificationID=30

1. A new portfolio of learning (POL), which will be implemented with effect from 1 March 2022, **will be mandatory for all registrars commencing training in 2022.**
2. Registrars who are already in training may retain the current POL but are welcome to supplement it with sections of the new POL for prospective rotations where feasible. Registrars are advised to keep scanned / electronic copies of all the required documents for the portfolio of learning. A platform where all documents should be uploaded will be communicated to all registrars via the CMSA website once a new service provider has been confirmed
3. Upon registering for the examination, candidates must download the entire portfolio in a single document, in the attached prescribed order, and hand in both a hardcopy and an electronic PDF copy to their respective HODs. Refer to document REQUIREMENTS FOR REGISTERING FOR FCPSYCH II.
4. Candidates whose portfolios have been submitted and are found to lack evidence for the minimum eligibility requirements as stipulated in the Regulations will NOT be allowed to sit the examination.

A P P E N D I X E

(Website link to be inserted for the guidelines and appeals mechanism)

GUIDELINES FOR CANDIDATES

https://www.cmsa.co.za/view_exam.aspx?QualificationID=30

APPEALS MECHANISM

file://cmsa-dc01.cmsa.local/home$/web.regs/Downloads/CMSA_-_Policy_Document_-_CANDIDATES_7_5_2019.pdf

JOHANNESBURG
August 2023

A P P E N D I X F

FC PSYCH(SA) PART II CURRICULUM AND EXAMINATION BLUEPRINT

This document is to be considered as a guideline. It is not prescriptive, and the number of questions per topics will not always be exact, as the topics overlap and may interface with each other

Number of years of study: 4
PART A: Curriculum Content Blueprint
PART B: CANMED Competency Framework
PART C: Formative and Summative Assessment details (includes nature and weighting of final examination components)

A. CURRICULUM CORE CONTENT BLUEPRINT

Module	Components
GENERAL ADULT PSYCHIATRY	Mental Health and Psychiatry Across the Lifespan Schizophrenia Spectrum and Other Psychotic Disorders Depressive Disorders Bipolar and Related Disorders Anxiety Disorders Obsessive-Compulsive & Related disorders Trauma & Stressor-related Disorders Dissociative Disorders Impulse Control Disorders Personality Disorders Sleep-Wake Disorders Paraphilias Laboratory testing and Imaging studies in psychiatry Multidisciplinary assessments in psychiatry
EMERGENCY PSYCHIATRY	Severe Behavioural Disturbance Suicide & Deliberate Self-Harm Catatonia Medication-induced Movement Disorders Neuroleptic malignant syndrome Serotonin syndrome Other life-threatening medication induced side effects e.g. lithium toxicity
SUBSTANCE-RELATED AND ADDICTIVE DISORDERS	Alcohol-related disorders Sedative-Hypnotic, or Anxiolytic-Related Disorders Opioid-Related Disorders Hallucinogen-Related Disorders Cannabis related Disorders Club Drug Addiction Stimulant – Related Disorders Nicotine-Related Disorders Other Substances
CONSULTATION-LIAISON PSYCHIATRY	Somatic Symptom & Related Disorders Feeding and eating Disorders Gender Dysphoria Sexual dysfunctions Comorbidity with other medical conditions HIV, neurology, CVS, lung, GIT, renal disease, oncology, chronic fatigue and fibromyalgia, pain, dermatology, surgery, organ transplantation, obstetrics and gynaecology) Women's Mental Health /perinatal mental health Palliative care

NEUROPSYCHIATRY…/

NEUROPSYCHIATRY	Neurocognitive Disorders Delirium Neurocognitive Disorders due to Alzheimer's Disease Frontotemporal Neurocognitive Disorder Vascular Neurocognitive Disorder Neurocognitive Disorder Due to Parkinson's Disease Movement Disorders Epilepsy Cerebrovascular Disorders Traumatic Brain Injury CNS Infections HIV related disorders Autoimmune Disorders Endocrine and Metabolic Disorders Neurotoxic substances Cerebral tumours Covid-19 related neuropsychiatric manifestations
OLD AGE PSYCHIATRY	Normal ageing Acute Confusion Cognition Sleep Anxiety Suspiciousness and Agitation Mood Disorders Substance Use Psychopharmacology
NEURODEVELOPMENTAL DISORDERS	Diagnosis, clinical management and comorbidity Intellectual disability Ethics, Legislation & Forensics in ID Communication Disorders Autism Spectrum Attention-Deficit/Hyperactivity Disorder Specific Learning Disorder Motor Disorders
CHILD & ADOLESCENT PSYCHIATRY	Disruptive & Conduct Disorders Elimination Disorders Attachment Disorders Anxiety Disorders in C&A Depressive Disorders in C&A Bipolar Disorder in C&A Psychotic Disorders in C&A Substance Use Disorders in C & A C&A Suicide Child Abuse & Neglect Ethics, Legislation & C&A Forensics Services for C&A Psychopharmacology in C&A Assessment

FORENSIC PSYCHIATRY…/

FORENSIC PSYCHIATRY	Violence Sexual Offences The Mentally Ill Offender Risk Assessment Criminal Capacity Fitness to Plead State Patients The Mental Health of Prisoners Legislation Forensic Reports & Giving Evidence Forensic Services & Liaison Forensic Psychosocial Rehabilitation Mental Health Care Act (2002) Malingering
PSYCHOPHARMACOLOGY	Principles of Prescribing Prescribing in Pregnancy & Lactation Prescribing in Medical Disorders Side Effects Monitoring Medication Adherence Antipsychotics Antidepressants Mood Stabilisers Anxiolytics Cognitive Enhancers Hypnotics Stimulants Other Medications e.g. chronic pain
BRAIN STIMULATION TREATMENTS (ECT, TMS, DBS, VNS)	Principles Clinical Indications Practical application and techniques Limitations and adverse effects Regulatory and legal aspects
PSYCHOTHERAPY	Principles of Psychotherapy Assessment for Psychotherapy Counselling Brief Therapies Behavioural Therapy Cognitive Behavioural Therapy Mindfulness-based therapies Dialectical Behaviour Therapy Interpersonal Therapy Psychodynamic Therapy Group Therapy Family Therapy Motivational Interviewing
PUBLIC MENTAL HEALTH, COMMUNITY PSYCHIATRY & SOCIAL INTERVENTIONS	Promotion of Mental Health Prevention of Mental Illness Psychosocial Rehabilitation Levels of Care Case Management & Continuity of Care Mental Health Economics Mental Health Services The EDL Stigma Multidisciplinary management Community Mental Health Models

ETHICS…/

ETHICS	Ethics Confidentiality Consent Coercion and Human Rights in Psychiatry Impaired practitioners Professional ethics Relationship with Pharma Industry Resources and justice
RESEARCH	Research Theory & Concepts Research Methodology Principles of Epidemiology Research Ethics Study Design & Protocol Development Biostatistics Scientific Writing Critical Appraisal
CULTURE & SPIRITUALITY	Concepts of Culture, including definitions Cultural Presentation of Mental Disorders Cultural Formulation of Mental Disorders Culture-Bound Syndromes, local and world-wide: their identification and treatment Language Issues Traditional Healers & Psychiatry, including healing practices in distinctive ethnic groups Cultural Competence

B. CANMED COMPETENCY FRAMEWORK

COMPETENCY FRAMEWORK. Refer to the Portfolio of Learning for details about the required CORE and MINIMUM competencies necessary to enter the final examination.

C. Formative and Summative Assessments

A. FORMATIVE ASSESSMENTS: Departmental level as per portfolio

B. SUMMATIVE ASSESSMENTS: Final CMSA FC Psych II Examinations

A P P E N D I X G

1.0 PSYCHIATRY LONG CASE PRESENTATION FORMAT

1.1 Organisation, Presentation and Communication Skills

When presenting a case the candidate must provide a logical narrative of the patient's story that flows from the main complaint. Please note that the headings below serve only as a guide and the order and content are flexible depending on the patient and the nature of the presenting problem. After hearing a case history, examiners should have a good understanding of the patient's presenting complaint, current situation and relevant background developmental, psychiatric, medical, family and social history. The patient's mental state needs to be described in detail including relevant bedside cognitive testing and a physical examination is essential. Candidates must present a well-integrated summary, case formulation, management plan and the patient's prognosis.

1.2 History

Mention any difficulties obtaining the history at the beginning of the presentation and comment on the reliability.

1.3 Demographics

- Name
- Age
- Language
- Marital Status
- Number of children
- Employment status, if unemployed: disability grant/pension/medical boarding
- Accommodation: location, formal versus informal housing, number of people residing in dwelling
- Religion
- Handedness
- Context of where patient was seen i.e. inpatient versus outpatient
- Route of referral
- MHCA status

1.4 Presenting Complaint

History of the presenting symptoms of the current illness episode, use the patient's own words where possible.

History of Presenting Complaint

Include positive and negative findings:

- Onset of symptoms
- Precipitant/s
- Temporal relationship between precipitant/s (eg substance misuse) and symptoms
- Duration of symptoms
- Evolution of symptoms
- Aggravating and relieving factors
- Associated medical and psychiatric symptoms including screen for DSM criteria symptoms of the current provisional diagnoses
- Response to medication and or therapy
- Systematic Enquiry: Screen for other relevant symptom clusters that may suggest the presence of another disorder eg mood, anxiety, psychotic, eating, substance use, cognitive and personality disorders

1.5…/

1.5 **Past Psychiatric History**

- First illness episode
- First contact with primary care physician, psychiatry, psychology, traditional or spiritual healer
- Previous psychiatric diagnoses
- Number and details of previous illness episodes: precipitants, duration, severity of symptoms, response to treatment, duration of remission
- First admission
- Number and details of admissions: MHCA status, duration, treatments
- Last admission
- Previous pharmacological, psychological and social managements and response to treatment. There should be sufficient detail to enable an assessment of the adequacy of the treatment eg. dose, duration, adverse effects, adherence
- Previous ECT –no. of treatments and response/side-effects
- Psychosocial rehabilitation interventions
- Adherence
- Details of previous suicide attempts and deliberate self-harm

1.6 **Past Medical and Surgical History**

- Neurological conditions: head trauma, epilepsy, delirium, CNS infections
- Non-neurological conditions: diabetes, hypertension, thyroid disease, asthma, TB, HIV, syphilis, cardiac disease, renal failure, liver disease
- Gynaecological/obstetric history; contraception; pregnancy status/LMP
- Previous surgeries
- Known allergies
- Past and current treatments: side effects, adherence

1.7 **Past Drug and Alcohol History**

Current substance misuse problems must be explored in detail in the history of the presenting complaint including onset, precipitant/s, amount, effects, features of abuse and dependence, medical and psychiatric complications, attempts to stop, stage of change.

- Cigarettes: onset, duration, amount (pack years), attempts to stop
- Alcohol: onset, precipitant/s, duration, frequency, amount in units, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission
- Other drugs: Specify drugs used, onset, precipitant/s, duration, frequency, amount, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission
- Caffeine: amount, duration
- Over the counter medications: onset, precipitant/s, duration, frequency, amount, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission

1.9 **Forensic History**

- Cautions, charges, convictions for criminal behaviour
- Prison sentences: charge, duration, probation
- Current court cases pending
- Screen for antisocial behaviour

1.10 **Family History**

- Genogram including parents, siblings, spouse/partners and children
- Deaths: note age and cause
- Medical illness
- Mental illness: suspected symptoms, psychiatric diagnoses, suicide, substance misuse, treatments
- Nature of relationships: Refer to quality of attachment with primary caregivers.

1.11…/

1.11 **Personal History**

The depth and focus of the personal history should be guided by the working diagnosis.

Developmental

- Pregnancy: planned vs unplanned, mother's mental state, substance use, intrauterine infections, duration
- Mode of delivery, complications of labour, neonatal complications
- Milestones
- Illness/ physical trauma
- Abuse, neglect
- Parental separation, parental violence
- Enuresis, encopresis
- Traumatic events

Educational

- Age in grade 1
- Type of schooling
- Primary school
- Secondary school
- Tertiary education
- Problems: academic problems (eg. learning difficulties, failures), bullying, separation anxiety, school refusal, truancy, conduct disorder symptoms, ADHD
- Protective factors: friendships, sports, hobbies, enjoyment of school

Occupational

- First job
- Number of and duration spent in subsequent jobs, reasons for leaving
- Most recent job
- Problems: discrimination, fired, mental and physical health hazards, medical boarding, disability grant

Psychosexual and relationships

- Current relationship status: duration, quality, domestic violence
- Previous relationships: number and average duration, patterns or problems, marriage/separation/divorce
- Sexual orientation
- Sexual problems
- Previous sexual trauma
- Number of sexual partners
- Previous STDs
- Contraception
- Number of pregnancies and complications including antepartum and post-partum psychiatric disorders
- Children

Current Social Circumstances

- Accommodation: water, electricity, overcrowding
- Employment
- Functioning: ADLs and IADL
- Support: family, friends, colleagues, religious organisations, hobbies
- Finances

Premorbid personality

- Self-description
- Hobbies and interests
- Religious affiliation/spiritual beliefs/cultural influences
- Coping skills, reaction to stress

2.0 MENTAL STATE EXAMINATION

2.1 Appearance and Behaviour

- Self-care: grooming, hygiene, nutrition
- Dress
- Cooperation, rapport
- Posture and eye contact
- Involuntary/abnormal movements: tremor, tardive dyskinesia, compulsions, stereotypies, mannerisms, tics, choreoform, athetoid, parkinsonian, catatonia, agitation, psychomotor slowing
- Disinhibition
- Responding to hallucinations

2.2 Speech

- Rate, tone, volume, clarity, grammar, syntax, rhythm

2.3 Mood

- Mood: Describe your impression of the patient's pervasive mood state eg. dysphoric, euthymic, expansive, irritable, labile, elevated, euphoria, depression, anhedonia, alexithymia, anxiety, apathy
- Affect:
  - Describe the most enduring affect during interview
  - Range: eg. Reactive, restrictive, blunted, flat
  - Stability: eg. Stable/labile
  - Congruency:eg. Appropriate/inappropriate, congruent/incongruent,

2.4 Thought

- Form: Formal thought disorder- neologisms, word salad, circumstantiality, tangentiality, incoherence, perseveration, verbigeration, echolalia, condensation, irrelevant, loosening of association, derailment, flight of ideas, clang association, blocking,
- Content: overvalued ideas, delusions, preoccupations, ruminations, obsessions, phobias, negative thinking, poverty, passivity phenomena, suicidal ideation

2.5 Perception

- Hallucinations: hypnogogic, hypnopompic, auditory, visual, olfactory, gustatory, tactile, somatic, vestibular, cenesthetic
- Illusions
- Depersonalization
- Derealisation

2.6 Cognition

- Level of consciousness
- Orientation
- Attention and concentration
- Memory: Short and long term
- Language: Expressive and naming functions
- Executive function / Instrumental activities of daily living
- Brief bedside tests as appropriate to case eg. frontal lobes (may include inhibitory function, set-shifting, verbal fluency, abstraction and social cognition), parietal lobes (may include gnosis and praxis, acalculia), temporal lobes (may include memory and receptive language), occipital lobes
  (may include visual agnosia, optic apraxia), and sub-cortical function (movement disorder and processing speed).

2.7 Insight and judgement

- Acceptance and understanding of mental illness, cause, effect on life
- Attitude toward treatment
- Attitude toward admission
- Judgment: An assessment as to how the clinical status/diagnosis impacts upon patient's judgment with emphasis on decisions/actions that have safety implications

2.8…/

2.8 **Physical Examination**

A brief, focussed physical examination is essential and must be guided by the history and mental state of the patient. Mention important positive and negative findings.

- General: vital signs, weight, hydration, EPSE, thyroid, dentation, stigmata of HIV, signs of liver disease
- Relevant systems examinations including neurological examination.
- Signs of deliberate self-harm (lacerations, scars, ligature marks etc.)
- Signs of alcohol misuse/intoxication/withdrawal
- Signs of drug misuse/intoxication/withdrawal
- Signs of eating disorder
- Signs of medication side effects
- Signs of thyroid disease
- Signs of HIV
- Signs of syphilis
- Comment on BMI/Metabolic syndrome if relevant

2.9 **Summary**

Synthesize a brief (3-4 sentences) summary of:

- Demographics
- Relevant past psychiatric, medical, substance use, forensic, family, personal
- History of presenting complaint
- Relevant mental state, cognitive testing and physical examination findings

3.0 CASE FORMULATION

3.1 **Diagnostic Formulation**

Diagnosis

Provide a DSM-5 differential diagnosis listing most likely(or principal) diagnosis first and providing motivation for each diagnosis and reasons for discounting differential diagnosis in favour of principal diagnosis. (Do not include DSM-5 Cross-Cutting Symptom Measure Scales, Psychosis Symptom Severity or Alternative Model for Personality Disorders.)

Psychosocial and contextual factors

Add any important psychosocial and contextual factors (See DSM-5 Chapter: Other Conditions that may be a Focus of Clinical Attention). Include under diagnosis if it is a focus of clinical attention and a reason for the current admission, special investigations or management.

3.2 **Disability**

Comment briefly on any difficulties the patient may have in any of the following activities:

- Understanding and communicating
- Getting around
- Self-care
- Getting along with people
- Household activities
- School/Work activities
- Participation in society

3.3 **Risk Assessment and Management** (Immediate and long term, include the reasons for your assessment)

- To Self: suicide, deliberate self-harm, neglect, impulsivity, substance misuse, abscond, non-adherence.
- To Others (staff, patients, family, public): violence, homicide, accidental
- By Others
- Property

3.4 **Aetiological Formulation**-(present as a narrative and try to avoid a checklist, include any relevant cultural factors eg., cultural expression of symptoms, cultural perceptions of illness causation, cultural factors that may be impacting on treatment-seeking and treatment)

- Predisposing factors: biological, psychological, social, cultural
- Precipitating factors: biological, psychological, social, cultural
- Perpetuating factors: biological, psychological, social, cultural
- Protective factors: biological, psychological, social, cultural

3.5 **Management and Prognosis**

Begin with a risk management plan and then discuss an evidence-based immediate, medium term and long term management plan in the local context taking into account cultural and ethical considerations. Include the role of other members of the multidisciplinary team.

The following framework can be used as guide:

	Setting	**Biological Factors**	**Psychological Factors**	**Social Factors**
Immediate	Inpatient versus outpatient MHCA GP, community health clinic, district hospital, tertiary hospital	Investigations (provide motivation): blood, CSF, urine, ECG, EEG, CT, MRI, PET, X-ray Monitoring: vital signs, bloods Rapid tranquilisation Emergency medical management Detox	Screening tools: eg Beck Depression Inventory, Young Mania Rating Scale, Positive and Negative Syndrome Scale, Hamilton Anxiety Scale, Yale-Brown Obsessive Compulsive Scale, International HIV Dementia Scale Psycho-education Supportive counselling Determine stages of change	Collateral history Social services Housing Care of children, dependants
Medium Term	Inpatient versus outpatient MHCA GP, community health clinic, district hospital, tertiary hospital	Appropriate use of: Antidepressants Antipsychotics Mood stabilisers Hypnotics Anxiolytics Complementary and alternative medicines Dietary plan Monitoring	Appropriate use of: CBT DBT Motivational interviewing Bereavement counselling Support groups	Information regarding community resources, support groups Disability/child care grant application Medical boarding
Long term	Inpatient versus outpatient MHCA GP, community health clinic, district hospital, tertiary hospital	Appropriate use of: Antidepressants Antipsychotics Mood stabilisers Hypnotics Anxiolytics Complementary and alternative medicines Dietary plan Monitoring Adherence	Appropriate use of: CBT DBT Couple therapy Family therapy Group therapy Psychodynamic therapy Support groups	Psychosocial rehabilitation Carer support Occupational therapy Community resources

3.6 **Prognosis**

- Short term
- Long term
- Good and poor prognostic factors
- Consider: support, substance misuse, co-morbidity, insight, adherence, physical illness, family and community influences

4.0…/

4.0 CASE ASSESSMENT MARKSHEET

FCPSYCH PART II : CASE PRESENTATION MARKSHEET

CANDIDATE NUMBER:_____

A REMINDER WILL BE GIVEN TO THE CANDIDATE AT 25 MINUTES. PRESENTATIONS WILL BE <u>STOPPED AT 30 MINUTES</u> AND ANY AREAS NOT COVERED BY THEN WILL BE MARKED NOT DONE

	SCORING GUIDELINE - PLEASE TICK THE APPROPRIATE BOX							
PRESENTATION	**COMPREHENSIVE HISTORY**	**NOT DONE**	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
	MSE	**NOT DONE**	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
	PHYSICAL EXAMINATON	**NOT DONE**	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
FORMULATION	**SUMMARY**	**NOT DONE**	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
	DIFFERENTIAL DIAGNOSIS	**NOT DONE**	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
	BIOPSYCHO-SOCIO-SPIRITUAL-CULTURAL	**NOT DONE**	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
	RISK- ASSESSMENT	**NOT DONE**	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
MANAGEMENT	**MANAGEMENT AND PROGNOSIS**	***NOT DONE OR NOT FINIS***	**VERY POOR**	**POOR**	**BORDERLINE**	**SATISFACTORY**	**GOOD**	**EXCELLENT**
OVERALL PERFORMANCE	**ORGANIZATION AT SPECIALIST LEVEL**		**VERY POOR**	**POOR**		**SATISFACTORY**	**GOOD**	**EXCELLENT**
	INTEGRATION AT SPECIALIST LEVEL		**VERY POOR**	**POOR**		**SATISFACTORY**	**GOOD**	**EXCELLENT**
	KNOWLEDGE AT SPECIALIST LEVEL		**NO**			**YES**		
	COMPETENCE AT SPECIALIST LEVEL		**NO**			**YES**		

CASE OVERALL COMPLEXITY FOR AN ENTRRY LEVEL SPECIALIST (CIRCLE):

STANDARD DIFFICULT VERY DIFFICULT

DESCRIPTORS FOR…/

DESCRIPTORS		Tick relevant box	COMMENTS
VERY POOR/ FAIL < 40%	Fails to elicit most and/or important aspects of the history and/or physical examination, as expected of a competent specialist **AND/OR**		
	Knowledge and /or clinical competence clearly deficient in several and key clinical areas e.g. risk assessment, diagnostic criteria, pharmacology, medical conditions- signs, symptoms, management **AND/OR**		
	Reaches his/her conclusions by fraudulent or dishonest means **AND/OR**		
	Displays serious disrespect towards the patient **AND/OR**		
	Clearly dangerous – omission or commission **AND/OR**		
	Presentation very disorganized with failure to integrate information at a specialist level and manage time appropriately		
	OR Did not present management within 30 minutes		
POOR/FAIL 40 or 45%	Fails to elicit important aspects of the history		

	and/or physical examination and/fails to critically appraise key components, as would be expected of a competent specialist **AND/OR**		
	Presents history or examination findings which are not correct or present **AND/ OR**		
	Is unable to make a plausible clinical assessment, with an appropriate differential diagnosis, a rational plan of further investigation and management **AND/OR**		
	Fails to assess and /or manage risk adequately thus compromising safety **AND/OR**		
	Presentation disorganized with failure to integrate information at a specialist level and/or displays poor time management		
	OR Did not present management within 30 minutes		
BORDERLINE	Superficial history and		

50%	physical examination (not at specialist level) with clinically significant omissions **OR**		
	Makes a plausible clinical assessment, with a reasonable differential diagnosis and management plan, **BUT** with a clinically significant omission.		
	*significant omission/s relate to diagnostic and/or management. **AND/OR**		
	Presentation poorly organized in most areas and with integration of information at a specialist level lacking in several key areas		
SATISFACTORY PASS 55/60/65%	Successfully elicits most of the relevant aspects of the history and physical examination, as would be expected of a competent specialist. No important aspects of the history or physical examination have been missed		
	AND Makes a plausible clinical assessment, with an appropriate differential diagnosis, and a rational plan of further investigation and management		
	AND presentation is organised with integration of information at specialist level		
GOOD PASS 70%	Successfully, elicits all the relevant aspects of		

	the history and physical examination, as expected of a competent specialist		
	AND Makes a plausible clinical assessment, an appropriate differential diagnosis, and a rational plan of further investigation and management		
	AND Demonstrates clinical maturity, insight and a breadth of experience and knowledge		
	AND Presentation is well-organized and integrated at specialist level		
EXCELLENT PASS 75%+	Successfully, elicits all the relevant aspects of the history and physical examination, as expected of a competent specialist		
	AND Makes a plausible clinical assessment, an appropriate differential diagnosis, and a rational plan of further investigation and management		
	AND demonstrates an outstanding grasp of clinical medicine, including both a broad and deep experience and theoretical knowledge		
	AND organization and integration of information is combined with outstanding presentation skills		

EXAMINER'S FINAL SCORE (in multiples of 5)		**OVERALL FINAL COMMENTS**

The candidate is…/

The candidate is assessed on whether they perform competently in the following domains as would be expected of a **competent specialist**:

History Taking:

- Demonstrates the ability to take a comprehensive and appropriately focused history using clinical acumen to provide sufficient detail in key/relevant areas
- Demonstrates an understanding of the relevant aspects of the history at specialist level
- Must evidence sound theoretical knowledge of diagnostic criteria, risk and relevant clinical factors related to presenting problem
- NB Superficial enquiry as well as failure to explore related, clinically relevant details at specialist level must be penalised

Mental State Examination:

- Presents a concise and relevant mental state; where indicated, bedside cognitive testing included

Physical examination:

- Demonstrates the ability to do an appropriate physical examination with attention to relevant detail as elucidated during the interview

Summary:

- Presents a comprehensive and relevant summary which accurately encompasses all the important findings from the interview
- Presents a succinct summary which demonstrates the ability to discern clinically significant details of history and conclusions/clinical insights gleaned from the physical and mental state examination

Differential diagnosis:

- Is able to formulate an accurate working diagnosis supported by findings from the interview
- Is able to compile a relevant differential diagnosis and discount irrelevant and unlikely diagnoses
- NB Inability to elicit diagnostic criteria according to DSM on history or critically argue for/against differentials at specialist level proposed must be penalised

Etiological formulation:

- Demonstrates a comprehensive understanding of the factors that influence the patient's presenting complaint, past history and mental state
- Demonstrates the ability to reflect on biological, psychological (including psychodynamic),social , cultural and spiritual factors and understand how they shape the patient's experiences and environment and inform management

Risk Assessment and management:

- Is able to formulate an accurate risk-assessment and demonstrate an understanding of the management implications associated with specific risks

Management:

- Is able to formulate a comprehensive and appropriate biopsychosocial specialist level management plan sensitive to local treatment resources and financial implications
- Demonstrates understanding of the risks and benefits associated with treatment choices
- Demonstrates the ability to make evidence-based management decisions
- Captures details of logical progression from acute to short-term to long term/maintenance priorities

Overall performance…/

Overall performance:

- Refers to presentation and response to case-based questions
- Integration: Demonstrates the ability to appropriately and effectively synthesise and contextualize information
- Organization: Structures the presentation logically with appropriate management of time and without compromising relevant information; able to competently manage time
- Knowledge: Demonstrates appropriate knowledge of diagnostic criteria and evidence-based treatment approaches
- Competence: Displays good clinical judgement, accurate diagnostic ability and sound clinical reasoning and decision-making