Teaching Tool description		
Title	Explanation and planning in consultation - Tutor guide- Medicine- Dundee- Jarvis	
Language:	• English	
Profession:	• Medicine	
Level of learner(s):	• Undergraduate • Year 2	One tutor with ten student, 1 hour, 30 mintues
Topic:	Primarily What to Teach/Assess resource • gathering information • giving information • relationship building (including empathy) • shared decision making • challenging situations	
Core curriculum objectives match	This tool covers the following HPCCC objective(s) – A1-16, 17-23 B1-9 C1-9	
Goals/educational objectives	1. Develop understanding of Explanation and Planning within a consultation. 2. Be able to create a list of skills relating to E&P in the consultation 3. Develop skills of critical analysis and peer feedback	
Type of tool:	• facilitator guide	
Brief description: Limit to 200 words	Tutors guide for Consultation Methods – Musculoskeletal System Block. Students will gain understanding of the skills of explanation and planning. In smaller groups, students will discuss and gather information of each category in relation to; correct type	
Practical resources	Simulated patient, tutors for facilitation of group sessions and feedback	
Contact (name and email), other authors	Rob Jarvis	
List of tool files	Musculoskeletal explanation and planning year 2–Dundee- 111108.pdf	

Consultation Skills

2010-11

Jeroen Sparla – The Conversation

Tutor Guide

Consultation Methods – Musculoskeletal System Block

Explanation and Planning

Rob Jarvis January 2010

Explanation and Planning

Format
One tutor with ten students
1 hour 30 minutes (9-10.30am)

Materials/resources
One Simulated Patient.

Scenarios
The scenario in this session is based around one patient with pain in their hands. Their problem is likely to be 'arthritic' but it is unclear whether this is a wear and tear problem (osteoarthritis) or whether this is early rheumatoid arthritis (an autoimmune disease). The patient wishes to have some more painkillers. The point of the scenario is to demonstrate that even simple clinical issues have several options which need to be discussed with the patient and tied in with their wishes.

This session requires significant set-up. Please ensure you are familiar with the materials. There is an appendix which explains some clinical aspects to those tutors with less clinical experience in this area.

Learning objectives

Develop understanding of Explanation and Planning within a consultation
Be able to create a list of skills relating to E&P in the consultation
Develop skills of critical analysis and peer feedback

9.00 Introductions

9.05 Setting the scene for the session

What is this session about? – Explanation and Planning
Why is this important? Ask students for experience/thoughts.
Briefly explain format of session.

9.10 Introduce the skills of Explanation and Planning

Calgary Cambridge guide groups these as -

1. Correct type and amount of information (What)
2. Aid accurate recall and understanding (How)
3. Achieve a shared understanding ⎫ (suggest group 3&4 together
4. Planning – shared decision making ⎭ to make things simpler)

Split into 4 small groups - ask the students to identify elements within each category such as:

Correct type and amount of information (CONTENT)

- Preparation
  Disease/problem/results/management
  Patient - biomedical and patient's perspective
- What/how much info to give
  Necessary vs. optional?
  Starting point?
  Ascertain level of involvement patient wants

Aid accurate recall and understanding (PROCESS)

- Organise
- Chunk
- Signpost
- Summarising & repetition
- Language
- Cues
- Non-verbals (of the doctor)
- Visual aides
- Check understanding

Shared decision making (mix of CONTENT, PROCESS AND PERCEPTION)

- Share own thinking
- Encourage patient contribution and reactions/beliefs/feelings
- Relate discussion to patient's ideas, concerns and expectations
- Negotiate acceptable plan

9.25 Introduce clinical scenario

"You are playing the role of a qualified GP. Your next patient is Marion/Mark Tarbuck. They saw one of your colleagues last week and you have a note in the records which reads –

Pain in hands. Req. analgesia. 2 years. Progressive. Mostly MCPs – esp R thumb. Worse early am when thumb also stiff. Well otherwise. No Hx or FHx rheumatoid dx. No other jt probs. ADL OK.
OE – Well. No red/deformity on hands. Grip and pinch strength normal.
Imp – prob OA - ??RhA. Plan bloods and XR R hand. R/V 1/52"

Test results

Hb	12.2	UE	normal	PV	170 (normal)
WCC	7.8	LFT	normal		
Plt	198	CRP	<5		

XR right hand. No joint changes or soft tissue swelling visible.

Ask students to look at the notes and the test results (copy in appendix). Ask them to interpret these and to think about what they want to do with the patient.

What information do they need to give and how are they going to manage this patient?

9.45 Run the consultation

When looking at the consultation and setting up feedback please try to organise the other students into the CONTENT (what info was given), PROCESS (how was it given) AND PERCEPTION (what was the doctor thinking) system.

10.20 Revisit skill list

Ask students what they have learnt - ask them to write down two things each.
Can they recall the skills for this session?

Appendix – crib for tutors

Translation of GP record for tutors:

Patient requests pain killers. Pain for the last two years in the hands at the knuckle joints (Metacarpophalyngeal joints – this could be either osteoarthritis (OA) or rheumatoid arthritis (RhA). Worst at base of right thumb (could be OA or RhA). Thumb pain is worst early morning when it also feels stiff (both OA and RhA jts get stiff when not used). Otherwise the patient is well (RhA can make patients feel ill – but not always). No family history or personal history of rheumatoid disease (a FHx of RhA makes it a lot more likely – this is not the case here). All other joints are OK. Patient is OK with activities of daily living (ADL).

On examination – well, with no redness or deformity (which would have pointed to RhA). Basic function tests of the hand are OK.

Impression – probably osteoarthritis, but possibility of rheumatoid – probably best to check some blood tests and XR to make more sure. Review in one week.

Interpretation of test results

Blood results are all normal. We wouldn't expect any changes with OA – so this really reassures us that RhA is unlikely. Of particular note are CRP and PV which tend to be elevated in inflammatory disaease (of which RhA is one, OA is not).

XR suggests possibly neither OA or RhA.

Synopsis

We don't know what is causing this patient's pain. It is unlikely to be RhA or OA. It may be something to do with the soft tissues around her joints (eg ligaments). The location of the problem, length of history, and fact that the patient is well make it very unlikely that this is something serious.

Management options for this patient

1. Inform patient of the results of tests – most likely not RhA but perhaps not OA either.

2. <u>Increase analgesia</u>

a. More **paracetamol**; up to two tablets, four times each day.

<u>Pro</u> - Probably works better if taken regularly. It is safe.

<u>Con</u> – May not be strong enough.

b. A 'stronger' version of paracetamol – eg **co-codamol** (paracetamol plus codeine). Again – can have two tablets up to four times each day.
Pro – Different strengths of codeine available in combination with paracetamol (8mg per tablet– moderate and 30mg per tablet – strong).
Con – Causes some side effects – in particular constipation, but also can cause dizziness and drowsiness.

c. **Non Steroidal anti inflammatory drug** (NSAID) eg ibuprofen; 400mg three times each day.
Pros – works in a different way to paracetamol and therefore its painkilling action is 'in addition'.
Is anti-inflammatory, thus if the problem is inflammation related this may help.
Cons – can cause problems with excess stomach acid – which in the worst case can cause peptic ulcers which can bleed and lead to death. This still happens quite a lot in UK.
Chances of problems with acid are increased if taken alongside aspirin (also a NSAID). Often patients are offered another medication alongside NSAIDs to 'protect' the stomach against excess acid. These are known as Proton Pump Inhibitors (PPIs), e.g. omeprazole.

3. **Physiotherapy**
Unsure how helpful this would be in this case. Could refer to physio for opinion. NHS physio waiting list – 6 weeks+. Private physio costs about £40 for a consultation.

Could do own exercises without a formal referral.

4. Refer to **rheumatologist**. Probably an overkill/expensive for the NHS, but patient may want a more definite diagnosis.

5. Complimentary and alternative therapies

6. Time. See how things go. Come back if getting worse and we can reconsider the situation.

MSS Consultation Methods

Patient record

Name	Marion/Mark Tarbuck
DOB	01/02/1950,
CHI	010250 0101
Address	1 Brown Lane, Dundee

Last GP appt:	prior to this one - two years ago for a sore throat
PMH	Hypertension
DH	Amlodipine 5mg
	Aspirin 75mg
Allergy	nil known

Note from GP visit last week (locum):

> **Pain in hands. 2 years. Progressive. Mostly MCPs – esp R thumb. Worse early am when thumb also stiff. Well otherwise. No Hx or FHx rheumatoid dx. No other jt probs. ADL OK.**
> **OE – Well. No red/deformity on hands. Grip and pinch strength normal.**
> **Imp – prob OA - ??RhA. Plan bloods and XR R hand. R/V 1/52**

Test results from last week

Hb	**12.2**	**UE**	**normal**	**Plasma viscosity**	**170 (normal)**
WCC	**7.8**	**LFT**	**normal**		
Plt	**198**	**CRP**	**<5**		

<u>XR right hand</u>.
No joint changes or soft tissue swelling visible.

MSS year 2- Consultation Methods
Patient script – joint pain

Name Marion/Mark Tarbuck
DOB 01/02/1950,
Address 1 Brown Lane, Dundee

You are normally fit and well apart from a little problem noted by the GP two years ago with your blood pressure (for which you take a tablet). You are happily retired and live with your other half in Dundee. You had a satisfying career (you choose) and have some family (you choose).

You came to the GP last week and saw another one of the doctors (Dr Brown – a locum). You have been having pain at the base of your right thumb for the last two years or so, recently this has been getting worse. You notice that is worse in the morning and eases when you do things. It can be quite sharp at times. Some of the other knuckle joints in your hands can be sore too.

You take some paracetamol as you need it – usually two tablets, just once a day – and this does help the pain a little, but not completely. Sometimes you take ibuprofen which you buy from Tesco – this also helps quite a lot, but again not to kill the pain completely. You came to the GP last week looking for something stronger – but things got a little sidetracked when the GP raised the possibility that this might be rheumatoid arthritis; you had previously assumed it was some sort of wear and tear.

You decided between you that some tests (blood tests and an X-ray of your hand) would be a good idea to make sure it wasn't anything more serious. You have come back today for the results and to get more in the way of painkillers.

You are otherwise well. Your blood pressure is under control as far as you know. You take one tablet for the blood pressure – amlodipine, and you also take a small aspirin every day which was recommended to help prevent strokes or heart attacks. You don't take any other medication and have no allergies.

You are keen to know about the pros and cons of different options that the GP may have for extra pain killers and you want to be helped to make decisions for yourself. You don't really like being told what to do.
You don't want anything dangerous. You don't mind taking extra fruit/veg or a laxative if told that the pain killers cause constipation.

You are not so concerned that you feel you need referral.