Committee for Examinations
Objective Structured Clinical Examination
Station 5
Sydney April 2018

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

This station is about assessing capacity in a 66-year-old woman who has chronic renal failure secondary to hypertension. She has been on haemodialysis for the past 5 years but now wants to stop this treatment. There is evidence of cognitive impairment on cross-sectional examination using the Mini-Mental State Examination. The candidate must synthesis the data obtained in the capacity assessment and present their conclusion to the examiner. In addition, the candidate is expected to discuss the initial management of an older person who requests euthanasia.

1.1 The main assessment aims are to:

- Obtain the key clinical information necessary for undertaking a capacity assessment in an older person with physical illness.
- Draw a conclusion from the capacity assessment specific to the request to stop dialysis.
- Discuss the initial management of an older person who has cognitive impairment and who requests euthanasia.

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

- Assess past and current self-harm / suicidal behaviours / depressive symptoms.
- Conclude Mrs Jones lacks capacity as she does not fully understand the consequences of stopping dialysis.
- Prioritise the need to explore whether Mrs Jones has an imminent plan to act on her euthanasia belief.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.)
- **Area of Practice:** Old Age Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:**
  Medical Expert (Assessment – data gathering content, Diagnosis, Management – initial plan)

References:

- AMA Position Statement: Euthanasia and Physician Assisted Suicide 2016. Australian Medical Association Limited ABN 37 008 426 793.
- Darzins P, Molloy DW, Strang D. Who Can Decide? The Six Step Capacity Assessment Process. (2000) Memory Australia Press. South Australia.
- Douglass A, Young G, McMillan J. A Toolkit for Assessing Capacity in A Douglass 'Mental Capacity: updating New Zealand's Law and Practice'. Report for the New Zealand Law Foundation(2016) www.lawfoundation.org.nz/
- Gastmans C, Van Neste F, Schotsmans P. Facing requests for euthanasia: a clinical practice guideline. J Med Ethics. 2004; 30:212-217.
- Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. BMJ. 2003 Feb 1; 326(7383): 271–273.
- NZMA. Investigation into ending one's life in New Zealand: Submission to the Health Select Committee. New Zealand Medical Association. February 2016
- RANZCP Position Statement 67: Physician Assisted Suicide
- Snyder L, Sulmasy DP. Physician assisted suicide. Ann Intern Med. 2001; 135(3): 209-216.
- The National Kidney Foundation. Dialysis: Deciding to stop. Available from: https://www.kidney.org/atoz/content/dialysisstop

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1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Brief video on haemodialysis: https://www.kidney.org/atoz/content/hemodialysis (For Training Day only)
- Role player: Medium build woman aged 60-65, conservatively 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 consultation-liaison service.

The renal team refers Mrs Jones for a capacity assessment. Mrs Jones is a 66-year-old widow with chronic kidney disease, from hypertension, who has been on haemodialysis 3 times per week for 5 years. She now tells the renal team that she wants to stop her dialysis.

Her current blood pressure control is good. She has no other concurrent medical illness.

The renal team wants you to assess whether Mrs Jones has capacity to make a decision to stop dialysis. They have explained to Mrs Jones on several occasions that she will die from renal failure within weeks of stopping dialysis.

Mrs Jones's Mini-Mental State Examination performed by the renal team was 23 out of 30: lost three points in orientation to time, three points in three-word recall at five minutes, and one point in spelling 'WORLD' backwards.

You have **three (3) tasks**:

- Conduct an assessment of Mrs Jones's capacity to make a decision to stop dialysis, including a focussed history relevant in this situation.
- Present and justify your capacity assessment to **the examiner**.
- At **six (6) minutes** the examiner will give you a VIVA task to address to **the examiner**.

NOTE: A cognitive assessment is **NOT** required in this station.

Station 5 - 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 (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.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- TAKE NOTE of the time for the third task you are to give at **six (6) minutes** while stating:

  'Please proceed to address the third task.'

  The <u>THIRD TASK</u> is:

  The renal team has forgotten to tell you that Mrs Jones has also been requesting euthanasia. Describe your initial management of this situation to <u>the examiner</u>.
- 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**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your 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 first and second task (i.e. before 6 minutes):

- You are to state the following:

  'Are you satisfied you have completed the first and second tasks?

  If so, do you want to proceed to the third task?'
- If yes, handover the third task to the candidate and say the following:

  'Please proceed to the third task and you can return to the first and second task at a later time.'

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.

You have no opening statement.

The role player opens with the following statement:

'I don't know why my doctor wants me to see a psychiatrist.'

At **six (6) minutes** the examiner hands the third task to the candidate and says:

'***Please proceed to address the third task***.'

The <u>THIRD TASK</u> is:

The renal team has forgotten to tell you that Mrs Jones has also been requesting euthanasia. Describe your initial management of this situation to <u>the examiner</u>.

3.2 Background information for examiners

In this station the candidate is expected to assess the capacity of an 66-year-old widow who has been on haemodialysis 3 times a week for the last 5 years. There is also evidence of cognitive impairment on the Mini-Mental State Examination (score = 23/30). As part of the asessment, the candidate is expected to obtain relevant history from the patient and demonstrate their expertise in eliciting the key clinical information necessary for undertaking a capacity assessment taking into consideration the impact of chronic physical illness, any evidence of cognitive disorder or potentially an undiagnosed depression.

Finally, the candidate is asked to discuss the initial management of an older person who has cognitive impairment and who requests euthanasia. A candidate should appreciate the specific expertise of psychiatrists in identifying psychiatric illnesses and assessing suicidal ideation in patients, even those who are medically ill, and being able to differentiate between suicide ideation in the context of depression and a physician assisted dying / euthanasia request. Candidates should also be able to describe the impact of cognitive impairment on capacity, and to demonstrate a high awareness of the current public, professional and political debate on these issues.

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

- Assess past and current self-harm / suicidal behaviours / depressive symptoms.
- Conclude Mrs Jones lacks capacity as she does not fully understand the consequences of stopping dialysis.
- Prioritise the need to explore whether Mrs Jones has an imminent plan to act on her euthanasia belief.

A surpassing candidate will focus specifically on conducting a sophisticated capacity assessment related to the request of stopping dialysis; skilfully use a range of well-formulated questions to test the various capacity domains; demonstrate an understanding of the limitation of cross-sectional capacity assessment; consider involving the family in the assessment process.

Dialysis: Deciding to stop

Dialysis patients are allowed to make decisions about stopping dialysis treatment. They are encouraged to discuss their reasons for wanting to stop treatment with their doctor, other members of their health care team and their loved ones before making a final decision. Health practitioners need to have a clear understanding of rationales for this decision (worsening health, worsening quality of life, specific treatment problems, depression) to determine if any improvements might be made that could affect their decision.

A psychiatrist assessment is beneficial if concerns are raised that a patient wants to stop dialysis for solely emotional reasons or because of depression, they may be asked to speak with a psychiatrist. A psychiatrist can play an important role in determining whether patients understand the full impact of stopping dialysis.

People who stop dialysis may live anywhere from one week to several weeks, depending on the residual level of kidney function and their overall medical condition.

Capacity Assessment:

The candidate should be able to demonstrate their ability to identify important information to assist them in the assessment of capacity. Taking a biopsychosocial approach, information about both physical and psychological wellbeing is critical, as will be the effects of illness and treatment of quality of life in a seriously ill patient. Clinical information that will be relevant in this case includes: past self-harm and / or suicidal behaviours, past and current depressive symptoms and current cognitive functioning.

Mental capacity is concerned with a person's decision-making ability. It focuses on whether the person retains that ability and, if not, who should decide on their behalf and on what basis. Capacity or incapacity is a legal decision informed by medical and other evidence. A capacity assessment is used to establish whether a person lacks capacity for decision-making in respect of specific decisions at a specific time.

People are presumed to have capacity until proven otherwise by a qualified health professional. In regard to capacity assessment, Darzins et al. (2000) has outlined the six steps involved in this process:

Step 1: Perform capacity assessment only when there are valid triggers.

Step 2: Find out from family members, health professionals, solicitors or financial advisors about the context in which decisions are to be taken.

Step 3: Provide education to the person because ignorance can be mistaken for incapacity.

Step 4: Involve the person, explaining the benefits of being able to document that they are competent, or to have opportunity for some protections to be put in place if their capacity is impaired.

Step 5: Make conditions of examination as good as possible, for example exclude concurrent reversible illness and the person should be seen on his or her own to minimise coercion or undue influence.

Step 6: Perform the assessment by determining whether the person can (i) understand the relevant information; (ii) reason about treatment / management options; (iii) appreciate the situation and its consequences; and (iv) communicate a choice.

Domains	Patient's Task	Physician's Assessment Approach	Questions for clinical assessment
1. Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor (or I) told you about ▫ The problem with your health now ▫ The recommended treatment ▫ The possible benefits and risks of the treatment ▫ The risks and benefits of no treatment
2. Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	▫ How did you decide to accept or reject the recommended treatment? ▫ What makes (chosen option) better than (alternative option)?
3. Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	▫ What do you believe is wrong with your health now? ▫ Do you believe that you need some kind of treatment? ▫ What makes you believe it will have that effect? ▫ What do you believe will happen if you are not treated? ▫ Why do you think your doctor has (or I have) recommended this treatment?
4. Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	▫ Have you decided whether to follow your doctor's (or my) recommendation for treatment? ▫ Can you tell me what the decision is? ▫ (if no decision) What is making it hard for you to decide?

Key practice points:

- A person is presumed to have the capacity to make a decision unless there are good reasons to doubt this presumption.
- In general, capacity is assessed with respect to a specific decision at a specific time.
- Assessment is of a person's ability to make a decision, not the decision they make. A person is entitled in law to make unwise or imprudent decisions, provided they have the capacity to make the decision.
- It is important to explain to the person that the capacity assessment can result in confirming they are competent to make decisions independently; or if they are not competent, some protection can be put in place to support their decision-making ability.

Physician-assisted suicide and euthanasia:

RANZCP Position Statement 67

Background

The RANZCP notes that there is considerable debate about the use of terminology in the euthanasia context. The terminology used by the RANZCP in this position statement is based on the psychiatric and medical literature.

The focus of this position statement is physician-assisted suicide (PAS), which is sometimes also called 'physician assisted dying', 'physician assisted death' or 'physician aided dying'. PAS refers to situations where doctors prescribe, but do not administer, lethal substances to informed patients who have a terminal illness or a grievous and irremediable medical condition and have the legal capacity to decide that they may end their own lives at a time of their own choosing. By contrast, 'euthanasia' refers to the act of deliberately ending another person's life at his or her request. If a doctor prescribes or supplies the drug at the patient's request, this constitutes 'PAS' whereas if a doctor administers a drug to bring about a patient's death at the patient's explicit request, this constitutes 'euthanasia'.

The issue of capacity is a critical consideration on the debate on PAS. Generally, in Australia and New Zealand, all adults are presumed to have decision making capacity but that can be rebutted if it can be shown, for instance, that the person is either unable to understand and retain the information relevant to the decision or to understand the consequences of the decision. The capacity test is not diagnosis-specific but rather focuses on a person's ability to make the decision at hand in the situation.

RANZCP members should note that legalising any activity does not make it ethically correct. The Australian Medical Association, New Zealand Medical Association and World Medical Association consider that doctors' involvement in euthanasia to be inappropriate and unethical. This position statement is not intended to bring any resolution to the ethical debate.

Although PAS is currently illegal in Australia and New Zealand, the RANZCP notes that some patients may request PAS of their doctors. There are also anecdotal reports of patients requesting assessment of their capacity by psychiatrists in Australia and New Zealand in order to facilitate PAS in another country.

Public opinion is divided over PAS and euthanasia in Australia and New Zealand. Recent surveys suggest that around 85% of Australians and 70% of New Zealanders support the legalisation of some kind of medically assisted dying.

PAS legislation

PAS (and euthanasia) was legalised in Australia's Northern Territory in 1995 by the *Rights of the Terminally Ill Act*. In 1997, the Northern Territory legislation was quashed by the Federal Parliament, using its power to overturn Territorial (as opposed to State) laws.

Currently, the provision of PAS is a criminal offence in all Australian jurisdictions and New Zealand. A 2015 New Zealand case – *Seales v Attorney-General* [2015] NZHC 1239 – confirmed that only Parliament could change the law to legalise PAS.

In recent years, both Australia and New Zealand have debated the issue of PAS. Recent examples of legislation that have been introduced into parliament include Medical Services (Dying with Dignity) Bill 2014 (Australia) and the End of Life Choice Bill 2015 (New Zealand).

The RANZCP notes that PAS or, in some cases, euthanasia has been legalised in some overseas jurisdictions. These include some European countries and some states of the United States of America.

PAS and role of psychiatrists

The RANZCP considers that the primary role of medical practitioners, including psychiatrists in end of life care is to facilitate the provision of good quality patient-centred care. Palliative care should strive to achieve the best quality of life during the final stages of patients' illnesses and allow patients to die with dignity. This should be adequately resourced and widely available.

Psychiatrists have specific skills and expertise to identify psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill. A person's capacity to make decisions may be affected by both mental and physical illness, including a treatable psychiatric condition.

Psychiatrists may have a role with patients who are considering or wish to discuss PAS through the identification and treatment of mental illness and, when appropriate, making recommendations for patients' mental health treatment and care.

To help inform the PAS debate, the RANZCP believes that the following issues should be considered in the Australian and New Zealand context:

- **The rights of people with mental illness** – The RANZCP does not believe that psychiatric illness should ever be the basis for PAS. The RANZCP also considers that unrelievable psychiatric suffering is rare and that ensuring that a person with mental illness has capacity in the PAS context may pose significant challenges.
- **The rights of older people, including people with dementia** – There is growing evidence to suggest that people who develop dementia under the age of 70 are at increased risk of suicide, especially if there are symptoms of depression and anxiety, meaning that they might, in some circumstances, consider PAS. The RANZCP strongly supports good quality assessment, care and support mechanisms for people with dementia.
- **Misconceptions about older people, PAS and suicide** – Figures show that Australia's oldest citizens, those aged 80 and above, are the age group most likely to die by suicide. This has led to a misconception that suicide in older people is largely driven by suffering associated with chronic, debilitating or terminal illness whereas the aetiology factors of suicide are complex and multifactorial. The RANZCP is concerned about the potential impact of the debate about euthanasia on older persons and considers that suicide prevention programs must be extended to, and target, older persons.
- **The right of medical practitioners to choose whether or not they wish to be involved in a PAS situation and the extent of their involvement, if any** – While psychiatrists see the psychiatric assessment and treatment of patients who are considering suicide as a core part of their role, psychiatrists may not wish to take on a 'gatekeeper role' in a potential PAS scenario.
- Research shows that while some 64% of British psychiatrists agree that psychiatric assessments are important in the PAS context, only 35% would be willing to carry out such assessments.

Recommendations

- The RANZCP considers that the primary role of medical practitioners in end of life care is to facilitate the provision of good quality, comprehensive and accessible patient-centred care.
- The need for psychiatric assessment and treatment should be considered for patients who request PAS of their doctors.
- RANZCP members should note that currently PAS is illegal in Australia and New Zealand.
- The RANZCP recommends that psychiatrists in Australia and New Zealand carefully consider their position if asked to undertake a capacity assessment of patients who are seeking to obtain PAS in another country.
- By virtue of their expertise about physical and mental illness, psychiatrists can play a crucial role in informing the debate about PAS.

Australian Medical Association: Euthanasia and Physician Assisted Suicide 2016

1. Good quality end of life care and the relief of pain and suffering

1.1 Doctors (medical practitioners) have an ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity.

1.2 Doctors should understand that they have a responsibility to initiate and provide good quality end of life care which:

- strives to ensure that a dying patient is free from pain and suffering; and
- endeavours to uphold the patient's values, preferences and goals of care.

1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life. There are some instances where it is difficult to achieve satisfactory relief of suffering.

1.4 All dying patients have the right to receive relief from pain and suffering, even where this may shorten their life. (1)

1.5 Access to timely, good quality end of life and palliative care can vary throughout Australia. As a society, we must ensure that no individual requests euthanasia or PAS simply because they are unable to access this care (2).

1.6 As a matter of the highest priority, governments should strive to improve end of life care for all Australians through:

- the adequate resourcing of palliative care services and advance care planning;
- the development of clear and nationally consistent legislation protecting doctors in providing good end of life care; (1) and,
- increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia.

2. Patient requests for euthanasia and PAS

2.1. A patient's request to deliberately hasten their death by providing either euthanasia or PAS should be fully explored by their doctor. Such a request may be associated with conditions such as depression or other mental disorders, dementia, reduced decision-making capacity and / or poorly controlled clinical symptoms. Understanding and addressing the reasons for such a request will allow the doctor to adjust the patient's clinical management accordingly or seek specialist assistance.

2.2 If a doctor acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or PAS:

- not initiating life-prolonging measures;
- not continuing life-prolonging measures; or
- the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

3. AMA position on euthanasia and PAS

3.1 The AMA believes that doctors should not be involved in interventions that have, as their primary intention, the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.

3.2 The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and PAS.

3.3 The AMA acknowledges that laws in relation to euthanasia and PAS are ultimately a matter for society and government.

3.4 If governments decide that laws should be changed to allow for the practice of euthanasia and / or PAS, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:

- all doctors acting within the law;
- vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
- patients and doctors who do not want to participate; and
- the functioning of the health system as a whole.

3.5 Any change to the laws in relation to euthanasia and / or PAS must never compromise the provision and resourcing of end of life care and palliative care services.

3.6 Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.

1. *The AMA supports nationally consistent legislation which holds that a doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under a medical practitioner's supervision, incurs no civil or criminal liability by administering or prescribing medical treatment with the intention of relieving pain or distress:*
   a) with the consent of the patient or the patient's representative; and
   b) in good faith and without negligence; and
   c) in accordance with the proper professional standards;
   even though an incidental effect of the treatment may be to hasten the death of the patient.
   A doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under the doctor's supervision, is under no duty to use, or to continue to use, life sustaining measures which are of no medical benefit in treating the patient if the effect of doing so would be merely to prolong life.
2. *Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and / or suffering. Physician assisted suicide is where the assistance of the doctor is intentionally directed at enabling an individual to end his or her own life.*

In their 2016 submission to the Health Select Committee the **New Zealand Medical Association** stated that:

'It is the NZMA's view that euthanasia and doctor-assisted suicide are contrary to the ethics of the profession:

The NZMA is opposed to both the concept and practice of euthanasia and doctor assisted suicide.

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical. Doctor-assisted suicide, like euthanasia, is unethical.

The NZMA, however, encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care.

In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical.

This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.'

Gastmans et al. (2004) described the initial management when a patient requests PAS or euthanasia. Such request can be the first place a signal that the patient gives to elucidate their views towards being ill, the physical pain, the possible deterioration that can come, and the hopeless nature of the situation. Each PAS / euthanasia request must therefore be open to discussion, even if medically speaking the actual dying is still far away. It is essential that the clinician shows their willingness to listen to the patient requesting PAS / euthanasia, while at the same time ensuring the decision of the patient is based on an autonomous, free, and informed choice. The following questions could be posed:

- What motivation lies at the ground of the request for PAS / euthanasia? Is this really a request to put actively an end to their life, or is the patient asking for caring guidance in the last days or weeks of their life?
- Does the patient have sufficient information (for example, diagnosis and prognosis) on the grounds on which they make their request?
- Is the patient mentally competent at the moment when making their request?
- Has the patient discussed their euthanasia request with other people?
- Does the patient make the request voluntarily? Is there no question of any form of coercion or pressure?

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 Mrs Jones, a 66-year-old woman, living alone in a city apartment. You are very independent and manage all your own affairs. Your husband died of a lung cancer about 20 years ago at the age of 49 years.

You have two daughters who both live in Melbourne: Elizabeth (45 years old) and Margaret (40 years old). They phone you every week. Your best friend and support person is Camila, a neighbour of 10 years.

You worked as a receptionist in a local medical centre for most of your working life. You retired about 5 years ago, around the time you started haemodialysis.

You have chronic kidney disease from high blood pressure. You have been on haemodialysis for the past 5 years. You are under the renal team (Doctor William, Nurse Kate). You come to the dialysis unit in this hospital 3 times a week. You do not drive and the long bus trip to the hospital takes an over an hour each way. You want to stop the dialysis because you are getting old and want to have more spare time to do the things you enjoy. You like reading and researching your family tree. You work at the local hospice shop as a volunteer in the weekends.

You have NO recent losses or significant life changes.

You will be shown a brief video on haemodialysis: https://www.kidney.org/atoz/content/hemodialysis

Dialysis: Deciding to stop

Like any treatment, dialysis patients are allowed to make decisions about stopping dialysis. People are encouraged to discuss their reasons for wanting to stop treatment with their doctor, other members of health care team and their loved ones before making a final decision.

In this scenario your clinicians will want to have a clear understanding of why you are making this decision (for instance, whether it is because of worsening health, specific treatment problems, or depression) in order to decide if any improvements might be made that could affect your decision. If they are concerned that you want to stop dialysis for solely emotional reasons or because you are suffering depression, they may ask for a psychiatrist opinion. The team may also want you to speak with a psychiatrist to make sure you understand the full impact of what stopping dialysis will mean.

How you feel and think

You are feeling good because you are convinced that stopping dialysis will free up your time from coming to the hospital 3 times a week plus it takes four hours each dialysis session. You get frustrated having to come to the hospital and find dialysis very time consuming. The bus trip takes an hour each way. Having dialysis makes you feel tired and bored and you hate the way it interferes with all the things you want to do.

You do not want to stop dialysis because you wish you were dead, in fact you also hold a clear belief that it will take a few years to die after stopping dialysis. You realise that this is a very sensitive and contentious topic, but you think you should be allowed to make this decision on your own. You feel fine in yourself and don't have any other concerns.

You have not really talked with your daughters about this decision; as you have no intention of worrying them with this: anyway, if you were not on dialysis three times a week you would be able to visit them inter-state more often. You don't know whether or not your daughters agree with your decision to stop dialysis.

Dr William has strongly advised you not to stop as he does not agree that you will have a better life with more time on your hands. You think he is probably just being overly conservative.

Your past psychiatric history

You have no past history of mental health or emotional problems. You have never suffered from depression, and do not feel low in mood now, nor have you ever attempted to commit suicide or even thought about it.

Other medical problems

You have high blood pressure, but it is controlled with taking a blood pressure tablet every day. You do not have any other medical problems.

You have good hearing and vision.

You do not drink alcohol or smoke.

The capacity assessment:

The candidate has been asked to assess whether you have capacity to make this decision to stop dialysis. The table below outlines the key questions that are often asked in order to assist a doctor to decide whether you have capacity:

Memory:	You deny anything wrong with your memory or thinking abilities and you think it is pretty good for your age.
Activities of daily living	You believe you take good care of yourself and don't need any help from anyone. You deny any problem with your activities of daily living such as cooking, shopping, cleaning, paying bills, transport, personal care. You have never driven a car.
Depression, anxiety:	***'Apart from dialysis, I am fine.'*** You do not feel depressed or particularly anxious. There are things you very much enjoy and look forward to, e.g. spending time with your family. You sleep well. Your energy is on the low side given your chronic kidney disease, but this is not new. Your appetite is small, but this is not new, and you enjoy your food. Your concentration is good.
Suicidal thoughts:	You are not suicidal. You don't want to die, but you don't want to suffer the burden of dialysis.
Unusual strong beliefs or paranoia (delusions) or experiences such as voices, suspiciousness (hallucinations):	Nil
Your understanding of dialysis:	You have read all the pamphlets. After having it for 5 years, you think you should know everything about it.
Your understanding of stopping dialysis:	***'It takes a few years to die after stopping dialysis, I guess, but in the meantime I would have a good life'***
Should the candidate follow this up with an explanation that it will be 'weeks' rather than 'years' if you stopped the dialysis:	You are quite shocked and don't believe in them. You are sure you will not die in just a few weeks. You will NOT accept the fact that you will die in a few weeks.

4.2 How to play the role:

You are conservatively dressed and take good care of your appearance. You are stern but cooperative with the assessment. You are slightly puzzled why your doctor asked a psychiatrist to see you, but you are prepared to listen to their explanation. You speak in a normal tone and listen carefully to the psychiatrist. You tend to provide short answers to the psychiatrist's questions.

4.3 Opening statement:

'I don't know why my doctor wants me to see a psychiatrist.'

4.4 What to expect from the candidate:

The candidate needs to establish your reasons for wanting to stop dialysis and ask questions to support your decision. They may ask about a range of symptoms, and the details of what medications you have been taking. They should also ask you about your mental wellbeing like thoughts of suicide.

The candidate may also ask you about your personal life like your relationships and work history (answer as above).

4.5 Responses you MUST make:

'I really want to stop dialysis.'

'Apart from dialysis, I am fine.'

4.6 Responses you MIGHT make:

'It is my right to stop treatment, isn't it?'

If asked about how you know you will die in a few years and not weeks:

Scripted Response: ***'I just know, I know my body better than anyone else.'***

'Do you know how long it will take before I die? A few years right?'

If asked your understanding of what will happen if you stop dialysis:

Scripted Response: ***'It takes a few years to die after stopping dialysis, I guess, but in the meantime I would have a good life'***

4.7 Medication and dosage that you need to remember:

Quinapril (KWIN-A-PRIL) 40 milligrams every morning for your blood pressure. You have taken this medication for 10 years.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

- Obtain the key clinical information necessary for undertaking a capacity assessment in an older person with physical illness.
- Draw a conclusion from the capacity assessment specific to the request to stop dialysis.
- Discuss the initial management of an older person who has cognitive impairment and who requests euthanasia.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history relevant to the capacity assessment? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; expertly progresses through process of assessing capacity within the specific context.

Achieves the Standard by:
conducting a detailed but targeted assessment, using the framework of understanding, reasoning, appreciating and communicating a choice when assessing capacity; obtaining a history relevant to the patient's circumstances with appropriate depth and breadth; eliciting the reason for stopping dialysis; demonstrating ability to prioritise; eliciting the key issues; clarifying important positive and negative features; exploring cognitive functioning and activities of daily living; specifically exploring Mrs Jones's understanding of the consequences of stopping dialysis.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Assess past and current self-harm / suicidal behaviours and depressive symptoms.

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

Does Not Achieve the Standard (scores 0) if:
omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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

1.9 Did candidate formulate and describe the findings of capacity assessment? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
demonstrates a superior performance; appropriately identifies the limitations of a cross-sectional capacity assessment.

Achieves the Standard by:
demonstrating the ability to integrate available information in order to reach a conclusion on the capacity assessment; explaining the benefits of participating in a capacity assessment; adequately prioritising conditions relevant to the obtained history and linking the possibility of cognitive impairment to issue with capacity; communicating in appropriate language and detail and according to good judgment; outlining the framework of understanding, reasoning, appreciating and communicating a choice when assessing capacity; recommending protections if capacity is impaired.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Conclude Mrs Jones lacks capacity as she does not fully understand the consequences of stopping dialysis.

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

Does Not Achieve the Standard (scores 0) if:
inaccurate or inadequate conclusion on the findings; errors or omissions are significant and do materially adversely affect conclusions.

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

1.13 Did the candidate formulate and describe a relevant initial management plan to the request for euthanasia? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
clearly addresses difficulties in planning an approach to the euthanasia request; provides a sophisticated link between the plan and key issues identified; prioritise and implement plans for risk management.

Achieves the Standard by:
identifying the need to further explore the euthanasia request with the person; evaluating prior personal beliefs and values in regards in to end of life issues; assessing for psychiatric illnesses and suicidal ideation in a person requesting euthanasia; considering the possibility of stopping dialysis as a passive way of ending one's life; differentiating between suicide ideation in the context of depression and euthanasia request; describing the impact of cognitive impairment on capacity to make this euthanasia request; demonstrating a good awareness of the current public, professional and political debate on euthanasia; clarifying that physician-assisted suicide is not legal in Australia and New Zealand; recognising the need for consultation / supervision; involving the family to support the person in this situation.

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

a. Prioritise the need to explore whether Mrs Jones has an imminent plan to act on her euthanasia belief.

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) if:
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:
errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

1.13. Category: MANAGEMENT - Initial Plan	**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**