UNIVERSITY OF OXFORD

TUTOR HANDBOOK

4TH YEAR COMMUNICATION SKILLS COURSE

2011 - 2012

Contents

NB Text also appearing in Student Handbook will be in this font, *whereas this is the font used for text only in this Tutor Handbook*

Communication Skills
Introduction

Background and context of teaching

Communication skills have been taught as a structured course at the Oxford University Medical School since 1991.

The communication skills course is a thread that runs from the first to the final year. Students begin to learn communication skills in Patient-Doctor 1, an early clinical contact course which runs for seven sessions in years 1 and 2. During this course they meet patients with conditions related to the science they have been studying.

The bulk of the teaching occurs in year 4, the first year of the clinical course when there are seven sessions spread throughout the year and an OSCE (Objective Structured Clinical Examination) assessment at the end of that year. The tutors are drawn from general practice, hospital specialties and nursing. Most of the sessions happen as small groups working with an actor playing the role of a patient.

In year 5 the concept of the patient-centred consultation is re-emphasised during their specialty rotations and the students have an opportunity to work again on breaking bad news during the palliative care attachment. In some of the specialty attachments there are sessions led by expert patients enhancing the students' understanding of the patients' perspective, and the general practice attachment provides a further chance to focus on consultation skills.

By the time of the final BM exam students will have integrated their clinical and communication skills and these are examined together.

Teaching Methods

Most of the teaching occurs in small groups. Each session begins with an introduction outlining some of the theory behind what we are learning, but the bulk of the work is experiential. Each group of 4-7 students works with a tutor and an actor, with the students taking the role of doctor or medical student and the actor as patient. It is important that every student has the experience of consulting in each session.

In the small groups the students take turns to practise their skills in a consultation while their peers observe. The students and the tutor then give feedback on what they have observed. For this to work well, it is important that all participants feel safe in the group: some time is spent in the initial session working out group rules around supportiveness and confidentiality.

Feedback methods

There are various models available for giving feedback and tutors are encouraged to choose according to the needs and experience of the group. In general, the initial sessions often require the supportive but sometimes cumbersome framework of Pendleton's Rules[1]:

1) Learner comments on what was well done and how
2) Observers comment on what was well done and how
3) Learner comments on what could have been done differently and how
4) Observers comment on what could have been done differently and how

An alternative, particularly for later sessions when the students are more confident, is the agenda-led, outcome-based analysis method put forward in the Calgary-Cambridge guide[2]:

1) *Start with the learner's agenda – what problems was s/he experiencing?*
2) *Look at the outcomes the learner and the patient were trying to achieve*
3) *Encourage self-assessment and self-problem solving first*
4) *Involve the whole group in problem solving*

In practice most tutors use a mixture of feedback methods, varying flexibly to meet the demands of the situation.

Student feedback

An important element of the course is that the students learn from observing each other and from giving and receiving feedback not only from their tutor but also from their peers. The third session of the course concentrates on how to observe communication skills and how to give and receive feedback.

Actor feedback

Many of the actors who help with this teaching are now experienced in giving feedback. Their comments, particularly on how a student's behaviour or comments made them feel in their role as patient, can be more powerful than the tutor or fellow students' observations.

Timing

Whatever the method of feedback used it is essential that no student is left struggling for any length of time. If a problem is encountered, the tutor should stop the role play, analyse the problem and generate some solutions. The role play may then continue either with the same student or with another student swapping into the hot seat. The actors are all capable of rewinding to a certain point in the consultation and restarting it from wherever you choose. The sessions are short and there is a conflict between letting a role play develop at a realistic pace and ensuring all the students have a chance to consult. A high-energy approach, with lots of swapping in and students picking up where the previous one left off, will often generate a lot of teaching points, although the students will justifiably criticise the lack of verisimilitude.

The problem student

Students vary enormously in their enthusiasm for roleplay and a minority find the sessions a real struggle. Starting the session with a quick 'three words from each person about how they feel about role playing' can help to forewarn the tutor of any likely problems. No student can or should be forced to roleplay but it should be emphasised that all higher medical exams will involve being observed, usually with simulated patients.

If a student refuses to role play, every effort should be made to involve them in the observation and discussion. At the end of the session the tutor should have a quiet discussion with the student and if that does not seem likely to have solved the problem, the course organiser should be informed. Some students need extra individual coaching in this particular area and for some it uncovers deeper problems with the course as a whole.

Examining

Communication skills are examined in the joint medical and surgical OSCE exam at the end of the 4th year (2nd year for graduate entry students). There is a five minute station looking at a specific communication skill (usually explanation) and communication is also assessed in a history taking station. Students who struggle in this exam are interviewed and offered further communications skills support where a need is identified.

Aims and Objectives

Aims:

To help the students develop effective patient-centred consultation skills which are relevant to their clinical practice.

To enable students to work together in groups and to give constructive feedback to each other, share feelings and provide support.

Objectives:

Patient-centred consulting

Students should be able to interview a patient so that they can:

- Establish an effective relationship with the patient and demonstrate respect for the patient as a person.
- Establish the patient's history and symptoms, their chronology and related factor, sufficiently to establish their possible causes
- Explore the patient's understanding and ideas about the nature and cause of the problems and their management.
- Explore and respond to the patient's worries about the problems and their management.
- Offer appropriate explanations to the patient of the problem and its management which are related to the patient's own ideas.
- Check that the patient understands any explanations and that their concerns have been addressed.
- Take the opportunity to involve the patient in decision making and his or her own management.
- Listen to the patient and respond to offers. And demonstrate the appropriate use of open, closed and reflective questions.
- Conduct the consultation in a sequence logical to that particular patient's need and let the patient know that sequence so that time is used effectively.

Consultations in special circumstances

The student should be able to conduct effective consultations when they are required to:

- Give lifestyle advice
- Deal with sexual issues in clinical practice

- Break bad news
- Deal with anger and aggression
- Work with patients from diverse backgrounds
- Consult using an interpreter

Working with colleagues

The student should be able to:

- Make appropriate observations on the consultations s/he observes.
- Give and receive feedback constructively
- Share their own feelings and give support to others.

Helen Salisbury July 2011

References

1. D Pendleton et al, The Consultation: an Approach to Learning and Teaching, 1984

2. Suzanne Kurtz, Jonathan Silverman and Juliet Draper. Teaching and Learning Communication Skills in Medicine. Radcliffe Publishing 2005

Communication Skills

Sessions

There are seven Communication Skills sessions and you will be allocated to groups to attend these. Please **do not swap** from the group you are allocated to without checking with Caroline Jordan caroline.jordan@phc.ox.ac.uk This is important as there have to be the correct number of students per session. You will be notified of your groups in due course but in the meantime the dates are listed below for your information.

Standard Entry Students

Sessions 1 and 2	in September and October
Sessions 3 to 7	in January to May (1 session during Medicine and 4 sessions during Threads course)

Graduate Entry Students

Sessions 1 and 2	in January to May of the first year
Sessions 5 and 6	in September of the second year
Sessions 3, 4 and 7	in January to May of the second year

Thurs 8 Sept PM	Session 5 - Breaking Bad News (Graduate Entry Year 2)
Thurs 15 Sept PM	Session 6 - Anger & Aggression (Graduate Entry Year 2)
Tues 20 Sept PM	Session 1 - Listening
Thurs 22 Sept PM	Session 1 - Listening
Tues 27 Sept PM	Session 1 - Listening
Thurs 29 Sept PM	Session 2 - Explanation & Planning
Tues 4 Oct PM	Session 2 - Explanation & Planning
Thurs 6 Oct PM	Session 2 - Explanation & Planning
Thurs 5 Jan PM	Session 3 – Feedback (A)
Tues 17 Jan PM	Session 1 – Listening (Graduate Entry Year 1)
Tues 31 Jan AM	Session 3 – Feedback (C)
Thurs 2 Feb AM	Session 4 - Sex & sexuality (C)
Tues 7 Feb PM	Session 5 - Breaking Bad News (C)
Thurs 9 Feb PM	Session 6 - Anger & Aggression (C)
Tues 14 Feb PM	Session 3 – Feedback (B)
Tues 13 Mar AM	Session 3 – Feedback (D)
Thurs 15 Mar AM	Session 4 - Sex & sexuality (D)
Tues 20 Mar PM	Session 5 - Breaking Bad News (D)
Thurs 22 Mar PM	Session 6 - Anger & Aggression (D)
Tues 27 Mar PM	Session 7 - Language & Culture (C)
Tues 24 Apr AM	Session 4 - Sex & sexuality (A)
Tues 24 Apr PM	Session 7 - Language & Culture (Graduate Entry Year 2)
Thurs 26 Apr AM	Session 5 - Breaking Bad News (A)
Tues 1 May PM	Session 6 - Anger & Aggression (A)
Thurs 3 May PM	Session 7 - Language & Culture (A)
Tues 8 May AM	Session 4 - Sex & sexuality (B)
Tues 8 May PM	Session 7 - Language & Culture (D)
Thurs 10 May AM	Session 5 - Breaking Bad News (B)
Tues 15 May PM	Session 6 - Anger & Aggression (B)
Thurs 17 May PM	Session 7 - Language & Culture (B)
Tues 22 May PM	Session 2 - Explanation & Planning (Graduate Entry Year 1)

Communication Skills
Session One
The Patient-Centred Consultation

Aims:

In this session students will revise basic listening skills. They will consider the two agenda model of the consultation and practise interviewing skills: rapport building, information gathering, clarification and summarising and exploration of patients' ideas, concerns and expectations.

Session outline: ***12 mins***

Introduction to course, outline of sessions to come.
The two-agenda model of the consultation.
The initial tasks of the consultation: rapport building, information gathering, exploration of patient's perspective.

In small groups: ***3 mins***

Ask students to brainstorm group rules and write these down NB confidentiality.
Emphasise feedback should be specific, useful and supportive.

Exercise 1 - Basic listening skills*.* ***5 mins***

In pairs, think of an event that meant a lot to you and you don't mind sharing (e.g. passing an exam, losing a pet). Take turns to tell your partner about the event. The partner should do everything to show they are not listening. 1 minute each way
Discuss – what non-listening behaviours did they demonstrate?

- *what did it feel like not to be listened to?*
- *Generate a list of listening skills- verbal and non-verbal (opening questions, encouraging noises, body language, facial expression, gaze, etc)*

Role play 1 ***40 mins***

(Mr/Mrs Simpson with chest pain)
Give the students the information sheets. This gives the students all the medical information they require for the role play so go through it with them to be sure there are no clinical questions. Also give out and discuss the Calgary-Cambridge observation guide for information gathering.

The Patient-Centred Consultation

Move swiftly into the role play. Initially focus on the first few minutes of the consultation:

1. *How students introduced themselves to the patients.*

2. *Listening to the patient's presenting complaint. Students should be encouraged to ask an initial open question and then to facilitate the patient telling their story without interrupting the patient or going into a routine of closed questions. You may need to clarify the concepts of open, closed and focused questions.*

3. *Being alert to both verbal and non-verbal cues as to the patients' concerns.*

Take a high energy approach to this session. Swap the students in and out of the role play fairly quickly so that nobody is left in the 'hot seat' for too long and everyone has a turn.

With some groups it is necessary to give all the students jobs to do to get them involved e.g.

Student A - observe the non-verbal behaviour
Student B – observe the initiation of the session
Student C – observe the exploration of the patient's problems
Student D – observe the exploration of the patient's perspective
Student E – observe the structure of the consultation.

Areas for discussion

a) Active Listening
How do doctors show that they are actively listening?
Refer back to the list of listening skills generated in the exercise at the beginning of the session- you may wish to consider:

- Giving space and time - use of silence
- Verbal encouragement and facilitation - neutral phrases early and later use repetition, paraphrasing and interpretation
- non-verbal encouragement
- picking up cues

The Patient-Centred Consultation

b) Non-verbal skills in the consultation.

Add to the list of non-verbal skills generated:
posture
movement
proximity
direction of gaze
eye contact
gestures
affect vocal cues (tone and speed of speech)
facial expression
physical appearance
environment
If verbal and non-verbal cues contradict each other the non-verbal cues are the ones most attended to.

Roleplay 2 ***30 mins***

Mr /Mrs Heston with abdo pain
Give the students the clinical information and go through it briefly
Continue the observations as in roleplay one but focus particularly on how to explore the patient's perspective.

Useful phrases and ways to explore the patient's ideas

i. Direct approach - how did that make you feel

ii. Pick up cues - you say you have been worried

iii. Repetition of cues with non verbal encouragement

iv. Picking up and checking out verbal cues 'You said that you were worried that the pain might be something serious, what theories did you have yourself about what it might be?'

v. Picking up and checking out non-verbal cues 'I sense that you're not quite happy with the explanations you've been given in the past, is that right?'

Feedback

At the end of the session please allow 5 minutes for the students to fill in feedback forms and collect them back in. Ask the students to identify and share one thing they have learnt in the session. They should also write down feedback on the session /improvements that could be made.

The Patient-Centred Consultation

Evidence

Doctors frequently interrupt patients so soon after they begin their opening statement that patients fail to disclose significant concerns (Beckman and Frankel 1984 (mean time to interruption 18 seconds); Marvel et al 1999 (mean time to interruption 23 seconds))

Even patients with complex problems tend to be remarkably succinct. When internists in a tertiary care centre were trained to actively listen without interrupting until patients had completed their initial descriptions of their problems, patients' mean talking time was only 92 seconds (Langewitz et al 2002).

Picking up and responding to cues shortens rather than lengthens visits (Levinson et al 2000)

Doctors who are poor at communication get sued (Tamblyn et al 2007)
Low scores in the communication element of the clinical skills exam of the Medical Council of Canada (taken shortly after graduating) are associated with an increased rate of subsequent complaints registered with the medical regulatory authorities

References:

The effect of physician behavior on the collection of data. Beckman HB, Frankel RM. Ann Intern Med. 1984;101:692-696.

Soliciting the Patient's Agenda: Have We Improved? M. Kim Marvel, PhD; Ronald M. Epstein, MD; Kristine Flowers, MD; Howard B. Beckman, MD JAMA. 1999;281:283-287.

Spontaneous talking time at start of consultation in outpatient clinic: cohort study Wolf Langewitz, Martin Denz, Anne Keller, Alexander Kiss, Sigmund Rüttimann, Brigitta Wössmer BMJ 2002;325:682-683

A Study of Patient Clues and Physician Responses in Primary Care and Surgical Settings. Wendy Levinson, MD; Rita Gorawara-Bhat, PhD; Jennifer Lamb, BS JAMA. 2000;284:1021-1027

Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities Tamblyn R, Abrahamowicz M, Dauphinee D, Wenghofer E, Jacques A, Klass D et al.. JAMA 2007;298:993-1001.

The Patient-Centred Consultation

Notes for actor

The aim of the session is to give the students practice at responding to patient ideas, concerns and expectations.

Role play 1A Mr/Mrs Simpson

Presents to A and E with chest pain.

You run a post office and look after your elderly father. You have had odd twinges of pain in your chest on and off for a while, sometimes early in the morning or lifting heavy bags – you thought it was probably a muscle strain. After lunch yesterday (a Cornish pasty) you were digging the garden and got horrible indigestion, you really felt quite sick with it but when you sat down and took some Rennies it wore off. However today it came back when you were walking up the hill to Safeways and you worried in case it might be something to do with your heart. The pain has eased off a bit now.

Mum died of a heart attack in her 50s. You are worried about who will look after the shop and your dad if you are ill. You have cut down your smoking recently quite a lot – only 20 a day now. Your GP did say once that you had high BP and should have it checked again soon, but that was 2 yrs ago and you haven't had time to go back

You are scared that this is a heart attack and you will surely die young as your Mum did.

You tend to worry a lot and blame yourself for anything bad that happens.

1B: Mr/Mrs Simpson

Presents to A and E with chest pain.

You work in a small company setting up conferences and exhibitions. This morning you were moving some display boards around when you felt some pain in your chest. You would like to think this was a muscle strain – the boards were quite heavy – but your friend insisted on bringing you to A and E. If pressed you will admit that your friend said you went very pale and looked sweaty when this happened. The pain lasted about 3 minutes. You've occasionally had twinges of pain before when carrying heavy objects but nothing as bad as this. You smoke about 15 cigarettes a day and your brother had heart bypass surgery last year.

You are very apologetic about wasting the doctor's time. Your friend was fussing and you feel fine now. Underneath this façade you are worried but really not in a hurry to acknowledge this.

Role play 2A Mr/Mrs Heston

Presenting to A and E with abdo pain

You are a council officer, married with 2 children. You have been generally fit and well recently but this morning you didn't feel quite right when you woke up and you didn't fancy any breakfast. You started getting pain in the middle of your stomach at around lunch time and felt a bit sick, and now the pain has got worse and has moved down to the right. It is better if you keep still and worse if you move around. You haven't opened your bowels today but you normally go every day with no problems. You feel a bit feverish now, but a bit better since you took some painkillers before coming in.
If asked what you think: you wonder if this could be appendicitis – you have looked up your symptoms on the internet. Your main concern is about who will look after your mum (who has dementia) if you have to come into hospital.

Role play 2B Mr/Mrs Heston

Presenting to A and E with abdo pain

You work as an office cleaner. Your symptoms are exactly the same as role 2A above. A close friend has recently been diagnosed with cancer of the colon and had symptoms a bit like this when her bowel became blocked. You are terrified that you may have cancer too. Your replies may be very brief until this worry is uncovered: once it has been aired (even if the student is not able to put your mind completely at rest) you will become obviously more at ease and able to describe your symptoms in more detail.

The Patient-Centred Consultation

Notes for students

You have been asked to see Mr/Mrs Simpson in A and E. The nurse has already done some basic tests: pulse 90 regular, BP 150/95, temp 36.7. ECG – no obvious signs of acute MI but slight left ventricular hypertrophy. The patient is not unwell and no urgent action is required so they are able to talk to you.

Differential diagnosis

Skilled doctors tend to use four initial 'diagnostic' categories when assessing a patient:

1. Is the patient so sick that I cannot go through a full clerking - **must I start treatment urgently?**
2. What is the **broad system** which is primarily affected (e.g. respiratory; cardiac)?
3. What are the **serious causes** of these symptoms (which I must exclude)?
4. What are the **common causes** of these symptoms?

Chest Pain

There are three systems to think of when a person has chest pain

Cardiac
Two common causes are:

- **angina** – constricting pain that can radiate up into the jaw and down the arm. Comes on with exercise and goes with rest.
- **myocardial infarction** – constricting pain that may radiate up into the jaw and down the arm but is much more severe in intensity and duration than angina ('I thought I was going to die'). Often associated with nausea, sweating and breathlessness.

Respiratory
Two common causes are:

- **chest infection:** cough usually with sputum; feels ill in addition to breathlessness (e.g. fever)
- **pulmonary embolism:** sharp pain with sudden onset of breathlessness. Breathless at rest.

GI tract

- **oesophagitis:** central chest pain. May be brought on by food, lying flat, hot drinks or alcohol. Relief with antacids.

The Patient-Centred Consultation

Notes for students

You are asked to see Mr/Mrs Heston in A and E

Right Lower Quadrant Pain

Possible causes:

- Appendicitis – begins with colicky, central abdominal pain then pain shifts to the right iliac fossa. Constipation is usual. The patient will go off their food and may have a slight temperature.
- Salpingitis – cramping lower abdominal pain. May be associated with pain when having sexual intercourse, fever and nausea
- Tubo-ovarian abscess – persistent spiking fever, lower abdominal pain and pain with sex
- Ruptured Ectopic Pregnancy – lower abdominal pain with or without vaginal bleeding. Pregnancy test is usually (but not always) positive
- Mesenteric adenitis
- Crohn's disease – often with weight loss, diarrhoea and pr bleeding
- Bowel Obstruction - anorexia, nausea, vomiting, colicky abdominal pain with distension and constipation.

CALGARY – CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW – COMMUNICATION PROCESS

INITIATING THE SESSION

Establishing initial rapport

1. **Greets** patient and obtains patient's name

2. **Introduces** self, role and nature of interview; obtains consent if necessary

3. **Demonstrates respect** and interest, attends to patient's physical comfort

Identifying the reason(s) for the consultation

4. **Identifies** the patient's problems or the issues that the patient wishes to address with appropriate **opening question** (e.g. "What problems brought you to the hospital?" or "What would you like to discuss today?" or "What questions did you hope to get answered today?")

5. **Listens** attentively to the patient's opening statement, without interrupting or directing patient's response

6. **Confirms list and screens** for further problems (e.g. "So that's headaches and tiredness; anything else …..?")

7. **Negotiates agenda** taking both patient's and physician's needs into account

GATHERING INFORMATION

Exploration of patient's problems

8. **Encourages patient to tell the story** of the problem(s) from when first started to the present in own words (clarifying reason for presenting now)

9. **Uses open and closed questioning technique**, appropriately moving from open to closed

10. **Listens** attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing

11. **Facilitates** patient's responses verbally and non-verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation

12. **Picks up** verbal and non-verbal **cues** (body language, speech, facial expression, affect); **checks out and acknowledges** as appropriate.

13. **Clarifies** patient's statements that are unclear or need amplification (e.g. "Could you explain what you mean by light headed")

14. **Periodically summarises** to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information

15. **Uses** concise, **easily understood questions and comments**, avoids or adequately explains jargon

16. **Establishes dates and sequence** of events

Additional skills for understanding the patient's perspective

17. Actively **determines and appropriately explores:**

patient's **ideas** (i.e. beliefs re cause)

patient's **concerns** (i.e. worries) regarding each problem

patient's **expectations** (i.e.goals, what help the patient had expected for each problem)

effects: how each problem **affects** the patient's life

18. **Encourages patient to express feelings**

PROVIDING STRUCTURE

Making organisation overt

19. **Summarises** at the end of a specific line of inquiry to confirm understanding before moving on to the next section

20. Progresses from one section to another using **signposting, transitional statements**; includes rationale for next section

Attending to flow

21. Structures interview in **logical sequence**

22. Attends to **timing** and keeping interview on task

BUILDING RELATIONSHIP

Using appropriate non-verbal behaviour

23. **Demonstrates appropriate non-verbal behaviour**

eye contact, facial expression
posture, position & movement
vocal cues e.g. rate, volume, tone

24. If reads, writes **notes** or uses computer, does **in a manner that does not interfere with dialogue or rapport**

25. **Demonstrates** appropriate **confidence**

Developing rapport

26. **Accepts** legitimacy of patient's views and feelings; is not judgmental

27. **Uses empathy** to communicate understanding and appreciation of the patient's feelings or predicament; overtly **acknowledges patient's views** and feelings

28. **Provides support**: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership

29. **Deals sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

30. **Shares thinking** with patient to encourage patient's involvement (e.g. "What I'm thinking now is ….")

31. **Explains rationale** for questions or parts of physical examination that could appear to be non-sequiturs

32. During **physical examination**, explain process, asks permission

Communication Skills Teaching
Session Two
Explanation and Consent and Lifestyle Change

Aims

Explanation:

By the end of the session students should be able to:

- Find out what the patient knows already
- Offer a patient-centred explanation of a diagnosis or intervention with the appropriate amount of detail
- Use appropriate language, avoiding jargon
- Use the patient's explanatory models where possible
- Be confident to use diagrams to aid understanding
- Check that they have been understood

Lifestyle change

- Establish the patients ideas, beliefs and readiness to change
- Explain the nature and reasons for the advice
- Agree goals together
- Provide ongoing support

Consent

- Establish the patient's views on their own care
- Involve the patient in making informed choices
- Promote the patient's involvement in their own care

Explanation and Consent and Lifestyle Change

Introduction (plenary) ***10 mins***

Outline aims of session

Explanations:

Brainstorm *What needs explaining? (diagnosis, aetiology, treatment, risk, prognosis)*
What are the prerequisites? (time, inclination, knowledge)
What are the elements of a good explanation?
(takes account of prior knowledge, patient centred, clearly understood)

Consent *Introduce concept of consent as an ongoing facet of the doctor/patient relationship not just a signature.*

Small group work

Discussion ***10 mins***

Either as a whole group or in pairs. Discuss examples of successful and unsuccessful explanations they have witnessed so far. What factors were involved? Go through the Calgary Cambridge Guide section on explanation and planning – either now or later in the session.

Role play 1 ***30 mins***

Explaining a diagnosis – angina

You may need to do a bit of group revision to make sure that all are confident in their knowledge of basic pathophysiology of ischaemic heart disease.
The aim of this roleplay is for the students to learn to fit their explanation to the patient's needs. Exploration of prior understanding is key. Remind the students if necessary about picking up on the patient's emotional cues but don't make this the main emphasis of the session. Encourage them to use diagrams or analogies to aid their explanation.

Your actor will be primed to be at least 2 different characters with the same basic clinical history but different social histories.

Role play 2 ***25 mins***

Lifestyle change – smoking and exercise

The aim of this roleplay is to consider what is effective in giving advice. Rehearse the basic steps of considering reasons and desire for change, readiness to change, barriers and need for ongoing support. You can run this roleplay on from the previous one, using the same characters as before in the same clinical situation.

Explanation and Consent and Lifestyle Change

Role play 3 ***25 mins***

Explanation of a procedure and patient involvement

This is an exercise in giving a patient-centred explanation of a procedure, and involving the patient in decision making. Which procedure(s) you pick will depend on what the students have observed – inserting a cannula or a catheter, endoscopy, angiography and many more are suitable.

The main teaching points of the roleplay are the framing of the explanation ("this is what you will experience" rather than "this is what we will do to you") and the appreciation of the patient's role in decision making.

Feedback ***5 mins***

At the end of the session please allow 5 minutes for the students to fill in feedback forms and collect them back in. Ask the students to identify and share one thing they have learnt in the session. They should also write down feedback on the session and improvements that could be made.

Theory and Evidence

Explanations

Asking patients to repeat in their own words what they understand of the information they have just been given increases their retention of the information by 30% (Bertakis 1977)

Patient recall is increased by categorisation, signposting, summarising, repetition, clarity and the use of diagrams (Ley 1988)

There is decreased understanding of information given if the patient's and doctor's explanatory frameworks are at odds and this is not discovered and addressed during the interview. (Tuckett et al 1985)

Patient satisfaction is directly related to the amount of information that patients perceive they have been given by their doctors (Hall et al 1988)

Behaviour Change

Doctors typically rely on health information and their professional status to convince patients to change. Health-behaviour theories and models suggest more effective methods for accomplishing patient compliance and other behaviour change (See Elder et al 1999 for a summary of theories and models).

Recognising ambivalence and assessing readiness to change is a key to successfully negotiating behavioural change in a medical setting (Rollnick et al 1992)

Explanation and Consent and Lifestyle Change

Notes for actors

Role play 1 Mr/Mrs Higgs

The purpose of this roleplay is to give the students practice at giving clear, appropriate explanations.

Basic information:
You are a smoker in your 50s. About 4 weeks ago you started getting chest pain on exertion (lifting something heavy, running for a bus – think of an activity which fits your character –see below). The pain was in the centre of your chest, was severe, crushing and you felt a bit nauseated with it. You had some aching in your left arm at the same time. The pain never lasted more than a few minutes in all and began to get less severe as soon as you rested. You didn't have palpitations and were not short of breath.

Your mother had a heart attack age 60 and died of another one 6 years later.

You saw your GP who said it sounded like angina and sent you for an exercise test, where you had to run on a treadmill and have your heart tested at the same time. That was positive and now, a week later, you are waiting to see the cardiologist. You want to use this meeting with the medical student to find out what angina means.

Role play 2 Mr/Mrs Higgs

The purpose of this roleplay is for the students to discuss lifestyle issues affecting health with the patient in a way which will promote positive change.

You have the same history as above. You have been smoking 15-20 cigarettes a day for 30 years.

You walk a bit but do no strenuous exercise.

Characters
Please prepare two different characters for these role plays, with different levels of education, experience of heart disease and anxiety about it.

Consider – Are you working and if so what is your job?
What is your family setup?
Who do you know who had heart problems and what happened to them?
Are you very worried or fairly blasé?
Do you want to give up smoking? Or take up exercise?

We will work on what you have created in the training session.

Explanation and Consent and Lifestyle Change

Role play 3 Mr/Ms Griffiths

The purpose of this role play is for the students to practise giving a patient-centred explanation of a procedure and involving the patient in decision making. What procedure they explain will depend on what they have learnt about so far on the wards and the tutor will sort that out.
You cannot prepare background information for this scenario but be prepared to react to the student's explanation of whatever they are proposing. If they explain poorly or make it sound too unpleasant, you might actually refuse to have it done!

Notes for students

A good explanation in a medical setting will be patient centred: it will take account of what the patient already knows, focus on what the patient needs and wants to learn and be given in language that is clearly understood by the patient. Thus a good explanation will be tailored to the individual and will vary widely with different patient.

The 1st role play in this session will focus on explaining a diagnosis of angina. You do not need to worry too much about treatment in this session; the emphasis will be on translating your knowledge of the anatomy and pathophysiology into a useful explanation for the patient. Following on from this we will consider the lifestyle issues related to cardiovascular disease and consider what approaches may be helpful to patients who need to make changes.

The final role play will focus on patient centred explanations of medical procedures. The scenarios used will depend on what procedures you have seen.

Role play 1

You are sitting in on cardiology outpatients. Mr/Ms Higgs is a 55 year old patient who has recent onset angina and had a positive exercise test last week. He/she will be seeing the cardiologist today to discuss whether any further investigations are needed and to optimise his/her medications. The cardiologist has sent you along to see the patient first and answer some of his/her questions.

Role play 2

You have been asked to discuss lifestyle issues with your patient in the cardiology clinic.

CALGARY – CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW – COMMUNICATION PROCESS

EXPLANATION AND PLANNING

Providing the correct amount and type of information

33. **Chunks and checks:** gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed

34. **Assesses patient's starting point**: asks for patient's prior knowledge early on when giving information, discovers extent of patient's wish for information

35. **Asks patients what other information would be helpful** e.g. aetiology, prognosis

36. **Gives explanation at appropriate times:** avoids giving advice, information or reassurance prematurely

Aiding accurate recall and understanding

37. **Organises explanation:** divides into discrete sections, develops a logical sequence

38. **Uses explicit categorisation or signposting** (e.g. "There are three important things that I would like to discuss. 1st … "Now, shall we move on to.")

39. **Uses repetition and summarising** to reinforce information

40. **Uses** concise, **easily understood language,** avoids or explains jargon

41. **Uses visual methods of conveying information:** diagrams, models, written information and instructions

42. **Checks patient's understanding** of information given (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary

Achieving a shared understanding: incorporating the patient's perspective

43. **Relates explanations to patient's illness framework:** to previously elicited ideas, concerns and expectations

44. **Provides opportunities and encourages patient to contribute:** to ask questions, seek clarification or express doubts; responds appropriately

45. **Picks up verbal and non-verbal cues** e.g. patient's need to contribute information or ask questions, information overload, distress

46. **Elicits patient's beliefs, reactions and feelings** re information given, terms used; acknowledges and addresses where necessary

Planning: shared decision making

47. **Shares own thinking as appropriate:** ideas, thought processes, dilemmas

48. **Involves patient** by making suggestions rather than directives

49. **Encourages patient to contribute their thoughts:** ideas, suggestions and preferences

50. **Negotiates** a mutually **acceptable plan**

51. **Offers choices:** encourages patient to make choices and decisions to the level that they wish

52. **Checks with patient** if accepts plans, if concerns have been addressed

CLOSING THE SESSION

Forward planning

53. **Contracts** with patient re next steps for patient and physician

54. **Safety nets,** explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

Ensuring appropriate point of closure

55. **Summarises session** briefly and clarifies plan of care

56. **Final check** that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss

OPTIONS IN EXPLANATION AND PLANNING (includes content)

IF discussing investigations and procedures

57. Provides clear information on procedures, e.g. what patient might experience, how patient will be informed of results

58. Relates procedures to treatment plan: value, purpose

59. Encourages questions about and discussion of potential anxieties or negative outcomes

IF discussing opinion and significance of problem

60. Offers opinion of what is going on and names if possible

61. Reveals rationale for opinion

62. Explains causation, seriousness, expected outcome, short and long term consequences

63. Elicits patient's beliefs, reactions, concerns re opinion

IF negotiating mutual plan of action

64. Discusses options eg no action, investigation, medication or surgery, non-drug treatments (physiotherapy, walking aids, fluids, counselling, preventive measures)

65. Provides information on action or treatment offered
    - name
    - steps involved, how it works
    - benefits and advantages
    - possible side effects

66. Obtains patient's view of need for action, perceived benefits, barriers, motivation

67. Accepts patient's views, advocates alternative viewpoint as necessary

68. Elicits patient's reactions and concerns about plans and treatments including acceptability

69. Takes patient's lifestyle, beliefs, cultural background and abilities into consideration

70. Encourages patient to be involved in implementing plans, to take responsibility and be self-reliant

71. Asks about patient support systems, discusses other support available

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Communication Skills
Session Three
Feedback

Aims:

To learn to observe the communication skills at work in a consultation
To learn what makes useful feedback
To learn and practise how to give and receive feedback constructively

Feedback is an essential part of learning any skill and good feedback will help you improve more rapidly. There is a growing trend towards peer appraisals in professional education which you will meet formally in your Foundation posts, so it will be helpful to you to get used to giving and receiving feedback during your training

During this session you will observe video'd consultations that are deliberately less than ideal and analyse them from a communication perspective using a rating scale. We will consider what makes feedback useful and practise giving feedback.

This is preparation for an exercise in peer observation of communication skills to be done on the wards after this session.

Introduction (in big group)

Rationale for this exercise: main method of learning in the apprenticeship model. If you don't receive any feedback, or fail to hear it, how can you improve?
Growing trend towards peer appraisals in professional education – we can help each other.
Agenda for the session – observing video'd consultations (NB deliberately less than ideal consultations) learning to use an observation scale, what is useful as feedback, how to deliver it – all a prelude to doing this for real.
After the session students will go to the wards in pairs and observe each other taking a full history and give feedback on the communication they observe

In small groups:

Each group will need a copy of the DVD and some spare copies of the Oxbridge rating scale for those who have forgotten their books.

Watch consultation 1 and ask the students to note down positive criticisms and points for improvement in the consultation.

Share what was observed.

Discuss what makes useful feedback – brainstorm first, then look at the handout on characteristics of useful feedback. Allowing the consulter to comment first is often a good strategy.

Watch consultation 2

Ask the students to observe as before but think about what their feedback would be. Try to pick out both positive points and areas for improvement – specific, observable, modifiable. Ask the students to address the feedback to you as if you were the doctor on the video.

Watch consultation 3

Make observations as before and then either go round the group giving feedback to your neighbour as if he/she was the doctor on the screen or do this in pairs simultaneously, before asking for examples to share with the whole group. Ask students to share the problems they experienced in delivering or receiving the feedback (were there areas they would have liked to tackle but didn't?) and work on solving them together

Explain the task on the wards:

Working in pairs, each student should clerk a patient while a colleague observes and make notes on the communication skills they observe using the format we have just practised. Away from the bedside, the observer should discuss their feedback with the interviewer. Students should then swap roles and repeat the process. Don't forget to ask permission from the patients. Following the exercise, please fill in the feedback forms and return them to Dr Salisbury at the medical school office.

Feedback

At the end of the session please allow 5 minutes for the students to fill in feedback forms and collect them back in. Ask the students to identify and share one thing they have learnt in the session. They should also write down feedback on the session and improvements that could be made.

Modified Oxbridge Rating Scale for Peer Reviewed Consultations

(for use in the session)

Interviewer_____

Observer_____ Date_____

Does the interviewer:

1) Develop an effective relationship with the patient?

2) Elicit the patient's history and symptoms?

3) Listen actively to the patient and respond to cues?

4) Structure the consultation appropriately for the patient's needs

5) Elicit and explore the patient's understanding and ideas?

6) Explore and respond to the patient's worries and concerns?

Characteristics of Useful Feedback: - Specific, observable, modifiable

- Useful – for the benefit of the receiver
- Realistic – refers to behaviour that can be changed
- Descriptive not judgemental
- Concentrates on behaviour not personality
- Specific not general

The Skills in Giving Feedback

- Allow the recipient choice – make sure they want feedback
- Be sensitive to the climate and acknowledge emotion
- Be clear about what you want to say
- Select priority areas
- Own the feedback – e.g. "In my view…"

The Skills in Receiving Feedback

- Be clear about what is being said
- Listen to the feedback, don't immediately react
- Check it out with others
- Ask for the feedback you want
- Decide on what you will do because of the feedback

Instructions for peer observation exercise

Pair up with a colleague.
Ask permission from a patient to clerk them as you would routinely (preferably a patient you don't already know well). Explain that your colleague will be observing you.
When you have finished clerking, the observer gives feedback to the interviewer away from the bedside (remember – specific, observable, modifiable). Repeat the exercise with a new patient, swapping roles.

The content of your feedback is confidential; however the medical school does want to know that the task was done and whether you encountered any difficulties. Please fill in the feedback sheets and return them to the medical school office **ASAP**.

Feedback on peer observation of communication skills

Please circle your answers and feel free to write comments.
(This sheet is duplicated at the back of this book for you to tear out)

Were there any practical difficulties in carrying out this task? Yes No

As the <u>interviewer</u>:

Was positive feedback given? Yes No

Did you feel this feedback was valid? not at all completely

1 2 3 4 5

Were areas for improvement given? Yes No

Did you feel this feedback was valid? not at all completely

1 2 3 4 5

How well was the feedback delivered? very badly very well

1 2 3 4 5

How willing would you be to receive feedback on your communication skills from a student again? very unwilling very willing

1 2 3 4 5

Will any of the feedback you received affect the way you interact with patients in the future?

Yes No

Compared to any feedback you have received from doctors, how useful was this?
less useful as useful more useful

1 2 3 4 5

Comments:

Feedback on peer observation of communication skills

Please circle your answers and feel free to write comments.
(This sheet is duplicated at the back of this book for you to tear out)

As the <u>observer</u>:

Was it easy to identify points for positive feedback? difficult easy

1 2 3 4 5

Was it easy to identify points for improvement? difficult easy

1 2 3 4 5

How easy or difficult did you find it to give positive feedback?
very difficult very easy

1 2 3 4 5

How easy or difficult did you find it to discuss areas for improvement?
very difficult very easy

1 2 3 4 5

Were there issues you observed which you did not feel able to comment on?

Yes No

If yes, please write a comment on why that was:

Did you think it was appropriate for you to be giving feedback to your colleague?
inappropriate appropriate

1 2 3 4 5

How much did you learn from observing and giving feedback?
nothing a lot

1 2 3 4 5

Do you think it would be useful to repeat this exercise in Year 5?

Yes No

Thank for completing this feedback form. **Please return it to Dr Salisbury via the Medical School Office ASAP.**

Communication Skills Teaching
Session Four
Discussing Sex and Sexuality

Aims of the session

To learn the components of a sexual history

To realise when sex may be relevant in the medical setting

To understand the difficulties patients may have in discussing matters relating to sex

To build confidence in initiating a discussion about sex with a patient in a general hospital setting

In this session students will practise talking to patients about matters relating to sex when it is obviously the main focus of the consultation (e.g. in genito-urinary medicine) and when it is less obvious (in a medical or surgical setting). Students will consider the different skills that are needed in each situation.

Students should become aware of their own assumptions regarding sex and sexuality and will be encouraged to adopt neutral and non judgemental language when talking about sex and relationships.

Introduction

The introduction will cover:

- *Registration*
- *When might sex be an issue? (in relation to nearly all branches of medicine and surgery)*
- *Why it is our job as doctors to raise the subject*

Sex and Sexuality

(10 mins)

Has sex been discussed in any of the clinics they have been in? If not, why not?

Brainstorm

You might like to split your group into two for this and then ask them to share their conclusions:

What are the patient factors which may prevent discussion? (eg embarrassment, concerns about confidentiality, concerns about prejudice, lack of identity with the doctor (gender, ethnicity), concern that this problem will seem trivial)

What are the doctor factors? (eg embarrassment, know the patient too well, lack of identity with the patient, lack of time, feeling inadequately skilled/knowledgeable)

What are the components of a sexual history?

The students have not yet received any teaching on this so it will be necessary to go over this in some detail. The GUM proforma is a useful teaching aid here.

- Presenting complaint - nature of and duration of symptoms:
  discharge – vaginal/urethral/rectal
  dysuria
  lumps or bumps – genital/inguinal
  cuts or ulcers
  pain – pelvic, testicular or other genital pain, including dyspareunia
- Sexual partners – recent and current:
  male/female
  date of most recent contact
  duration of relationship
  presence or absence of symptoms
  nature of sexual contact (oral, vaginal, anal)
  country of origin/history of recent travel
- Contraception used, particularly barrier methods.
- Other risks for HIV infection; IV drug use, needle stick injuries
- Previous history of STI and diagnosis
- Menstrual history, pregnancies, miscarriages, cervical smear history, intermenstrual or post coital bleeding
- Other medical history, current illness, drug history etc.

NB Some infections can be asymptomatic or ignored for months or years before presentation. However, a recent change in symptoms would tend to suggest recent infection.

Insert GUIM form here

Sex and Sexuality

Discussion about what components of a sexual history might be relevant in various settings – the difference between a GUM consultation and a consultation about the impact of a colostomy on a patient's sex life.

Role play – you will have a male actor for half the session and a female actor for the other half so will cover all four topics with your group. If you start with a male actor you will do the role plays in the order 1,3 (swap actors)2,4.

Role play 1 GUM clinic –male or female
Role play 2 Dyspareunia – female

SWAP ACTORS – (60 mins after the start of the session)

Role play 3 TURP – male
Role play 4 angina –male or female

Role play 1 Robert Lee/Sue Muir (20mins)

The aim of this role play is to discuss the factors that may be involved in risk of sexually transmitted diseases. It will be challenging for some students to talk about gay and lesbian sex without embarrassment. The patient presents 'worried well' to a GUM clinic and wants to know whether they should be tested for sexually transmitted infections (including HIV). The bottom line is that if there is any doubt there are huge advantages to knowing so the answer is nearly always yes, but we can use this scenario to get used to asking questions about sex. As it is set in GUM the patient is clearly expecting to answer questions about their sex life.

Role play 2 Mrs James (20mins)

The aim of this role play is to get the student to be able to discuss sex in an unembarrassed way using appropriate unambiguous vocabulary.

This role play is set in a GP surgery and relates to the topic of dyspareunia. The patient presents with the problem of sex being painful. The student will need to find out exactly what the problem is (is it deep or superficial dyspareunia? Is there any pain at other times? Has sex always been painful? Is there a problem with arousal? What is going on in the relationship? Why has she sought help now? Etc)

Role play 3 Mr Roth (20mins)

This role play is set in urology outpatients where a patient is considering undergoing a TURP (transurethral resection of the prostate). It is important that the student takes an accurate social history to enable him/her to offer appropriate advice.

Role play 4 Mr/Mrs Spring (20 mins)

This role play is set in cardiology outpatients. The aim is to get the student to raise the issue of sex and uncover the patient's (or his/her partner's) anxiety in order to be able to explain and reassure. The actor has prepared two characters – one where the patient is worried and one where the partner is worried. Rehearse different ways of approaching the topic.

During the afternoon the students should have developed the vocabulary to ask non-judgemental questions about sex. It may help to list these in the closing few minutes.

They should have a wider appreciation of when to ask about sex and to assume nothing and expect anything in reply.

Feedback ***(5 mins)***

At the end of the session please allow 5 minutes for the students to fill in feedback forms and collect them back in. Ask the students to identify and share one thing they have learnt in the session. They should also write down feedback on the session and improvements that could be made.

References

Fast Facts: Sexually Transmitted Infections
Anne Edwards, Jackie Sherrard and Jonathan Zenilman Second edition Feb 2007
Health Press ISBN 978-1-903734-95-7

Sex and Sexuality

Notes for actors

Role play 1a - Robert Lee

You are Robert Lee, a 50 year old businessman. You have self referred to a GU clinic because you are worried about HIV infection.

You are in a stable marriage but you do not communicate with your wife much and you have sex rarely, once a month or so. Fifteen years ago you had your first homosexual encounter. You do not have a regular male partner and only pick up men rarely (about once or twice a year). Usually you just have oral sex with men and mutual masturbation.

About 2 months ago a young man you picked up attempted anal sex with you without a condom but failed. You have been slightly concerned about HIV since and would like to have an HIV test. You have not slept with your wife since this incident

You are quite at ease with your lifestyle but neither your wife nor work colleagues know about your male encounters. Your wife does not know that you are attending clinic today and you are concerned about issues of confidentiality.

Role play 1b - Sue Muir

You are a 50 year old nurse. Your husband is a civil engineer and is often travelling with work.

About a month ago you noticed a change in your vaginal discharge. It seemed heavier than normal. You thought it might be thrush so bought some Canesten from the chemist to treat it after which the discharged settled a little, but did not go away entirely.

You have regular sex with your husband and use a coil for contraception. Your periods are regular but have been a little heavier than usual. You have had no abdominal pain or pain having sex. Your last smear was 18 months ago and normal. You have had two pregnancies, with no complications

You have been married to your husband for twenty years. You have recently started a relationship with a woman colleague at work and in the last six weeks this has become a sexual relationship. You have shared sex toys and are worried that this could have caused an infection. Your husband does not know about this.

Your GP is a an old family friend and you do not want to go to him with this problem which you find embarrassing, so you have come to the GU clinic.

You would like a full check up.

Role play 2 - Mrs James

You are 48 and have been married for 6 months and are coming to see your GP because sex is painful. You find penetration very uncomfortable and it has got to the stage where you are avoiding sex altogether. Your husband is very understanding but you are worried that he will get fed up and leave if you cannot sort this out. You love him very much and do not want this to happen.

You did not have sex with your husband before you married, as you do not believe that is right. You did have sex once when you were a teenager, and it was a horrible experience. You are

worried that you may have been damaged in some way physically by this experience, or be in some way not normal in that area.

Role play 3 - Henry Roth

You are Henry Roth aged 60 years old. You have been having problems passing urine which have gradually increased over the last few years. The stream is poor and you have to get up 4 or 5 times at night to go to the loo. You had a blood test and there is no evidence of cancer. You have also tried some tablets but they did not help. Your GP has referred you for an operation on the prostate which you hope will sort out your symptoms.

Your wife died four years ago. Your two children (a boy and a girl) are grown-up. You live alone but you have a woman friend who is 38 years old and a widow. You see each other frequently and are sexually active. You have recently been talking about starting a family with her.

Role play 4 - Mr/Mrs Spring

You are a teacher. Eight weeks ago you had a small heart attack and were admitted to hospital for a week. You had high blood pressure diagnosed 5 years ago and gave up smoking 18 years ago. Your father died of a heart attack.

You are coming to outpatients for routine follow-up. You are taking aspirin, a pill for cholesterol and a beta-blocker to control blood pressure. You were also given a spray to use if the chest pain recurred but you have not needed it. You have had no chest pain or breathlessness and are undertaking moderate exercise but are feeling quite tired all the time. You have been off work since the heart attack but are due to return soon.

Since leaving hospital you have not had sex.

Character 1 – You are really scared that any exertion will bring on the pain again and so you have been doing as little as possible.

Character 2 - You feel quite well but your partner is wrapping you in cotton wool, frightened that the effort of sex may result in another heart attack.

Sex and Sexuality

Notes for students

Role plays

Each group will have a male actor for half the session and a female actor for the other half so will cover all four topics with your group.

Role play 1a Robert Lee / 1b Sue Muir

The aim of this role play is to discuss the factors that may be involved in risk of sexually transmitted diseases. As it is set in GUM clinic the patient is clearly expecting to answer questions about their sex life.

You are the junior doctor in the GUM walk in clinic. You do not have any notes about Mr Lee/ Mrs Muir.

Role play 2 Mrs James

You are an F2 in general practice. Mrs James is a 48 year old woman with no children who recently married. From her notes you see she is in good general health and rarely attends the practice. You do not know why she is coming today.

Role play 3 Henry Roth

Henry Roth is 60 years old. He has been having problems passing urine. He has been referred to urology clinic for consideration of a transurethral resection of the prostate.
You are the F1 doctor and you have almost finished the clerking. You will need to check that he is fully aware of the possible side-effects of TURP.

Useful Information

Transurethral resection of the prostate (TURP) is a common operation with few problems. Of note: approximately 10% suffer erectile dysfunction and 70% will have retrograde ejaculation which reduces fertility.

Advice to patients following a TURP (OHCM)

- Avoid driving for 2 weeks
- Avoid sex for 2 weeks. Then get back to normal. The amount you ejaculate may be reduced. This is because it flows backwards into the bladder. This is not harmful, but may make the urine cloudy. It means that you may be infertile.
- Expect to pass blood in the urine for the first 2 weeks. A small amount of blood colours the urine bright red. Do not be alarmed.
- At first you may need to urinate *more* frequently than before. Do not be despondent. In 6 weeks things should be much better.
- If you get hot or cold (fevers), or if urination hurts, take a sample of urine to your doctor.

Role play 4 Mr/Mrs Spring

You are in cardiology outpatients and have been asked to see Mr/Mrs Spring. He/she had a small heart attack 8 weeks ago and is now in outpatients for a routine follow up. You can see from the notes that he/she has a history of hypertension and is taking beta-blockers (Atenolol 50mg daily) simvastatin, aspirin and a GTN spray. His/her blood pressure today is 120/80 as measured by the nurse and an ECG shows evidence of an old anterior infarct.

You need to see whether he/she is experiencing any problems.

Useful information

- Anxiety, depression and the stress of making lifestyle changes after a heart attack can reduce a persons interest in sex

- Both men and women can achieve the same degree of sexual arousal after a heart attack. Unless there are complications such as congestive heart failure or arrhythmias there should be no reason to modify sexual habits.

- Some sexual dysfunction may occur with the use of some types of medications.

- Generally patients can resume their previous sexual life about 4-6 weeks after their heart attack. Wait 2-3 hours after a meal as digestion places added stress on the heart. Avoid alcohol 2-3 hours prior to intercourse. Rest is beneficial prior to intercourse, so morning is an ideal time.

- During the four phases of sexual response (excitement, plateau, orgasm and resolution) the heart works the hardest during the brief (10-15 second) phase of orgasm. The maximal heart rate achieved during this time is similar to that achieved during typical occupational activities (120 beats per minute). Therefore, sex usually does not put excessive strain on the heart.

References

Fast Facts: Sexually Transmitted Infections
Anne Edwards, Jackie Sherrard and Jonathan Zenilman Second edition Feb 2007
Health Press ISBN 978-1-903734-95-7
http://www.gmc-uk.org/about/valuing_diversity_sexual_orientation.asp#x2

Communication Skills Teaching
Session Five
Breaking Bad News

Introduction ***10 mins***

The introduction will cover:

- *Registration*

- Aims of the session:

    - To understand the wide variety of news which may be bad news for the patient.
    - To learn a framework for breaking bad news
    - To understand the importance of the right setting for breaking bad news; and to practice ensuring that the right setting is established.
    - To practise breaking bad news in a safe environment.
    - To begin to understand the variety of responses patients have to bad news and be able to cope with those responses.
    - To continue to develop skills after this session.

As foundation doctors, students will break bad news to patients and their relatives. This is an opportunity to start learning how to do this.

Exercise in pairs:

What is bad news? Generate a wide range of examples of what might be bad news.

Breaking Bad News

Discussion ***(5 mins)***

What have you observed about breaking bad news on the wards or in clinics?

Role plays 1 and 2 ***(10 mins)***

The aim of these role plays is to make the students aware of the setting in which they break bad news.

The role plays should be fast and good fun. Don't dwell on them too much.

In the first role play the patient is drowsy post-anaesthetic and the consultant is due to do her ward round in an hour. The aim is that the student should realise that he/she does not have to break the bad news – it may be more appropriate to leave it to another time/place/person

One way to approach them is to ask a student to check the fluid chart in ***role play 1****. Don't allow them to get to breaking bad news but stop the role play and ask another student to do the same thing. When one or two students have done this, ask the group to comment on what they see and open the discussion to the best place to break bad news.*

Role play 2 covers some of the same ground. Issues raised include: how do you get the relative into the side room?

What signals do you/should you send that bad news is coming?

Students should learn how to delay giving the bad news until they have the relative in a quiet room.

Role play 3 ***(50 mins)***

This focuses on the process of giving bad news. Look together at Dr. Rob Buckman's 6 step protocol to giving bad news in their handbooks. Try to build on previous communication skills work, emphasising the need to find out what the patient knows already, and what they are fearing or expecting. The actors will have prepared several different characters with different expectations and reactions to the bad news. Make sure every student gets a chance to practise breaking the bad news in either this or the next scenario.

Role play 2 revisited ***(20 mins)***

(If role play 3 needs more time this can be omitted)
Return to role play 2 and instruct the group that Flora Smith has now died and start the role play in the quiet room so the students have to break this news to the relative.

Feedback ***(5 mins)***

At the end of the session please allow 5 minutes for the students to fill in feedback forms and collect them back in. Ask the students to identify and share one thing they have learnt in the session. They should also write down feedback on the session /improvements that could be made.

Breaking Bad News

Notes for actor

Role play 1 - Mr/Mrs White

The learning point for this role play is that this is not the right time to break bad news. You are still too drowsy.

You were well until three days ago when abdominal pain started which gradually got worse and you went off your food. After one day of being unwell you went to the doctor. The doctor thought it might be appendicitis and sent you to hospital. You had an operation for appendicitis late last night. You have been drowsy all morning and this is the first time you have woken up. You have a drip in the arm. You see a doctor approach the end of the bed and look at the charts and want to be reassured that the operation went well.

Role play 2 - Flora Smith

The learning point for this role play is that the nurses' station in the middle of the ward is not the right place for breaking bad news.

Flora Smith came into hospital four days ago with pneumonia and she has been treated with antibiotics. She has improved each day. You are a son/daughter and visit every day. She was well yesterday and you were told that the drip would come down yesterday and that she would be out in a day or two. You have brought in some clothes ready to take her home. You see that her bed is empty and assume she has gone to the loo. You see a doctor and ask, 'How is she today as I have brought in her clothes ready for her to come home tomorrow?'

Role play 3 - Philip/Philippa Hughes

The teaching points for this role play are firstly to practise breaking bad news (specifically, talking about cancer) and secondly to start to learn to cope with the responses that might occur.

You have had indigestion for three months and have lost about a stone in weight in that time. You went to the GP 3 weeks ago and were surprised the GP seemed to take it seriously and arranged an urgent endoscopy (telescope test to look in your stomach). This took place at the hospital two weeks later. You were sedated for the endoscopy and when you woke up you were told several things but you were too sleepy to take most of it in. The doctors seemed pretty reassuring and you were told they found an ulcer and had taken a small sample of it for tests.

You were told to come back in a week for the test results.

You are now in the outpatients a week later to see the doctor.

Prepare three distinct characters with different ideas and expectations of their consultation who will have three very different responses to the bad news.

For example:

- *You are not too worried because your father had a stomach ulcer and took white medicine for this and he is still alive at 85. Your attitude is that it is a bit of a nuisance but you are a little confused as to why the GP seemed worried. This news will be completely*

unexpected. You may react by going into denial (no doctor, you must have the wrong notes…)

- *You are convinced there must be something dreadfully wrong: a friend of a colleague had symptoms like yours and had stomach cancer. She had a big operation but died not long after it and suffered terribly. You are terrified, and may be almost too scared to speak.*

- *You knew this was a possibility, but you were trying not to think about it. You have a young family and are the only breadwinner. You may be outwardly very calm and practical initially, but may give way to anger or tears if given the space to do so.*

Breaking Bad News

How to share bad news: the six step protocol

1. Getting started - the right environment

2. Finding out how much the patient knows

3. Finding out how much the patient wants to know – picking up cues

4. Sharing the information - begin the process of education from the patient's starting point

5. Responding to the patient's feelings

6. Planning and follow-through

(Rob Buckman - How to Break Bad News, Macmillan Press, 1992)

Notes for students

Role play 1 - Mr/Mrs White

You are the F1 doctor on a surgical firm. You were on take yesterday when Mr/Mrs White was admitted with suspected appendicitis. Late last night he/she went to theatre and you assisted. At operation the appendix was found to be normal but the there was a malignancy noted in the colon. A laparotomy was performed and there were liver metastases noted in the liver. A portion of the bowel was resected and a primary anastamosis made. The mass has been sent to pathology for investigation.

Mr/Mrs White has been drowsy all morning. You approach the bed to check his/her fluid balance chart before your consultant ward round.

Role play 2 - Flora Smith

You are an F1 doctor on a medical firm. Flora Smith aged 75 was admitted four days ago with pneumonia and improved with antibiotics. She was due for discharge tomorrow. Three hours ago Flora Smith developed central chest pain and an ECG confirmed a large anterior MI. She was transferred urgently to CCU where her condition is serious.

You are back on the medical ward. You notice Mrs Smith's son/daughter approaching you.

Role play 3 - Philip/Philippa Hughes

You are an F2 doctor in medical outpatients. A week ago Mr/Ms Hughes aged 45 had an urgent endoscopy, requested by his/her GP. The referral letter said that Mr/Ms Hughes had had dyspepsia for three months associated with weight loss.

At endoscopy a malignant looking gastric ulcer was noted on the lesser curve near the pylorus and a biopsy was taken for histology. Mr/Ms Hughes was informed after the endoscopy that an ulcer had been seen and a biopsy taken and she was given an appointment to attend outpatients today for the results.

The histology confirms an adenocarcinoma with evidence of spread through the muscle wall. There is no evidence of metastatic spread although this cannot be excluded – the patient needs a spiral CT of the thorax and abdomen.

Useful Information - Carcinoma of the stomach

80% of patients have distant metastases (stage 4) at diagnosis and the 5 year survival in this situation is <5%.
Invasion of the muscle layer means that this patient has at least stage 2 disease. The 5 year survival for stage 2 is 56%.

In the absence of metastases, curative surgery involves wide excision of the tumour (5cm margins) and lymph nodes. For tumours in the distal two-thirds, a partial gastrectomy may suffice, whereas more proximal tumours usually need total gastrectomy. Surgery is usually combined with chemotherapy either before the operation (to shrink the tumour) or afterwards.

If curative surgery is not indicated, palliation is often needed for obstruction, pain or haemorrhage and involves judicious use of drugs, surgery and radiotherapy.

Although the treatment of patients with disseminated gastric cancer may result in palliation of symptoms and some prolongation of survival, long remissions are uncommon.

(Ref: http://www.cancerhelp.org.uk/type/stomach-cancer/treatment/statistics-and-outlook-for-stomach-cancer accessed 2.6.11
http://www.patient.co.uk/doctor/Gastric-Carcinoma.htm August 09)

Communication Skills Teaching
Session Six
Anger and Aggression

Introduction

The introduction will cover: ***10 mins***

Registration

Aims:

To help students to know how to respond when a patient or relative is angry.
To understand the factors which might contribute to patient anger and what might calm down (or escalate) the situation.
To increase awareness of one's own reactions and feelings when angry
To consider personal safety and how to preserve it with potentially aggressive patients
To practise dealing with an angry patient in a safe setting.

Anger is not uncommon in a medical setting, in patients, relatives and staff. In this session we will consider why this is so, and explore ways of responding to anger.

Interactive discussion on a situation in which students have felt angry

Generation of a list of factors that could accelerate the situation and factors that could defuse the situation.

Anger and Aggression

Recap ***(5 mins)***

Recap the factors that can escalate or defuse a situation when a patient or relative is angry. You may wish to lengthen the discussion and use a different student's example of when they were angry or a situation on the wards that they have witnessed. Look at ***Avoiding Escalation*** *in the handbook*

It may also be helpful to ask the students to reflect on their own reactions to anger- do they shout back? Cry? Drink?

Role play 1 – Mr/s North ***(15 mins)***

This role play is set in general medical outpatients. The patient is angry because s/he has been waiting for an hour and twenty minutes to be seen and has just learnt that the consultant is not in the clinic today. This role play tests the student's ability to diffuse patient's anger. They must also understand that there is no point in continuing with the clinical task until this has been achieved.

Role play 2 – Ms/Mr Eastman ***(15 mins)***

This role play is set in general practice and involves the student negotiating with the patient about a prescription for night sedation. One outcome might be that a prescription could be given for a few tablets and an arrangement made to discuss more at a later date. Students should learn that early reassurance that the patient will be helped may diffuse the anxiety that is feeding the anger in this scenario. They may also learn that rules and protocols may be less effective in building rapport than individualised concern.

Discussion on violent patients ***(10 mins)***

Interactive discussion on approach strategies to the following situations:

- *You are asked to see a patient who is aggressive in Accident and Emergency. The patient has been ushered into a side room. Possible areas of discussion:*

  How do you prepare before going into the room?
  What attitude do you go into the room with?
  Do you take someone else with you?
  What is the role of taking somebody with you? - to run for help not to help with a fight.
  Where do you sit when you are in the room?

- *Discuss the possible medical causes of aggression*

  Hypoglycaemia
  Hypoxia
  Acute confusional state
  Serious mental illness
  Alcohol and alcohol withdrawal
  Pain - e.g. urinary retention

Change actors at this point - 55 mins after start of session

Role play 3 – Mrs/Mr Southwell ***(15 mins)***

In this role play the patient has had some seizures and has been started on antiepileptic medication which appears to be controlling the seizures. Unfortunately the patient is still driving and the student (as F2 doctor in general practice) needs to tell the patient that s/he must stop driving and inform the DVLA about the fits. If the patient will not then the doctor has a legal obligation to.

This is a situation when the doctor needs to explore what the difficulties are for the patient, be empathetic but nevertheless stand their ground, despite the angry patient.

Role play 4 - Mr/Ms West ***(15 mins)***

A patient has fallen out of bed and fractured her hip.

In this role play the student will need to discuss with the relative why the patient fell in the hospital and explain why the patient now requires an operation. It also raises the issues about blaming or accepting blame for other members of staff.

Role play 5 - more of Ms/Mr West ***(15 mins)***

We are now two weeks later. Mrs West has had her operation and is now due for discharge. The doctor wants to discuss discharge with the relative.

They will have to address:

- *The lack of diagnosis. A possible solution is that the doctors should go through the investigations carried out and the reasons for them in some detail.*
- *How should the issue of Mrs. West going home be negotiated?*

  Establish the main worries for the relative and patient

  Address the worries

  Be prepared to allow Mrs West to stay until the appropriate home measures are sorted out.

Please ensure that the students are given adequate time to debrief from a highly charged encounter with the actor.

Feedback ***5 mins***

At the end of the session please allow 5 minutes for the students to fill in feedback forms and collect them back in. Ask the students to identify and share one thing they have learnt in the session. They should also write down feedback on the session /improvements that could be made.

Anger and Aggression

Avoiding Escalation

Listen - Listening to someone getting everything off their chest is very therapeutic in its own right. It also enables you to avoid jumping to conclusions which might escalate the situation.

Summarise - Summarise with the complainer the point they have made. This serves to confirm that you have listened carefully to what they are saying and to make sure that both of you are talking about the same problem.

Clarify - Ask if there is anything to add. Once again this values the complainer and allows an opportunity for other issues which may be important but which have not yet surfaced to be aired.

Commiserate - Agree with the complainer that you too would feel upset over the issues.

Apology - Apologise for those issues for which you feel an apology would be appropriate. This includes apologising for other people working in your service.

Avoid Transferring Blame - Trying to diffuse the situation by showing that the complainer is in fact wrong, rarely helps in diffusing the situation.

Bargaining - Find out what the complainer wants and, if it is not possible to provide that, then try to offer alternatives of equivalent value which you can offer. .

Private Agenda - When you have the position of the complainer and yourself clear in your mind, try to work out what is driving the complainer, particularly what underlying feelings such as guilt may be creating a lot of the anxiety. Also try to analyse why you are taking your particular position

Time Out - Do no hesitate if the situation is escalating to try and put a pause in the discussion, either of a short period to cool down or make an appointment on another occasion when there is not an acute situation to discuss.

Call for Help - Do not hesitate to involve people more senior than yourself who are there to assist you. Seniority in itself can be used to diffuse a situation. Your seniors may not be as tired as you and they may have alternative skills that enable them to come fresh at the problems and resolve it.

Non-verbal responses

- Try to ensure that everybody is sitting down
- Do not invade the 'personal space' of the other person
- Do not meet anger with anger
- Assertive behaviour is generally better than aggressive or submissive behaviour.

When a situation is dangerous

- Absolutely no heroics.
- If it is predictable make adequate preparation. This will usually mean taking someone with you (who can fetch help if needed).
- Keep a means of rapid escape - eg the patient is not between you and the door
- Do not get into a fight. Only restrain physically when this is medically appropriate and there are sufficient people to help ensure that safe restraint is possible.
- Do not hesitate to call police, security staff etc.
- Keep your distance.
- Face the patient.
- If you can prepare the interview room beforehand minimise the number of potential missiles and weapons (e.g. coffee cups).

Looking after yourself

You will feel as though you are foundering at times. Don't expect always to be in control. Try and foresee when anger may occur both to enable you to think through the reasons, and to 'steel yourself'

Sometimes you will be taken by surprise.

It can be very upsetting when a patient or relative is angry. Ask for support from colleagues and friends.

Some potential medical causes of aggression:

Hypoglycaemia
Hypoxia
Acute confusional state
Serious mental illness/psychosis
Alcohol and alcohol withdrawal
Drugs and drug withdrawal
Pain - e.g. urinary retention

Anger and Aggression

Notes for actors

Role play 1 - Mr/Mrs North

You have been sent by your GP to medical outpatients because despite trying 4 different sorts of blood pressure pills your blood pressure is not controlled. (One lot made you tired, another lot made your ankles swell up and the others haven't worked). Your mother had a stroke in her 50s and you are worried the same might happen to you. You initially waited 10 weeks for your appointment, but then the clinic was cancelled and you had to wait another 4 weeks. You arrived in plenty of time (about half an hour before your appointment) and you are now an hour and 20 minutes late being seen. When you asked the clerk at reception why, you learned that they are short staffed today because the consultant is not here. You have gradually been getting crosser and crosser and will vent this immediately on the doctor.

Role play 2 - Mr/Ms Eastman

You have had trouble sleeping for about 6 months and you have been using temazepam to help you sleep. Initially you took it one or two nights a week but in the last two months you have been taking it every night and sometimes taking a second one if you wake in the middle of the night. You have recently moved house because your marriage has fallen apart and signed on with a new GP. Your job is under threat and your concentration there has been poor. You had a repeat prescription from your previous GP but when you asked for more at the reception you were told you needed to see the doctor before it could be prescribed. Initially you assume the doctor will just sign the prescription for you, but if that doesn't happen you will be cross at this waste of your time and are anxious to get back to work. You really don't know how you would cope without the sleeping tablets, you know your life is in a mess but you haven't got time to talk about it now.

Role play 3 - Mrs/Mr Southwell

You have recently had some funny turns where you lost consciousness. You felt a bit sick first and then blacked out and you were told you were shaking. After the seizure you were sleepy for several hours. The first occurred at a party, the second at work and your colleagues took you to casualty. You were referred on to see the neurologist who has told you that you probably have epilepsy, and you are awaiting a scan and an EEG. Meanwhile you have been started on some tablets (lamictal) which have not caused any adverse effects. You had one minor seizure (you felt sick and a bit drowsy but didn't black out) when you first started the tablets but none in the last 3 weeks, since you've been on the full dose. You now need a new supply of medication. You were told not to drive and to inform the DVLA, but you haven't done so. You have parked in the health centre car park. You live in a small village and are entirely dependent on your car for transport. You cannot imagine how you would begin to cope without it.

Role Play 4 - Mr/Ms West

You are an executive leading a very hectic life with a lot of trips abroad. You have been worried for some time about whether your mother is coping and perhaps because you didn't want to address the problem, you have not visited her for a while. You feel guilty about this and was very shocked to hear a week ago, that she had collapsed and been admitted to hospital.

You spoke to her on the telephone earlier in the week and she was well but a little shocked by the fall. She mentioned that she was having several tests done.

This morning you received a call from the hospital asking you to come in because your mum had suffered another fall. You were quite distressed about this and immediately cancelled all your work plans.

When you arrived you were relieved to find your mum was ok but were told by the nurse that she has injured her hip. The nurse informed you that your mum was finding it hard to sleep last night so the on call doctor wrote her up for a mild sleeping tablet. During the night your mum tried to get up to go to the bathroom but she fell and broke her hip. You mum is shocked and confessed she was told to ring for the nurse if she wanted anything but hadn't wanted to disturb the nurses.

You are angry about the situation your mother has found herself in. The doctor is meeting you to explain the plan for your mother's care.

Role play 5 – More of Ms/Mr West
Following on from role play 4.

Your mother has had the operation on her hip and is recovering well. No cause has yet been found for her original fall.

You came to visit today and one of the nurses asked when you'd be able to take her home. You were shocked to hear that the hospital planned to discharge her. Amongst other things they haven't found a cause for her collapse. You have a busy life and feel a great burden on your shoulders when it comes to the care of your mother. You feel she would be safer in hospital until they do know what caused her fall.

Anger and Aggression

Notes for students

Role play 1 - Mr/Mrs North

You are the medical F2 in general medical outpatients. Your consultant is away at a conference and you and the SpR are running the clinic. Your firm had a very busy take last night and you were late starting this clinic. The next patient is a 50 y.o who has been referred with hypertension which has been difficult to control. The GP letter states that they have tried a calcium channel blocker and a B blocker which were not tolerated and an ACE inhibitor and a diuretic which have not been effective. The GP's letter asks what else should be tried and does this patient need investigations for causes of hypertension.

(Do not worry too much about the detailed pharmacology here – this is not the main point of the role play).

Please take a history from the patient.

Role play 2 - Mrs/Mr Eastman

You are an F2 doctor in general practice. Mr/Mrs Eastman has just joined the practice as a patient and this is his/her first appointment. The reception staff have informed you that s/he wanted a repeat prescription of sleeping tablets, but practice policy is to review all such prescriptions. Long term regular use of night sedation is not advised given the addictive potential of benzodiazepines and their loss of efficacy over time.

Role play 3 - Mr/Mrs Southwell

You are an F2 doctor in general practice. You have had a letter from the neurology clinic about this patient who was seen following two seizures. EEG and MRI scan have been requested and the patient has been started on lamotrigine (lamictal) and given advice on safety issues, including instructions not to drive and to inform the DVLA. Mr/Mrs Southwell has just parked in the health centre car park.

In this consultation you need to find out how the patient is, whether he/she has any further seizures or problems with the medication and raise the issue of driving. By law, a patient with seizures must inform the DVLA and must not drive until they have been fit free for 12 months (6 months if a single seizure and no abnormalities on investigation). If you believe they have not informed the DVLA it is your duty to do so.

Role play 4 - Mrs West

You are the F1 doctor on the medical firm looking after Mrs West. A week ago she was admitted having collapsed at home. You have been investigating Mrs West during the week and have found no cause for her collapse.

You were not on duty last night but one of your colleagues was asked to write up some Temazepam for Mrs West to help her sleep. This morning you arrived on the ward to be told that Mrs West had fallen during the night when she tried to get out of bed to go to the bathroom with the result that she has fractured her right neck of femur. The nurse had asked Mrs West to call if she wanted to get up but for some reason the patient did not.

The fracture needs to be repaired and you have asked the orthopaedic team to come and review Mrs West with a view to her having surgery tomorrow.

You have just been called onto the ward to explain the plan to Mrs West's son/daughter.

Role play 5

It is now 3 weeks later. Mrs West has recovered well from her total hip replacement and is mobilising about the ward with a stick. No cause has been found for her original collapse – ECG was normal, CT brain should no evidence of stroke. She has been assessed by the physios as able to cope with stairs and has had a brief home visit with the OTs where she managed well. She seems keen to get out of hospital. Her daughter/son is visiting and you hope that s/he may be able to take Mrs West home today or tomorrow.

References

http://www.dft.gov.uk/dvla/medical/ataglance.aspx

Communication Skills
Term Two
Cultural Competence

The introduction will cover:

- *Registration*
- *An outline of the aims of the session:*
    - To make students aware of the impact a person's culture and beliefs can have on the consultation
    - To make students aware of how their own cultural beliefs can impact on the consultation
    - To help students conduct consultations in a way that respects a person's culture
    - To help students with the use of interpreters

In this short session it will not be possible to teach a lot of facts about the varieties of health beliefs in different cultures and religions. It is hoped by the end of the session students will be more able to recognise when cultural differences arise in a medical setting, and more able to ask when they do not understand.

This session is in three parts: role plays with interpreters; discussion and role play on cultural issues; and viewing and discussion of a video covering both topics.
More details of the role plays will be available at the session.

Introduction ***10 mins***

What do we mean by culture? What makes up a person's culture?
Ideas from the students – language, ethnicity, religion or beliefs, social class, education.
The main aim of the session is to get the students thinking about how a person's culture affects them as a patient. When might a person's cultural beliefs impact on their interaction with health professionals or access to health care? (beliefs around birth and death, modesty, cleanliness, fasting and diet…)
They will only learn a small number of facts, but they should learn to be sensitive to cultural differences and how to ask when they do not understand.

The rest of this session is in three parts and the different groups will do them in a different order:

Roleplays

Discussion and DVD

Working with interpreters

Communication Skills
Term Two
Cultural Competence

Role plays ***30 mins***

These are the role plays that were used in Spring 2011 – they are likely to be revised in future sessions to fit the ethnicity of the actor(s) available.

There may not be time to complete all the role plays in this section – don't worry if you don't get to number 3.

Exercise

Ask the students to imagine that they are on elective in a remote part of the world. In groups of two ask them to think up a list of questions and worries they might have being ill in a foreign country (Will their medicine work? What is the infection risk? Will I have to pay? Will I be fed and if so with what? Etc)

Role play 1 - *Mr Chan*

In this role play the patient is coming for a BP check up having had high blood pressure diagnosed opportunistically 2 weeks previously. His BP then was 186/104 and he was prescribed lisinopril 10mg od. Today it is 180/102. The task for the student is to find out whether the patient has been taking his medication and if not, what are the reasons for this. This will involve a discussion about beliefs about traditional Chinese vs western medicine if the student handles it sensitively. S/he will also have to tackle the issue of alternative medicine trying to balance patient autonomy with patient safety.

Role play 2 - *Mr Wei*

This patient presents with a simple 'flu-like illness and the role play is about exploring expectations – the patient is expecting not only medication but also advice about what to eat, whether he can shower etc

Role play 3 - *Mr Lim*

Mr Lim (junior) has come to ask about his father who has heart failure. This consultation is about attitudes to confidentiality and the family. Mr Lim would like to know what is happening to his father who has heart failure but his father does not want him fussing. This consultation could lead to a discussion of perceived cultural differences with regard to confidentiality and autonomy within the family.

Communication skills
Term Two
Cultural Competence

Discussion and video – 30 minutes

There are three suggested video clips that can be used, two related to the use of interpreters (Unit 2 2B (She thinks it might be bad news) and 2C (Please tell Miss Li) and one about a cultural clash over informed consent (4C Family business). If your group has just done the role play about cultural ideas it may be best to start with 4C, if your group has just been working with interpreters, start with the videos about interpreters. Watch the video clips and discuss the issues arising from them. (How well did the doctor handle the situation? What might have been done differently?)

Discussion on cultural differences

Have the students been aware of occasions when a patient's culture has influenced their consultation?
In groups of 3, ask the students to come up with a list of areas where a person's culture might have an influence on their interaction with health services
Ask each group to present their list
Possible areas of discussion include:
Body language and eye contact – possible differences in rapport building
Dietary regulations eg kosher, halal,
Foods assoc with health and illness – e.g. concept of 'hot' and 'cold' foods
Fasting eg Ramadan
Menstruation – concepts on uncleanliness, days discounted from Ramadan fast
Rituals around death and burial e.g. Irish wake, Muslim burial within 24 hours.

Watch video clip 4C

Discussion on use of interpreters

1. *How might a doctor find it difficult to communicate with a patient from a different culture?*
2. *How can you improve good communication with people who don't speak your language?*
   Example: *Show interest and concern*
   Allow time, show patience, use non-verbal reassurance
   Pay attention to non-verbal communication
   Simplify language
   Avoid assumptions and stereotypes
   Establish specific fears and concerns
   Use pictures, diagrams, mime
   Write down important points clearly
   Provide information in the patient's language
   Check the patient understands and that you understand the patient

Watch video clips 2B and 2C *and discuss what happens and what might be done differently.*

Communication Skills
Term Two
Cultural Competence

Role play – Interpreters ***– 30 minutes***

This role play uses interpreters and will give the students the opportunity to practise.

There are many pitfalls:

Do:

- Allow time for the consultation
- Brief the interpreter before the consultation if possible
- Check that the interpreter and patient speak the same language
- Allow time for the interpreter to introduce himself and explain their role
- Be patient
- Respect the skills of the interpreter
- Encourage the interpreter to ask questions
- Use simpler language
- Listen to the interpreter
- Check that the patient has understood and encourage questions

If things go wrong:

- Check that the interpreter speaks fluently
- Check the interpreter is acceptable to the patient
- Is the interpreter translation what you and your patient are saying, or advancing his/her own views?
- Does the interpreter understand the purpose of the interview?
- Does the interpreter feel free to interrupt you as necessary, to indicate problems or seek clarification?
- Is the interpreter embarrassed by the patient or the subject of the consultation?
- Are you giving the interpreter sufficient time?

(Source: Kai J ed Valuing Diversity: a resource for effective health care of ethnically diverse communities)

Summary and feedback forms ***5 mins***

Ask each student to highlight one take home message from today's session

Communication Skills
Term Two
Cultural Competence

Interpreters' roleplay

Role play 1

Patient

You are suffering from terrible headaches. They come on quite suddenly and last for days sometimes. No medication seems to touch them. You are worried that it might be something serious. You don't get any blurred vision. You sometimes feel sick. You feel tired all the time. You moved to the UK six years ago and occasionally feel low. You don't enjoy things as much as you did when you were 'back home' but had to move here for financial reasons. You are here with an interpreter.

Interpreter

Role 1

You are an appointed interpreter. You speak the same language as the patient and interpret well.

Role 2

You are a relative. You try to hijack the consultation. You ask questions about your own headaches that you get from time to time.

Role play 2

Patient

You are in gynaecology outpatients with a history of irregular bleeding and some pain in your left side on intercourse. You are not happy to use this interpreter as you recognise him and think other people in your family know him.

Role 3

You are an official interpreter. You do not know this patient.

Communication Skills
Term Two
Cultural Competence

These are the role plays used in Spring 2011 – they are likely to be revised in future sessions to fit the ethnicity of the actor(s) available.

Notes for actor *- Chang Da*

Role play 1 - Mr Chan

You are a 35 year old office worker. You saw your GP 3 weeks ago with an infected finger. You took some antibiotics and the finger is better but at that consultation your blood pressure was found to be high and you were prescribed some tablets for it (lisinopril). You have been feeling tired recently and wondered whether the high blood pressure might explain this. Your mother had a stroke at the age of 68 and your older brother has heart problems. You took the tablets for a week but didn't notice any difference to your tiredness. You did not notice any side effects of the tablets (if the student asks about cough, the answer is no). You are worried about how strong the medicine might be and whether it might damage your health in the long term. If you start will you be able to stop? Will you need a higher dose in the future? You went to see a traditional Chinese medicine doctor who has also given you some treatment for your blood pressure. You are worried that the medicines might not mix well. You are reluctant to talk about your consultation with the Chinese doctor as you worry your GP might disapprove. However if she/he seems interested and non-judgemental you will explain your thoughts to him/her.

Role play 2 - Mr Wei

You have a cough and a cold and have come to the doctor hoping for some advice about diet to help you get better. You are not particularly expecting to be given antibiotics, but are expecting to hear about how you should modify your diet and behaviour. If given the opportunity you should discuss your ideas about what might have caused the cold (e.g. not showering after going out in the rain).

Role play 3 - Mr Lim

You have come to see the GP about your father who is unwell, getting progressively more breathless and his ankles are swelling up. You know he has been to see his doctor but he won't tell you about it, just tells you he's fine, stop fussing. You missed the last hospital appointment with your father and know that he won't attend the next because it is in the 7th month and therefore an unlucky time to go to hospital. You are worried about your dad's condition and would like to know what's wrong, what can be done about it and also how serious it is. Is he going to die soon? You do not want your father to know that you have been talking to his GP because he will be cross with you for making a fuss. You may find it difficult to grasp why the doctor cannot just tell you what is going on with your father.

Communication Skills
Term two
Cultural Competence

Notes for students

Interpreters

Role play 1
You are a junior doctor in neurology outpatients. A patient has been referred for investigation of headaches.

Take a history.

Role play 2
You are a junior doctor in gynaecology outpatients. A patient has been referred for investigation of irregular bleeding and dyspareunia.

Take a history.

Culture role plays 2011

Role play 1 - Mr Chan

You are an F2 in general practice. Mr Chan is a 35 year old patient who was seen by one of the GP partners with an infected finger 3 weeks ago. He was given antibiotics and also had his BP checked which was found to be very high (186/104) and he was prescribed lisinopril 10mg once daily and asked to come back to have his BP checked again. Today his BP is 180/102 (best of three readings). Please see the patient and discuss this.

Role play 2 - Mr Wei

This patient is new to your practice and you do not have any notes for him.

Role play 3 - Mr Lim

Mr Lim (senior) is an elderly patient whom you have been treating for heart failure. He has also been attending the hospital cardiology clinic and has another appointment there in August. He is now severely dyspnoeic despite maximal diuretic therapy and is probably in the last few months of his life. You have tried to raise this topic with him but he is not keen to discuss the future. Now his son, whom you have not met before, has made an appointment with you.
Useful assessment questions:

1. What do you think caused your problems?
2. Why do you think it started when it did?
3. What does your sickness do to you? How does it work?
4. How severe is your sickness? How long do you expect it to last?
5. What problems has your sickness caused you?
6. What do you fear about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to receive from this treatment?

Communication Skills Teaching

Tutor Feedback

Your comments would be appreciated in order to improve the teaching. Please could you spare a few minutes at the end of the session to fill this in.

Tutor Name:

Actor(s) worked with:

Session:

General comments and any suggestions for improvement (include information about actor performance):

Comment on the session before the break:

Comment on the session after the break:

Please list any students not at the session:

Communication Skills Teaching

Actor Feedback

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Actor Name:

Tutor(s) worked with:

Session:

General Comments:

Comment on first session (before tea break)

Comment on second session (after tea break)

Any comments on how actors could be used more efficiently:

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Session:

General Comments:

Comment on first session (before tea break)

Comment on second session (after tea break)

Any comments on how actors could be used more efficiently:

Tutor Observation Planning

Date Session

Before being observed teaching, are there any specific areas on which you would like the observer to give you feedback?

Are there any aspects of this session that you find difficult/don't look forward to teaching?

Are there any techniques you use in this session which you think work particularly well?

Please share this with your observer before the start of the session.

Communication skills teaching - observation sheet

Observer

Observed

Date

Topic

Please comment on:
Meeting the stated objectives of the session

The balance between teaching by the tutor and exploration/experiential learning by the group

Student engagement in the session

An aspect of the session that worked particularly well

Changes the tutor could make to improve his/her teaching