Committee for Examinations
Objective Structured Clinical Examination
Station 11
Adelaide September 2017

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is to assess a man with bipolar disorder which is usually well controlled. He has occasionally become acutely unwell leading to involuntary admissions, and requiring Clopixol-Acuphase® injection to control his agitation. He would like to make an advance health directive to decline the use of intramuscular Clopixol-Acuphase® in the future.

1.1 The main assessment aims are:

- To obtain adequate information about previous treatments for a patient with bipolar disorder.
- To weigh up ethical considerations regarding an advance health directive for this patient.

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

- Establish the high level of risk and need for urgent treatment when he is unwell.
- Identify that Clopixol-Acuphase® is the only treatment that works.
- Acknowledge that advance health directives can be overridden by the use of the Mental Health Act.
- Outline at least one ethical dilemma of applying advance health directives in psychiatry.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Process), Communicator (Synthesis), Professional (Ethics).

References:

Elbogen, E. et al (2007) Competence to Complete Psychiatric Advance Directives: Effects of Facilitated Decision Making. Law and Human Behaviour.

J Swanson and others 'Superseding Psychiatric Advance Directives: Ethical and Legal Considerations' (2006) 34(3) Journal of the American Academy of Psychiatry and the Law 385 at 394.

http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php

Papageorgiou and others 'Advance directives for patients compulsorily admitted to hospital with serious mental illness' (2002) 181 British Journal of Psychiatry 513 at 513.

http://mhrm.mhcc.org.au/chapter-5/5f.aspx

Atkinson, J. M., Garner, H. C. & Gilmour, W. H. (2004). Models of advance directives in mental health care: Stakeholder views. *Social Psychiatry and Psychiatric Epidemiology*, *39* (8), 673–680.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required
- Four chairs (examiner1 x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: a man in his 30s, well-dressed.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist in a local Mental Health Services Community Health Service. Mr Billy Bob is a 37-year old man, recently discharged from hospital after an urgent admission for mania that required intramuscular Clopixol-Acuphase® during the early part of the admission.

Mr Bob has read on the Internet about Advance Directives, and has come to you to talk about making an Advance Directive to decline Clopixol-Acuphase® in the future.

Your tasks are to:

- Obtain a focussed history pertaining to Mr Bob's illness and its treatment.
- Explain to the patient what an Advance Directive is, and its limitations.
- Outline the ethical implications of Advance Directives in Psychiatry **to the examiner**.

You will receive a time prompt at **six (6) minutes** if you have not commenced the final task.

Station 11 - Operation Summary

Prior to examination:

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

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE of the scripted time prompt you are to give at **six (6) minutes** if the candidate has not commenced the final task. You are to say:

  'Please proceed to the final task'.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:

  'Your information is in front of you – you are to do the best you can'.
- At **eight (8) minutes**, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the <u>final task</u>:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?
  If so, you <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings.'
- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the activity undertaken in the station and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:
'***I have found some stuff on the Internet about Advance Directives. I want to talk to you about getting one that forbids doctors from giving me Clopixol-Acuphase® injection again.***'

If the candidate has not commenced the final task by **six (6) minutes** - this is your specific prompt:
'Please proceed to the final task'.

3.2 Background information for examiners

The aim of this station is to assess the candidate's knowledge regarding the application of advance health directives in psychiatry and in particular the ethical issues they present clinicians with.

In order to achieve in this station, the candidate must demonstrate the ability to obtain a focussed history from a patient, particularly in relation to acute risk and the efficacy of previous treatments to manage mania. They must then sensitively explain to the patient what an advance directive including its limitations.

Finally the candidate must identify the ethical implications of advance health directives to the examiner - the candidate is required to outline at least one ethical dilemma.

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

- Establish the high level of risk and need for urgent treatment when he is unwell.
- Identify that Clopixol-Acuphase® is the only treatment that works.
- Acknowledge that advance health directives can be overridden by the use of the Mental Health Act.
- Outline at least one ethical dilemma of applying advance health directives in psychiatry.

A surpassing candidate may demonstrate the ability to identify a range of ethical implications in this case.

Advance Directives

Central to the debate in mental health policy, law, and bioethics lies a tension between the principle of respect for patient autonomy in healthcare decisions, and clinical responsibility to provide appropriate services to people with severe mental illness, many of whom experience intermittent impairment of decisional capacity and fluctuating attitudes towards accepting treatment.

Advance health directives have become more widely used in many areas of medicine. Advance health directives were originally developed to allow people to make decisions in relation to their end-of-life care, such as decisions to withdraw life support treatment ('do not resuscitate' orders), but they have subsequently been applied to mental health care.

A psychiatric advance directive (PAD) or mental health advance directive, is a written document that describes what a person wants to happen if at some time in the future they are judged to be suffering from a mental disorder in such a way that they are deemed unable to decide for themselves or to communicate their wishes effectively.

Generally, PADs enable individuals with mental illness to declare treatment preferences in the event they lose decision-making capacity in relation to those decisions in the future. An advance directive can inform others about what treatment patients want or do not want from psychiatrists or other mental health professionals, and it can identify a person to whom they have given the authority to make decisions on their behalf.

Advance directives can be viewed as legal instruments that allow patients to oppose a historical tradition of paternalism in mental health. Individuals with mental illness are very aware of the unequal bargaining power that can exist relative to their doctors in making decisions especially while under the Mental Health Act.

There are two major kinds of advance directives: proxy and instructional directives. A Proxy directive is a form of advance directive that specifies the person or persons who have power of attorney to make health care decisions for the patient if he or she is no longer competent to make choices. An Instructional directive is a type of advance directive that specifies particular health care interventions that a patient anticipates they will accept or reject during treatment for critical or life-threatening illness. A 'living will' is an example of such a directive.

General Advance Directives vs PADs

PADs can be distinguished from general advance directives in physical health care in three major aspects. First, people filling out general health care directives are often making decisions about end-of-life treatments they have never actually experienced. In contrast, psychiatric patients are generally dealing with chronic illness, and are therefore likely to have experienced the treatments they are describing. For example, a patient with schizophrenia may have an opinion about which antipsychotic drug is most effective, and which ones have not worked in the past.

Secondly, the goal of some general advance directives may be to increase the chance that life ends in comfort and dignity, whereas the goal of a psychiatric directive is often to maximise the chance of recovery while minimising unwanted interventions. More recent jurisprudence has recognised the power of PADs to give effect to patient participation, and the human rights approach to recovery in mental health.

Thirdly, the consequences of enforcing a general advance directive may also be different to enforcing PADs. Refusing treatment in end-of-life situations will usually hasten death. This can be seen as positive for the person (this is what they wanted), and arguably for their family, since not only have they respected the person's wishes but also do not have to watch a family member suffer. Refusing treatment for a mental illness is different to terminal physical illness in that it is unlikely to lead to death. However, a possible result of following a refusal of treatment in a PAD is that the patient could become severely ill, remain ill in hospital for longer than if treated, and possibly not recover to the previous level of function.

Purpose for making PADs (Grace Liang, 2013)

1. **Therapeutic effect**

   A strong argument for increasing awareness of PADs is that they provide a mechanism to include the patient's 'voice' during a mental health crisis, when patients are often unable to participate meaningfully in treatment decisions. People react very differently to the same treatment, and nobody understands an individual's needs, experiences and preference as much as the individuals themselves. So unlike proxy directives, instructional PADs can accurately reflect the wants and needs of the patient at the time they made the advance directive, using the individual's own words. Through increased consumer participation, it has been argued that every execution of a PAD is therapeutic as it 'provokes people who suspect that their problems might escalate to prepare treatment early, before the condition gets out of hand'. (Winick, 1996). Therefore, PADs can also support planned, effective crisis treatment by identifying and mobilising resources to de-escalate crises, and serve as viable alternatives to hospitalisation. An often-overlooked advantage of PADs is that the process of completing such documents allows individuals to gain insight, and learn how to self-manage their mental illness.

2. **Avoiding re-traumatisation**

   In particular circumstances, a PAD may be created directly in response to a negative experience with treatment. The PAD could refer to refusals of treatment or care which are catalysts for a previous traumatic experience. If adhered to, the PAD can prevent re-traumatisation where an individual relives the same negative experiences from a previous treatment or life event. For example, a patient who has suffered from sexual abuse or rape may be reminded of this traumatic time if pinned down (or put in other forms of restraint) during compulsory treatment. Without a PAD, and being unable to communicate, a common example of re-trauma can occur in a future similar situation.

3. **Patient autonomy and empowerment**

   Making an advance directive is about the exercise of autonomy – the autonomy of the competent person to make decisions about their treatment in accordance with the principle of consent. This may be done in different ways. Opting out of the treatment may be motivated by the desire of the well person to preserve more of the autonomy by avoiding the side-effects of some treatments. Equally, the motivation to opt out may be linked with preserving the 'autonomy' of the person when ill, or indeed, the existence of the ill person. However, opting into treatment may be associated with preserving the autonomy of the well person. For most people this would be assumed to be the logical choice. Often individuals are choosing the timing of the treatment as well as the type of treatment.

4. **Avoiding the stigma of coercive treatment**

   PADs can avoid the stigma of compulsory treatment, and provide an alternative to legal coercion. Formal commitment proceedings, or placing people under involuntary treatment, could be limited if patients included provisions in a PAD instrument to the effect that certain treatment or hospitalisation be provided to them on a voluntary basis notwithstanding an incompetent refusal by the patient. Such 'voluntary commitment contracts' would benefit those patients in particular who have previously had positive hospital experiences, but found the involuntary process to be demeaning, and can foresee future periods of commitment due to the relapsing nature of their mental illness.

5. **Information sharing**

   For clinicians and practitioners, PADs can serve as a repository for patient histories on treatment preferences. In particular, for clinicians treating a patient with whom they have had no previous history, a PAD might provide insightful information on treatments that have proven effective on the patient. A PAD that specifies treatment that has previously been successful or very unsuccessful may help a clinician not make the same mistake again. On a wider scale, there may also be improved communication between patients, family members, and providers in the sense that a consensus about appropriate forms of treatment can be met and set in place before crisis. For instance, the New Zealand Medical Association recognises the advantages of advance statements in terms of encouraging openness, dialogue, and forward planning between all parties involved in making PADs.

6. **PADs protecting bodily integrity**

   PADs give people who suffer from mental illness, and who are more likely to be subject to coercive treatment, a voice to reject medication that puts their general health at risk. Even when administered correctly, psychotropic drugs have been known to have particularly severe side effects, and in extreme cases could cause fatality. Although the newer antipsychotic drugs may be safer, they have still been known to cause weight gain, sexual dysfunction, and significantly increase the chance of developing diabetes. PADs give people a platform to expressly refuse these treatments on grounds of bodily integrity.

Will advance directives always be followed?

It is critical that patients identify that there may be circumstances where an advance directive is not followed. When deciding whether or not to follow an advance directive, the clinician will consider particular questions, for instance:

- Was the person competent to make the decision when they made the advance directive?
- Did the person make the decision of their own free will?
- Was the person sufficiently informed to make the decision?
- Did the person intend their directive to apply to the present circumstances, which may be different from those anticipated?
- Is the advance directive out of date?

An advance directive will not override the ability of a clinician to authorise compulsory treatment if the patient is subject to a compulsory treatment order under a Mental Health Act. Patients are advised this it may still be worth having an advance directive even if they are subject to a compulsory treatment because it will give clinicians an indication of their wishes.

Making a PAD

There is no set way to make an advance directive. However, the following are some guidelines:

- Make sure it is clear and easy to understand (an Advance Care Directive will not be enforced if it is vague and non-specific about what the patient actually wants to happen if they become unwell).
- A PAD must be witnessed by someone, preferably by someone independent who is not referred to in the document.
- PADs should be kept in a safe place and with a copy given to relatives, friends or carers, and to any person who has been involved in the treatment.

Advance directives are most effective if they are made in consultation with treating health care professionals (that is for example, GP, case manager and / or psychiatrist).

If the patient can afford to get private legal advice about preparing the advance directive, then this should be the next step.

An advance directive will not be valid, and can be ignored later, if the patient does not have capacity when signing it. To protect against an advance directive being challenged on this basis, the patient should ask their GP or psychiatrist to certify that they have capacity at the time they sign the advance directive.

A patient can include in their advance directive that they want to be treated with particular drugs and not with other drugs if they become unwell, and can include that they do not want to be treated (or do want to be treated) with particular procedures such as electro-convulsive therapy (ECT).

For instance, the Queensland Mental Health Act 2016 - Guide form for completing an Advance Health Directive, consent to receiving electroconvulsive therapy states:

> *You can consent to receiving electroconvulsive therapy under your advance health directive. If you consent to this, you may place limits on the consent, such as the number of treatments to which you consent. It is very important you discuss this type of treatment with a doctor who is likely to be responsible for your treatment and care if you do not have capacity to make decisions for yourself about your healthcare at a future time.*
>
> *You may also state in your advance health directive that you do not wish to receive electroconvulsive therapy.*
>
> *Under the Mental Health Act 2016, a doctor may perform electroconvulsive therapy on an adult only if the person gives informed consent or, if they are unable to give informed consent, the Mental Health Review Tribunal approves the treatment. In deciding whether or not to approve the treatment, the Tribunal must consider any views, wishes and preferences stated in an advance health directive. A doctor may also perform electroconvulsive therapy for specified involuntary patients under the Mental Health Act 2016 in emergency circumstances, which is then referred to the Tribunal for consideration.*

Patients can also put in their advance directive their wishes about life management arrangements if admitted to hospital with a mental illness in an acute phase. This could include details about what they want to happen about the care of their children, the care of pets, and who in their work place can be told.

Limitations of PADs

1. Patients believe that an advance statement is putting in place something that will be there for them in the event of an emergency but in reality, these wishes may be disregarded, e.g. if they are admitted as an involuntary patient under the Mental Health Act.

2. One of the factors related to completing a PAD, which can make them a difficult document for courts to uphold, is possible advances in medical technology, not evident at the time of making the statement. In other words, somebody may say that they want this and don't want that based on the knowledge of the time, but in fact the treatment may be much less intrusive than it was at that time, by the time that the PAD is called on to be used.

3. A Guardian appointed to act for the patient can also overturn PADs. Guardianship Acts provide for an appointed decision maker to consent to various treatments including medical and dental treatment where a patient is unable to do so. This means that a PAD made in common law would have to be respected while the patient was 'competent', but once the patient lost 'capacity', the person responsible for their care could make a decision that goes against the advance statement if they did not consider the advance statement to be in the best interests of the patient.

When the patient nominates someone to act on their behalf it should be someone who has good advocacy and negotiation skills, is assertive, and whom the patient trusts with their life. It also needs to be someone who is physically, geographically available, and at short notice. This nominated person needs to be someone who can cope with strong feelings, from all sides, if it becomes a situation, for example, where an aspect of the PAD is not being adhered to. It would work best if the nominated agent shared the values, and understood the health and treatment preferences of the patient. Unfortunately, not everyone has access to such a person.

4. If the individual becomes an involuntary patient under a Mental Health Act it will be up to the treating team to decide if they will follow the advance directive. They should take the information in the PAD into account, but they do not have to. It is unlikely that the courts would allow a PAD to overturn the choices of treatment made by a hospital to treat an involuntary patient**.**

5. There may be fears of potential litigation amongst medical professionals especially where doctors need to override advance directives that contained treatment refusals.

6. Lack of information has been identified as a major barrier to the successful implementation of PADs.

Other Ethical Aspects of PADs

Key issues related to advance directives are related to issues of autonomy and consent for the patient. A person might develop a PAD with full intentions of honouring it when they become unwell. However, they might change their minds. If patients change their minds, the issue is whether the new instructions must be heard, and new facts and circumstances considered.

Concern has been expressed about the potential for patients to have unrealistic expectations regarding the power of their advance directive. There is the requirement of a certain level of knowledge about the illness, and the likely chances of recovery that may not generally be known or considered when the PAD is made.

Moreover, potential conflicts can arise between family members if they did not agree with treatment discussed in the PAD.

The clinician needs to consider how the PAD enables non-maleficence and can promote beneficence. The level of risk associated with acute presentations may be too significant to allow the clinician to safely follow the PAD. The therapeutic alliance could potentially be damaged if the advance directive was overridden during a psychiatric crisis without the patient being prepared for this possibility. In such cases, to do justice to its development, clinicians should try as far as possible to follow aspects of the advance statement and take into account information provided in the PAD.

Overriding a PAD by clinicians may be linked to their failure to be aware of its existence, either because it is genuinely not available or because clinicians to do not take time to look / ask for the existence of one. Ensuring access to PADs by health practitioners is an important organisational challenge to be addressed.

3.3 The Standard Required

Surpasses the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieves the Standard – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).

ii. they can act as a ***communicator*** who effectively facilitates the doctor patient relationship.

iii. they can ***collaborate*** effectively within a healthcare team to optimise patient care.

iv. they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.

v. they can act as ***health advocates*** to advance the health and wellbeing of individual patients, communities and populations.

vi. they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.

vii. they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

Below the Standard – the candidate demonstrates significant defects in several of the domains listed above.

Does Not Achieve the Standard – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Billy Bob, a 37-year-old man who was discharged from hospital three weeks ago after an admission for an acute manic episode. You have suffered from bipolar disorder for the last 20 years. You have come to see the psychiatrist today as you want to write a specific document about your future expectations for treatment called an Advance Directive.

Reason for your request:

At this last admission, you had to be given a specific injection called **CLOPIXOL-ACUPHASE®** three times, on alternate days. You do not ever want to have this injection again if you get unwell.

You have no symptoms of depression or mania, you feel that you are back to your usual self, you are somewhat optimistic about the future, and your family is pleased with how you are doing.

You are sure there must be another way for things to be managed when you are in hospital, and you have been reading on the internet about Advance Directives. A psychiatric advance directive (PAD) or mental health advance directive, is a written document that describes what a person wants to happen if at some time in the future they are judged to be suffering from a mental disorder in such a way that they are unable to decide for themselves or to communicate their wishes effectively.

You wish to forbid treatment with this injection ever again, despite the fact that you have had this discussion with doctors many times, and have been repeatedly told that the injection is the safest way to make you well again quickly. Your wife agrees with the doctors. You do not remember your manic episodes, and wonder if they are exaggerating the risk. You are not convinced: it makes you feel dreadful, you sometimes need to be held down when you are receiving it, and so you never want to take it again. You think this is a bad product, and it should never be used for you again. In fact, you would prefer it if they never had to use any injectable medicine for you again.

Your psychiatric history:

You have a 20-year history of having bipolar disorder, which is a disorder presenting with depressed and elevated/irritable (manic) symptoms. You have had four hospital admissions in total. All your admissions have been due to manic episodes. You tend to be irritable and agitated when unwell, and tend to get into arguments and threaten people.

This is unlike your usual easy-going temperament, and family members say you are scary to be around at these times as you shout at people, and say you are going to hit them. Consequently, you are taken to hospital – against your will - and have ended up needing this injection Clopixol-Acuphase® at each of these admissions. On this last admission, your wife has told you this is the most unwell she has ever seen you.

You have been treated under the Mental Health Act every time, but since discharge from hospital you have been doing well. You are taking medications called mood stabilisers, even though you have been feeling tired. You do not intend to stop your medicines, as you know they keep you well. You have never stopped your medications in the past, and always obey the doctor's orders.

Why you became unwell:

The company you were employed at as an accountant closed down just prior to this admission, and the stress of losing a job you loved and are good at, precipitated a manic episode. You have been told that you were highly irritable, and physically aggressive towards nursing staff. You have no memory of this, feel that this is not like you, and wonder whether the injection actually made you aggressive.

Treatment:

In the past you have discussed the treatment that you received in hospital with the psychiatrist whom you saw in the community clinic after discharge. He had explained that the risk you pose to other patients, the staff, your family, and yourself when you are unwell is very high. They are concerned that you will assault someone, and need to control your symptoms as soon as they can. The medicines that they use when you relapse (in addition to the lithium that you are usually on) do not seem to be effective. The doctors have prescribed tablets of different antipsychotic medicines (olanzapine, quetiapine and risperidone), but apparently these do not calm you down. They have even tried diazepam tablets. They have tried injections of olanzapine, haloperidol, and lorazepam as well, but you were told that these did not work either.

Consequently, the doctors state that they need to give you an injection, and since the Clopixol-Acuphase® worked really well the first time they used it (when you were admitted at age 18), they continue to use it when things get really bad. You, however, wonder if it is the injections that make the illness worse, and they leave you feeling drained, tired and very slow in the head for 2-3 weeks after you receive them.

If you are asked about details of your current medications:

You always take your LITHIUM – 250 milligrams every morning, 500 milligrams every night. The side effects are manageable – you feel thirsty, have a dry mouth, and occasional diarrhoea. Your blood levels are usually 0.7 to 0.8 and your kidney and thyroid blood tests have been fine. You do not wish to stop lithium as you know it is the best medicine for your condition, and you do not want to risk relapses.

You do not wish to have electro convulsive therapy (ECT).

When you start becoming unwell:

You seem to lose awareness of this, but your family recognise the signs. You sleep poorly, feel energetic, talk loudly, begin challenging people, and believing that your ideas are right. You overestimate your abilities and achievements, drive rashly, and have an increased sexual drive. Your family has always managed to keep you safe from actually doing reckless things by getting you into treatment early. So far you have not endangered yourself or anybody at home, but are aware that '*something really bad could happen'* at these times.

Things go downhill rapidly over a few days, and you have been described as '*hard to control'* at home and in hospital. Your family and doctors have repeatedly told you that the quickest, and most efficient way to control your symptoms is the injection. The episodes usually resolve in 3-4 weeks, and you go home and return to work about 2 weeks after that. Your ex-boss has been very understanding about your illness, and you are worried you will never find such a good job again.

You describe yourself as a regular ordinary sort of person with an inconvenient illness. You have never had longer than a brief period of feeling sad or low, having no energy or appetite, and losing interest in life. To the best of your knowledge you have never had a depressive episode. You have never been suicidal or intentionally harmed yourself.

Specific history and symptoms:

You do not use drugs and have never done so. You rarely drink alcohol (5-6 times a year), and have never got drunk. You are not a gambler.

You have never had any problems with the law.

Your personal history:

You had an uneventful childhood and were not exposed to any traumatic events. You studied accounting in university. Your parents are alive and you have a good relationship with them. You have two older sisters, they are both well.

You are presently worried about your lack of job, but your wife works in a bank, and you are financially okay. You have no children – you are aware that bipolar runs in families, and did not want to risk passing your genes on to them. Your mother's brother had bipolar disorder but he died young, and you do not know anything about him.

4.2 How to play the role:

You are unhappy with the fact that you keep being given Clopixol-Acuphase® when you are unwell. You are very keen to put in place a plan that the medical staff will need to follow in the event that you get admitted again. You have been investigating these advance directives and the candidate will need to clearly demonstrate in a non-judgemental manner that this is not a good idea based on your psychiatric history.

Today you present as well groomed, with no signs or symptoms of depression or mania.

4.3 Opening statement:

'*I have found some stuff on the Internet about Advance Directives, I want to talk to you about getting one that forbids doctors from giving me Clopixol-Acuphase® injection again*.'

4.4 What to expect from the candidate:

A good candidate will be confident, and put you at ease whilst they gather information. They may repeat statements back to you, and empathise how difficult things are for you.

They will ask you about medications, admissions to hospital, and questions about risk. They should then explain what an Advance Directive is to you, and what its limitations are.

4.5 Responses you MUST make:

'I hate Clopixol-Acuphase®!'

'They tell me I'm really bad; I think they are exaggerating.'

About Clopixol-Acuphase®: ***'It makes your head fuzzy for weeks.'***

'I think it makes you worse; makes you more aggressive.'

About treatment options: ***'That's why I came to you; I thought you should know.'***

4.6 Responses you MIGHT make:

'It's hard to believe that there is no tablet which can be used instead.'

If asked if you have ever been admitted as a voluntary patient:

Scripted Response: ***'No, I have always been admitted under the Mental Health Act.'***

If asked about your thoughts on electroconvulsive therapy (ECT):

Scripted Response: ***'Is that the same as shock treatment? No, never, and I do not want to have it.'***

4.7 Medication and dosage that you need to remember:

- Lithium carbonate 250 mg every morning (1 tablet), 500 mg every night (2 tablets)
- Clopixol-Acuphase® injection.

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- To obtain adequate information about previous treatments for a patient with bipolar disorder.
- To weigh up ethical considerations regarding an advance health directive for this patient.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct an assessment of the patient's illness and treatment? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:
clearly achieves the standard overall with a superior performance in a number of areas; competent overall management of the interview; superior technical competence in eliciting information.

Achieves the Standard by:
managing the interview environment; engaging the patient as well as can be expected; demonstrating flexibility to adapt the interview style to the patient, problem or special needs; prioritising information to be gathered; appropriate balance of open and closed questions; summarising; being attuned to patient disclosures, including non-verbal communication; recognising emotional significance of the patient's material and responding empathically; sensitively evaluating quality and accuracy of information; clarifying inconsistent information efficiently; establishing the high level of risk and need for urgent treatment when patient is acutely unwell; enquiring about the use of ECT.

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

a. Establish the high level of risk and need for urgent treatment when he is unwell.

b. Identify that Clopixol-Acuphase® is the only treatment that works.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) or (b) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
significant deficiencies such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

1.1. Category: ASSESSMENT – Data Gathering Process	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills in addressing the patient's request for an advance directive, including its limitations? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
integrates information in a manner that can effectively be utilised by the patient; provides succinct and professional information; presents a balance of the advantages and limitations of an advance directive.

Achieves the Standard by:
providing accurate and structured information; prioritising and synthesising information; adapting communication style to the setting; tailoring appropriate use of language to the patients level of sophistication; demonstrating discernment in selection of content; having an awareness of the process of setting up a PAD, and its advantages and limitations without being overly pessimistic.

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

a. Acknowledge that advance health directives can be overridden by the use of the Mental Health Act.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) above or the information presented to the patient is too one sided, either for or against PADs with some minor inaccuracies; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
no information provided or information provided is grossly inaccurate.

2.5. Category: SYNTHESIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
comprehensively considers all major aspects of ethical conduct and use of PADs.

Achieves the Standard by:
demonstrating the capacity to: identify and adhere to professional standards of practice in accordance with College Code of Conduct / Code of Ethics and legal guidelines; integrating ethical practice into the clinical setting; apply ethical principles to resolve conflicting priorities; utilising ethical decision-making strategies to manage the impact on patient care; presenting ethical principles in the framework of beneficence, non-maleficence, autonomy and justice; identifying that patients may have unrealistic expectations of future treatment through the advance directives.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Outline at least one ethical dilemma of applying advance health directives in psychiatry.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
did not appear aware of ethical issues raised by advance directives.

7.1. Category: ETHICS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	**Definite Pass**	**Marginal Performance**	**Definite Fail**