

C O N S U L T A N C Y

V I V A

S Y S T E M

A Systematic Approach for Tackling the RANZCP Clinical Part I Consultancy Vivas

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INTRODUCTION

One of the core components of the Part I Clinical Vivas of the Royal Australian and New Zealand College of Psychiatrists is the Consultancy Viva. This document was originally compiled to assist the authors in their own endeavours to undertake and complete this task in the examination process during 1999. Because of the nature of the Consultancy Viva, it generally has less “uncontrollable variables” than the Part I Clinical Cases, and hence is more amenable to a systematic approach. Much of the approach within this guide is drawn from other sources, in particular a lecture by Dr John Congdon given to trainees in 1997.

The Consultancy Viva usually occurs on the last day of the examination schedule. Candidates are given three vignettes that outline situations they are likely to face in their role as a consultant psychiatrist. These can include difficult clinical scenarios, ethical tensions, staff issues, or administrative and political issues. Candidates are required to demonstrate orally that they have the requisite skills to enable a consultant psychiatrist to consider these vignettes in a broad framework that considers the multiple facets of each. For each vignette, candidates are allowed ten minutes to talk through the topic, and examiners may interrupt, ask specific questions, or offer further information regarding the vignette. Prior to the first vignette, the candidate is given five minutes to collect their thoughts and prepare an answer; this is not afforded for the second and third vignettes.

There have been a number of criticisms of the format and approach of the Consultancy Viva, particularly regarding its validity as an assessment tool, and its reliability amongst examiners. However, under current by-laws it continues to play a part in the examination process, and candidates occasionally do fail this component of the Part I Clinical Examinations.

This document is not intended to be a thorough guideline or wholly inclusive approach to the Consultancy Vivas. Using too rigid a structure during the Viva itself results in a sterile, inflexible approach to answering that is only too apparent to examiners on the day, much as a “grid” approach is evident in answering Part I Written Examinations. However the initial use of a structured approach can be invaluable in the initial stages of preparing for the Vivas, and when practised regularly the candidate is able to lay a sound template for tackling this component of the exams which is broad and inclusive without being formulaic. Candidates should also not let an initial structured approach interfere with their own interpersonal style, nor prevent them from including their own experiences in their answer. Remember that possible scenarios and vignettes are almost infinite in number; a systematic approach cannot hope to prepare you for all eventualities, but may afford you enough structure to embrace the most unexpected or seemingly insurmountable problems. The authors cannot accept any responsibility for candidates who attempt to utilise this approach but are unsuccessful in the examinations, as this document is only intended to be used as a guide.

Having noted that, we feel it may prove a useful document to assist trainees in their examination preparation. Feedback is welcomed.

Best wishes in the examinations process!

- Mark Walterfang
- James Scott

A GENERAL OUTLINE

CORE QUESTIONS: What are the **issues**?
Who are the **players**?
What is my **role**?
What are their, and my, **agendas**?

MNEMONIC: **IB-PPP-R**

Introduction
Background
Preparation
Planning
Performance
Review

INTRODUCTION: why **important/interesting/topical issues** – clinical, ethical, social, political
players – Dr, patient, unit, service, staff, family
role – clinical, professional, administrative

BACKGROUND: **sources:** requester, other parties
why me: give an answer
why now: give an answer
hidden agendas, traps, expectations
context, research, literature

PREPARATION: formal **research** – literature, library, college, consumer, government, legal
consult **senior colleague, expert**

PLANNING: **problems** anticipated (avoid, minimise)
approach/strategy – what to cover/take on
practical issues
scope of my involvement

PERFORMANCE: **what** I would do
how I would do it

REVIEW: **output**
outcome measures – (in)formal
plough data back in

AREAS OF KNOWLEDGE & POSSIBLE SCENARIOS

Consultation-liaison psychiatry: AIDS, Spinal, Transplant, Primary care, Pain, palliation

ATSI/Maori mental health

Impaired therapist: Supervisor/Supervisee, Registrar, Colleague, Boundary violations, Public health, National Mental Health Plan, Global Burden of Disease

Teaching of students, other professionals, public education
Supervision

Community psychiatry: Rehabilitation, De/trans-institutionalisation

Models of service delivery

Drug trials & ethics

Substance use, dual diagnosis

Adolescent mental health

Forensic psychiatry: Dangerousness, Court reports, Competency

Multidisciplinary team & systemic issues

The difficult/hateful patient

Rural/remote psychiatry

Grief & bereavement

Perinatal psychiatry: Fertility, Postpartum, Capacity to parent

Disaster

Suicide & suicide prevention

Dealing with the media, promotion of psychiatry

EXAMPLE 1: GIVING A TALK

INTRODUCTION

- Assume no right of refusal
- Why important or topical – public face of psychiatry, difficult issue, forging links
- Issues – topic-specific, group-specific, liaison
- Players – who is the group; size, subgroups & politics; hats I am wearing
- Roles – educate, liaise, promote profession, promote RANZCP

BACKGROUND

- Source – clarify request
- Expectations – theirs, yours
- Why me; why now; why this topic? Recent disaster/trauma/policy change or shift?
- Characteristics of the group – reputation, issues, ambush

PREPARATION

- Research the topic: literature, library, college, consumers, government, legal
- Ask a local/distant expert; ?take them with you
- Prior speaker on the topic

PLANNING

- “When I give a talk”... make it sound like you do frequently
- practical issues: audience size, composition; public vs private forum; presence of press; who else is on the programme; place & time; format, presentation, equipment
- the likely information covered; sensitive issues
- anticipated problems – hecklers, ambush, expectations not met

PERFORMANCE

- What I would say – in detail
- Discussion time – issues & questions that may arise; confidentiality; anecdotes; examples

REVIEW

- Questionnaire, discussion
- Meetings with group requesting contact
- Referrals

EXAMPLE 2: ESTABLISHING A SERVICE

INTRODUCTION

- Why important – need for service, expansion, disadvantaged group, psychiatric overlay
- Issues – Clinical, ethical, social, political
- Players – service, previous service, patients, staff, families, community, referrers, profession
- Roles – assessment, liaison, administration, teaching, research, supervision

BACKGROUND

- Who's asking – hospital, government, health service, community group
- Why now – crisis, money available, needs analysis, service redevelopment
- Why me – experience, knowledge, clinical focus, head of multidisciplinary team
- Expectations – change outcomes or throughput, satisfy demand, shift patients
- Context – political motivations, social change, fiscal tightening

PREPARATION

- Research – needs analysis: demographics, existing services, meet with stakeholders, local experts, questionnaires; literature, library, college, consumers, government, legal
- Local expert or developer of similar service

PLANNING

- Practical – funding, staffing (clinical, administrative, secretarial, IT), accommodation (site, safety, co-location, phones, office, cars), policies & procedures, intake, target population, clinical pathways, data collection, referral process
- Problems – supply/demand inequality, justifying recurrent funding, changing needs, referrals

PERFORMANCE

- Timeframe & delays, likely budget
- Setting up, promotion, notifying referrers
- Staff training, education, research; supervision; meetings

REVIEW

- Output data – justifying funding/staffing
- Outcome data – HoNoS, rating scales, days in hospital, referrer/patient satisfaction, QOL
- Accreditation
- Feedback

EXAMPLE 3: IMPAIRED DR

INTRODUCTION

- Why important – significant problem, under-recognised, increased risk, erodes public confidence
- Issues – boundaries, illness in doctor, duty of care, primum non nocere, duty to warn, negligence, deregistration, criminal/civil liability
- Players – unit, self, patients, RANZCP, HIC, health regulatory bodies, media, colleagues
- Roles – patient care, managing staff, reporting, supervision, referral

BACKGROUND

- Source – always remember that allegation may be **mad/malicious/misinformed**, but assume validity and confirm this as much as possible
- Why now – notification, complaint, decrease in performance, patient care, “inside” knowledge
- Expectations of source – treatment? Notification? Gossip? Transfer of responsibility?
- Context – lovesick, predatory, psychotic/manic/depressed, substance abuse

PREPARATION

- Ethics committee of local College branch; Doctors’ Health Advisory Service
- Consult senior colleague, individual supervision

PLANNING

- Practical – establishing validity, whether to directly approach, pre-existing professional or personal relationship
- Problems – defamation, deterioration in relationships, staff splitting, media involvement, deregistration, poor quality of information from source, establishing validity, harm to unit/staff/patient/doctor

PERFORMANCE

- Consider whether to approach person directly, or approach discipline supervisor/director of unit
- Consider involving other investigatory bodies – HRC, Medical Board; RANZCP Ethics Committee, Fellowships Board, & Board of Practice Standards
- Consider impact on doctor/staff and patients, duty to warn; confidentiality; natural justice (right to know who alleged, to take legal action)

REVIEW

- Outcome from regulatory bodies; discuss in supervision, peer review (confidentiality)

EXAMPLE 4: REVIEWING OR DESIGNING A PROTOCOL OR SYSTEM

INTRODUCTION

- Why important – evidence-based medicine, best practice, clinical pathways, role as head of team
- Issues – efficacy, outcomes, research, ethics, justifiable expenditure
- Players – self, patient, colleagues, RANZCP, community, government, funders/insurers

BACKGROUND

- Who's asking – hospital, government, college, university, community, funder/insurer
- Why now – EBM, funding, clinical pathways, clinical practice guidelines, Cochrane collaboration, adverse events
- Expectations – change in practice, redevelop service, change outcomes, save \$\$
- Context – social, political, administrative, fiscal, cultural

PREPARATION

- Research – key groups, needs analysis, existing services, experts, prior services, literature, library, college position/guidelines
- Feasibility – of assessment & design, of outcome measures, of funding proposals

PLANNING

- Committee – own role, appropriateness of role, chair; agendas, expectations; committee mix, representatives, disciplines; consumers, consumers being paid; group dynamics; splitting; practical – where, when, how, timeframe, review process
- Review – pilot study, study design, funding, ethics; validity of measure, feasibility, resources
- Problems – unfeasible proposal, limited or invalid assessment, false positive/negative review, sabotage, skewed results, feeling threatened

PERFORMANCE

- Nuts & bolts – what may need changing, how this is done, staffing, resource allocation, delegation
- Training, education, research, funding

REVIEW

- Output & outcome data
- How/when/to whom to report data to
- Publication
- Effecting service change & obstacles to change