MEDICINE IN THE COMMUNITY
COMMUNICATION SKILLS
CHALLENGING CONSULTATIONS

Year 5

WORKSHOPS 1&2

Tutor Workbook 2011/2012

Cardiff University
School of Medicine

Index:

About the workbook

Following the successful introduction of the year 5 workshop during 2006/7, feedback from students each year has been extremely positive. For 2011/12 an additional workshop has been added to the programme. This will allow the students chance to consolidate their learning from the first workshop, build upon their skills further and develop some issue specific skills surrounding a variety of challenging communication issues.

This course book aims to provide tutors with all the information they require to undertake teaching in Year 5 workshops. This year, we are seeking to give a more comprehensive resource for teachers, in that giving a more rounded explanation of the course & where it sits within the wider curriculum, that tutors will feel more confident in supporting students, and provide a consistent approach to the workshop. Please let us know if this is helpful, and whether there are any other gaps which you would find helpful for inclusion next year.

Through this course book we have provided brief summaries of the evidence to support our learning objectives. Feed this information in along with your own experience, anecdotes and views.

The students get a book broadly similar to this one and therefore they will have copies of the main diagrams, learning objectives etc.

About the teaching

Who?

This teaching is with groups of 8-10 medical students and we are grateful for the tutors' enthusiasm and willingness to help. We intend to make the teaching enjoyable for both tutors & students.

Where?

All teaching session from November 2011 (at the earliest, and possibly later) will be in the Cochrane Building, however, until that building is complete, the workshops will continue to run in the Learning Resource Centre (1st Floor), Ty Dewi Sant, University Hospital of Wales site.

When?

The teaching occurs during the first and last weeks of an eight week Medicine in the Community rotation. In between the two workshops, students undertake a six week placement in the community. It is hoped that the first workshop will provide students with a brief reminder of the basic principles of good communication skills, before offering them the opportunity to practice and observe peers having a go at some clearly challenging consultations in a protected setting. The idea of the second workshop is to consolidate the learning further with more supportive practice and observation and a chance to explore more challenging situations that they will face as Foundation Year 1 Doctors.

Thank you for your help

Paul Kinnersley Liz Metcalf Jane Fryer

kinnersley@cf.ac.uk metcalfep@cf.ac.uk sloanjm@cf.ac.uk

Staff contacts:

Professor Paul Kinnersley
Director of Teaching, Director of Clinical Communication Teaching,
Dept of Primary Care and Public Health,
The Medical School, Cardiff University
3rd floor, Neuadd Meirionydd, Heath Park, Cardiff CF14 4XN
02920 687638
Kinnersley@cf.ac.uk

Dr Liz Metcalf
Clinical Lecturer in Primary Care
Dept of Primary Care and Public Health,
The Medical School, Cardiff University
3rd floor, Neuadd Meirionydd, Heath Park, Cardiff CF14 4XN
02920 687170
metcalfep@cf.ac.uk

Dr Jane Fryer
Teaching Fellow
Tutor Development
Dept of Primary Care and Public Health,
The Medical School, Cardiff University
3rd floor, Neuadd Meirionydd, Heath Park, Cardiff CF14 4XN
02920 687173
fryerjl@cardiff.ac.uk

Mrs Joanne Sloan
Teaching Administrator
Dept of Primary Care and Public Health,
The Medical School, Cardiff University
3rd floor, Neuadd Meirionydd, Heath Park, Cardiff CF14 4XN
02920 687167
sloanjm@cf.ac.uk

An overview of undergraduate communication skills teaching 2011/12

About the course

This course was designed by Paul Kinnersley, Liz Metcalf and Jane Fryer of the Institute of Primary Care and Public Health, School of Medicine, Cardiff University. We have had very considerable help and support from Dr Jonathan Silverman of the University of Cambridge. Jonathan and co-authors have devised the Calgary-Cambridge framework on which we rely heavily. We believe this framework has been a major advance in the teaching of clinical method skills to students and we are grateful for being allowed to use it. Over the past few years, the communication skills curriculum has evolved significantly in response to feedback from both students & tutors. It is therefore useful for tutors to have an overview of the teaching available to students throughout their undergraduate years.

Over the next two years, the curriculum is likely to evolve and develop even further, as the School of Medicine prepares for **C21: A New Medical Curriculum for Cardiff**. As such, your feedback & views on the course are much appreciated.

Our overall aim is to develop an integrated theme throughout the curriculum which emphasises the importance of communication as a core clinical skill and provides the students with opportunities to practice their skills and discuss challenges.

We need to be told of students who do not turn up to the teaching sessions. It is important that the session registers are handed back to the supervisor or posted back to Joanne Sloan, 3rd floor Neuadd Meirionnydd, Heath Park.

Essential Clinical Communication eLearning Package

An eLearning package developed and provided by the UK Clinical Communication in Undergraduate Medical Education. This package is available to students through Learning Central (within the Communication Skills section) & comprises the following interactive modules:

- Essential clinical communication
- Initiating the consultation
- Structuring the consultation
- Gathering information & history taking
- Communicating through the physical examination
- Building the relationship
- Explaining & planning
- Closing the consultation

Year 1

Students attend a lecture from the Psychology Department, which illustrates the importance of communication in medicine. They will also have undertaken a number of 'early clinical contacts', during which they will have had the opportunity to observe a variety of clinical scenarios in a variety of primary & secondary care contexts. Each student has spent one day in the following specialities: General Practice, General Surgery, Medicine, Obstetrics/Gynaecology, Child Health, Accident and Emergency and Car of the Elderly.

Year 2

In Year 2, the students attend two workshops. These provide background teaching as to why good communication is important and some of the basic skills required.

Workshop 1:
The start of the consultation & key skills for gathering information

(Students then undertake their Family Case Study)

Workshop 2:
Focused histories & differential diagnoses

(Students will then undertake the Early Clinical Skills attachments, during which they will be asked to take 5 medical histories under observation & receive feedback on their communication skills whilst on placement)

Students are advised to undertake the 'gathering information & history taking, structuring the consultation & building the relationship' eLearning modules, prior to commencing their Year 3 workshops.

Year 3

Workshop 1:
History taking & gathering information & development of the differential diagnosis
The workshop will start by re-visiting the aims of the medical interview and a brief consideration of how to analyse the content of a consultation in order to arrive at a differential diagnosis. Students will then take turns to conduct a consultation with a simulated patient.

Workshop 2:
Explaining & planning
This workshop starts with a discussion of the skills needed for sharing information with patients and students will have an opportunity to practice these skills with simulated patients.

Workshop 3:
Challenging consultations
This workshop focuses on challenging consultations & Breaking Bad News. Again the structure of discussion with demonstration video followed by opportunities for students to practice consulting with simulated patients is used.

Pilot initiative for Year 3 students- spring 2012:

Clinical & Communication Skills Workshops
A number of pilot workshops will be offered to students on a 'first come, first served' basis from January 2012. These workshops will seek to merge the practical skills the students will have already learnt in the Clinical Skills Lab, for example intramuscular injection, with the communication skills required when interacting with patients. It is hoped that this initiative will then be offered to all year 3 students from 2012/13.

Year 4

During Year 4, students rotate through a variety of specialities, namely Child Health, obstetrics & gynaecology, psychological medicine & MOSS (dermatology, rheumatology and haematology). Students do not currently receive Communication Skills teaching as a separate curriculum during Year 4.

Pilot initiative for Year 4 students- spring 2012:
In spring 2012, we will be offering a pilot workshop to year 4 students during which they will receive specific teaching using a similar format to the teaching in years 3 & 5- i.e. they will discuss key areas of communication skills in the context of paediatric patients & their families, & have the opportunity to consult with simulated patients. Should this initiative be successful, it is anticipated that this would then be offered to all Year 4 students from 2012/13.

Year 5

Challenging consultations 1:
A workshop offered to all students at the beginning of their Medicine in the Community (MIC) placements, during which they will discuss the various strategies they might use when consulting with more challenging patients they might face on placement. Simulated patients will be used to practice their communication skills & offer feedback to students from the perspective of the patient.

Working in Teams:
This workshop was piloted to groups of final year students in 2010/11. It was well received and therefore is to be introduced to all year 5 medical students from 2011/12. The main challenge that we are trying to address in this workshop is for the students to consolidate their experiences of working within a variety of medical teams, across a variety of specialities, during their clinical years. Furthermore, we are aiming to prepare the students for taking active roles within medical teams, during their Foundation Training, understanding the guidance from the GMC Good Medical Practice: Working in Teams. The workshop revolves around a number of group activities & role play scenarios, and examines the individual's role within the activities.

Challenging consultations 2:
Another new workshop for 2011/12, this workshop will be offered to all final year students during the final week of their MIC placements. During this workshop, students will be invited to discuss & role play with simulated patients in the following areas:

- End of life care & decisions regarding resuscitation
- Consultations with the help of interpreters (re-visiting an initiative in year 3 Diversity & Medicine)
- Telephone communications- with patients & colleagues

School Students

Following a successful pilot in 2009/10, We may have groups of school students sitting in on some of these teaching sessions. These students are interested in applying to study medicine and should be 'silent observers' of the teaching. We hope that tutors will welcome them and answer any questions they have about the teaching itself or careers in medicine.

Communication Skills & the wider undergraduate curriculum

Merging History Taking and Communication Skills

A problem with putting emphasis on communication skills when teaching students is that they see this as a different activity to taking a history from a patient. We seek to overcome this by emphasising ***content*** (the information to be gathered) and ***process*** (the skills used to gather it). This helps but we need to further emphasise that communication skills are the 'how you do it' which can be applied to a range of task that doctors have to do – gather information, provide information, gain consent etc. We should all encourage students to consider how they may use their 'Communication skills' in order to focus on **tasks** - History taking, explaining and planning, breaking bad news, and the **skills** required for these tasks.

Students should be encouraged to take every opportunity to be observed communicating with patients and not just simply to report back the history they obtain. This observation and feedback might come from members of the medical team to whom they are attached, by peers, or from the patients themselves.

Development of Differential Diagnoses

We have some concerns that students have been placing insufficient emphasis on the importance of making clinical sense of the information they have gathered. One misconception by students might be that we are only interested in them 'being nice' to patients, whereas other parts of the course place great emphasis on making the right diagnosis. **To address this we would like all tutors to ask students to identify their differential diagnosis & how the student might plan to prove their diagnosis, as well as commenting on the skills used to acquire this information.** This is in keeping with the format used in the Intermediate MB OSCE examination and students should also be encouraged to practice this process when on clinical placements, in addition to developing their communication skills**.**

Learning Central

In addition to the learning opportunities offered during workshops and on clinical placements, students will find a section on Learning Central called **'Communication Skills'** in the left hand column of the home page. Materials have been added to Learning Central in response to feedback from previous students, who felt an online resource would compliment the existing course and help them to make the most of the wealth of information regarding clinical communication challenges on the internet.

If students open this link, they will find many useful resources, including staff contacts, course documents, reading material, external links, covering broader and more specific challenges students might face, for example communicating with the elderly and very young, or with those with hearing impairment. Students will also find practice case scenarios for use in between workshops and when preparing for the intermediate MB examination.

A key feature which we would ask all tutors to highlight to the students is the **'Essential eLearning Clinical Communication Package'**. This contains a

variety of modules designed to compliment the workshops, & students are asked to work through these before and after the workshops.

Feedback to students

Medical students frequently tell us that they find feedback essential in order that they can gain a better understanding of how they can develop their communication skills further. Unsurprisingly, there is much evidence in the literature for the merits of **good quality** feedback.

How to Give Feedback

Tutor Feedback

Over the past year, we have been encouraging an '**Agenda Led Outcome Based Analysis**' model for giving feedback to students. Where possible, we would propose that tutors develop this model of giving feedback to students, in order that a consistent approach is used. In the early stages of the workshops students might find it difficult to identify their own learning needs; however with further practice, we would expect this model to become a useful tool for both students & tutors. (see appendix 6)

There are generally 2 agendas for feedback in the workshops, and the tutor should seek to incorporate both:

What do the students feel they want/ need to learn?
What do we want to teach them?

Where possible, feedback should be:

S - specific, significant, stretching
M - measurable, meaningful, motivational
A - agreed upon, attainable, achievable, acceptable, action-oriented
R - realistic, relevant, reasonable, rewarding, results-oriented
T - time-based, timely, tangible, trackable

The way in which we give feedback can directly influence how the students respond to the learning experience, and so if we are to nurture them, we need to do this in a supportive, safe fashion.

- Review learner's original agenda
- Encourage self- feedback from student
- Constructive, timely feedback based on observations from tutor
- Encourage supportive input from other students to solve problems
- Re rehearsal of new skills, either by the individual, or by subsequent students incorporating lessons learnt earlier in workshop through observation of their peers.

  - Ask the student 'How did that go?'
  - Link this to the students own agenda
  - Ask the student 'What could be improved?'
  - Open discussion to the other things for them to improve/ focus upon

Often tutors find it difficult to elicit students' learning needs. Often the students don't know what their learning needs are. Try to phrase questions such as "is there anything that you think you might find difficult that you would like the group to concentrate on?" "in the past have you found anything that has come up that you would like us to concentrate on?" (make links to previous observations of communication skills)

Reflective learning: feedback to themselves:

At the outset, we should be clearly setting an agreed agenda at the beginning of each teaching session. Within the time constraints of the communication skills workshops, we want tutors to spend some time at the beginning of each session talking to students about their individual learning needs. By doing this, it is hoped the students will 'buy in' better, and achieve their unmet learning needs more effectively than if the tutor does not take account of individuality.

Particular emphasis is then be placed on students identifying *for themselves* the skills needed to achieve a successful consultation and the students then practising those skills. The students are encouraged to reflect on their own performance and identify ways in which they can improve in subsequent consultations. We thus hope to encourage the concept of 'reflective learning'. The use of video in the workshops will facilitate this process.

Feedback from student peers:
In order to keep the group engaged throughout, it can be helpful for tutors to encourage fellow students to give feedback to their peers. This might be informally, through discussion, or alternatively through the assigning of specific tasks. Some tutors in the past have used this more directive approach, asking students to observe, for example for specific examples of:

Initiating the consultation: how rapport was built
Open to closed questioning
Exploration of the patient's agenda
Use of summaries
Checking understanding

……and so on. Tutors might prefer to try different approaches, depending on their group, some will naturally function more cohesively and supportively giving feedback to one & other, whilst other groups may need tighter 'managing'.

Feedback from simulated patients:
We are lucky in Cardiff to have an experienced group of simulated patients, who you already familiar with. We have an ongoing programme of training for the simulated patients used across all the years as to how to give feedback to students. We hope that tutors take the opportunity to use the actors to give feedback to students *from the perspective of the patients' experience* of the consultation. Following this, tutors

are recommended to develop any issues raised from this feedback once the actor has left the room, in addition to giving feedback from a clinical perspective.

In addition to providing guidance on giving feedback, through training of the simulated patients, we aim to standardize the actor's responses to students as much as possible, particularly in the exam setting. At Cardiff, simulated patients are trained before every OSCE. The actors are provided with their roles and then come to a training session to discuss the role with a clinician. This enables clarification of areas of uncertainty and standardisation across actors portraying the same role to different students.

Video recording and feedback will be used in Workshops 1 and 2. Many students may worry about this but most find it helpful when they have got used to it. Some students will already have done a video with their general practice tutors before workshop 1.

Students with difficulties

It is important that students who struggle with talking to patients for whatever reason are identified early rather than left to fail the end of year assessment or have other difficulties. If a student in your group raises concerns, please take a little time at the end of the session to clarify how the student felt the session went. Some may just be nervous or unfamiliar with the teaching methods used. However, we routinely offer all students who need them the opportunity for extra sessions – but we want to target these at those who need them most and need your help to identify these students. There are no negative consequences for students in attending the extra sessions which will be organised for February/March 2012. Tutors are therefore encouraged to be proactive about identifying students who they feel might benefit from such extra support, and pass their details to Sheila Morris, so that students can be contacted at the appropriate time.

All students will be informed that you may raise your concerns with them and that this is meant to be helpful rather than to be seen as criticism.

Year 5 Communication Skills Learning Outcomes

These learning outcomes have been written to reflect the GMC Tomorrow's Doctors (2009) outcomes and standards for undergraduate medical education

At the end of this these teaching sessions, students will be able to:

- Demonstrate core communication skills such as listening, sharing information and responding to patients and relatives in preparation for exploring specific communication issues & challenges

- Demonstrate appropriate communication skills when dealing with difficult circumstances, such as breaking bad news, dealing with sensitive issues, dealing with difficult or violent patients and vulnerable patient groups. They must be able to communicate clearly, sensitively and effectively with individuals regardless of their age, social, cultural or ethnic backgrounds.

- Demonstrate an understanding of a patient centred approach to consultations

- Demonstrate a reflective approach to appraising their own consultations and those observed by others.

Teaching Tips for Running the Workshops

- Keep the teaching as Skills Based as possible- focus on what core communication skills are needed for each scenario
- Keep the teaching as clinically relevant as possible- try to weave in as much clinical teaching as time allows
- Recognise that students will struggle with these consultations as they have been designed to be challenging. Pause the consultations at approx 3-4 mins and check how the student is getting on. Encourage feedback and a chance to have another go if student feels its not going well. Reassure students that its normal to feel uncomfortable or out of their comfort zones in these situations
- Keep to time as much as possible- we recognise time is limited for these workshops and therefore try not to spend too much time on a particular topic. Students may raise other communication issues such as taking a history from a deaf person. Please welcome these questions although time is limited and attempt to give some brief guidance
- At the end of the session ensure that students have met their learning agendas- perhaps asking them to give you a “take home learning point” from the session. Place some emphasis on the message that there is no “right way” to consult in these situations but the session should have provided some opportunities to practice various approaches and skills to use.

Workshop 1- Revision of Core Communication Skills and Exploration of Patient Centred Consulting

Workshop Plan (Total: 105 minutes)

Introduction: 25 minutes (9.00-9.25 / 11.10-11.35)
- Outline aims & objectives of workshops
- Principles of patient- centred consulting
- Reflection on current communication skills-

Simulated consultations: (9.25-10.45 / 11.35-12.55)
Approx. 4x20 minutes (9 minutes consulting plus approx 10 minutes feedback)

Wrapping up: 5 minutes (10.45-10.50 / 12.55-1.00)
- Recap lessons learnt
- Any questions

Introduction- guidelines for tutors

Timing: 25 minutes for brief re-cap of Core Communication Skills (see appendix 5 for Calgary- Cambridge Guide to the medical interview)

Benefits of good communication:

For Doctor:
Diagnostic accuracy
Compliance with treatment
Reduced litigation
More effective use of resources
Physiological measures (BP, HbA1c)
Satisfaction

For patient:
Experience of healthcare
Emotional health
Symptom resolution
Functional status
Pain control
Satisfaction
Length of stay in hospital

Gathering information:

Content Skills – What?

Biomedical perspective:
Sequence of events
Symptom analysis
Relevant systems review
Patients perspective (ICEE):
Ideas, Concerns & Expectations
Effects on life
Context: background information

Process skills - How?

active listening to patient's narrative
open/ closed questions
(open→closed cone)
summaries
non- verbal communication

Explaining

Elicit, provide, elicit:

Elicit understanding of situation/illness; main concerns; thoughts on action
Provide information/explanation
Elicit understanding of explanation; what else they want to know/feelings

Planning- Shared decision making:

'A process by which patients are educated about likely treatment outcomes, with supporting evidence, and engaging with them in deciding which choice is best for them, taking into account their preferences, values and lifestyles'

Key Issue-Specific Skills and tips for managing consultations for Workshop 1:

Patient 'demanding' medication

- Patient's perspective first
- Empathic responses
- Negotiate (Acknowledge problems/set boundaries)
- Use reflective summaries
- May need to agree to disagree
- Maintain relationship
- Arrange follow up appointment

Dealing with complaints

- Communicating regret and empathy are not admissions of liability
- Failure to openly acknowledge and discuss adverse outcome can increase risk of litigation
- Culture of avoiding discussion – due to embarrassment, defensiveness, fear of compromising defence
- Only 1 in 4 adverse outcomes due to negligence

Patients complain in order to:
Correct deficient standards of care
Find out what happened and why
Enforce accountability
Rarely for financial compensation alone

Adverse outcomes unlikely to lead to litigation unless predisposing factors – rudeness, inattentiveness, lack of communication

Avoid complaints when adverse events occur by:

- Open and honest discussion

- Information to patient's level of satisfaction
- Acknowledgement of adverse outcome and apology for patient's distress ('I am sorry to hear of the distress you have been through' rather than 'I am sorry to hear that Dr Smith made a mistake in your operation'!!)
- Possible referral to another clinician

How to respond to difficult questions

- Non-verbal empathy- may be difficult to do if feeling defensive
- Verbal empathy
- Acceptance, acknowledgement
- Addressing the emotion behind the question- encouraging further expression of feelings and thoughts – so in response to question like 'How long has he got?' or 'Why has this happened?' might say ''this must be very tough to come to terms with'
- Silence
- Attentive listening
- Facilitation - paraphrasing of content and feelings
- Picking up cues, checking out interpretations or assumptions
- Non-judgmental non-defensive response

Breaking Bad News (see page 22 for framework)

- Setting the scene- ensure privacy, no interruptions, who will be with you, prepare yourself factually and emotionally
- Don't be afraid of silence
- Be sensitive to the amount of information required (chunking and checking) and allow for "shutdown"- watch the non-verbal communication
- Co-partnership and advocacy- providing support for the patient/ relative is essential
- Giving hope based upon realism surrounding the situation and the patients' feelings.
- Be prepared for your own emotions – doctors should not fear displaying emotion (Fallowfield, 1993) and it can be difficult to judge how much distress to share with the patient.

Simulated consultations: case scenarios workshop 1

The following case scenarios are to be used within this workshop, and could be used later on whilst students are practicing either on placement or with colleagues. Whilst it is hoped that they would never be expected as a student to deal with such challenging consultations, it is good to practice how they might deal with such situations once qualified.

Students should be encouraged to use the Student Self Assessment sheets in Appendix 1. As these are challenging consultations, it would be appropriate to interrupt the consultation and give feedback and suggestions to the student if it is apparent they are getting into difficulties.

For full details of the information given to the simulated patients, please see appendix 2.

Workshop 1 case scenarios: information for students

Type of challenge	Student information
Challenging Patient / delay in results of STD / Complaint **Graham Bennett** **Male** **Younger patient**	You are working in a GP surgery. Your computer screen indicates the next patient has come to see you with "ongoing symptoms". You notice on the patients' records that he attended 4 weeks ago with symptoms of dysuria and discharge. A urine sample and swabs were taken and the results showed that the Urine Culture was negative but the swab showed "Chlamydia". The Chlamydia result had been received by the practice 3 weeks ago and had been marked as "please make appointment". The patient is not aware of the results as yet. Please inform him of his results and answer his questions appropriately.
Patient Demanding Medication **Pat Jackson** **Female** **Older patient**	You are working in a GP surgery. Your next patient has been consulting with one of the GP partners regularly to discuss decreasing some medication (diazepam). She currently takes 5mg twice a day but was initially taking 15mg twice a day. She wants to discuss her medication with you.
Death of a Relative **Robert Bracken** **Male** **Older Patient**	You are working as a junior doctor on a medical firm on acute intake. An elderly male patient (Keith James) has been admitted with an MI, and unfortunately experienced a cardiac arrest, in which resuscitation attempts were unsuccessful. The medical team have been called away to another arrest and the nurse on the Medical Assessment Unit asks you to speak to the patient's partner and explain what has happened
Breaking Bad News **Bianca Davies** **Female** **Younger patient**	Mrs Davies is attending the early pregnancy assessment unit. She is thought to be 8 weeks pregnant in her first pregnancy. However she has had some bleeding and cramping pains. An ultrasound scan shows an incomplete miscarriage. Imagine you are working in the Early Pregnancy Assessment Unit. Please explain the scan result to the patient and address her concerns

Workshop 2- End of life care decisions, telephone consulting, working with interpreters & consulting with angry patients

Workshop Plan (Total: 105 minutes)

Introduction: 15 minutes (1.00-1.15 / 3.15-3.30)
Outline aims & objectives of workshops
Recap of previous workshop and learning on placement

Simulated consultations: (1.15-2.40 / 3.30-4.50)
4x20 minutes (9 minutes consulting plus approx 10 minutes feedback and discussion time surrounding the issues)

Wrapping up: 10 minutes (2.35-2.45 / 4.50-5.00)
Recap lessons learnt
Any questions

Introduction – Guidance for Tutors (15 mins)

Recap of core communication skills practiced in previous workshop and the opportunities students have had for observation and practice within the primary care setting on placement.

Introduction of Workshop 2 issues to cover:

- Telephone consultation with a patient
  See page 21 for the main points to cover when consulting with patients over the telephone.

- Communication with a relative surrounding end of life decisions
  Students have received a teaching session from Palliative Care during their introductory lectures in MMIC. This covered aspects of end of life management, symptom control and issues to discuss with the relatives. The students now have chance to practice their communication with the relative using the same scenario that they discussed previously. See page 22-23 for the Framework for Breaking Bad News.

- Using an interpreter within the consultation
  see page 24 & appendix 4 for suggested guidelines & further information sources for using interpreters

- Dealing with aggressive or violent patients or relatives
  See Page 25 for approaches and communication skills to use when dealing with angry and aggressive patients.

The stages of the telephone consultation (www.gptraining.net)

Stage 0	**PREPARATION**	• any available information about the caller • anticipate time delay • note taking
Stage 1	**TRUST**	• identify yourself • tone of voice • acknowledging caller's emotions • acknowledging caller's previous experience of health services • letting the caller know that they are being heard * empathy
Stage 2	**EXPLORATION**	• questioning choosing open or closed forms • probing through reflection
Stage 3	**CLARIFICATION**	• caller's agenda • caller's understanding • reflecting • summarising and paraphrasing • allow time for the caller to talk including silences
Stage 4	**ACTION**	• empower the caller to take action where possible • clarify what action you will take on their behalf • check that agreed plan is understood
Stage 5	**END**	• when the caller feels heard, respected and understood • end the call for the caller not for yourself
Stage 6	**AFTER THE CALL**	• time to reflect • note taking • other action

A FRAMEWORK FOR BREAKING BAD NEWS (AS DEVISED BY JONATHAN SILVERMAN)

Based on the work of Brod et al, 1986; Maguire and Faulkner, 1988; Sanson-Fisher, 1992, Buckman, 1994; Cushing and Jones 1995, Silverman et al 2003.

SUGGESTIONS FOR BREAKING BAD NEWS

Preparation:

- set up appointment as soon as possible
- allow enough uninterrupted time; avoid interruptions
- use a comfortable, familiar environment
- invite spouse, relative, friend, as appropriate
- be adequately prepared re clinical situation, records, patient's background
- doctor to put aside own "baggage" and personal feelings wherever possible

Beginning the session / setting the scene

- summarise where things have got to date, check with the patient
- discover what has happened since last seen
- calibrate how the patient is thinking/feeling
- negotiate agenda

Sharing the information

- assess the patient's understanding first: what the patient already knows, is thinking or has been told - **Elicit**
- gauge how much the patient wishes to know[1]
- give warning first that difficult information coming e.g. "I'm afraid we have some work to do...." "I'm afraid it looks more serious than we had hoped...."
- give basic information, simply and honestly; repeat important points - **Provide**
- relate your explanation to the patient's framework
- do not give too much information too early; don't pussyfoot but do not overwhelm
- give information in small "chunks"; categorise information giving
- watch the pace, check repeatedly for understanding and feelings as you proceed – **Elicit**
- use language carefully with regard given to the patient's intelligence, reactions, emotions: avoid jargon

Being sensitive to the patient

- read the non-verbal clues; face/body language, silences, tears
- allow for "shut down" (when patient turns off and stops listening) and then give time and space: allow possible denial
- keep pausing to give patient opportunity to ask questions
- gauge patient's need for further information as you go and give more information as requested, i.e. listen to the patient's wishes as patients vary greatly and one individual's preferences may vary over time or from situation to another
- encourage expression of feelings, give early permission for them to be expressed: i.e. "how does that news leave you feeling", "I'm sorry that was difficult for you", "you seem upset by that"

- respond to patient's feelings and predicament with acceptance, empathy and concern
- check patient's previous knowledge about information given - **Elicit**
- specifically elicit all the patient's concerns – **Elicit**
- check understanding of information given ("would you like to run through what are you going to tell your wife?")
- be aware of unshared meanings (i.e. what cancer means for the patient compared with what it means for the physician)
- do not be afraid to show emotion or distress

Planning and support

- having identified all the patient's specific concerns, offer specific help by breaking down overwhelming feelings into manageable concerns, prioritising and distinguishing the fixable from the unfixable
- identify a plan for what is to happen next
- give a broad time frame for what may lie ahead
- give hope tempered with realism ("preparing for the worst and hoping for the best")
- ally yourself with the patient ("we can work on this together ...between us") i.e. co-partnership with the patient / advocate of the patient
- emphasise the quality of life
- safety net

Follow up and closing

- summarise and check with patient
- don't rush the patient to treatment
- set up early further appointment, offer telephone calls etc.
- identify support systems; involve relatives and friends
- offer to see/tell spouse or others
- make written materials available

Remember doctor's anxiety - re giving information, previous experience, failure to cure or help

[1] various authors make different recommendations about how this task should be accomplished. **Buckman (1994)** suggests a direct preliminary question such as "if this condition turns out to be something serious, are you the type of person who likes to know exactly what is going on?". **Maguire and Faulkner (1988)** suggest a hierarchy of euphemisms for the bad news, pausing after each to gain the patient's reaction. Other authors suggest making a more direct start to giving the news after a warning shot and gauging how to proceed as you go: they argue that patients who wish to use denial mechanisms will still be able to blank out what they do not want to hear.

Working with interpreters in a healthcare setting

Here are some tips for working with interpreters in the Healthcare setting. (These have been developed from the resources cited in appendix 4).

Language needs analysis

- Establish in advance, where possible, what language will be required as special arrangements may be required. Service provision will be required within an organisation.

Locate an appropriate interpreter

- This will usually depend upon your local arrangements, for example the GP surgery may have a contract with Language Line or similar agency for provision of telephone consulting.
- Check the interpreter is qualified and appropriate to the needs of the consultation; ensure they understand the importance of **confidentiality**. These issues are especially relevant when using an interpreter from the same community, for example the deaf community.
- Avoid use of friend or family member (& **never a child**) if possible as this can lead to difficulty when discussing private or personal issues.

Preparation before the consultation

- Establish any ground rules you consider necessary with the interpreter in advance- for example that all spoken words require translation, seating arrangements etc. This will also give the interpreter the opportunity to brief you on any cultural issues that may have a bearing on the session.

Practical consideration

- Arranging for the same interpreter to be present when a patient has more than one consultation may help increase trust and improve the quality of communication.
- Ensure enough time is allowed as the consultation will usually last longer than when consulting without an interpreter

During the consultation

- Explain to the patient that you are responsible for the clinical content & decision making of the consultation.
- Always engage the patient directly; remembering the importance of demonstrating interest, good eye contact & body language. You need to work at establishing a rapport with the patient.
- Do not rush- speak slowly & clearly. If the patient understands some English, this will facilitate the consultation and this allows the interpreter sufficient time to translate fully what you are asking.
- Make sure the interpreter is clear 7 they do not answer questions on behalf of the patient- this is a common problem when using friends or family members.
- Ask the interpreter to translate exactly what you are asking to ensure clarity of communication- signposting will help both you & the patient follow the consultation

After the consultation

- Where appropriate & practical, ensure you allow time to debrief the interpreter

Interviewing patients who may be agitated or aggressive.

Clarify the main tasks to be achieved:

- Ensure own safety
- Establish rapport
- Explore the reasons behind the patient's behaviour.
- Explore the patient's anxieties and concerns.
- Good approach –silence, active listening, reflecting, summarising, checking etc.
- Be aware of changes in behaviour, signs of imminent aggression etc (see below).
- **Have a "Plan B" if it all goes wrong (see below)!**

Establish rapport

- Talk calmly and without raising your voice
- Appear confident (even if you don't feel it!)
- Be aware of how your body language may be read by the patient.
- Allow the patient time to "blow" and give them enough time to feel at ease.
- Be non-judgmental in your approach to the patient.

Make some assessment of their mental state/state of intoxication

- Appearance
- Speech
- Behaviour
- Odour (alcohol etc.)
- Obtain information from others if seeing patient in their own home, speak to relatives if patient happy to allow this.

Signs of imminent aggression from the patient

- Increased restlessness, body tension, pacing the room
- Increased volume of speech
- Erratic movements
- Refusal to communicate, withdrawal
- Poor concentration, thought processes unclear
- Delusions or hallucinations with violent content
- Verbal threats or gestures
- Carers reporting imminent violence

If it all goes wrong!

- Try to de-escalate the situation, be prepared to back pedal.
- Engage in conversation and acknowledge concerns and feelings, ask for the facts of the problem and encourage reasoning.
- Appear relaxed.
- If standing, stand side on to appear less threatening. Keep voice quiet, controlled and if appropriate comforting.
- If sitting, don't cross your legs as it's harder to move quickly should you need to.
- Keep talking and aim to get to a place of safety near your escape route.
- NEVER TURN YOUR BACK!
- Always be on the look-out for signs of imminent aggression from the patient.
- Ask for any weapon to be put down

- **<u>Remain calm at all times</u>**, your panic will escalate the situation
- Know how to summon help.
- KNOW WHERE YOUR ESCAPE ROUTE is and if all else fails …….. RUN!

After the event

- Take time to recover before seeing the next patient
- Talk it over with colleagues
- Learn from any mistakes.
- Make detailed notes in the patient's notes.

Type of challenge	Student information
Telephone Consultation **Elizabeth Allen**	You are working in a busy GP surgery. At the end of your morning surgery you have a request for a telephone consultation. The information you have been given on your appointment screen is "Elizabeth Allen dob 21/2/69 flu like symptoms". You open their medical notes and read her past medical history. Her last contact with the GP surgery was 2 years ago for a cervical smear. She has no relevant past medical history and is not taking any medications. Please phone the patient, take a history and formulate a management plan.
End of Life Discussion with Relative **Helen George** **2 relatives**	You are an F1 Doctor. A patient's wife wants to speak you. Her husband, Eddie George is a patient that your team have been caring for. He has a diagnosis of carcinoma of the colon, with multiple metastases. For the past hour he has become semi-unconscious, agitated, appears in pain and has noisy airway secretions. Explain to the wife what is happening and answer any questions that she may have. **NB To Tutor: This scenario has been explored in a previous teaching session surrounding end of life management. Please make a link to that session to enable the students to recall their discussions**
Consulting with an Interpreter **Young man and woman**	You are working in a GP Practice. A couple come to see you. The wife is unable to speak English and her husband offers to interpret for you. He tells you that she is having problems with her periods and that they are worried as they are trying to have a baby.
Consulting with an Angry Relative	You are working in a GP Practice. You saw a 16 year old female patient last week and started her on the Oral Contraceptive Pill. Her father has come to see you to talk to you about this. He is extremely angry.

Appendix 1

Student Self Assessment Sheet- information gathering

Students can use this to self assess their performance

	Not Achieved				Achieved with excellence
	1	2	3	4	5
Process Skills					
1 Starting the consultation					
Greets patient					
Introduces self and clarifies role					
Demonstrate interest and respect					
2 Gathering Information					
Encourages patient to tell story in own words					
Listens attentively					
Uses open and closed questions appropriately					
Uses easily understood questions					
Demonstrates appropriate non-verbal manner					
Empathises with and supports patient					
Content					
The bio-medical perspective					
Sequence of events					
Symptom analysis					
Relevant systems review					
Patient's perspective					
Explores ideas and concerns					
Elicits expectations					
Effects of illness					

Please comment briefly on:

What was done well?

What could be improved?

Student Self Assessment Sheet- explaining and planning

Students can use this to self assess their performance

	Not Achieved				Achieved with excellence
	1	2	3	4	5
Process Skills					
1 Starting the consultation					
Greets patient					
Introduces self and clarifies role					
Demonstrate interest and respect					
2 Elicits information prior to explanation					
Elicits patients understanding of situation					
Elicits what the patient wants to know					
Elicits patients expectations from consultation					
3 Provides information/ explanation					
Provides information appropriate to patient					
Elicits understanding of explanation					
Elicits what else patients want to know					
Tailors explanation to needs of patient					
Provides information sufficient for patients to make informed decisions about their care					
Closes interview by summarising briefly					
Generic communication skills					
Demonstrates appropriate non-verbal manner					
Empathises with and supports patient					
Content					
Explanation provided is medically accurate					

Please comment briefly on:

What was done well?

What could be improved?

Student Self Assessment Sheet- breaking bad news

	Not Achieved				Achieved with excellence
	1	2	3	4	5
Process Skills					
1 Starting the consultation					
Greets patient					
Introduces self and clarifies role					
Demonstrate interest and respect					
2 Elicits information prior to explanation					
Elicits patients understanding of situation					
Elicits what the patient wants to know					
Elicits patients expectations from consultation					
3 Provides information/ explanation					
Provides distressing information appropriate to patient in a sensitive manner					
Allows patient time to digest information					
Elicits understanding of explanation					
Elicits what else patients want to know & allows time for questions					
Tailors explanation to needs of patient					
Provides information sufficient for patients to make informed decisions about their care					
Closes interview by summarising briefly					
Provides clear plan as to what will happen next					
Generic communication skills					
Demonstrates appropriate non-verbal manner					
Empathises with and supports patient					
Content					
Explanation provided is medically accurate					

Please comment briefly on:

What was done well?

What could be improved?

Appendix 2: Workshop 1: simulated patient information

Challenging patient/ Delay in results of STD/ Complaint
Information given to student:

You are working in a GP surgery. Your computer screen indicates the next patient has come to see you with "ongoing symptoms". You notice on the patients' records that he attended 4 weeks ago with symptoms of dysuria and discharge. A urine sample and swabs were taken and the results showed that the Urine Culture was negative but the swab showed "Chlamydia". The Chlamydia result had been received by the practice 3 weeks ago and had been marked as "please make appointment". The patient is not aware of the results as yet. Please inform him of his results and answer his questions appropriately.

Opening statement: 'I was told to make an appointment, what's the problem?'

Information given to patient:

For the past 6 weeks you have been suffering with symptoms of burning when passing urine and have noticed a slight penile discharge. You saw the GP 4 weeks ago after finally plucking up courage to get it sorted out. The GP thought you might have had a "water infection" and gave you some antibiotics (Trimethoprim) which you took but did not make a huge change to your symptoms. You provided a urine sample and the GP took a swab (which was painful and embarrassing for you) and you rang the surgery 2 days later for the results and was told that everything was clear. You have come back to see the GP as the symptoms are still there.

Further information

Past Medical History: Childhood asthma (no treatment required as adult)
Treated for genital warts at GUM clinic 2 years ago (you declined further testing at time)

Drug history: no known drug allergies
No regular medications

Occupation: primary school teacher

Marital status: single, several casual relationships over past 2 years when separated from long term partner, with 'ad hoc' condom use

Smoking: Non smoker

Alcohol: average 10 units per week

(For your information: in this scenario we are seeking to explore how well the student can deal with a sensitive clinical history & how well they share the information regarding the results with the patient. In addition to being able to demonstrate clear & empathic communication skills when dealing with a complaint about medical care)

Demanding Medication-
Information given to student:

You are working in a GP surgery. Your next patient has been consulting with one of the GP partners regularly to discuss decreasing some medication (diazepam). She currently takes 10mg twice a day but was initially taking 20mg twice a day. She wants to discuss her medication with you.

Information given to patient:

As long as you can remember you have suffered with "bad nerves" You have been prescribed a tablet for this for over 20 years called Diazepam which has helped keep you calm.

Your surgery contacted you by letter several months ago to ask you to have your medication reviewed. You had an appointment with one of the GPs who explained that they wanted to reduce the dose of Diazepam that you were taking as they thought it was too much for you and you had admitted to feeling drowsy at times and a little unsteady on your feet.

You have been seeing the GP every 2 weeks and they have been reducing the dose for you from 15mg twice a day to more recently 5mg twice a day. However for the past week you have been feeling the symptoms of anxiety come back again – feeling sweaty and shaky, unable to sleep much and feel scared of coming off the tablets.

You want to go back to 15mg twice a day as you felt much better on that dose. If the doctor refuses to put this medication back up then you get very angry and upset. You are willing to negotiate a dose and will be happy for any increase in dose to feel better.

Further information

Past Medical History: hypertension (on medication)
Hysterectomy for fibroids aged 41 years

Drug history: no known drug allergies
Ramipril 5mg once daily

Occupation: retired secretary

Marital status: widowed 5 years ago (husband died from a stroke)
lives alone, no children

Smoking: ex smoker (stopped 20 years ago, previously smoking 10/day)

Alcohol: tee total

(For your information: we are seeking to test the students ability to be patient centred in this consultation, whilst demonstrating good skills for tailoring an explanation of risks etc to the individual patient and not being pushed into inappropriate prescribing by the patient)

Breaking bad news- Robert Bracken Death of Partner

Information given to student:

You are working as a junior doctor on a medical firm on acute intake. A male patient (Keith James) has been admitted with an MI, and unfortunately experienced a cardiac arrest, in which resuscitation attempts were unsuccessful. The medical team have been called away to another arrest and the nurse in the Medical Assessment Unit asks you to speak to the patient's partner and explain what has happened

Information given to patient's relative:

Your partner was rushed into hospital this morning. Your neighbour rang you at work to say that they had called an ambulance. You rang the hospital who told you that your partner was there, but they would not give you any further information. On arrival at hospital it appears the medical team are away at another emergency, and you are desperate for information. A nurse tells you that one of the junior doctors will have a word with you shortly.

You have been concerned about your partner's health recently – you have been trying to get him to stop smoking for years unsuccessfully and he has had high blood pressure for some time but kept saying he didn't like taking his tablets. He has been retired for 1 year and you are planning to retire shortly from accountancy. You have been meaning to go with him to the GP to discuss his health concerns – unfortunately you haven't had the time as you have been busy working with work.

Further information (relevant to you, <u>not</u> deceased partner)

Past Medical History: nil

Drug history: nil

Occupation: accountant

Marital status: civil partnership 3 years

Smoking: non smoker

Alcohol: tee total

(For your information: in this scenario we are expecting the students to demonstrate appropriate communication skills such as listening, sharing information and responding to you, the relative's needs when being given news of your partner's unexpected death)

Breaking bad news- Bianca Davies

Information given to student:
Mrs Davies is attending the early pregnancy assessment unit. She is thought to be 8 weeks pregnant in her first pregnancy. However she has had some bleeding and cramping pains. An ultrasound scan shows an incomplete miscarriage. Imagine you are working in the Early Pregnancy Assessment Unit. Please explain the scan result to the patient and address her concerns

Information given to actor:
You are thrilled to be approx. 8 weeks pregnant having been trying to conceive for 18 months. This is your first pregnancy. You were worried you might never be able to conceive because you suffered from anorexia nervosa for several years in your teens. You have no current issues regarding eating disorders, but it might be raised as an area you feel guilty with if the student discusses possible reasons for miscarriage (such guilt is unfounded as it would probably have no bearing upon your risk of miscarriage so many years previously but might be an interesting area for discussion with the student who appears to be doing well). You rang your GP yesterday afternoon to report some crampy, period like pain that had started that morning. Overnight you have also started spotting some brown blood. The GP arranged for you to come to the EPAU to see what might be causing the symptoms. The GP gave little explanation, though in you are convinced you are loosing the baby and were reluctant to ask the GP as you did not want your fears confirmed.

The student should discuss with you that you have had a miscarriage but that the foetus is still within your womb. You should not challenge them too much if they discuss possible ways to treat you (observe- watch & wait to see if miscarry spontaneously, medical management- give you various drugs to cause pregnancy to be expelled, or surgical- 'd&c'- relatively minor operation under general anaesthetic to remove contents of womb). You should however challenge them about why the miscarriage has happened & what the risks are of further miscarriages if you manage to get pregnant again.

Further information

Past Medical History:	moderate anorexia nervosa aged 13-16years, managed via adolescent psychiatry, never requiring hospital admission
Drug history:	no known drug allergies Folic acid tablets (400mcg once daily)
Occupation:	insurance company call centre
Marital status:	married 5 years
Smoking:	non smoker
Alcohol:	tee total

(For your information: a variation of this scenario has previously been used in year 3 and it was felt that students were sometimes missing the enormous emotional impact that a relatively early miscarriage might have on the patient who 'clinically' is at relatively low risk. We are looking to see whether this can be explored more empathically now the students are in year 5 and have had more experience at communicating with patients and have undertaken a placement in gynaecology in year 4)

Appendix 3: Workshop 2 Simulated consultations: case scenarios

Telephone Consultation: Elizabeth Allen Flu like symptoms

Information given to student:

You are working in a busy GP surgery. At the end of your morning surgery you have a request for a telephone consultation. The information you have been given on your appointment screen is "Elizabeth Allen dob 21/2/69 flu like symptoms". You open their medical notes and read her past medical history. Her last contact with the GP surgery was 2 years ago for a cervical smear. She has no relevant past medical history and is not taking any medications. Please phone the patient, take a history and formulate a management plan.

Information given to actor:

You are a 43 year old school teacher. You live alone having divorced 5 years ago and you have one daughter who lives in London. You developed symptoms of a sore throat, headache, sweating and aching all over yesterday evening and were unable to get out of bed this morning as you were feeling so terrible. You called in sick to work and spoke to your daughter on the phone who rang the surgery to get advice from the GP. You did not want her to do this as you felt she was wasting their time but your daughter was worried about you as you are never ill. When she phoned the surgery she was told that a GP will phone you back after morning surgery.

You think you probably have the flu, however one of the children in your class had recently been admitted to hospital with suspected meningitis. If asked you have NOT had any vomiting, sensitivity to looking at the light or a rash. You are grateful that the doctor has phoned you and are happy to manage your symptoms at home unless things get worse.

Further information

Past Medical History: nil of note

Drug history: no known drug allergies
Nil regular medications

Occupation: secondary school history

Marital status: divorced

Smoking: smoker- 5/day

Alcohol: 5-10 units/ week (wine or beer)

(For your information: in this scenario we are testing the students on a skill they are likely to have very little experience, but will be required of them upon qualification- not only to consult with patients, but also when dealing with colleagues over the phone)

End of Life Discussion with Relatives: Helen George (patient's wife) &Donald George (patient's brother)

Information given to student:

You are an F1 Doctor. A patient's wife wants to speak you. Her husband, Eddie George (age 52 years) is a patient that your team have been caring for. He has a diagnosis of carcinoma of the colon, with multiple metastases. For the past hour he has become semi-unconscious, agitated, appears in pain and has noisy airway secretions. Explain to the wife what is happening and answer any questions that she may have.

Information given to female actor:

Your husband first became unwell 2 years ago when he developed rectal bleeding and constipation. He went on to have a variety of investigations and was diagnosed as having carcinoma of the colon. He underwent surgery to remove part of the bowel and also had chemotherapy. You hoped at the time that he had been cured, but unfortunately his disease recurred 6 months ago, when he started complaining of weight loss and back pain. His health has deteriorated quite rapidly since then and he was admitted to hospital 2 weeks ago with vomiting and pain, which was found to be due to bowel obstruction by the tumour. A stent was inserted under sedation via a colonoscopy to bypass the blockage, but you were told that there was no other active treatment that could be offered and he was referred by the surgeons to the palliative care team to address his pain, vomiting & other symptoms. He has been unable to eat for several days and is receiving fluids via a drip in his arm and strong pain killers and anti-sickness medication via a syringe driver. He is sleeping for increasing periods and in pain when awake. You have left his bedside for as little as possible and are tired and anxious. You are struggling to come to terms with the fact that he is likely to die very soon. Your brother in law has been a good source of support and has visited daily, bringing you fresh pyjamas for your husband and snacks for you etc. You do not wish to see your husband suffer but want to speak to the doctor to see if there is anything else that can be done and ask how long they think it will be before your husband dies. You are happy to keep him in hospital as you have discussed with your husband previously and he does not want to die at home as his parents both died in the family home and this worried him.

Information given to male actor:

As above to female actor. Additional information- your wife die from breast cancer 5 years ago and died in difficult circumstances. Her cancer had also spread to her bones and she had pain until she died and the doctors never managed to control her nausea and vomiting. The death was extremely distressing for you to witness and you do not want your brother to suffer like your wife did. You haven't really discussed this with your sister in law as it was too personal at the time, but now you want to know after the initial discussion with the doctor whether your brother can be given anything than will 'shorten his suffering'.

Further information (relevant to both relatives, <u>not</u> deceased partner)

Past Medical History: nil
Drug history: nil
Occupation: wife: housewife; brother: plumber
Marital status: wife: married; brother: widowed
Smoking: non smoker
Alcohol: occasional only

(For your information: this scenario has been used as the point of discussion in a previous workshop with the palliative care team. The students will therefore approach the case with some experience of the issues that are likely to arise. We are expecting the students to demonstrate good empathy in this difficult situation in addition to the ability to consult with more than one person at a time, who in this case, have opposing views)

Consulting with an interpreter:

Information given to student:

You are working in a GP Practice. A couple come to see you. The wife is unable to speak English and her husband offers to interpret for you. He tells you that she is having problems with her periods and that they are worried as they are trying to have a baby.

Information given to female actor:

You started your periods when you were 15 years old and they have always been irregular (cycle 35-60 days). The periods have been getting heavier over the past 2 years and you have to change sanitary towel every hour for 6 of your average 9 day period. You sleep on a towel at night as you flood when asleep and generally feel rather drained.

You were brought up in a family that never discussed periods and in which it was frowned upon to complain about 'the curse'. You are from a strict catholic family and have never used contraception and had no sexual partners before you married at the aged 20 years. You have always practice natural family planning, i.e. avoiding intercourse when mid cycle, but this has been difficult with your irregular cycle- despite this you have never conceived. You do not get bleeding after intercourse or between periods. You have never been to the doctor before about period problems, and have not been to the surgery for several years.

You do not speak more than the odd word in English and certainly wouldn't be able to manage a consultation with a doctor without an interpreter. Your husband is quite overbearing and wants to keep private matters private so suggested he come to the doctor with you, rather than use a professional interpreter.

Further information

Past Medical History: nil of note
Drug history: no known drug allergies
Nil regular medications
Occupation: housewife
Marital status: married
Smoking: non smoker
Alcohol: teetotal

Information given to male actor:

You find the whole concept of discussing your wife's personal matters quite embarrassing and the fact that you are having difficulties with getting her pregnant emasculating.

For the purposes of this scenario, we are asking that you take a chauvinistic attitude and ask that you do not translate to your wife the full questions from the doctor if you do not feel the doctor needs to know personal points. In response, you should also not translate back to the doctor all your wife has to say, so the doctor gets the sense that not everything being discussed in welsh is being shared with them. This might be as extreme as yes/ no responses having obviously had quite lengthy discussion with your wife in front of the doctor, of may be different ways of phrasing the responses which alter the impact of emotions or symptoms on your wife's daily life. For example, if they ask about her periods, she might suffer severe period pains and been debilitated by heavy bleeding with flooding, but you find this too personal to convey and say 'no problems' or 'she manages'.

(For your information: we are asking students to consider the common challenges they might face when using interpreters and individual tutors may ask you to vary the level of cooperation according to how well the student is doing)

Appendix 4: Useful references on working with interpreters

http://www.languageline.co.uk/page/industry_healthcare/

www.ucl.ac.uk/.../Appendix_6_BPS_guidance_on_**working_with_interpreters**.pdf

http://nrif.homeoffice.gov.uk/Health/General/index.asp

Guidance on working effectively with interpreters is available from:

- Caring for dispersed asylum seekers: a resource pack
- The NHS information and resource pack, Meeting the health needs of refugees and asylum seekers in the UK
- Lambeth NHS Primary Care Trust's Resource Pack to help General Practitioners and other Primary Health Care Professionals in their work with Refugees and Asylum Seekers
- Guidance on Developing Local Communication Support Services and Strategies
- ethnicity online
- The Consultation – Communicating Effectively with Refugee Clients (Ministry of Health, New Zealand)
- How To Do It: Work with an interpreter
- Scottish Translation, Interpreting and Communication Support Forum provides guidelines on the role of the interpreter
- Working with Interpreters in Health Settings Rachel Tribe and Kate Thompson for *British Psychological Society 2008* These good practice guidelines give an overview of the issues psychologists need to consider when working with interpreters to ensure that they are able to be as effective as possible.

Consulting with an angry relative:

You are working in a GP Practice. You saw a 16 year old female patient last week and started her on the Oral Contraceptive Pill. Her father has come to see you to talk to you about this. He is extremely angry.

Information given to male actor:

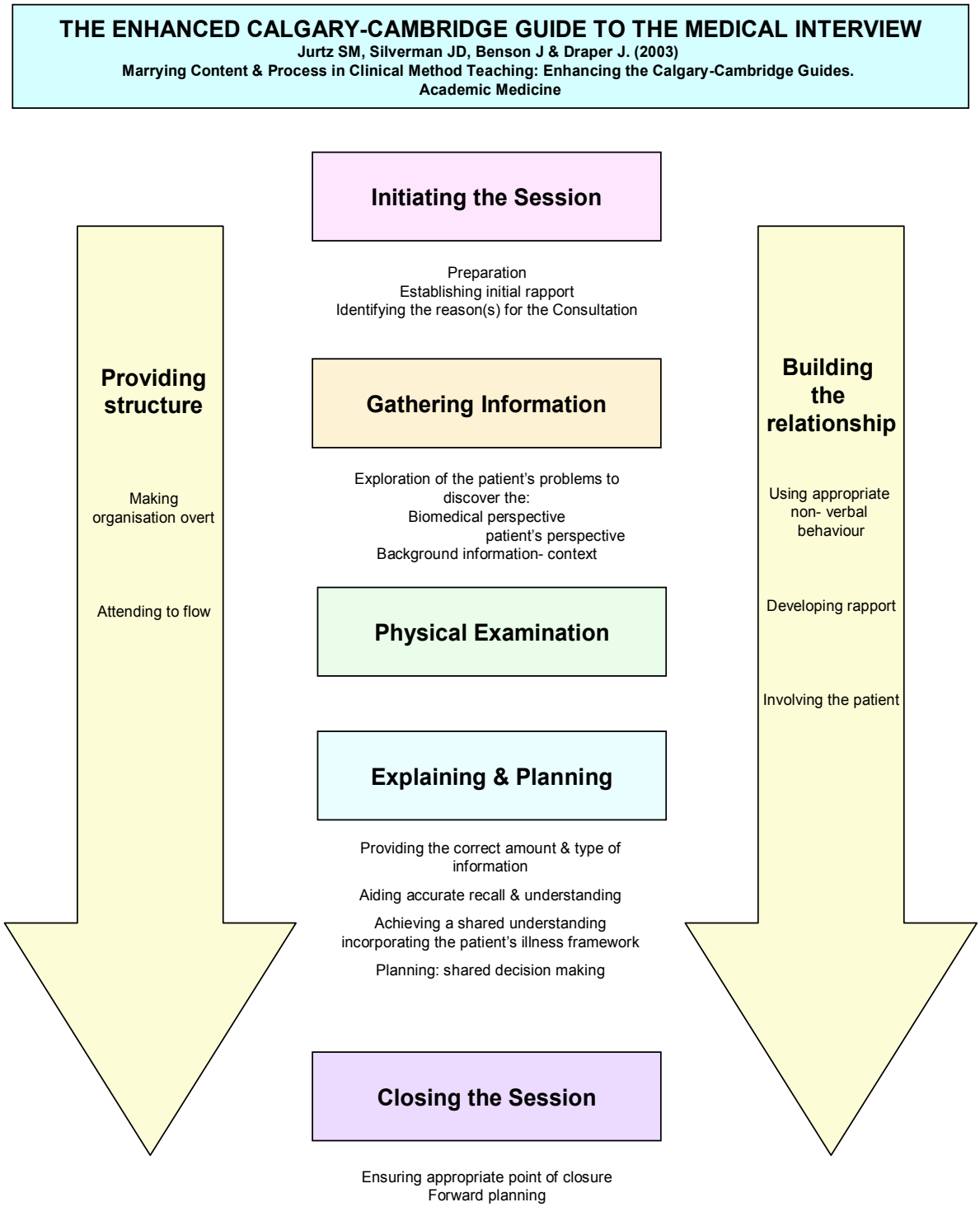
Last night you found a packet of contraceptive pills in your 16 year old daughter's bedroom. You confronted your daughter when she came home from her friends' house and she told you that she had seen the GP last week for problems with her periods and that the GP had suggested that she goes on to the Pill to help with these. You are furious as you do not think she should have been allowed to start the Pill without speaking to her parents first. You phoned the surgery this morning and demanded to see the GP who prescribed them to her.

You are shocked and upset that your daughter decided to keep this information from you and your wife as you feel that you have always had an open relationship with her. Your daughter has had a boyfriend for the past few months who you have met. You think he is a bit of a "waste of space" and you would prefer for her to concentrate on her forthcoming GCSE exams rather than spending time with him. You certainly don't want to entertain the idea that she has started a sexual relationship with him as you think she is too young and you are worried that she may end up getting pregnant and "ruining the rest of her life".

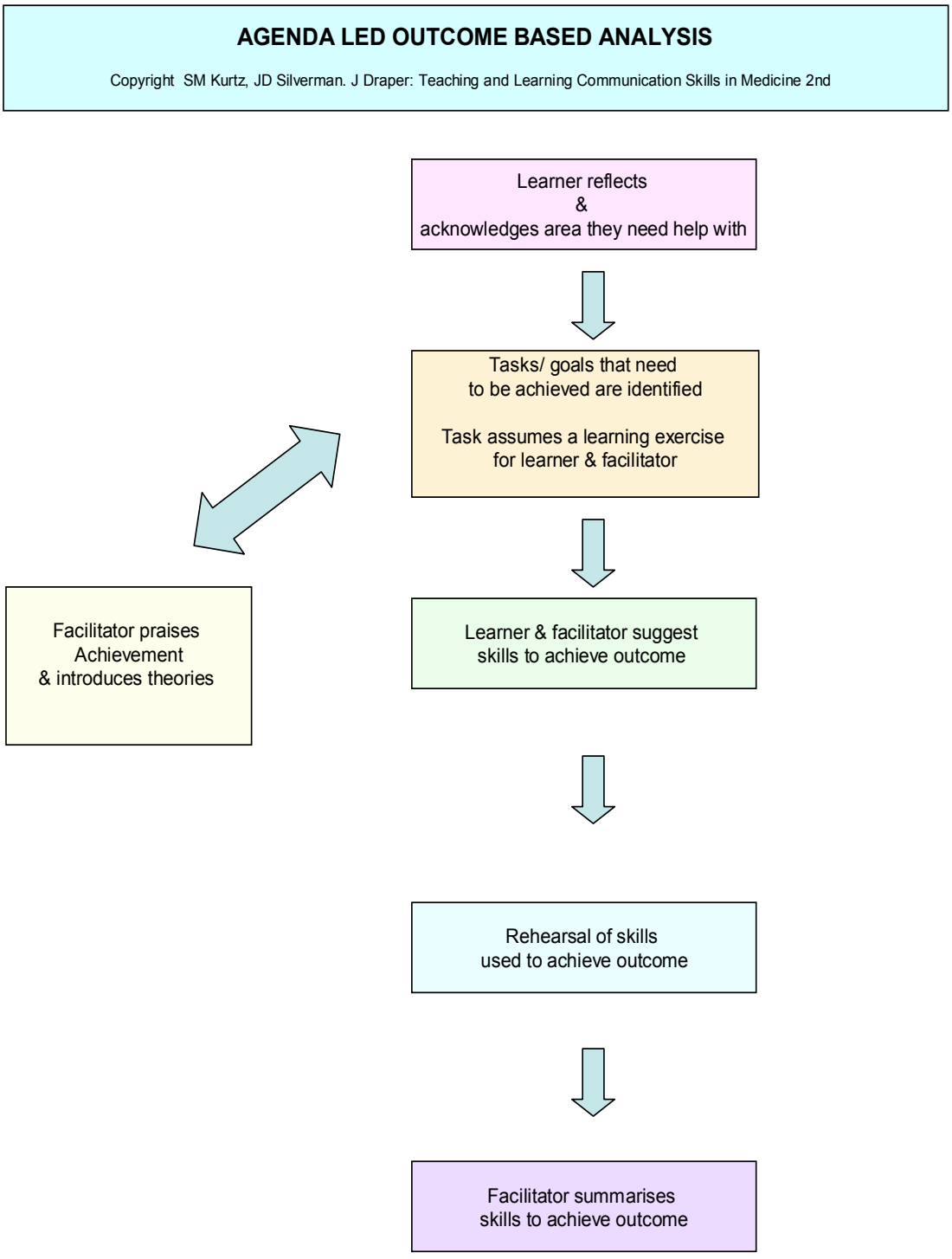
You want an explanation from as to why she has been given the Pill. If the immediate response is that they are unable to discuss this with you for confidentiality reasons then you get extremely angry banging your fists on the table and shouting that you demand an explanation.

(For your information: we are asking students to consider strategies for dealing with angry patients or relatives who may be violent or aggressive towards the doctor. There are some tips with dealing with aggressive patients on page 28. You may want to discuss variations on this scenario within the group such as what if the daughter was 14 years of age? How would that change the approach to this situation?)

Appendix 5


THE ENHANCED CALGARY-CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW
Jurtz SM, Silverman JD, Benson J & Draper J. (2003)
Marrying Content & Process in Clinical Method Teaching: Enhancing the Calgary-Cambridge Guides.
Academic Medicine
Initiating the Session
Preparation
Establishing initial rapport
Identifying the reason(s) for the Consultation
Providing structure
Making organisation overt
Attending to flow
Building the relationship
Using appropriate non- verbal behaviour
Developing rapport
Involving the patient
Gathering Information
Exploration of the patient's problems to discover the:
Biomedical perspective
patient's perspective
Background information- context
Physical Examination
Explaining & Planning
Providing the correct amount & type of information
Aiding accurate recall & understanding
Achieving a shared understanding incorporating the patient's illness framework
Planning: shared decision making
Closing the Session
Ensuring appropriate point of closure
Forward planning

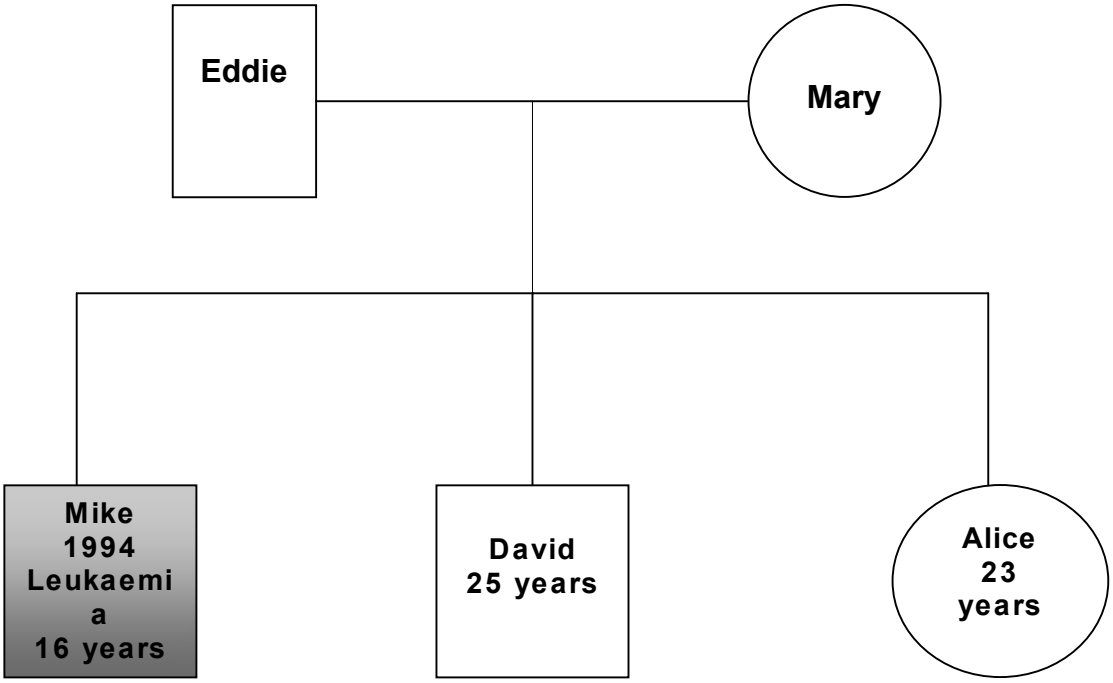
Appendix 6: Model for Agenda Led Outcome Based Analysis



Appendix 7: Case scenario given to students previously in palliative care workshop with Dr Mel Jefferson (for information only)

Mr Eddie George is a 52 year old man with carcinoma of the colon, liver, lung and bone metastases. He is now clearly dying, semi conscious, agitated, appears in pain and has noisy airway secretions.

His family tree is: -



Current medication
MST 60 mgs bd
Oramorph 20mgs prn
Diclofenac 50 mgs tds
Codanthrusate 2 bd
IV Fluids 3 litres/24 hours
Clexane 40 mg /day

Mary stops you in the corridor, very distressed and asks you to give him an injection to end it all.

Questions

1. How would you prioritise your use of time in this situation?
2. What would you look for when assessing Eddie?
3. What would you do to control his symptoms?
4. What issues would you aim to discuss with his relatives?
5. How might this situation have been prevented?

Reference

Oxford Textbook of Palliative Medicine The terminal phase 656 – 660