CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 1: 2011-2012

INTERVIEWING THE ELDERLY PATIENT

FACILITATORS' PACK V.7 (15/09/2011)

CCS Stage/Level 1 Co-ordinator:
Sally Quilligan
Lecturer in Clinical Communication

Standard Course Contact Details:
Clinical Communication Skills Assistant
(01223) 760751
ccs@medschl.cam.ac.uk

CGC Course Contact Details:
Ruth Turner
Undergraduate Medical Education Assistant
(01284) 712985
Ruth.Turner@wsufftrust.org.uk

INTERVIEWING THE ELDERLY PATIENT

Introduction:

This session on interviewing the elderly patient occurs within Stage/Level 1 of the curriculum and has been jointly planned by the Medicine for the Elderly team and the Clinical Communication Skills department.

Aims:

Specific aims of the Medicine for the Elderly team

1. to enable students to explore the differences between interviewing young and elderly patients
2. to explore **important key areas of the content of the interview of the elderly patient:**
    a. **social history**
    b. **cognitive state**
    c. **multiple problems**
3. to provide an opportunity for students to have safe, observed practice in taking the history from an elderly patient

Specific aims of the CCS curriculum:

1. raising awareness of the importance of attitudinal issues in caring for and interviewing the elderly patient
2. reiteration of the students' communication skills learning in the passed CCS sessions
3. exploration of the specific communication issue of interviewing the elderly patient with:
    a. emphasis on the core skills of gathering information and of building the relationship
    b. exploration of the specific communication challenges presented by interviewing elderly patients

At this stage in students' development we are concentrating on information gathering rather than information giving skills.

Please note that student packs now contain the following information:

Facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish with ten minutes to spare to allow time for this and student evaluation/feedback.

Format of the session:

Each three hour session will be divided into 2 sections:

1. 30 minutes introduction in each of the three small groups to communication with the elderly
    a. what they have seen so far
    b. difficulties in content and process of communicating with the elderly
    c. attitudes, not just skills

2. 2½ hours session with 1 simulated patient per group who can perform 2 scenarios
    a. history taking: **multiple vague problem** with many issues (off legs, vomiting, vague cardiac failure, multiple medication)
    b. more **predominantly social history**

Also to include the **introduction of the cognitive assessment** at some point whenever it comes up

Recording equipment will be used in these sessions

All PowerPoints shown in this document will be available in each room if needed: please choose what would suit you and the group

Key skill areas to be covered

These interviews should allow you to cover beginnings, information gathering, structuring the session and building the relationship.

Specifically, the following are the key areas in medicine for the elderly interviews - please cover all of these as the session flows:

- **Building the relationship**
  - patience and time - without this, everything else will fail
  - sensitivity
  - empathy
- **Screening and prioritising**
  - type and number of problems do not predict function
  - not all problems current
  - not all need help
  - not all on patient's agenda
- **Discovering patient's expectations**
  - not always cure - it may just be to get home for instance and be able to cope
- **Dealing with complex narratives**
  - **time-framing - this is key in many elderly patient interviews - especially if the patient is confused, try to find out what they were like a few weeks ago and a few months ago; you may have to for instance say how were managing at Christmas or in the summer**
  - clarification
  - summarising and checking: particularly important to assess accuracy of information gathering and to let patient know what he/she has told so far
- **Structuring overtly** - if the patient is slightly rambling, summary and signposting can really help them as well as you
- **Exploring difficult areas**
  - picking up covert cues re embarrassing areas
  - asking directly re difficult areas such as incontinence

For more details re these skills, see overheads and pointers at end of this handout

Dementia and confusion

- **dementia 10% over 65, 25% over 85**
- **poorly recognised by doctors**
- **may need to discover if a problem early in history taking**
- **testing for cognitive function difficult to do early and sensitively**
  - the patient will often try to hide it (façade)
  - enquiring could be seen as making assumptions and labelling
  - needs signposting well

Plan

2.00 Small group introductions 30 mins

Facilitator – please go with the flow of the group and use whatever seems right from the following exercises. Simulated patient to join the group from the beginning and listen to discussion – same simulated patient will be with you for the whole session, can play both roles and vary the roles as you need.

Without being too ageist, please note that in this session, the facilitator often has to cue the simulated patient more than usual on what has actually just happened in the role-play to feedback about!

Welcome to the next element of the CCS theme.
This session was introduced because so many students in previous years experienced difficulties with interviewing elderly patients. Interviewing the elderly patient is not easy and can be frustrating: the aim is to help students think through what they are doing, why it is often so difficult and to give as much practical help as possible. Mind you, many of us find dealing with the elderly the most rewarding.

Outline a plan for the session
Round of names

What they have seen so far
Have you all watched medicine for the elderly interviews? What have you seen so far? What have you done yourself?

Divide into pairs
Discuss problems that you have had or might have in interviewing elderly patients – difficulties you have already had or could anticipate experiencing
Each report in turn and then **state what areas that they would find difficult and that they would like to practise** - flipchart

Turn it round to the problem of being in hospital for the patient. If you experience these difficulties, what is it like for the patients?

Ask if this experience of difficulties and how elderly patients are reflects how patients are outside of hospital. Ask to think who the oldest member of their family is still alive and how well they are– anyone has someone over 75 who is really well: tell us.

What we see in hospital does not reflect old people – and how each individual is outside is poorly reflected by what you see on the wards – depersonalisation, when an elderly person gets ill they often look very frail very fast – has anyone seen that happen to their elderly relatives?

State that these are the key areas that we have identified and form our objectives:

1. **the complex narrative: multiple problems, multiple PMH, what is current, what can you do something about, prioritising**
2. **taking a meaningful social history, care giving and receiving**
3. **screening for dementia**
4. **the patient's perspective, ideas, concerns and expectations - what does the patient want - what do they feel is an acceptable quality of life**

Common interviewing difficulties for students

- the complex narrative
- taking a meaningful social history
- screening for dementia
- the patient's perspective

Facilitator: please be very flexible but possibly try to cover all these above areas by the end

Mention that issues can be divided into the following key areas

1. Difficulties with the content of the medical interview
2. Differences in process of the medical interview
3. Attitudes of patients and doctors

It is a mistake to think that the barriers to communication come only from the patient and that all you need to overcome them is to improve your skills. When dealing with the elderly there is no doubt that attitudinal issues are equally important and that they emanate from the doctor as much as the patient

Ask what negative comments they have heard themselves about dealing with elderly patients

Objectives in interviewing the elderly patient

- **obtaining a medical history**
- **what else?**

Not necessarily the best place to learn history taking

Remember interviewing is not just for the history – that may need careful triangulation (why is it sometimes difficult to trust anyone, patient, relative or GP!) – interviewing here is for all sorts of other reasons – list

- Rapport
- Feeling for their quality of life
- Feeling for their cognitive level
- Understanding of their insight
- Consideration of their social situation and eventual placement
- How they interact with their relatives and carers
- What they want help with

2.30 First actor role 60 mins

Get started as soon as possible to maximise the time with the simulated patient

First role – multiple vague problems in slightly rambling patient

Facilitator to set up communication session:

- **describe the specific scenario to orientate the group (setting, information already known, show GP letter)**
- specifically explain who the learners are and what their role is in the scenario (i.e. medical students on med for the elderly ward)
- get the students to discuss the general issues that the role provides first, before the first student sets their own objectives as below
- ? hand out the CC guides
- ask the students if they wish to chunk this into small aliquots or do longer bits – if they are skilled longer portions than in the intro course are really helpful now. It will be much easier to do however if

we break it down into sections and get everyone involved - five minutes or so each rather than 40 minutes for one!

- obtain first volunteer – **remind them that this is practice for the OSCE!**
- encourage one of the students to start the process:
  - *What would be the particular issues for you here (try to get the participant to hone them down)*
  - *What are your personal aims and objectives for the role-play*
  - *What would you like to practise and refine and get feedback on*
  - *How can the group help you best*
  - *How and what would you like feedback on*
- explain that the interviewer can stop and start and break for help whenever they would like
- before the initial interview starts, get another student to volunteer to write up the information obtained as the interview proceeds, including both disease and illness
- when the learner rejoins the group, provide communication skills feedback on the interview so far

Stop each person at an appropriate point e.g. at the end of the introductions and establishing rapport or after taking an open history and before asking detailed questions. At each stage do good well paced communication skills teaching.

Remember to:

- look at the micro-skills of communication and the exact words used
- use the recordings
- practise and rehearse new techniques after suggestions from the group
- make sure to balance positive and negative feedback
- bring out patient centred skills (both direct questions and picking up cues) as well as discovering facts
- utilise actor feedback

Feedback

- Start with the learner –
  how do you feel?
  can we go back to the objectives? Have they changed?
  how do you feel in general about the role-play in relation to your objectives?
  tell us what went well, specifically in relation to the objectives that you defined?
  what went less well in relation to your specific objectives?
  or "you obviously have a clear idea of what you would like to try."
  would you like to have another go?
  what do you want feedback on?
- Then get descriptive feedback from the group
- If participants make suggestions, ask prime learner if they would like to try this out or if they would like the other group member to have a go. Try to get someone else to role-play a section if they make a suggestion for doing it differently. "Would anyone else like to practise?"
- Bring in the simulated patient for insights and further rehearsal: ask them (in role) questions that the group has honed down

Do give demos

3.30 Tea – or later if you wish	**15 mins**

3.45 Continuation of 1st role-play or move onto 2nd role-play, as you wish	**70 mins**

As the session proceeds, move specifically into the content areas of:

- ***taking a meaningful social history***
- ***introducing the mental state examination***

These can be done at any time.

Please note that the key issue of introduction of the mental state examination is signposting well

- just asking could be seen as making assumptions and labelling
- needs signposting well

Phrases such as ‘can I ask you some important questions to see how good your memory is’ work better than ‘can I ask you some silly questions to test if your memory is OK’

The second role-play is of a very mentally alert patient – here the issue is discovering the social issues in particular and her fitness for discharge

Scenario: *Maud Preston, a retired headmistress, was admitted 5 days ago following a fall at home. She fell and sustained extensive bruising but no fractures.*
Miss Preston has just been transferred to your ward. You have a quick look at the medical notes and the notes say 'doing well, steady improvement, plan to discharge in a few days time'. You go to take a history with a view to particularly assessing her social situation and fitness for discharge.

Get the student to take her history to the point where they establish that she is relatively fit and that this was an accident. Then after having given feedback get them to discuss what happens next. They often think she is fit for home but normally haven't thought through the process of how to get her home.

There are real issues for getting her home, e.g. she is still in pain, there is no downstairs toilet and she is just managing a few steps. Through discussion they need to work out that they need to involve:

- Physiotherapist - to assess her mobility – can she get up from a chair, walk (what walking aid if any does she use) and climb stairs? Physio can help improve mobility strength and balance.
- Occupational Therapist to assess her daily function, to consider whether a home visit is necessary, and to check what equipment/assistance she may need.
- Social Worker to assess eligibility for funding for a downstairs toilet and bathroom. This may be a way of maintaining her longer term independence in her home, which is clearly what she wants.

Also would she consider 'meals on wheels' initially?
Does she need a visit to the home every couple of days to see she is ok when first discharged?
Would she wear a call alert system?

This generates the important discussion of discharge planning, which is often left to the junior on the ward, and how there can still be quite a lot of planning issues preventing discharge, even though a patient is medically fit for discharge.

If there is time, get one of them to do the Mini-mental with her. There are occasions when students will need to do the mini mental test on patients who appear to have no issues with their mental state and it is useful to try and generate innovative ways to charm her through this and provides a light note to end the session on.

4.45 Endings

Rounds of what learnt
Summary of skills from facilitator
Handouts

4.50 Evaluation and feedback

Handout Provided in Student Pack:

CALGARY - CAMBRIDGE GUIDE ONE – INTERVEWING THE PATIENT

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?")

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**; 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**, explains process, asks permission	

CLOSING THE SESSION (PRELIMINARY EXPLANATION & PLANNING)

33. **Gives any preliminary information** in clear well organised manner, avoids or explains jargon 34. **Checks patient understanding** and acceptance of explanation and plans; ensures that concerns have been addressed 35. **Encourages patient to discuss** any additional points and provides opportunity to do so (eg. "Are there any questions you'd like to ask or anything at all you'd like to discuss further?") 36. **Summarises session** briefly 37. **Contracts** with patient re next steps for patient and physician	

References:

Kurtz SM, Silverman JD, Draper J (2005) Teaching and Learning Communication Skills in Medicine 2nd Edition. Radcliffe Publishing (Oxford)

Silverman JD, Kurtz SM, Draper J (2005) Skills for Communicating with Patients 2nd Edition. Radcliffe Publishing (Oxford)

Kurtz S, Silverman J, Benson J, Draper J (2003) Marrying Content and Process in Clinical Method Teaching: Enhancing the Calgary-Cambridge Guides Academic Medicine;78(8):802-809

Handout Provided in Student Pack:

Abbreviated Mental Test score (AMT)

Name: ***Age:*** ***Dob:***

1. Age?
2. Time (to nearest hour)?
3. Address for recall at end (e.g. 42 West Street)
4. What year is it?
5. Name of institution?
6. Recognition of two persons (can the patient identify your job and that of someone else who is visible to you both)
7. Date of birth (day and month)?
8. Year of First World War?
9. Name of present monarch?
10. Count backwards from 20 to 1?

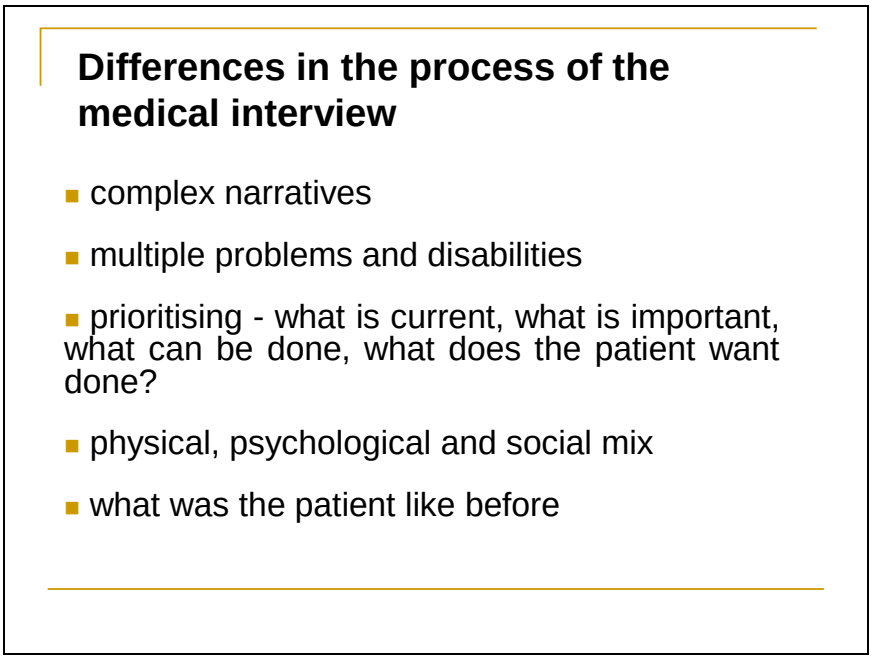
Score ___ / 10

Handout Provided in Student Pack:

Activities of daily living

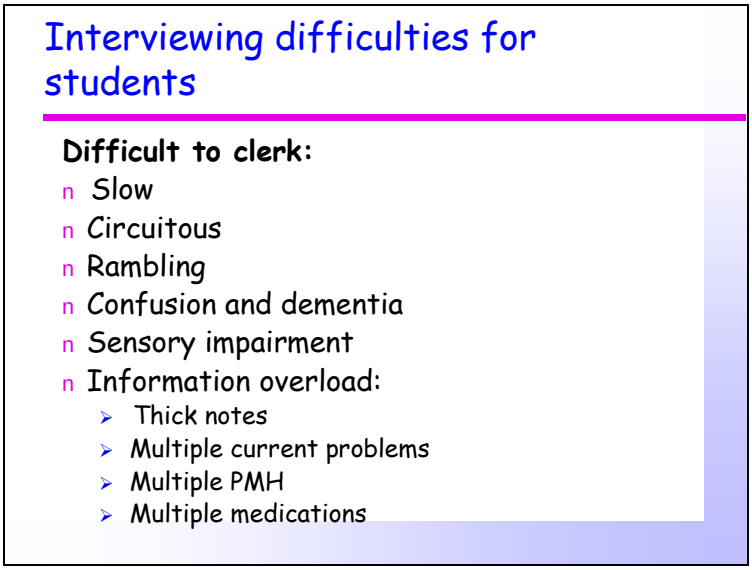
1. **Grooming**
2. **Bathing**
3. **Toilet Use**
4. **Bowel continence**
5. **Bladder continence**
6. **Feeding/cooking**
7. **Transfer**
8. **Mobility**
9. **Dressing**
10. **Stairs**

PowerPoint's and notes on interviewing the elderly patient available for facilitators to use as they wish:

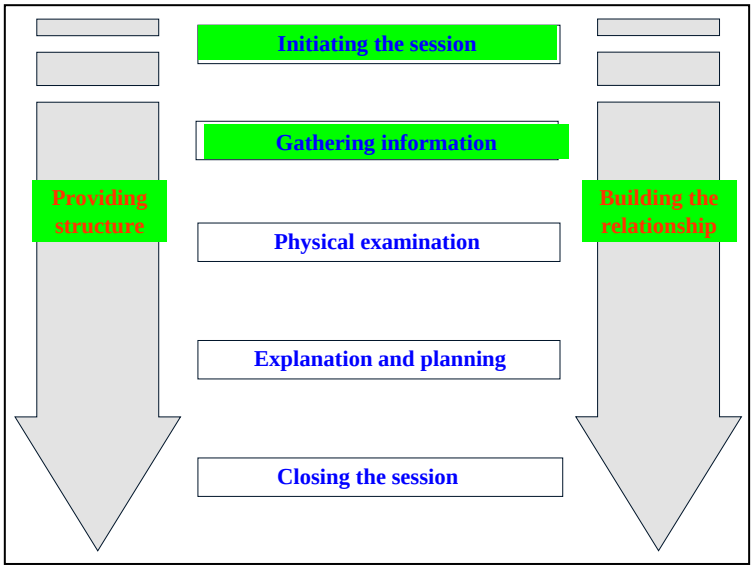


What makes it different from interviewing younger patients?

- Complex narratives: large amounts of seemingly elusive data
- Multiple problems, disabilities, multiple PMH, chronicity of problems
- Prioritising
- what is current?
- what can you do something about? no solution to some problems, expectations of cure for each problem may not be high - avoid investigating and treating everything; equally avoid labelling all as 'old age'
- what does the patient want done e.g. toenails
- Physical, psychological and social mix
- Considering what the patient was like before admission and what the changes have been



These interviews should allow you to cover beginnings, information gathering, structuring the session and building the relationship.



Specifically, the following are the key areas in medicine for the elderly interviews:

- **Building the relationship**
  - patience and time
  - sensitivity
  - empathy
- **Screening and prioritising**
  - type and number of problems do not predict function
  - not all problems current
  - not all need help
  - not all on patient's agenda
- **Discovering patient's expectations**
  - not always cure
- **Dealing with complex narratives**
  - **time-framing**
  - clarification
  - summarising and checking: particularly important to assess accuracy of information gathering and to let patient know what he/she has told so far
- **Structuring overtly**
- **Exploring difficult areas**
  - picking up covert cues re embarrassing areas
  - asking directly re difficult areas such as incontinence

INITIATING THE SESSION

Establishing initial rapport

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

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

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

Rapport all important

BUILDING RELATIONSHIP

Non-verbal behaviour

Demonstrates appropriate **non–verbal behaviour** e.g. eye contact, posture & position, movement, facial expression, use of voice

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

Developing rapport

Acknowledges patient's views and feelings; **accepts** legitimacy; is not judgmental

Uses **empathy** to communicate understanding and appreciation of the patient's feelings or predicament

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

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

Patience and time - without this, everything else will fail

Empathy – trying to put yourself in the patient's position

Sensitivity

- Asking re difficult areas such as incontinence – so often the patient is embarrassed to bring up but so grateful if you do
- Dealing sensitively with the family - collateral information, not excluding the patient

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?")

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

6. Checks and screens for further problems (e.g. "so that's headaches and tiredness, what other problems have you noticed?"

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

Screening and prioritising (is a 76 year old male with heart disease, diabetes, arthritis, and cancer a nursing home resident or a high court judge?) – type and number of problems do not predict function; not all current; not all need help; not all on patient's agenda

Gathering Information

process skills for exploration of the patient's problems
(the bio-medical perspective and the patient's perspective)

- patient's narrative
- question style: open to closed cone
- attentive listening
- facilitative response
- picking up cues
- clarification
- time-framing
- internal summary
- appropriate use of language
- additional skills for understanding patient's perspective

Dealing with complex narratives

- Clarification
- Time-framing- **this is key in many elderly patient interviews - especially if the patient is confused, try to find out what they were like a few weeks ago and a few months ago; you may have to for instance say how were managing at Christmas or in the summer**
- Summarising and checking particularly important to assess accuracy of info gathering – and remember checking understanding of information given to patients
- Picking up covert cues re embarrassing or difficult areas

content to be discovered:

the bio-medical perspective (disease)	*the patient's perspective (illness)*
sequence of events	ideas and concerns
symptom analysis	expectations
relevant functional enquiry	effects
	feelings and thoughts

essential background information

past medical history
drug and allergy history
social history
family history
functional enquiry

Patient's agenda especially expectations

- not always cure - it may just be to get home for instance and be able to cope

PROVIDING STRUCTURE TO THE CONSULTATION

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

19. Progresses from one section to another using **signposting**; includes rationale for next section

20. Structures interview in logical **sequence**

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

Often necessary to be quite directive – key is how you do this
Overt structuring - if the patient is slightly rambling, summary and signposting can really help them as well as you

Facilitator Information Only:

Medicine for the elderly - hospital bedside – simulated patient role

Name: Alfred Davey **Age**: 80

Setting
You are lying in your bed in a geriatric ward at Addenbrooke's at eleven in the afternoon, feeling tired and disorientated. You have a drip in a vein in your left forearm that was put in last night. You are wearing hospital pyjamas. You came in late last evening having been sent in by your GP: it seemed to take ages to get out of the emergency department to a ward and be allowed just to curl up. Several people asked you questions you couldn't really manage to answer which made you confused - you couldn't say who they all were, nurses, doctors etc. You had loads of blood tests, X-rays and other things. People keep coming up to you now smiling and saying 'are you all right?' – one gave you a drink which you could not reach and then took it away again untouched. You have seen a doctor briefly since getting to this ward and one nurse has introduced herself as your key nurse – you have no idea what that is but she was very nice.

Your GP said that you should go to hospital as you couldn't manage at home – she said it would be just a short time but you feel you might never get back home. You had tried to make her and the district nurse see that you could cope at home but they wouldn't have it and you reluctantly agreed to come in to hospital. In your heart of hearts you knew that you couldn't manage any more but you were desperate to stay at home and were not willing or able to explain why so you just said you would be fine despite mounting evidence to the contrary.

Clinical details
Over the last three weeks, things have got steadily more difficult. You have felt weaker and more short of breath and in the last two days you have had falls. In the first fall, you lost your balance and luckily your daughter who was with you was able to stop you from falling over completely. In the second one, you fell in the early hours between the bed and the wall and got stuck. You managed to pull a blanket over you till morning but you got quite cold and were found by the care assistant at 8.00 am – that was two days ago you think - you haven't been able to get out of bed since – your knees just give way. You have become incontinent of urine to some extent – you just can't get there in time. You feel weak and frail – you are far off your normal self. You are not hungry at all, feel sick and dizzy and were actually sick twice yesterday. This was brown stuff, presumably because you had been drinking Bovril to build up your strength. You can't think straight and now you are in here you are a little confused and certainly bewildered. They felt that you couldn't manage by yourself – for the first day your daughter stayed at home with you but she needs to get back to her job and couldn't keep coming to be with you.

You normally manage OK at home with a lot of support. You can get around your house with a Zimmer frame very slowly and make a cup of tea safely. You can't cook meals but can do toast and margarine. You get meals on wheels at lunchtime and your daughter who lives nearby makes you a little something at tea time after she gets in from work. You can't get out easily now - you make brief forays into the garden if someone is with you and your daughter will take you by wheelchair to her house in the car at Xmas for instance but it is a big effort. But people pop in to see you which is good of them. A care assistant comes in each morning to help you get up and dressed.

In general, you find everything much more of an effort than you did. Until three years ago, you were pruning the apple tree in the garden up a ladder but not now – life is much more limited. You are short of breath if you do too much and your limbs ache. Your ankles are swollen. Your hands haven't the strength you had they are a bit arthritic, but overall you can't complain – you are glad to be alive and in your own home. As long as you are there you are fine.

As far as what specific illnesses you have had in the past you are pretty unsure. You are not demented just hazy about medicine and what has happened to you medically in the past - this is because you really don't understand this sort of thing. You know that you had a stroke a few years back which left you with a little weakness in your right hand which you hardly notice now and last year you came into hospital with pneumonia – you were in for two weeks and it took you ages to recover – in fact you never did quite. You were anaemic a couple of years back with 'fluid on the lung' – you are not sure why and you used to take iron tablets but not now. You take lots of pills – you take what the care assistant and your daughter give you – they are for blood pressure, for your water, for your heart and to help you

breathe you think; some are for indigestion, some for cramps and others to help you sleep. You know the colours and sizes of them but not the names.

Past medical history
See above
Any previous operations: two cataract operations 1998 and 1999; gall bladder removed years ago; you had a fall and broke your ankle several years back that needed an operation
Wears hearing aid

Medication
Any medication: nurofen for pain, otherwise as above

Family history
Parents both dead, not sure what they died of, 'hard work', in their sixties
6 brothers and sisters all lived locally, all dead now except for one sister in a home who has 'lost her mind, it's sad'

Smoking: used to smoke 20 a day roll-ups but gave up years ago
Alcohol: enjoy the odd Guinness

Social history
You were married for over 50 years, wife died 5 years ago from a stroke after spending some time in Addenbrooke's
Children: three children, all alive, daughter lives in the village and another son in Cambridge. One daughter lives in Essex
Occupation: farm labourer all your life, working on the local farm, ploughing etc, retired 10 years ago
Where do you live: in Weston Colville, a small village in Cambridgeshire
Type of housing: council house, 2 storey with a good garden, all going to seed. You tend to live in the kitchen around the old Rayburn and apart from your bedroom, the other rooms are all cold and unused
Pets: a small dog, mongrel, 12 years old and getting old himself – one of the main reasons for you wanting not to leave home

Patient's framework
- **ideas and thoughts**

what did you think might have caused your problem: old age plus some infection maybe, 'getting past it now'
what have they told you so far: can't remember, the GP said it could be a water infection or chest infection

- **concerns**

what are you concerned about: getting home and your dog
have you any underlying fears: dying really although equally you have had enough now, if you are going to die you want to be at home

- **expectations**

what are you hoping for: some kindness and slowness of pace, not being mucked about too much

- **feelings**

how are you feeling about it all: mostly just ill and weak, but anxious – it was a shock ending up in hospital again

Presenting symptom(s) or problem(s)
If the medical student asks you "what problems brought you to the hospital", you answer:

- 'I don't know I just feel poorly doctor – I just can't get my legs to go and I feel washed up if you know what I mean – the dog's gone to Marianne'

Then as the student asks you more, just meander around the symptoms in any order, tending to minimise the practical difficulties and the falls, mentioning them but not dwelling on them. Some symptoms may get missed altogether

Behaviour

You are frail, weak and feeling helpless. You look much more dependent than you would sitting in your own chair at home. You are in bed. You are happy to talk and quite forthcoming but forgetful and vague at times about details. You talk at a moderate pace in a quiet voice with a fair degree of faltering. Very good memory for the past and recent memory reasonable but would get hazy re illnesses or drugs. Tend to wander slowly off the point. Friendly but underneath frightened about not ever getting home. You tend to slightly minimise the problems that you have in coping. Whatever the student says, you won't come clean re the fact that even you think in your present state you couldn't manage at home. Nor do you divulge your fear of being here and the fact that you won't leave alive. That is implied but never divulged.

The aim of this role-play is for the students to learn how to speak to an elderly, vague, rather rambling person with poor grasp of the medical details. We want them to be able to take a social history and check for dementia sensitively and cope with someone who is not able or willing to tell the whole picture. We want them to show empathy and concern and respect.

Handout Provided In Student Pack:

Referring GP: **Dr. Alison Rogers**
Linton Health Centre, Linton, Cambridge

To: **Admitting doctor**
Medicine for the elderly
Addenbrooke's Hospital

Re: **Mr. Alfred Davey/ Mrs. Freda Davey, 18 Horseshoe Lane, Weston Colville, Cambridge**
Age 80, Hospital Number 374910

Dear Doctor,

Thank you very much indeed for admitting this 80 year old man/woman with recent vomiting? haematemesis who is becoming increasingly frail. He has fallen and is having difficulty coping at home by himself despite support.

Past medical history

1. 1993 – CVA
2. 1995 – fracture ankle
3. 1997 – anaemia, no cause found, right pleural effusion
4. 1998 and 1999 – bilat cataract op
5. 1999 – pneumonia
6. Hypertension
7. Mild heart failure

Medication

1. Enalapril 5mg mane
2. Diltiazem 30 mg mane
3. Furosemide 40 mg mane
4. Aspirin disp 75mg daily
5. Digoxin 0.625mg mane
6. Metoclopramide 10mg tds
7. Omeprazole 20mg daily
8. Quinine sulphate 200mg nocte
9. Temazepam 10mg nocte

SH
Lives alone
Normally frail but manages reasonably well with support
Daughter nearby

On examination
Frail
Pale
Unable to weight bear
T 36 RR 28 P100 AF
BP 150/98
Chest: scattered creps
Abdo: no bladder palpable
No localising neuro signs

Impression
Vomiting, off legs, unable to cope.
If can get back to where he was, no reason why cannot return home

Thank you very much,

Yours sincerely

Dr. Alison Rogers

Facilitator Information Only:

SOCIAL HISTORY IN MEDICINE FOR THE ELDERLY

Name: Miss Maud Preston **Age 75**

You are the retired headmistress of a village college, having read English at Oxford. You are alert and mentally very agile, but are troubled by a painful back and are on treatment for osteoporosis.

Setting:
You are sitting next to your bed in a Medicine for the Elderly ward at Addenbrooke's in your own clothes. You were admitted to hospital 5 days ago. You were collecting the newspaper from the hall when you tripped over the telephone cord which sent you flying. You lay on the ground in great pain and unable to move and were terrified you had broken your hip. You have few visitors and were beginning to think you would be stuck on the ground forever when the doorbell rang. You managed to shout so loudly that the caller heard you – it was the postman, but to your great embarrassment he had to call the police to break the door down. You were taken to Addenbrooke's by ambulance. A fractured hip was ruled out.

Housing
You live in a small neat terraced house in the middle of Cambridge. Your bedroom, the lavatory and bathroom are upstairs. The flight of stairs is steep and there is a banister on one side. There are no toilet facilities downstairs and there are 2 steps between the kitchen and passage to the sitting room.

Social support
You have delightful neighbours but you don't like to call on them. Your nearest relative is a nephew in Haverhill, however he has a young family. His role as a senior marketing executive requires a lot of international travel and you know he already feels he doesn't spend enough time with his family. You certainly wouldn't want to make things worse by involving him in your care. .Before admission, you were managing light housework and cooking, employed a cleaner weekly and could wash but have not been able to get in the bath for some time. You were able to walk unaided around the house but used a stick outside. You were able to get out in a taxi to do a weekly shop in Waitrose and buy the other things you needed from catalogues. Several former colleagues keep in touch by phone.

Financial Position
Although you receive a good pension you used a large portion of your capital to pay for your nephew's school and university education. You also enjoy travelling and have drawn on your capital to pay for several holidays a year. You do not think you would be able to fund the adaptations needed to your own home.

Present situation in hospital
You can walk 20 yards with a frame but haven't tried to walk with a stick or attempted the stairs. You can wash independently and can manage in the lavatory, but the nurses insist on helping. You are not sure if you will be able to stand up for long enough to cook. You want to get home as soon as possible – this place is a mad house - full of wandering patients and young nurses who call you Maud and have a lamentable grasp of English. However, the pain from the bruising is severe, walking is still difficult and you are frightened of falling again and lying on the floor for days. You are particularly worried about having to get upstairs to the lavatory and if you are asked what would help, say that a downstairs lavatory would make a great difference.