UNIVERSITY OF DUNDEE

College of Medicine, Dentistry and Nursing

Clinical Communication Skills Course

Phase Two (Year 3)

Programme

Reproductive Block

Student Course Book

"Anyone can swallow with their ears; if you're smart you can listen with your eyes."

The Inner Consultation, Roger Neighbour

Introduction

The Clinical Communication Skills Course is an integrated skills based course. The course runs throughout the 5 year undergraduate medical curriculum and will allow you as students to acquire the necessary basic skills necessary for effective communication with patients.

Progress so Far

In Years One and Two you have been introduced to carrying out an interview with patients using the Calgary Cambridge approach. This approach divides the communication skills needed into 5 separate sections. It acknowledges that each section is not a separate stand alone section and that the skills have to be taught and learned together. However for ease of explanation the outcomes are divided up into the 5 sections.

These are:

- **Initiating the Interview**
- **Gathering Information**
- **Explanation and Planning**
- **Closing the session**
- **Building the Relationship (Throughout)**
- **Structuring the Consultation (Throughout)**

Remember too that the course acknowledges three types of Core Skills, which are interlinked and cannot be taught independent of each other.

These are:

1. **Content Skills**

These include
- what doctors communicate
- the substance of their questions and responses
- the information they gather and give
- the treatments they discuss

2. **Process Skills**

- How they do it
    - the ways they communicate with patients
    - how they go about discovering the history of providing information
    - the verbal and non-verbal skills they use
    - how they develop the relationship with the patient
    - the way they organise and structure communication

3. Perceptual Skills

- What they are thinking and feeling
    - their internal decision making, clinical reasoning and problem solving
    - their awareness of feelings and thought about the patient their illness and other issues that may be of concern to them
    - awareness of their own self-concept and confidence in their own biases, attitudes, intentions and distractions

Reproductive System
Year 3

This block is your second block of the more complex contextual communication skills training and will allow you to consolidate learning from Years One and Two. By focusing on giving information and creating management plans around serious and sensitive issues, you will have to be clear about the purpose of the consultation with these patients and your intended outcomes. You will be able to develop your skills in taking an intimate sexual history and also exploring some of the ethical challenges around screening and obstetric care which by their very nature make communication challenging.

The roles are designed to follow the topics as laid out in the Core timetable. If you are asked to carry out an interview around a topic you have not yet covered in detail you will not be expected to have extensive knowledge, these roles are designed to allow you to discuss the issues in a more general manner with the patient.

Remember, you can ask for "Time Out" with all these roles. The guidance notes are attached. However you should restrict the use of Time Out as much as possible. There are no right or wrong ways to communicate with patients, there is for you, only your way. These sessions will give you the chance to learn more about your way and to get guidance and support from experienced clinical tutors to help make your way effective and satisfying for both you, and your patients.

Prior to the sessions

Please review the notes on roles for the week in which you are attending. There are notes to guide you in your preparation for these roles. Some, but not all, require the application of recent knowledge! Also please be prepared to volunteer. The tutors will ensure that all of you have at least one opportunity to try out one of the roles with the actors. Remember this is a safe environment in which to try out new skills.

Clinical Communication Skills
Reproductive System

Intimate History Taking (Weeks 1 and 2)

- **Infertility Clinic**

Sylvia and Robert Prichard

Background

The couple are attending the infertility clinic, having been referred by their GP (see attached GP letter). This is an infertility clinic jointly managed by specialised midwives and doctors. Unfortunately, the couple are unable to attend at the same appointment due to work commitments. They will, therefore, be seen separately and then seen together. There are 3 separate but related role play scenarios.

These are difficult scenarios involving sensitive areas with an anxious woman and her husband, who has attended reluctantly. It is important for the student to gain, as far as possible, both patients' trust in order to become aware of all of the complex issues underlying the problem, some of which are not shared by both the husband and the wife.

The student should be encouraged to take time out if having difficulties.

Scene Setting for Students

Role Play One and Two

You are a Foundation Doctor working at an Infertility Clinic. You have a referral letter (see below) and are initially seeing Sylvia Prichard, (on her own). A second consultation will take place with Richard Prichard, (on his own).

Communication Issues

The student should:

- use the history sheet proforma attached to take an history (including sexual history)
- allow the patients to tell their story
- provide advice on life-style
- construct a care plan

Learning Objectives:

- taking a history from both male and female (including infertility, sexual and social history)
- obtaining relevant information (both from verbal and non-verbal clues)
- giving advice on life-style (weight, smoking, frequency sexual intercourse and alcohol)

- consider issues of confidentiality
- reflect on how own feelings and experiences may influence the communication process

Scene Setting for Students

Role Play 3

You are seeing both patients back at the clinic and have already written to them to tell them all the investigations so far are negative. You want to discuss with them the options around further treatment. As you haven't see them together before, you feel you need to explore their individual expectations and intentions around future treatment.

Communication Issues

The student should:

- make explicit both patients current agenda as individuals and as a couple
- attempt to resolve any dichotomy in these agenda
- be sensitive to their different perspectives
- ensure that they are able to remain supportive of each other but also honest about their own issues
- achieve a care plan that is acceptable to both, whilst still supportive of both

Learning Objectives:

- clarify the patient's agenda
- explore patient's complex concerns
- provide the correct amount and type of information
- achieve a shared understanding (recognising this might not be equally shared by all groups)
- achieve shared decision making
- construct a care plan
- reflect on how own feelings and experiences may influence the communication process

GP Referral Letter

Sylvia Prichard
CHI: 0507690042
5, March Street,
Dundee

Dear Doctor/Midwife,

I would be grateful if you could see this couple at the infertility clinic, who have been trying for a baby for 7 years. Mrs Prichard is aged 39 years and she previously had a termination of pregnancy (husband unaware). Her periods are regular. She is currently being treated for depression with fluoxetine.

Investigations show the following: day 21 progesterone 42nmol/l, immune to rubella and endocervical swab is negative for Chlamydia. Mr Prichard is not registered at this surgery. He has an 11 year old daughter from a previous marriage. I have advised him to attend his own GP to arrange a semen analysis.

Thanks you for seeing them.

Yours sincerely,

Dr Johnstone

HISTORY SHEET PROFORMA

Name, age, parity	
Presenting complaint • duration of infertility • primary or secondary • duration of relationship • investigations to date • treatment to date	
<u>Gynaecological History</u> **Menstrual history** • age menarche/menopause • cycle frequency and duration • K = .../.... • any dysmenorrhoea • menorrhagia • date of last menstrual period **Cervical smear history** • date and result of last smear • ever abnormal • ever required treatment **Contraceptive history** **Sexual history** • frequency • libido • dyspareunia • timing with cycle	

Vaginal discharge • colour • odour • vulval irritation • previous sexually transmitted disease	
Obstetric History • chronological order: year, gestation • paternity • any problems: antenatal/intrapartum/postnatal • outcome : birth weight	
Systematic Enquiry	
Past Medical and Surgical History	
Drug History and Allergies (including recreational drugs)	
Family History (including genetic abnormalities)	
Social History (including occupation, partner, children at home, smoke cigarettes, alcohol consumption)	

HISTORY SHEET PROFORMA
PARTNER HISTORY

Name, age	
Presenting Complaint • duration of infertility • primary or secondary • duration of relationship • investigations to date • treatment to date	
Andrology History • previous UTI or STI • testicular damage • previous surgery • sexual history (including coital frequency, any erectile or ejaculatory problems) • previous andrology treatment	
Fertility History (in chronological order) Year, gestation, maternity, outcome	
Systematic Enquiry	
Past Medical and Surgical History	
Drug History and Allergies (including recreational drugs)	

Family History (including genetic abnormalities)	
Social History (including occupation, partner, children at home, smoke cigarettes, alcohol consumption)	

Clinical Communication Skills
Reproductive System

Down's syndrome (Weeks 3 and 4)

- **Antenatal Clinic**

Laura Blair

This is a series of consultation with a patient at a hospital antenatal clinic.

Role Play One

First consultations

This patient has a complex history and consequently complex emotions around becoming pregnant and the expectation of that pregnancy. These complex issues all lead to a large numbers of areas which need to be tackled with her as her pregnancy progresses. In particular you need to discuss the screening options for Down's syndrome.

Down's syndrome information is available - both here attached and as web links;

Communication Issues

The student should:

- explain the options for screening using clear language
- explore patient's attitude to management, including termination of pregnancy and coping with a child with Down's Syndrome

- involve the patient in decision making and ensure screening methods are acceptable, taking into account background and religious influences
- explain advantages and disadvantages of screening
- provide support

Clinical Communication Skills
Reproductive System

Down's syndrome (Weeks 3 and 4)

- **Antenatal Clinic**

Laura Blair
Role Play Two

Second Consultation

This is to give the patient the results of the screening tests which confirm the diagnosis of Down's syndrome, to explain the diagnosis and to explore options. There is an element of time pressure here, as if the option of a termination is accepted it will need to be done as soon as possible.

Communication Issues

The students should:

- break the news of the results of investigations, explaining in clear language
- present clear options to patient regarding possible management and outcomes
- provide support
- support the patient's autonomy whilst still offering "guidance"
- encourage the patient to make a decision as the time to make that decision is imminent

Learning Objectives:

- how to break difficult news
- how patient's background/religion can influence communication/management
- use clear language to explain complex issues
- be sensitive to non-verbal clues
- to use rapport and empathy as effective tools for support
- to help share own thoughts, ideas and feelings to support patient and to do this in a neutral manner
- to ensure patient support systems are adequate
- reflect on how own feelings and experiences may influence the communication process

Clinical Communication Skills
Reproductive System

Down's syndrome (Weeks 3 and 4)

- **Antenatal Clinic**

Laura Blair
Role play Three

Third consultation

This role play is about getting the result of an ultrasound scan which demonstrates an inter-uterine death.

Communication Issues

The students should:

- Break the news of the diagnosis of an intra-uterine death
- Give information in terms the patient can understand
- Allow time for the patient to respond to the information
- Use listening skills to enable the patient to express concerns
- Demonstrate an empathic approach

Learning Outcomes

- Giving information in terms patient can understand
- Strategies for breaking bad news
- Strategies for dealing with emotional response
- Reflecting on own feelings during the interview, particularly the feeling of helplessness

Clinical Communication Skills
Reproductive System

Down's syndrome (Weeks 3 and 4)

- **Antenatal Clinic**

Laura Blair

Scene Setting for Students

This is a series of consultation with a patient at a hospital antenatal clinic.

Role Play One

First consultation

You are a Foundation Doctor working in the Antenatal Clinic. The patient is 37 year old teacher who has become pregnant after the second attempt at In vitro Fertilisation (IVF). It is her first pregnancy and she is attending for a booking clinic at 9 weeks. She has a history of 8 years of infertility and 2 cycles IVF treatment.

You need to discuss the options available for screening in early pregnancy and in particular given her age, the screening option for Down's syndrome.

Communication Issues

The student should:

- explain the options for screening using clear language
- explore patient's attitude to management, including termination of pregnancy and coping with a child with Down's Syndrome
- involve the patient in decision making and ensure screening methods are acceptable, taking into account background and religious influences
- explain advantages and disadvantages of screening
- provide support

Clinical Communication Skills
Reproductive System

Down's syndrome (Weeks 3 and 4)

- **Antenatal Clinic**

Laura Blair

Scene Setting for Students

Role play 2

Second Consultation

Mrs Blair opted for serum screening for Down's syndrome and her age related risk came back as 1:49 chance of Down's syndrome. She therefore decided to undergo amniocentesis. The result of amniocentesis confirms the diagnosis of Down's syndrome.

You must give the result of the amniocentesis and confirm the diagnosis, then exploring options and making decisions. There is an element of time pressure, as if the option of termination is accepted then that will need to be carried out as soon as possible.

Test Results Summary

Blood Test:	Age relate 1:49 chance of Down's syndrome (< 1:250)	*(Scanned and attached)*
AFP:	0.283	
HCG:	1.581 Elevated risk of Down's syndrome	
Scan:	Several soft markers, including cardiac abnormality and increased nuchal thickness	*(Scanned and attached)*
Amniocentesis result:	Female foetus with trisomy of chromosome 21 (Down's syndrome)	

Communication Issues

The students should:

- break the news of the results of investigations, explaining in clear language
- present clear options to patient regarding possible management and outcomes
- provide support
- support the patient's autonomy whilst still offering "guidance"
- encourage the patient to make a decision as the time to make that decision is imminent

Learning Objectives:

- how to break difficult news
- how patient's background/religion can influence communication/management
- use clear language to explain complex issues
- be sensitive to non-verbal clues
- to use rapport and empathy as effective tools for support
- to help share own thoughts, ideas and feelings to support patient and to do this in a neutral manner
- to ensure patient support systems are adequate
- reflect on how own feelings and experiences may influence the communication process

Clinical Communication Skills
Reproductive System

Down's syndrome (Weeks 3 and 4)

- **Antenatal Clinic**

Laura Blair

Scene Setting for Students

Role play Three

Third consultation

The patient has come back today to the antenatal clinic at 36 weeks. She has just had a routine scan and the ultra-sonographer has diagnosed an intra-uterine death. She has asked you to see the patients and break this news to her. You will then have to explain what needs to happen next.

Communication Issues

The students should:

- Break the news of the diagnosis of an intra-uterine death
- Give information in terms the patient can understand
- Allow time for the patient to respond to the information
- Use listening skills to enable the patient to express concerns
- Demonstrate an empathic approach

Learning Outcomes

- Giving information in terms patient can understand
- Strategies for breaking bad news

- Strategies for dealing with emotional response
- Reflecting on own feelings during the interview, particularly the feeling of helplessness

Role reviewed 01.12.08

GP Referral Letter

Laura Blair

22.01.71

37 Middleton Street

Dundee

Dear Doctor/Midwife,

Thank you for seeing this 37 year old patient at the ante-natal clinic, who is currently 8 weeks into her first pregnancy. She has become pregnant after her second attempt at In Vitro Fertilization which was provided after 8 years of infertility. She is clearly delighted to be pregnant.

She is keeping well apart from some early morning nausea which has been a little difficult to cope with as she is a teacher in a busy school. Her blood pressure today is 122/74 and she is of normal weight and build.

Thank you for accepting her for shared ante-natal care. Our mid-wife clinic is on a Tuesday and she knows to make an appointment for that once she has been booked by yourselves.

Yours sincerely,

Dr C Tait

Q and A on Down's syndrome Screening

Before attending this session read the patient information provided on Down's syndrome Screening, Amniocentesis, Chorionic Villus Sampling and "When a Baby has Down's Syndrome". This will give you information from different perspectives.

Please find below examples of possible comments and questions, with suggested replies. Clearly these need to be tailored to the individual, as everyone has different beliefs and issues.

Q1) I'm too young to have a baby with Down's syndrome. *(Aged 19)*

You are young, so your risk by age will start as "Low risk"; that means a chance of 1:250 or over, however that does not guarantee your actual risk will be in that group. Once your risk is calculated by including the hormone and protein levels in your blood sample, and how far into the pregnancy you are there is always a possibility that you could come back in the "Increased Risk" group. You have to consider this before deciding if you want to have the test done. It is unusual, but not unknown for a woman as young as 16 to have a baby with Down's syndrome.

Q2) I'm not sure; do you need an answer now?

No. If you are not sure take time to think of the possibility of being in the "Increased Risk" group, and consider what you would you do.

- Would you have an Amniocentesis?
- What would you do if the Amniocentesis came back positive?

I will give you this information leaflet that has a contact phone number for the Down's syndrome screening service on it. If you or your partner needs to discuss the test further, please call the Midwives there and they will be happy to help. If you do decide to have Screening, I have written the week it would be preferable for the blood to be taken on the leaflet. But remember, the blood test only provides a risk factor, it is not a diagnosis.

Q3) I'll have the test, but I would keep the baby whatever the result.

How would you react if you were asked back for a further appointment because you were in the "Increased Risk" group, and you were told the risk is 1:10?

If it would make no difference to the outcome of the pregnancy then do you need to know this? What is a happy time will have a shadow cast over it? It is your decision, but please keep in mind there is always a possibility that you may be asked back and offered investigative procedures.

Q4) What is Down's syndrome?

Down's syndrome is a genetic abnormality, where the baby has an extra chromosome 21. There is nothing you have done to cause this to happen. This extra chromosome results in the baby having recognisable features like extra creases below their eyes, small low set ears and sometimes slightly smaller than expected limbs.
The main problem is that these children have varying degrees of learning disabilities. Some children can attend mainstream school with the support of a special needs teacher, others are unable to do even the most basic tasks, and need 24 hour nursing.

This condition used to be called "Mongolism". Also as they grow up there is an increased possibility of developing conditions such as cardiac disease, diabetes, thyroid problems, weight problems, depression, Alzheimer's disease, and certain cancers. But then anyone can develop these conditions. If you need more information I can provide information leaflets from the Scottish Down's Syndrome Association.

Q5) So, if I'm "Low Risk" everything will be fine? Good.

A "Low Risk" result does not mean "No Risk". Every one has a risk factor of some description. Low risk means your chance of having a baby with Down's syndrome is small, not impossible.

Q6) If I'm "Increased Risk" will my baby have Down's Syndrome?

No, an "Increased Risk" means your figure has come back in the range of between 1:3 and 1:250. This test only works out your "chance" of having an affected baby. It is not a diagnosis. Any woman in this group is invited back to discuss further testing. The only way a definite answer can be given is to carry out a diagnostic test like an Amniocentesis; however this is still your choice.

Q7) Can't you tell by scan?

Unfortunately not. We can sometimes see "soft tissue markers" which can increase your risk further, or occasionally an actual physical abnormality like a heart defect that can be associated with Down's syndrome. 50% of babies with this condition will have what would be termed as a "normal" scan. Conversely, babies showing soft tissue markers and physical abnormalities often have normal chromosomes.

Q8) I'll have screening, but I wouldn't consider an Amniocentesis.

What do you know about Amniocentesis?

If it is fear of the procedure I can discuss it with you so you can make an informed decision. If you are screened and come back in the "Increased Risk" group, the test will be discussed but it will still be your decision, based on the information we can provide.

If you wouldn't have an Amniocentesis for fear of a miscarriage, or you would not consider the possibility of a termination at any cost, then perhaps it would be wiser not to have the screening test done. I can give you an information leaflet explaining both tests, to help you make your decision. *(A copy is supplied at the back of this learning pack.)*

Q9) I don't agree with screening; you're playing God. (Hostile voice).

I realize not everyone agrees with screening for abnormalities, which is why women are invited to make their own decision, based on their own beliefs. I am not recruiting women for the test; I am simply providing information about a service for those who chose to be screened. I do not offer advice, or opinions, and I respect everyone has their own feelings on this subject.

Q10) What do you think I should do?

I can't answer that. You need to consider what you would do if you were told your baby had Down's syndrome and work back from there. You need to discuss this with your partner or family, and I will give you this information leaflet to help you. It is ultimately your decision, as difficult as it is. Please phone the contact number on the leaflet if you need some extra information.

Q11) At the age of 36, I'll be "Increased Risk" anyway won't I?

Not necessarily, but it is a possibility. Your risk based on your age alone is fairly near the cut off point of 1:250, but it depends on the combination of all the information we use. The main thing to consider is we are discussing a risk factor, not a diagnosis. Would you be reassured with a "Low Risk" result, as this is not a guarantee that the baby is "normal"? If not, it is possible to arrange an Amniocentesis at your request.

Q12) I know I just couldn't cope with a handicapped child.

If you feel that you really need to know, the screening programme cannot give you that guarantee. It is possible to arrange an Amniocentesis at your request. You have to be aware that there is a very small risk to the pregnancy following the procedure, however if you need to know for certain then this is the only way we can identify or eliminate the possibility of a chromosomal abnormality. I can give you a leaflet explaining the test, and I can arrange an appointment with the Midwife Counsellors

to discuss any further queries you may have. An appointment will be arranged for you to attend Ultrasound for the Amniocentesis when you are over 15 week's gestation.

Q13) Is there anyone else I can talk to about this?

There are Midwife Counsellors who are available to discuss the test with you. I can phone to see if someone is available now and if not, I can make an appointment for you. Alternatively, you could phone the number on the information leaflet I will give you.

Questions copied with permission

'Down's Syndrome Screening: Just a Blood Test?'
Written by Amanda Sullivan, Midwife counsellor, Ninewells Hopsital

Background Reading

Scottish Down's Syndrome Association	www.sda.org.uk
NHS Tayside Leaflets	- LN479 - LN198 - LN199 - Tate, P. 2001
The Doctors Communication Handbook (fourth edition)	Oxford Radcliffe Medical Press

Additional Reading

Skills for Communicating with Patients	Silverman JD, Kurtz SM, Draper J (1998) Oxford Radcliffe Medical Press
Patient Centred Medicine, Transforming the Clinical Method (second edition)	Stewart M et al (2003) Oxford Radcliffe Medical Press

Appendix 1: Time out within Communication Skills Role Plays

Time out (when the role play is stopped and the student can seek advice on how to proceed) can be initiated by either the student or by the tutor. It is important that this is done effectively and with the minimum of disruption and threat to the student.

Student Led

- Time out can be disruptive
- Time out can be unsettling for the student and requires the tutor to manage the event
- By bringing the student into the group effectively
- By supporting the student back into the role play effectively
- Time out should only look at the "stuckness" of the student at that point in time (with minimal digging back into how they had got to that stuck point)
- The group should only be involved in asking for ways ahead, not in reflecting on the reasons for the "stuckness"
- The SP should not be involved at this time in discussion around the process, they can reflect on it during the final discussions
- It can be difficult for some students to take time out if the teaching is being done in a linked interview room rather than the group room
- It can still be too easy for some students to take time out, if the tutor thinks they are using it excessively he should guide them to carry on and see where they get to. As a working rule it should only happen as a maximum of once/role play.

Tutor Led

- This is very difficult to manage well and so should only be used as a desperate measure
- The student being interrupted feels very threatened and vulnerable
- If the tutor has to call time out then it might be best for only the tutor to speak to the student with a few key messages on how to proceed
- Reflection on this overall can then take place in the group at the end when the whole process is over and the student is less exposed

SP Led

- This should never happen as it is too disruptive and threatening and would require the SP to step out of role during the role play, which is not appropriate