Teaching Tool description	
Title	UCL Medical School Clinical Communication Course (1st clinical year)
For whom? (pregrad, postgrad, residents…)	First year clinical undergraduate medical students
Goals/educational objectives	Basic interviewing skills, gathering information, responding in different types of consultation, sharing information and discussing treatment, breaking bad news.
Methods (small group, lecture,…)	Small group practical work with simulated patients, 3 hour session, one tutor and one simulated patient per session. Designed for students to be videoed and receive feedback.
Short Description	This is a set of four teaching sessions using small group work with simulated patients for first year clinical students to practise skills in: basic interviewing, gathering information, adapting their consultation style in different types of consultation, sharing information and discussing treatment, and breaking bad news. The packs include information on the format of the sessions, tutor notes, actor briefing and student handouts.

Practical Implementation Advice	Requires trained tutors and simulated patients.
Tips for success Pitfalls	Training to brief the actors on the level of student performance to expect and guidelines for appropriate feedback, as well as specific aims for each scenario. This is a tried and tested course and works well.
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UCL Medical School
MBBS Year 3
Communication Skills Course
2011-12

Information for tutors

Block 1: Gathering information and the role of the clinical student

Member of:

UK Council of clinical communication

Contents

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The Year 3 Communication Skills course

Course aims

In their first clinical year, students will spend most of their time on their attachments on the wards, and will have the opportunity to develop their consultation skills with patients, particularly *history-taking*, and to observe more advanced skills, such as *giving information* and *breaking bad news*.
The Communication Skills sessions are an opportunity for students to be given **feedback** about their **own communication skills** and to **develop them further**.
The course includes topics related to communication with patients, relatives and colleagues, and includes both routine and difficult or more problematic situations.

Aims

The overall aim of the course is to enable students to ***communicate effectively and sensitively in their role as a clinical student***, by providing opportunities to:

- **reflect** on their experiences of communication in medical settings, including their own consultations and consultations observed on their attachments
- **practise** communication skills that they should be using on their clinical attachments, which includes:
    - basic skills in setting up and conducting medical consultations
    - staying within the boundaries of their role as a clinical student
    - responding to different patient presentation styles
    - gathering information to obtain a medical history
- **learn the principles** of more advanced consultations, to enable them to learn more effectively from consultations they *observe* on their attachments; these include situations in which:
    - information is given to patients and relatives
    - decisions are made about treatment with patients and relatives
    - bad news is broken
- **learn how to evaluate** the communication taking place in consultations and give constructive feedback to others.

Learning objectives

By the end of the year, students should be able to:

- conduct effective consultations with patients and relatives in their role as a clinical student
- gather information to obtain a medical history
- adapt their communication styles to different types of consultations
- establish and maintain good working relationships with patients and relatives
- adhere to the professional boundaries of their role as clinical students
- communicate effectively with colleagues in medicine and other professions
- demonstrate (e.g. by role playing in the role of a junior doctor) how they would:
    - provide information about diagnosis, prognosis and treatment
    - discuss treatment decisions
    - address sensitive and difficult issues (e.g. breaking bad news)
    - respond to patients or relatives who are in distress
    - deal with problems in working with colleagues

Format of the sessions

There are four Communication Skills sessions in Year 3, one in each block. These cover:

Block 1: Gathering information and the role of the clinical student
Block 2: Responding in different types of consultations
Block 3: Sharing information and discussing treatment
Block 4: Breaking bad news

The students will be in small groups (about 8-9 students per group). The sessions are practical, working with prepared scenarios enacted by simulated patients (actors). Students will receive feedback about their own communication from their peers, the simulated patient, and the tutor. The consultations are videoed, and video review is used in feedback.

The course is based on evidence that practice with feedback is the active ingredient of effective communication skills teaching. We are aiming for each student to conduct **two videoed consultations** during the year which they are given feedback on. These are whole consultations (i.e. each with a beginning and an ending as well as the task in the middle). This means that in each session, **four students** will need to conduct consultations. *Please stick to this – student feedback consistently shows that they prefer more students to do a consultation each time and have less discussion.* Where group sizes are larger than 8, please ensure that **more than 4 students** have the opportunity to conduct part of a consultation.
In a $2^1/_2$ hour session, the likelihood is that the consultations will be 6-8 minutes long and there will be about fifteen minutes for feedback per student. Please note that four consultations per session does not mean that you need to run four different scenarios: consultations can work very well if two students split the tasks to be accomplished between them – so two students consecutively see the same patient (with a short handover in between). Students should attend *all four sessions* during the year (i.e. even if they have done two consultations before the last session.)

The consultations should be videoed so that parts of the video can be shown as needed during the feedback for each consultation. It is not necessary for the students to see their whole consultation again, but it is important to enable every student to see part of their own consultation.

Simulated patients are used to enable a range of patient situations to be demonstrated and to enable students to receive feedback from the patient's perspective. Simulated patients are pre-briefed in the aims and format of the course, a core set of roles, and general instructions for giving feedback. There will be a simulated patient available for the whole time (booked from 2.00-5.00 pm, with the half hour before the students arrive used for additional briefing). On each site there will be two simulated patients (usually one male and one female), so tutors may wish to swap half way through the session.

Information given to students

Handouts for students are available on the Year 3 Moodle website. These include:

- learning objectives for the year
- aims of the course and format of sessions
- information about student assessment, monitoring and attendance
- specific information about each session, including skills to practise, and rules of feedback

In the Introductory Course in Clinical Medicine, the students have had sessions on:

- History-taking: a lecture and demonstration focusing on the content of the medical history
- Effective clinical communication skills: a lecture outlining the key skills in communication to focus on in their first clinical year, including a description of the Calgary-Cambridge Guide to the Medical Interview
- History-taking practice in the form of role play, co-ordinated by senior medical students (peer-assisted learning scheme)

Students have also been given:

- The Calgary-Cambridge Guide to the Medical Interview fold-out card

The following textbook has been recommended to students:
Silverman J, Kurtz S, Draper J. (2005) ***Skills for communicating with patients.*** **Oxford: Radcliffe Publishing.**
Tutors are recommended to read this book and its companion volume:
Kurtz S, Silverman J, Draper J (2005) *Teaching and learning communication skills in medicine.* Oxford: Radcliffe Publishing.

Assessment

Communication skills are assessed during the end-of-year clinical exam (OSCE) in a number of stations, which can be combined with other topics such as Ethics and Law or Practical Skills. Students should be able to demonstrate the skills described in the Calgary-Cambridge Guide to the Medical Interview.

Working with simulated patients

The roles included in this pack are those which have been used to brief the simulated patients prior to the session. You may wish to use alternative roles or to adjust the roles provided, e.g. in response to student requests to re-run consultations they have experienced or observed. Please forward any information or comments about the roles to Lorraine Noble.

The roles used to pre-brief simulated patients usually contain **much more information** than can be covered in the time available (i.e. a 6-8 minute consultation). This is to enable actors to have plenty of *background information*, as different students are likely to take the consultation in different directions. It *does not mean* that students should try to cover everything in the time available. *Please discourage students from rushing through (for example, their histories) in the mistaken belief that they need to cover everything in a short consultation.*

Give students a **clear and manageable task** to be completed in each consultation, and encourage them to consider how to manage their time, so that each consultation has a clear beginning, middle and end. It is part of the learning on this course that students get a sense of what they can and can't achieve in a short period of time (i.e. less than 10 minutes face-to-face with a patient or relative).

Equally, students need to know that this is not a 'different' approach to the learning they have on their attachments: they are still expected to show clinical accuracy and operate within the boundaries of their knowledge and role. ***Encourage students to conduct their consultation in the same way as they would on the wards or in their clinics***, so that they can be given on how they *do* actually conduct their consultations, not on how they think they should be 'performing' for a communication skills tutor. Encourage students to take notes during their consultations.

Simulated patients have been given information about the course aims and format, instructions for how to play the roles, and instructions about giving feedback (see below).

Rules for simulated patient feedback

Rules of feedback

- say positive feedback first
- be specific e.g. 'your manner was warm and friendly and you listened', not 'it was fine'
- then comment on points the patient was unhappy about
- be constructive and make suggestions for improvement, rather than being critical

→ the feedback should be balanced

Order of feedback

- the student interviewing the patient will feedback first
- their peers will be asked to comment next
- then you will be asked for feedback
- the tutor will give feedback last

→ we are aiming for one 'round' of feedback, rather than a circular discussion

Type of feedback to give

- you are giving information about how the patient felt, but you are not still 'in role'
- if the student who interviewed you asks for specific information (e.g. about a particular aspect of the interview they were concerned about), include this in your feedback
- your feedback should be specific to how *you* felt as the patient in *this* consultation – do *not* generalise (e.g. 'I'm not sure other patients would have responded as I did to your manner')
- do *not* discuss personal experiences (e.g. your own visits to doctors)
- do *not* discuss the brief you were given (e.g. 'I was told not to ask if I have cancer')
- do *not* compare the student's performance with others who have seen 'this patient'

Tutor feedback

- the tutor's feedback may overlap with yours, often to a large degree
- sometimes the feedback will be different (e.g. the patient may be unhappy because a medication was not prescribed, but it might have been the right thing to do)
- the tutor may draw out further implications (e.g. how this situation applies to different types of patients)

Particular skills to look out for

The session has a particular focus in terms of the skills that students are practising. Please tailor your feedback to address the skills which are discussed in the training sessions.

Block 1 – Gathering information and the role of the clinical student

Aims

Students have been told in the introductory course that one of the key aims of their first clinical year is to learn how to **assess the patient's problems**, and to do this by practising the structured assessment that is called the **medical history**. They will spend a lot of time on their attachments clerking patients and giving case presentations. *This course is intended to* ***complement*** *this clinical experience,* by giving students the opportunity to:

- show how they communicate with patients so that they can receive feedback on what they are doing well and how they can improve
- practise reflecting on consultations (their own and observed consultations) in order to identify strategies for effective communication that they can take back to the wards.

Whilst they will have the opportunity to clerk patients on their attachments, they may receive little or no feedback about the consultations they have on the wards and therefore how they communicate with patients.

Although their main role this year is to practise 'taking the medical history', when students are on the wards they often find themselves faced with **situations about which they have received no teaching or guidance**. These may be situations involving **patients, relatives or colleagues**. They may find that they are faced with **conflicting demands**, or put in a position which goes **against what they have been taught to expect** (e.g. poor practice from staff). They will also find themselves in situations where they have to think on their feet and be aware of their role more generally as a part of the medical team. It is important that students are aware that this is a normal part of professional life, and to start thinking about how they – even as students – must consider how to respond in a **professional manner** regardless of the situations they find themselves in.

The scenarios in this session therefore include *history-taking roles*, for students to practise their *information gathering* and their *general approach to setting up and managing consultations*. There are also roles which put them in difficult *interprofessional situations*, which are realistic (based on experiences of previous students) and test their understanding of their role and how to behave professionally.

Tutors should use their discretion in choosing roles, e.g. a group of students may be very nervous about the whole process of clerking patients, particularly in front of others and being videoed, so may want less of a challenge. Tutors can also brief actors to either play up or down the more challenging aspects of the roles. Actors are always briefed *not to make the scenarios more difficult* than the briefing notes describe. It is helpful in the history-taking roles to ensure that students can do the basics in terms of introducing themselves, explaining what they are there for, gaining consent, and ending appropriately *(always including a summary).*

As this is the first session, students need to be introduced to the format of the sessions, i.e. the focus is on them *practising their skills* and *reflecting through feedback* (in contrast to watching others on the wards or practice without feedback). Students need to be taken through the *ground rules* (e.g. feedback rules) and the use of video in these sessions.

Learning objectives
By the end of this session students should be able to:

- demonstrate how to conduct a basic medical interview with a patient, which includes:
    - introducing themselves appropriately and seeking consent to clerk a patient
    - establishing good rapport
    - gathering information about a patient's health problems
    - exploring the patient's ideas, concerns and expectations
    - summarising and concluding effectively
- demonstrate how to conduct themselves appropriately in their role as a first year clinical student, which includes:
    - defining the boundaries of their role as a clinical student
    - being able to discuss which communication strategies are appropriate when faced with unexpected or conflicting demands
    - demonstrating how to conduct professional and sensitive discussions with patients, relatives and colleagues at a level appropriate to their role as a first year clinical student
- reflect on consultations in order to identify strategies for effective communication, which includes:
    - being able to report on which aspects of communication were helpful or need improvement in both their own and observed consultations
    - giving constructive feedback to others

Please pay particular attention to:

Introductions

- Introduce yourself clearly: state your **full name clearly** *(not just first name)* and explain that you are a **medical student** and that you are **learning to be a doctor** *(not a 'student doctor', or 'doctor in training')*.
- Address adult patients with their **title and surname** *(not their first name only, not 'could you let me know how to address you', and they should clarify the title for a woman if they don't have it at the outset)*.
- **Clarify** the purpose of the consultation and give an **overview** of what you plan to cover. **Avoid jargon** *(e.g. they should not say that they want to 'take a history').*
- **Ask** the patient if they are willing to speak to you *(and not proceeding without the patient's consent)*.

Endings
5-point plan:

- Indicate that you have covered everything you need to.
- Check that the patient has nothing more to add.
- Summarise the information and check that it is complete and accurate.
- Explain what will happen next: i.e. you will pass the information to the doctor.
- Thank the patient and leave immediately after concluding the interview.

Students should practise properly ending their consultations, as they should on the wards.

Please see the student handout for Block 1.

Suggested lesson plan

2.30 Introduction
Welcome students, take register, query any known reasons for non-attendance.
Explain the aims and learning objectives.
Explain the format of the session: the focus is giving students the opportunity to practise – **and show what they normally do when they meet patients** – and to discuss which strategies are effective and where consultations can be improved.
Refer students to their **course handout** (information for Block 1).
Check that students can remember the principles of *giving feedback* in a group.
2.45-3.45 Scenarios 1 and 2 (first actor)
Gathering information
Explain that the aim of these scenarios is to give students the opportunity to show how they:

- begin a consultation and establish rapport
- gather information appropriately for the purpose of obtaining a medical history
- stay within the boundaries of their role as a first year clinical student
- summarise and conclude the consultation effectively.

Half an hour per scenario: to include preparation, consultation and feedback.
So: give information about the scenario to the student who will see the patient.
Explain time constraints (i.e. that they will have 6-8 minutes, so they should explore the presenting complaint thoroughly and other relevant aspects of the history if they have time).
Check that the student feels prepared for the consultation. Do consultation. Feedback.
Do this twice, i.e. 2 scenarios. Alternatively, ask student number 2 to carry on where the first student left off the history. (This is a good strategy if running short of time.)
3.45 Swap actors between groups
3.45-4.45 Scenarios 3 and 4 (second actor)
The role of the clinical student
Explain that the aim of these consultations is to give students the opportunity to:

- think about strategies for responding appropriately when faced with more challenging situations either with patients, relatives or colleagues
- consider the boundaries of the medical student role

As before, half an hour per scenario, doing two scenarios.
4.45 Ending
Review learning objectives.
Note that they will be giving electronic feedback on the sessions but that you would like some immediate feedback. Ask students each for:

- one thing they have learned from the session that they will do on the wards
- what else they might like to see covered on this course

Give information about Block 2 session (i.e. that it will focus on how students adapt their communication in different types of consultation.
Refer students to their **course handout** (information for Block 2).
4.55-5.00 Finish

Summary of roles

- Charles or Caroline Wilson – history taking: post-operative recovery on ward
- David or Deborah Brown – history taking: collapsed at work
- Cameron or Claire Davis – history taking: alcohol
- Terry or Theresa Dickinson – history-taking: intermittent abdominal pain
- Jim or Jill Frank – history-taking: constipation
- Mr or Mrs Hepper – history-taking: daughter has taken overdose
- Mr or Mrs Myers – inter-professional: being criticised by a member of staff
- Dr Le Grange – inter-professional: being asked to do something the patient has refused

The scenarios do not have particular ages attached to them, so if the actors are asked their age when in character, they should give a **reasonable age which fits in with their appearance**. Similarly, the **patient characters look the same as the actors**, i.e. the actors are *not* pretending to be overweight, etc, or to be somehow different to their own appearance.
Each of the history-taking scenarios includes one issue which prompts them to think about **how to respond appropriately in their role as a clinical student**. These include patient emotions (e.g. disappointment about the operation, wanting reassurance), patient wishes (e.g. for information about diagnosis or test results), and general boundary-testing (e.g. wanting the student to collude with racist/sexist attitudes). These issues should not overshadow the whole consultation with the patient, however, as it is important that students are given the opportunity to practise - and be given feedback on - beginnings and endings, how to gather information appropriately, and how to establish and maintain rapport.

General briefing notes for actors

Block 1 – Gathering information and the role of the clinical student

There are two aims of this session:

- To focus students on properly setting up a consultation, which emphasises: the importance of introducing themselves, agreeing an agenda, gaining consent, telling the patient what they are going to do with information and properly closing (including an immediate plan).
- To focus them on the boundaries of the student role and consider what to do when they are put in a difficult position, e.g. if a patient or relative asks for information, or they are treated inappropriately by other staff.

Students should be clear about their role and instil confidence. They should make it clear who they are, what they are going to discuss during the conversation and what they are going to do with the information they have gathered.
Students should not give information to patients, either about the health problem or treatment. They should acknowledge any queries or requests they can't address and explain what they are going to do about them. They should show empathy and interest in the patient's perspective.
None of the scenarios has an age attached. Actors are to play the age and appearance that they are.
No accents should be used.
The students are new Year 3 students who have just gone on the wards and might be nervous about talking to patients in general, let alone in front of peers and with video. Actors should not make the scenarios more difficult than they are (so no shouting, strong emotions, or trying to be deliberately difficult or confrontational). Actors should only raise the difficulty up a notch if *explicitly requested* by the tutor. Note that playing a scenario down can make it more of a challenge for the student, as it feels more realistic.
The roles are designed to have much more information than might be covered in a 6-7 minute consultation – this is to ensure there is plenty of background material. Students *do not* have to gather all the information or address every issue.
Tutors are asked to ensure that *at least* **four students** have a consultation in a session. This may be run as four different scenarios or more than one consultation per scenario. Tutors may swap actors half-way through the session.
Actors should come prepared to play any of the roles.

Charles or Caroline Wilson (Block 1)

Props: blanket to cover chest and abdomen.

Instructions for student

Scenario
You are a clinical student on your surgery attachment.
Task
Your registrar (Mr Reid) has suggested that you take a history from Charles/Caroline Wilson, who has been on the ward for 3 days following surgery.

Instructions for the simulated patient

You are married, with three children (pick suitable ages to fit in with your age). You work for a bank in a high street branch. You are usually fit and well, apart from an under-active thyroid, for which you take thyroxine (100 micrograms per day). This has never bothered you, as this seems to run in your family. You have blood tests each year to make sure you are on the right dose. You don't smoke, and share a bottle of wine with your spouse approximately three times per week. Your mother died 8 years ago of breast cancer. Your father is alive and well, and lives in Scotland (choose suitable ages).
Over the past few months you were getting attacks of what you describe as 'tummy pain'. The pain was high up, just below your rib cage at the front, on the RIGHT hand side. The pain often went through to your back, and would last an hour or two. It tended to wax and wane, or build up and then ease off, over the course of about 20 mins or so. You wondered whether it was an ulcer, but hadn't got round to seeing your GP. About 6 weeks ago, the pain became much stronger, it was constant, and any movement was very uncomfortable. You were sick (vomited), had a high fever and felt very unwell. You were sent into hospital by your GP, where they told you that you had an 'inflamed gallbladder'. They put you on a drip, and gave you injections of painkillers for a few days. The surgeon said that they would have to remove your gallbladder in a few weeks' time, otherwise there was a possibility of it getting worse and they said that you 'could get jaundiced' or go bright yellow. You don't fully understand what a gallbladder is, but you remember that you were told it was something to do with digesting fatty food, and that you can live happily without it.
You came into hospital 3 days ago to have your gallbladder taken out. This was apparently successful. However, it is painful, you feel bloated, and your bowels haven't properly worked yet since the operation. You are hoping that all this will get better before you go home. You had been under the impression that it would be a 'keyhole' operation and although they warned you there was a chance that they might have to do a bigger operation, you were not aware that (or prepared for what) this would mean, namely such a big scar underneath your right ribcage and that it was such major surgery. You are disappointed about this, as you will be in hospital for longer (missing your spouse's 40^{th} or 50^{th} birthday) and you've been told it will take longer for you to recover. You do not know when you can expect to leave hospital.
You are happy to talk to a medical student, and help them with their training. You are feeling a bit tired and sore, though, so you are hoping it won't be a long session.

[based on ABA-03A]

David or Deborah Brown (Block 1)

Instructions for student

Scenario
You are a clinical student in the Emergency Department.
Task
The triage nurse (Miss Forbes) has suggested that you take a history from David/Deborah Brown, who is in 'minors'.

Instructions for the simulated patient

You are an accountant for an engineering firm. You live with your partner and have no children. You like to consider yourself as very fit. You have never been ill before and take no regular medications. You don't smoke, but have alcohol occasionally (a few drinks two or three times a month). Your family are all well. You try and see your parents as often as you can, but due to work commitments this isn't as often as you would like. You are an only child. You grew up outside London (depending on your accent) but have been living in London since your student days. You work long hours but also try to make the most of your weekends by enjoying the outdoors: walking, cycling, and hill walking.
This morning, you felt fine when you woke, had breakfast and then drove to work. After an hour-long meeting you noticed a slight headache across your forehead. After returning to your desk to take a phone call, you noticed that your words were slurred and you were unable to speak normally. There were no problems with your vision. You don't recall feeling any pain in your chest or any palpitations, but only offer this information if directly asked. The next thing you can remember is waking up slouched in your chair and a colleague calling your name. *If asked,* you had not bitten your tongue, been incontinent, or made any twitching movements. Your colleague could not initially understand what you were saying when you 'woke up' but after about 10 minutes that had completely resolved. You felt tired subsequently and your office manager called 999 as soon as they were unable to rouse you at your desk.
You are now in the Accident and Emergency department. You have seen a nurse and you are waiting for the doctor to see you. The nurse has asked if you would mind speaking to a medical student. You don't mind, but you hope you don't 'miss your slot' if the doctor comes round whilst you are talking to the student.
This episode has frightened you as you consider yourself healthy. You have no idea what it was and your main concern is to know what caused this (and that it's not serious). You worry that, if this is something long term, it will stop you from doing things like your outdoor activities. You also worry about what if this had happened when you were driving your car….
You may ask the student whether they think it sounds serious. You would like to get back to work, but expect that they'll have to do some sort of tests, although you don't really know what. You don't even know whether you'll have to stay in hospital now. You know you have to call your partner but you're worried you'll scare them and don't really know what to say to them.

[based on ABA-07A]

Cameron or Claire Davis (Block 1)

Instructions for student

Scenario
You are a clinical student attached to a GP surgery. Cameron/Claire Davis attended the practice 3 weeks ago, reporting feeling tired all the time. The GP (Dr Williams) ordered blood tests and gave the patient the results over the phone. She has asked the patient to come back for another appointment.
Task
Dr Williams has asked you to obtain an alcohol history from Cameron/Claire Davis, before she sees the patient.

Instructions for the simulated patient

You are married and work as a book keeper in the family building firm. You have had no particular medical problems in the past and generally keep well. You saw your GP (Dr Williams) three weeks ago. You were feeling tired all the time, and this had gone on for about 3-4 months now. You hadn't been sleeping particularly well either. Dr Williams arranged a blood test for the next day and asked you to phone for the results (she said something about a 'full count' and 'thyroid test').
When you spoke to Dr Williams, she said that you had some "swollen red blood cells". When you pressed Dr Williams for the possible causes of this, she explained that the cause is sometimes a vitamin deficiency or sometimes a problem with drinking too much alcohol.
Dr Williams asked you to have another blood test "to check your liver and vitamins". You were told in a second phone conversation that the vitamin tests were normal but your "liver test was was not normal". She said: *"Your liver is a bit stressed. We ought to talk about your alcohol intake, so please make an appointment soon."*
You drink wine **every evening** with dinner (4 or 5 glasses for a man, 3 or 4 glasses for a woman). It has been gradually creeping up over the past 20 years. On direct questioning you will also admit to drinking whilst cooking every evening ("Oh maybe a glass or two - does that count?") and at lunchtime at weekends. You have a brandy nightcap perhaps twice a week. This is all with your spouse, who drinks about the same as you do.
If asked these specific questions: You never have a 'day off' drinking, you never have blackouts, you have never vomitted, you have never seriously thought about cutting down, you never drink in the mornings, you *have* felt guilty when your son (aged 20) has commented on your drinking. No-one in your family has a problem with drinking.
You like your lifestyle, as does your spouse. You are simultaneously shocked at the thought of something wrong with your liver (what does that mean? – it sounds serious) whilst wanting reassurance that your lifestyle isn't that bad (you don't binge drink like teenagers). If the student appears judgemental (verbally or non-verbally) you may clam up and become defensive.

Terry or Theresa Dickinson (Block 1)

Instructions for student

Scenario
You are a clinical student in surgical outpatients.
Task
Your consultant (Mr Forbes) has asked you to clerk Terry or Theresa Dickinson.

Instructions for the simulated patient

You work as a bus driver for London Transport. You and your spouse live in a small two-bedroomed house that you bought from the council. You are rarely unwell, and do not visit the doctor very often. Your father died of a heart attack at the age of 58. Your mother is still alive at the age of 74. She lives in an old people's home and you visit every Sunday. She has the beginnings of dementia ('going a bit senile'), which makes you sad, as you know you are losing her slowly.
You have recently developed pain in the right side of you abdomen (point at this when explaining to the student) which comes and goes. This is uncomfortable when you are at work driving the buses. The pain has been going on for several months now. It occurs both in the morning and in the afternoon, but not in the evening. You have tried anti-indigestion tablets but they don't help. You have been to see your GP, who didn't say what was wrong, but you were impressed with them because they referred you straight to the hospital.
You and your spouse go to the pub three nights a week to meet friends. You are not a heavy drinker, and will normally have a few half-pints (4 half-pints for a man, 2 half-pints for a woman) and then go home. You are aware that alcohol can linger in the system and would not want to drive a bus the following morning if you were even remotely close to the limit. You are very particular about this. You smoke about ten cigarettes a day.
Your spouse has started to become interested in having a healthier lifestyle, which is something that is causing a little friction between you. He/she insists on having a healthy cooked meal in the evenings. However, you have breakfast (a traditional English breakfast) and lunch (something-and-chips) at the canteen at work. You take no exercise at all.
You are quite chatty and go off the point at times. You will state fairly early on in the proceedings that you were hoping that you are going to be given a sicknote. In fact you think your GP sort of intimated that, that was why he was making the referral and why the hospital had sent you an appointment so quickly. Because the pain only really happens at work, you reasonably associate it being caused by your job and feel that if you stopped work it would get better. Hence the request. Suggest that the student can put in a good word for you with the doctor to get you a sicknote.
You actually have a good work ethic and you are proud of your sickness record, as you have had the least number of days off work for sickness in your depot for many years now, and feel that it is time that you had some time off sick now. You have worked as a bus driver for 20 years but do not enjoy the job anymore. You are secretly hoping that the hospital doctor will pronounce you ill enough to apply for early retirement, as you feel that you worked hard enough in life (you started work at age 16) and that the state should now be able to support you for a change.

Jim or Jill Frank (Block 1)

Instructions for student

Scenario
You are a clinical student attached to a General Practice surgery. Jim/Jill Frank has attended today, with a new problem, and is not a regular attender.
Task
The GP (Dr Barnard) has asked you to clerk Jim/Jill Frank before he sees the patient.

Instructions for the simulated patient

You recently started work as a gardener for a small local company; previously you worked in a garden centre. Over the past three to four weeks when you go to the toilet it is really quite painful (colicky in nature, i.e. builds up and eases down over 20 minutes or so) and what you pass is hard and small, like pellets. You now have to sit and strain for a long time. When you actually 'go' it is painful, sore where it comes out and where you wipe yourself. You are going only once every three days (normally you would go once every one to two days). The other thing which has freaked you out a little is that when you wipe your bottom, you have noticed that there is blood on the paper (every time), which (if asked) is bright red.
Breakfast is white toast. You normally go to the nearest burger place for lunch. Your evening meal is a ready meal or a takeaway, with friends. You have a couple of lagers an evening (2 pints for a man, 2 half-pints for a woman). In your last job there was a good café nearby, and you often had pies, potatoes and veg. You don't get the opportunity to go to the toilet much and you have little time to have a proper lunch hour.
You have no particular concerns about what this might be. You really want the problem to be sorted out before your workmates notice anything about how long it takes you to go.
Variations on Frank:
(1) Terminology used to describe going to the toilet. Could either be vague ("I've got a problem, when I, you know… And when I, you know, it's sore…") or using colourful language ("when I go for a shit… but I don't have problems going for a piss, only a shit").
(2) Making inappropriate remarks (either racist or sexist, advised by the tutor). You are friendly, not intending to be offensive, and are unaware that your comments can be regarded as inappropriate. Comments are good-natured, such as "nice that people like you are being given job opportunities" or "nice to see a pretty face around here". For white students, you might make comments such as "you're the first English person I've seen here today!" These remarks come up as part of normal chit chat – you are just making conversation.
Start with one remark early on, then follow up later. The remarks can be personal to an extent (e.g. "I don't eat the kind of foreign food you do" or "You'll be lucky to get a job at the end of it with all these foreigners around here") and made in a jokey style (e.g. "It's all very well you learning to be a doctor, but you're going to go off and have babies in a few years, so what's the point, know what I mean?").
Allow the student time to respond and don't overdo it – the point is *not* to try to get the student to react during the consultation, but to get them to *experience* it. Note: ***do not*** push it into being *clearly* offensive, and avoid all references to religion or specific cultures. You are *not* trying to intimidate students or pick a fight.

Mr or Mrs Hepper (Block 1)

Instructions for the student

Scenario

You are a clinical attached to the Intensive Treatment Unit. A young woman, Sylvia Hepper (20 years old), has been brought in unconscious this morning having taken an overdose. The paramedics had brought in all the empty bottles they found at the scene, which included Temazepam, beta-blockers, medication for osteoporosis and quinine.

Task

You have been asked by your consultant to speak to her parent, who is waiting outside. The team is extremely busy this morning, and you have been asked to gather some information from the parent about Sylvia's medical history, and any other relevant information about the events that have led up to this admission.

Instructions for the simulated relative

You are the parent of Sylvia Hepper, who is 20 years old and unconscious in intensive care. You found Sylvia on the floor of the bathroom earlier today. She had taken an overdose, by basically taking all the tablets she could find in the bathroom cabinet. This included some Temazepam (which are your own, which you take to help you sleep), some blood pressure tablets (belonging to Mr Hepper), some medication for your bones (osteoporosis, Mrs Hepper's), and some quinine you tried a while back to help with leg cramps in bed. You've not used the quinine for ages and you'd meant to throw them away but kept forgetting that they were there. You called an ambulance and got her rushed to hospital. You do not know exactly how many tablets were left in each of the bottles, if you are asked – they were perhaps all a quarter full, maybe less. The doctors had asked you that earlier.

The student has been asked to gather some information about Sylvia's medical history. This is all basically normal. She has had no significant illnesses in the past, had never been admitted to hospital before, and was not taking any regular medication. Respond to any questions with an answer that indicates that Sylvia was healthy. She had not given any indication recently that she was unhappy, although you know she wasn't getting on so well with her boyfriend, and her lack of a job had caused some friction in the household. This seems so unimportant now. She has no history of mental health problems (depression, etc.) and had never had treatment or counselling for any psychological issues.

You and your spouse are broadly healthy as well (the only conditions you have are indicated by the medications mentioned above). Sylvia has no brothers or sisters.

Sylvia is living at home with you, although she did have a row with you and your spouse last night – your spouse said she needed to get a job (she dropped out of college because her boyfriend didn't like her spending her evenings studying). You are feeling guilty and alone. Your spouse is in an all-day meeting today outside town and is out of contact.

The doctors have told you that she will probably sleep off the Temazepam, but there is a possibility that she might go blind because of the quinine. You have no idea how long it might take her to wake up, or whether there is still a possibility that she might die from the overdose. You got the impression that she would come out of it, but you want some reassurance that she will not go blind.

You want the medical student to give you some information or at least say what they think might happen. Partly because the student is there, and everyone else seems so busy. You've been accosting every doctor and nurse you've seen, but no-one has any answers – the last doctor you saw simply said "You'll have to wait, it's too early to tell". You keep pushing for information, and are basically stuck at the point of wanting reassurance that everything will be alright.

Mr or Mrs Myers (Block 1)

Instructions for the student

Scenario

About half an hour ago you were on the ward, and the consultant, Mr Collins, had drawn the curtains around the bed of Mr McEvoy. Mr Collins was about to do a rectal examination and had asked you to go and get some gauze and KY Jelly.

You were just returning when the nurse in charge of the ward (Mr/Mrs Myers), stopped you from going past the curtains, with a loud exclamation that you were not to go in there, as the consultant was seeing a patient. The nurse said that the curtains are closed for a reason and made a comment about students thinking that they can just waltz in as they please wherever they like. The nurse made these comments loudly, in front of other patients and other nursing staff on the ward.

In response, you tried to explain about the gauze and the KY Jelly. The nurse said you should ask the nursing staff rather than rummaging around in the cupboards. You got the impression that the nurse regards medical students as a nuisance. The nurse had no qualms about telling you off in front of the ward.

The nurse took the gauze and KY Jelly from you and went in to see the consultant and patient, leaving you outside.

As the consultant finished seeing Mr McEvoy he got a call and left the ward.

Task

The registrar had witnessed the whole incident from the bedside of another patient. He said "Just go and have a word with the nurse and smooth things over. I know it's not your fault, but you're going to need to get on with the nursing staff."

The nurse has returned to the office and you need to ask about getting the medical notes of another patient, Mrs Kingston.

Instructions for the actor

You are Mr/Mrs Myers, the senior nurse on the ward. You are in your office attending to some patient administration. You are two members of staff short this week and everything is getting behind. With the start of term the wards are now crawling with medical students who really do nothing useful, and waltz about as if they own the place. Medical students don't seem to understand the role of nurses in keeping the wards running smoothly and act as if only the doctors matter. Furthermore they never understand that it is ultimately the nurse who gets it in the neck when things that are needed, often in an emergency, are not there when they're required. You are not expecting to talk to this medical student about what has just happened on the ward – as far as you are concerned the episode is over.

You are the kind of person who speaks sharply one minute and has completely forgotten about it the next. When the student comes to see you *let them broach the subject* (do *not* start by telling them off). Your response is brisk and factual ('You should ask before going into the cupboards'), but not angry. You will be mollified by a student who is tactful and particularly one who apologises.

Whilst you will not admit that you were in the wrong to shout at the student in front of everyone, if the student maintains your goodwill and shows they respect the hierarchy, you may just privately think twice next time. The maximum they will get from you in terms of a climb down would be to say: "Well thank you for apologising, and let's try and make sure things happen more smoothly in the future."

Dr Le Grange (Block 1)

Instructions for the student

Scenario
You are on the ward and Dr Le Grange, the registrar, has told you take blood from the patient Mr Hume. You have just tried to do this and been unsuccessful. The patient has said "Under no circumstances do I want you to try to take blood from me again".
Task
Explain to Dr Le Grange that the patient has refused to let you take blood.

Instructions for the actor

You are Dr Le Grange, a registrar on the ward. You sent the medical student to take blood from Mr Hume. You've just had an urgent call from casualty and have to go now. You see the medical student coming towards you and expect them to have the blood sample – it has to go off this afternoon to be tested.
If the student returns empty-handed, you will be pretty cross or very disappointed with their performance. There is no-one else on the ward to take blood (none of the nurses are trained, as this is a general ward) and the phlebotomist (paramedic whose job is to go round the hospital taking blood samples) has already been round this morning and is not returning. You are too busy to take the blood yourself and you expect the medical student to make themself useful (you always took blood when you were at their stage of training).
If the student tells you that the patient has refused, then you will tell the student to tell the patient that you have said it is OK. If the student says they couldn't find a vein, tell them to try again: how else are they going to learn?
Your manner is generally brusque to the point of being rude/contemptuous. You expect the student to get the blood for you: they do want to be a doctor, don't they?
You may end the consultation by saying that you have to go to casualty, and that you want the blood sorted and given to sister to be sent off.
If the student responds with jargon you are unfamiliar with (as an actor) (e.g. talking about 'cannulation' or 'putting in a line'), be stony-faced and blank it. If he/she asks you a question which refers to procedures or protocols that you are unfamiliar with, bat it back to them (e.g. 'what do you think the answer to that question would be?' or 'what are you trying to tell me?').

Student handout – Year 3 Communication Skills course overview

The Communication Skills Course in Year 3 2011-12

General information

The Year 3 Communication Skills course provides dedicated time to practise consultations with patients, relatives and colleagues in small groups. The consultations are simulated to enable you to practise (and make mistakes) in a safe environment. You will have the opportunity to receive feedback from your tutor, the actor, and your peers, and to review your consultation from video.

Topics

You have one session in each of the four blocks this year:

Block 1: Gathering information and your role as a clinical student

Block 2: Responding to different types of consultation

Block 3: Sharing information and discussing treatment

Block 4: Breaking bad news

The scenarios reflect the skills that you will:

(a) **develop in your first clinical year** for communicating with patients, relatives or colleagues

(b) need **when you are qualified** but which are difficult to experience first-hand as a student (e.g. breaking bad news), or which you may not yet have encountered on your firms.

Format of the sessions

The sessions take place on Thursday afternoons, 2.30-5.00 pm.

Do come prepared to practise consultations (i.e. be dressed appropriately for clinical work and bring a note pad and pen).

If you wish to take away a copy of your videoed consultation (recommended), bring a memory stick to the session.

Assessment

Clinical communication is assessed in the Year 3 clinical examination (OSCE) at the end of the year. Any of the topics covered in the four blocks may appear, and scenarios are combined with clinical (practical) skills, ethics and law, and other topics covered in Year 3.

Course lead

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Student handout - Block 1

Communication Skills in Year 3 2011-12

Block 1 – Gathering information and your role as a clinical student

Learning objectives for this session

In this session you are working towards being able to:

- conduct professional and sensitive discussions with patients, relatives and colleagues in your role as a clinical student
- establish and maintain good working relationships with patients and relatives (e.g. achieving rapport, exploring ideas and concerns, responding to emotions)
- conduct a consultation to obtain a detailed history from an adult patient
- provide constructive feedback about consultations you observe and reflect on your own communication

The role of the clinical student

Starting as a clinical medical student entails developing a professional role, and a new perspective about communication being a professional tool, rather than part of your social personality. One of the key aims of your first clinical year is to learn how to **assess a patient's problems**, by practising the structured assessment that is called the **medical history**. *This course is intended to complement your experiences on your clinical firms,* by giving you the opportunity to:

- demonstrate how you communicate with patients, so you can receive feedback on what you are doing well and how you can improve
- practise reflecting on consultations (your own and your peers') in order to identify strategies for effective communication that you can take back to your firms.

The scenarios in this session include *history-taking roles*, for you to practise *information gathering* and your *general approach to setting up and managing consultations*.

There are also roles which put you in difficult *interprofessional situations*, for you to practise how to respond effectively and professionally within the boundaries of your role. As a clinical student, you will often find yourself faced with demands for which you have received no teaching or guidance, either to do with patient or relative issues, or to do with colleagues. You may find that you are faced with conflicting demands, or put in a position which goes against what you have been taught to expect. For example you might:

- be asked by a patient or relative to provide information about a patient's condition
- be told by a member of staff to do something the patient has not consented to
- be criticised by a member of staff

It is important to be aware of:

- the boundaries of your role as a clinical student
- the professional guidelines you are required to follow
- the effects of these demands on you

In this session, you will explore some of these types of situations in order to help you define more clearly your role and enable you to consider communication strategies in response to these demands.

Recommended reading

Good Medical Practice (GMC 2006). (Available from the website: www.gmc-uk.org/guidance/good_medical_practice.asp)

Silverman J, Kurtz S, Draper J. (2005). *Skills for Communicating with Patients*. Oxford: Radcliffe Publishing.

The Calgary-Cambridge Guides to the Medical Interview (www.skillscascade.com/index.html)

Gathering information

In this session, you will have the opportunity to practise conducting an effective, patient-centred consultation in order to gather information to obtain a medical history. This will include information about the patient's:

- physical condition
- social circumstances
- perspective of the problem for which they are seeking medical help

Basic medical interviewing skills in your role as a clinical student

The consultation is a professional discussion between you and the patient or relative. It is not a 'social chat' – as a clinical student you have a task to perform in every consultation, whether it is to find out information to pass on to the doctor, or for you to practise discussing certain topics. Equally, it is not an interrogation – the aim is not just to get through a checklist of questions. Listen to the patient and be aware of what they want.

Particularly important are beginnings and endings, so try not to rush these.

The beginning of the consultation sets out the 'agenda', when you explain who you are and the reason for the consultation. It is important because:

- it orients the patient or relative, who needs to know how a discussion with you fits into the whole process of care
- you establish your role – what you are there to do and what you cannot do
- it is where you start to establish rapport and develop a working relationship.

The ending enables you to check the information obtained is complete and accurate and to put this consultation into the context of the patient's care. This is important because:

- the patient or relative needs to know that the information you are taking away is a proper reflection of what they want to tell you
- it is reassuring for patients to know that their concerns have been noted
- you will be more satisfied with a consultation if you conclude it cleanly and confidently and everyone is clear about what will happen next.

Rules of feedback about clinical consultations

- Consider the aims of the consultation – what outcomes were you were trying to achieve?
- What went well – what outcomes were achieved, and what skills or strategies were helpful in achieving these?
- What went less well – what did you feel you hadn't been able to achieve, and what skills and strategies might have helped with this?
- Feedback is most helpful when it is specific (e.g. 'the patient felt comfortable talking with you because your manner was warm and friendly and you listened'), rather than a general evaluation ('it was really good')
- Focus on aspects that can be changed (e.g. non-verbal communication, rephrasing questions)
- Try to find the opportunity to practise the skills discussed soon afterwards, and if possible, ask someone to observe and comment.

Specific communication skills to practise

Opening the interview

- Check the setting: can you sit comfortably near the patient (not standing and not sitting on the bed)? If possible reduce distracting noises. Can you can be overheard? Patients sometimes feel more comfortable if a curtain is drawn.
- Introduce yourself clearly: **state your full name** and explain that you are a **medical student** and that you are **learning to be a doctor**.
- Address adult patients with their **title and surname** (check the title of a female patient if you do not know).
- Explain why you would like to speak to the patient and give an **overview** of what you plan to cover. Ask the patient if they are willing to speak to you. If they decline, thank them, and leave.

Establishing and maintaining rapport

- It helps to begin with a smile and a comment about a non-medical topic to break the ice.
- Show that you are listening: tailor your questions to the information you are being given, reflect back what the patient has said, periodically summarise.
- Respond to the patient's needs: e.g. if the patient seems in discomfort, or tired, or upset, acknowledge this and respond appropriately.

Structuring the interview

- Make a list of the information you need to obtain.
- Be aware of language: ***translate any and all medical jargon***, and clarify any ambiguous terms or any jargon used by the patient.
- Take notes. Saying what you are writing down, as you are writing it down, is reassuring, and prevents a break in the consultation.
- Summarise periodically.

- You don't have to stick to your history-taking plan rigidly – you can always come back to topics later if you need more information.
- If you are asked questions (e.g. about what you think the medical problem is), explain that you are a student and still learning, and that you will pass on the request for information to the doctor. Always acknowledge a query or concern, and explain that you will pass it on.

Ending the interview

- Indicate that you have covered everything you need to.
- Check that the patient has nothing more to add.
- Summarise the information and check that it is complete and accurate.
- Explain what will happen next: i.e. you will pass the information to the doctor.
- Thank the patient and leave immediately after concluding the interview.

Gathering information

There are two parts to making an assessment of a patient's problems.

(1) Establishing the full problem list

Novice interviewers tend to start a consultation by identifying one symptom or problem, and immediately asking detailed questions about this. But the first symptom or problem *may not be the only or the most important* problem. Patients don't necessarily start with the symptom they are most afraid of - they often build up to it. Also patients don't necessarily know which symptoms best help to establish a diagnosis. To avoid finding yourself in a situation where you realise towards the end of the consultation that there is a more to cover that you've missed - and that you've run out of time – establishing the full list of problems helps you pace the consultation.

Skills to practise:

- Start with an **open-ended question** (e.g. 'Can you tell me why you've come to the clinic today/why you are in hospital?').
- Encourage a **full description of the problem** – this is facilitated by **reflecting back** what the patient has said and avoiding asking detailed questions at this point.
- Ask if there is **anything else** and **keep asking** until the patient says that there is nothing else.
- Be careful when using the word 'symptom' – your definition of what constitutes a symptom might be very different to that of the patient – try open-ended questions (e.g. 'is there anything else different that you've noticed about your health?' or 'are there any other problems you would like to mention?').
- **Write down** each problem or symptom as it is mentioned so you keep track.
- Once you have established the full problem list, **summarise** back to the patient and say that you will ask about each in turn.

After establishing the full problem list, move on to:

(2) Detailed questioning

This is to get a comprehensive picture of each of the problems in turn: precise details of what, when, where, how severe, how long, and how often. Don't worry about finding a perfect

question for each – patients are reassured when you ask in detail, as it shows you are being thorough.

Skills to practise:

- Use **signposting** to orient the patient as to what you are going to ask about (e.g. 'now I'd like to ask you about how your health has been in the past')
- Use **open and closed questions** - neither type alone will get the full picture. Starting with open questions and then focusing on detail with closed questions is the most effective approach (called '**open to closed cone' questioning**).
- Often at this stage you can use **checklists** from your attachments for questioning about particular topics, but…
- **Avoid jargon.** This includes medical words (e.g. gastroenterology, oncology, metastatic) and more commonplace words or turns of phrase used in medical sense (e.g. history, drugs, disease, does anything exacerbate or alleviate this?). Translate into ordinary language (e.g. 'I'd like to ask you about your family's health. Has anyone in your family had a similar problem…'). Be careful about introducing words describing symptoms or diagnoses (e.g. 'Have you ever had angina?): be ready to clarify what this means. Similarly **clarify any jargon** used by the patient or any part of their description that isn't clear.
- Adapt the **number of questions** you ask, depending on the patient: some people require more, others require fewer, to give you the same information. Consultations work best when you can be ***responsive*** – rather than an 'interviewer reads out a questionnaire' approach.
- Watch **phrasing of questions:** avoid leading questions ('You've never had this before?') and multiple questions ('Have you ever had epilepsy, diabetes, rheumatic fever, stroke, heart attack, any serious childhood illnesses?'). Keep questions simple, one point at a time.
- Remember that patients **need time to digest** each question and **time to answer**.
- **Listen to the answers** you get. Novice interviewers often concentrate on thinking about their next question rather than listening to the answer to the previous question. People understandably get annoyed when you ask questions about information they have already given. Pauses or silences will seem much longer to you than to the patient. Patients will often fill a pause with more information (without you having to think of a question, and often raising something that you might not have thought to ask about).
- Show that you have received information by **acknowledging** what the patient has said, i.e. by **reflecting** it back ('So, you've had this pain for six weeks') and by **summarising** from time to time, e.g. at the end of each section. **Use the information** you have been given to inform your line of questioning.
- *Before asking questions* about any sensitive issues, or any issues the patient might not expect to be asked about (such as their living or social circumstances, use of alcohol or drugs, or sexual health), give a **brief explanation** of why you need the information. Try not to jump in with a direct question with no warning or circle round an issue.
- If there is detailed information you need about **sensitive personal aspects** (such as issues regarding sexual health risks or amount of alcohol drunk), be confident in asking **detailed questions** – don't ask a series of vague questions in the hope that the patient know what you are talking about. Patients expect medical staff to treat such matters as routine. Embarrassment is a particularly contagious emotion, so try to avoid reflecting a patient's embarrassment back towards them.
- Be aware that your **goals** may be different from the patient. You may be seeking a biomedical diagnosis to present to your consultant. The patient may want to know when

they are going to get back to work. The patient's **perception of their problem, expectations and wishes** are important in determining management of the problem and the success of this management. **Acknowledging** the patient's perspective on the situation and **recording** this information as part of the history to be passed on will be helpful to the doctors involved in the patient's care.

Course lead:

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UCL Medical School
MBBS Year 3
Communication Skills Course
2011-12

Information for tutors

Block 2: Responding in different types of consultations

Member of:

UK Council of clinical communication

Block 2 – Responding in different types of consultations

Aims

The aims of this session are for students to further **develop their skills in gathering information from patients** and to practise **adapting their communication styles** to the needs of the consultation. Students need to be able to conduct consultations with patients of **all ages**, from **different social and cultural backgrounds**, to **listen** to patients, and to **respond to their concerns and preferences** (Good Medical Practice, General Medical Council, 2006).

This is session is designed to *hone and refine* students' skills, in the light of their experiences in meeting patients on the wards. Regardless of which attachments students have attended so far, they should be able to **apply the basic principles** of **initiating a consultation, providing structure, gathering information, building a relationship, and effectively concluding a consultation**, appropriately in their role as a medical student (Skills for Communicating with Patients, Silverman, Kurtz & Draper, 2005).

Learning objectives

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

- introduce themselves appropriately and seek consent to obtain a medical history
- establish good rapport
- gather information about a patient's health problems, which includes:
    - establishing a problem list
    - conducting detailed questioning
- explore the patient's ideas, concerns and expectations
- summarise and conclude effectively
- adapt their style of communication to respond to the needs of the consultation, which includes:
    - responding appropriately different communicative styles and emotions
    - establishing and taking account of patients' concerns, preferences and perspectives

Information given to students

Students have been told to familiarise themselves with the handout before this session:

- **Communication Skills in Year 3 Block 2** handout on the Year 3 Moodle site.

Course lead

Dr Lorraine Noble, Senior Lecturer in Clinical Communication
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Suggested lesson plan

2.30 Introduction
Welcome students, take register, query any known reasons for non-attendance.
Explain the aims and learning objectives.
Explain the format of the session: the focus is giving students the opportunity to practise – **and show what they normally do when they meet patients** – and to discuss which strategies are effective and where consultations can be improved.
Refer students to the **Communication Skills in Year 3 Block 2 handout.**
Check that students can remember the principles of giving feedback in a group.
2.45-3.45 Scenarios 1 and 2 (first actor)
Half an hour per scenario: to include preparation, consultation and feedback.
So: give information about the scenario to the student who will see the patient.
Explain time allocation (i.e. that they will have 6-8 minutes, so they should explore the presenting complaint thoroughly and other relevant aspects of the history if they have time).
Check that the student feels prepared for the consultation, do consultation, feedback.
Repeat for second scenario. Alternatively, ask student number 2 to carry on where the first student left off the history. (This is a good strategy if running short of time.)
3.45 Swap actors between groups
3.45-4.45 Scenarios 3 and 4 (second actor)
As before, half an hour per scenario, doing two scenarios.
4.45 Ending
Review learning objectives.
Note that they will be giving electronic feedback on the sessions but that you would like some immediate feedback. Ask students each for:

- one thing they have learned from the session that they will do on the wards

Give information about Block 3 session: focuses on the skills of giving information to patients and relatives. Preparatory reading: Chapter 6 (Silverman, Kurtz & Draper 2005) and Communication Skills Block 3 handout on the Moodle site.
4.55-5.00 Finish

Summary of roles

- **Leigh / Lee Roberts** - reticent / embarrassed, sexually transmitted infection
- **Carly / Carl Torrington** – angry, recurrent sore throat
- **Janet / Jim Richards** – depressed mood, neck pain
- **Nada / Nikola Mandelstan** – language barrier, probable tuberculosis
- **Anna / Roman Gilowska** – language barrier, probable malnutrition
- **Jenny / Jack Rogers** – worried, probable pulmonary embolism
- **Kim / Ken Matthews** – talkative, probable irritable bowel syndrome

The actors should give a reasonable age which fits in with their appearance, and also should portray the characters in a way that is consistent with their appearance and speech (e.g. they are not trying to pretend to be overweight, and should not use a fake accent/form of speech which doesn't suit them).

General briefing notes for actors

Block 2 – Responding in different types of consultations

This session focuses on:

- conducting an effective consultation to gather information
- adapting communication style to the needs of the consultation.

Students are playing themselves, i.e. *medical students*. They should be clear about their role, what they are going to discuss, and what they are going to do with the information they have gathered. They should show empathy and interest, and instil confidence.

The scenarios do not have particular ages attached to them, so give a reasonable age which fits in with your appearance. Similarly, you are *not* pretending to be overweight, or otherwise different to your own appearance. No accents should be used.

Each of the patients has a particular 'presentation style' (e.g. talkative, reticent, worried, angry, depressed). This style should be sufficiently strong as to provide a challenge (e.g. a talkative patient will digress and give long answers throughout a consultation).

However, you are *not* attempting to make it so difficult that it is beyond of the reach of the student – patients *must be realistic*. Be responsive to how you are treated.

It is the student's responsibility to lead the interview. Please *do not* 'feed' the interview by proffering information if the student seems unsure of where to take the interview next. (Real patients tend to be led by the medical person, and wait to be asked questions.) If the role specifies a talkative patient, it is the student's job to get you back on track.

If a student does something you are unhappy with (e.g. uses jargon) mention this in the feedback afterwards rather than correct the student at the time. (Real patients tend to suppress their reactions, e.g. rarely ask staff to explain jargon.)

If the student gets stuck they can call time out, and then will either collect their thoughts or ask for advice from the tutor or their peers. When time out is called, sit quietly until the student indicates that they are ready to continue.

The consultations will be about 6-8 minutes long. The roles are designed to have more information than might be covered to ensure there is plenty of background material. Students *do not* have to gather all the information or address every issue.

After each consultation there will then be a round of feedback according to the feedback rules (separate document). In total, there will be about 10 minutes available for feedback. Please watch the tutor for signals that the discussion needs to be wrapped up.

There will be a total of about 30 minutes for each role play and feedback.

Tutors are asked to ensure that at least **four students** have a consultation. This may be four different scenarios or more than one consultation per scenario.

Actors should come prepared to play any of the roles.

Particular skills to look out for

Ideally, students should demonstrate the following skills:

Basic interviewing skills

- Beginning the interview: The student states their name and role clearly. You are addressed appropriately, e.g. Mr/Mrs.... You are given a clear indication of the purpose of the interview and what is to be covered.
- Establishing rapport: The student should be approachable and friendly. You should feel safe and that you are being taken seriously. The consultation should not feel like an interrogation or a unstructured chat with no clear purpose.
- Responding to the patient's needs: You are likely to have questions and goals for the consultation (e.g. 'What do you think is wrong with me?' or 'I'd like some medication'). Students can give you information about what they are there to do, their role within the team, and what will happen next (i.e. that they will pass the information you give them onto the doctor). They are not allowed to give you specific medical information (e.g. what might be wrong with you or what might be done about it). However, they must acknowledge any questions or goals you express and let you know who *will* be able to deal with them.
- Ending the interview: The student should (1) indicate that their questioning is drawing to a close, (2) ask if there is anything more you wish to add, (3) summarise the information and check that you are happy with the summary, (4) explain what will happen next (e.g. they will pass the information on to the doctor, who will see you shortly), (5) thank you, (6) leave.

Gathering information

- Questioning style: The student should use a balance of open-ended questions (e.g. 'How are you feeling today?') and closed questions ('Is the pain sharp or dull?'). They should avoid leading questions (e.g. 'You've had no other symptoms?') or multiple questions (e.g. 'Have you had any dizziness, fainting, nausea, vomiting?).
- Structuring the interview: You should understand what the student wants to know at all times and the line of questioning should be clear. The student should explain why they need to ask apparently irrelevant or sensitive questions *before* they ask them. You should feel able to tell your own story – you shouldn't feel that they have missed something or misinterpreted what you have said. They should use language you can understand.

Responding to different patient styles

- The student should adapt their manner and questioning to accommodate your style. A reticent patient might need encouragement and extra time. An embarrassed patient might need a more business-like, deadpan style (particularly when sensitive questions are being asked). A talkative patient might need gently redirecting (but should not feel the student is uninterested or frustrated). A patient who speaks little English will need more time and creative questioning (e.g. using gestures or pictures).
- Regardless of the emotions you express, you should feel that the student is concerned, calm, comfortable in your presence, and in control of the consultation. The student should acknowledge your emotion – even if you are only expressing it non-verbally (you shouldn't have to say 'I'm really upset'). They should avoid trying to 'bandage' the situation by giving you empty reassurances, giving advice, or seeking premature solutions. You should feel listened to and given enough time.

Leigh / Lee Roberts (30-40 yrs) (Block 2)

Instructions for student

You are on attachment in general practice. You have been asked to speak with Mr/Ms Roberts to gather some information before he/she sees the GP. The GP says that she saw the patient briefly whilst passing the waiting room, and that Mr/Ms Roberts looked embarrassed and avoided looking her in the eye.

Instructions for the patient

Presenting complaint

Ten days ago you went out with your colleagues from work to celebrate a friend's birthday. It was a great evening and you ended up drinking too much. You ended up in a nightclub and spent the night with someone you'd met there.

If you are asked: You had sex twice, oral and vaginal both times. You did not use a condom. If you are a female you are on the pill. You have a long-term partner who is not aware of this one night stand, which you now feel bad about.

You are worried that you may have caught a sexually transmitted disease. You have a yellowish discharge from your vagina/penis. You searched the web and are now worried about gonorrhoea, and chlamydia (which can cause infertility in women). You are also worried that you could have passed something on to your long-term partner. You are not worried about HIV/AIDS, because you believe that mainly gay men get this.

You really hope that you haven't caught anything and would like the GP to reassure you of this. "You don't think I've got anything, do you, it was only one night?"

You are hoping you will be given antibiotics. You really don't want to tell your partner.

General history

You live with your partner in a flat in north London. You have been together for eight years, and although you feel that you have a steady relationship, there have been some rough patches recently. You work as an administrator. Your partner works in a local primary school. You have quite an active social life. You hardly ever drink alcohol (which is why it hit you so hard at the party), and you don't smoke. If you are female: you have never been pregnant, nor have you had any gynaecological problems in the past.

Patient style

In this situation you are <u>reticent and embarrassed</u>. You are worried and upset with yourself, but will mostly express this non-verbally. When you are asked initially why you have come to see the doctor, you will pause and it will clearly be difficult for you to explain the situation. *Do not say* 'I think I have a sexually transmitted disease' as your opening statement.

Response in the consultation

If the student gives you time and listens sympathetically you will find it much easier to give the details. They should strike a balance between allowing you time to formulate what you have to say, and not leaving you stranded trying to find the words. Any hint of being judged for having a one-night stand will make you defensive and clam up. You will respond well if the student shows an understanding of your confusion about the impact of this on your current relationship and avoids giving you false reassurances.

[based on CWI-01A]

Carly / Carl Torrington (late 40s) (Block 2)

Instructions for student

You are on your GP attachment. You have been asked to talk to Mr/Mrs Torrington, to find out what has brought him/her here today. The receptionist mentioned to the GP that the patient seemed a bit cross on arrival at the surgery, and had 'huffed and puffed' a bit when told that surgery was running a bit late. The GP has suggested that you see the patient first to *speed things along*.

Instructions for the patient

Presenting complaint and background

You have come back to the GP, feeling very cross, after a visit to an ear, nose and throat clinic. For the last three years you have had a very sore throat twice a year, and you want something done about it. You had insisted on being referred to a specialist.

You waited months for an appointment. When you arrived at the clinic, a mistake had been made with dates, and no one could see you. Your appointment was then postponed twice. You were finally seen three weeks ago. The doctor you saw was not the consultant, and you felt didn't take you seriously. You felt he did not really look into your throat properly. He told you it was normal and that nothing needed to be done. You again have a really sore throat now, so have come back to the GP.

General history

You live alone, separated from your spouse for two years now. You have three grown up children whom you see occasionally. You were made redundant from your job two months ago. You smoke 20 a day and normally drink 2-3 pints of lager a day. You mainly exist off ready-meals and take-aways.

Past medical history

When your marriage broke down two years ago, the GP put you on some antidepressants (can't remember the name). You stopped taking them after a couple of months (you felt they didn't help), and you do not feel that is a problem any more. No other illnesses. You don't take any medication or drugs. Parents are still alive, but no real contact.

Patient style

You are angry because: (1) time taken to get seen at the clinic, (2) made to feel a fool by the doctor at the clinic, (3) told nothing is wrong, (4) sore throat is back again.

Response in consultation

You initially refuse to sit down. You are not listening to reason, and it takes very little to set you off again. Things which may allow you to calm down are: if the student stays calm, letting you finish speaking without interruption, asking you if you have any suggestions as to how you might like to resolve this problem, and genuine empathy about how frustrating all this must have been for you.

Ideas, concerns, expectations, wishes

You want to be taken seriously. Your friend at the pub was found to have cancer in the tonsils last year [very very rare!] and even though you haven't really admitted it to yourself, you are worried you might have it too. What if the clinic doctor missed it?

[based on DUN-06A]

Janet / Jim Richards (35–45) (Block 2)

Instructions for student

You are on attachment in orthopaedics. You have been asked to take a history from Mr/Ms Richards, who has been referred following neck trauma. The GP's letter says: 'Mr/Mrs Richards has struggled since the injury, and neither medication nor physiotherapy have been effective. The physiotherapist reported that the patient did not really seem to try to follow the recommended exercises, and seemed a bit low'.

Instructions for the patient

Presenting problem

You developed neck pain after falling at work two months ago. You had X-rays at A&E but were told they were 'normal'. You've had physiotherapy (stretching and massage), but it didn't help. You take painkillers (Naproxen), which worked initially, but not as well now. Your neck pain is sometimes very sharp. You feel it at the bottom of your head [base of skull], in your shoulder, at the top of your chest and at the top of your back. There is no stiffness or muscle spasm, but your neck feels much *weaker* than it did before, you are frightened to move it. You also started to have headaches within the last few days. You have had these before, only now they are more intense. You *do not* have dizziness or blackouts.

During physiotherapy the therapist said that you were 'very passive' and that she had to push you all the time. You could not muster up the energy to do the exercises at home. You have difficulty falling asleep. You wake up several times during the night and cannot sleep after 5 a.m. You have lost your appetite (you have lost 4 kg). You find it hard to concentrate on things, and have found yourself losing track of conversations and TV programmes. You went back to work last week, but don't feel you can continue.

General history

You live with your partner and two children. You are drifting apart from your partner, so you haven't been able to confide in them. You feel sad most of the day, every day. You have lost interest in things, such as going out with friends or spending time with the kids. You feel very 'stuck', as if nothing interesting will happen to you in the future.

Patient style

You appear a little bit sad and withdrawn, taking just fractionally longer to respond when it is your turn to speak. You come across as having a very neutral, flat demeanour – no smiling, no animation – but not unfriendly.

Ideas, concerns, expectations, wishes

You are hoping to get something stronger for the pain. You are worried that the doctor will say there's nothing wrong with you and you just have to pull yourself together.

Response in consultation

Your symptoms of depression are best presented non-verbally in an understated way, with the student slowly realising that there is a problem. You will be more inclined to tell the student about these symptoms (loss of appetite, feelings of sadness, disinterest, and loss of concentration) if they broach it sensitively, listen without interrupting, and show empathy.

[based on BSM-01A]

Nada / Nikola Mandelstan (30-50 years) (Block 2)

Information for student

You are attached to a GP surgery. You have been asked to see **Mrs Nada / Mr Nikola Mandelstan**, who has lived in this country for the past few years. You have been asked to find out why the patient has attended today, so that you can report back to the GP.

Information for patient

Presenting complaint

You have been losing weight and have been having fevers and night sweats. You have developed a cough, and occasionally the sputum you cough up is streaked with blood. You have a pain in your back which interferes with your sleep.

General history

You run a small textiles business with your brother. You and your family have lived in England for three years.

Two months ago you visited your home town in Croatia for three weeks. The symptoms started since you returned.

You had been neglecting your symptoms due to commitments at work and looking after your family. However, your spouse persuaded you to seek treatment. You want to get better as quickly as possible as your family depends on the business.

Patient style

You are not a native English speaker. You know common English words but have difficulty with medical terms. You understand more than you can speak. You will let the 'doctor' guide the consultation (you are unlikely to understand that the person is a student). You are polite and will tend to nod and smile even if you haven't fully understood, as you do not want to seem ungrateful.

Response in the consultation

It will take much longer for the student to get each piece of information. It helps if the student starts by getting general information about who you are, where you are from and who is in your family – these are the topics about which you have the most vocabulary (very hesitant and broken English). For the medical questions, use of gestures, pictures and body language will help you, when supplementing simple questions delivered slowly. It is important that the student checks that you have understood and that they have understood you throughout (for each piece of information). You will be aware (but will not show it) if the student looks impatient, and if the student speeds up or uses more complex language towards the end of the consultation.

Anna / Roman Gilowska (30-40 years) (Block 2)

Information for student

You are attached to a GP surgery. You have been asked to see **Anna / Roman Gilowska**, who registered with the practice last week. She/he recently arrived from Poland. You are asked to find out why the patient has attended today, so that you can report back to the GP.

Information for the patient

Presenting complaint and background

You have been having 'dizzy spells' recently. You come over all lightheaded for 2-3 minutes and then it disappears. You suspect this is due not eating adequately as you have so little money. You are living in a one-room bedsit which is part of a multi-occupancy house (there are five other Polish men/families living in the house). Your place is tiny, and you have the use of one gas ring in your bedsit. The house has communal toilet and washing facilities.

Family circumstances

You have no family here: your parents, who still live in Poland, are elderly now and quite poor. You had wanted to make ends meet here and in a few years bring over your younger sister, who wants to work in fashion.

Ideas, concerns, expectations, wishes

You have come to the doctor today to ask about the dizziness, and on questioning, to proffer your theory that is related to not eating properly. You don't have any clear idea of what you want the doctor to do about it; you would like to know it is not something serious.

If asked, you have *not* had nausea or vomiting. Up until recently, you were fit and well, and are not taking any treatment for anything else.

Patient style

You have very little English. Your vocabulary is limited to the more common words, and you have a thick Eastern European accent. You need time to mentally translate what the 'doctor' says and also to formulate your response.

Your lack of English has been a real handicap in obtaining work. You had thought that work was more plentiful here than it seems to be. You have encountered a lot of prejudice – people telling you to go home and not 'take our jobs'. You are getting very disillusioned with your life here but you still would like to try to see it through and make a living in this country.

[based on CWI-04A]

Jenny / Jack Rogers (late 40s+) (Block 2)

Information for student

You are attached to the respiratory medicine ward. Mr/Mrs Rogers was brought in by yesterday, experiencing breathlessness and right-sided chest pain. He/she is awaiting the results of investigations. Your registrar has suggested that this is a good case for you to practise your history-taking.

Information for the patient

Presenting complaint and background

You have just come back from a holiday abroad in Florida. You found the outward flight a bit uncomfortable (you have arthritis in your knees) and your ankles were a little swollen on arrival. The return flight was easier but your legs felt stiff afterwards.

You were getting ready for work yesterday when you felt giddy for a few moments and had to steady yourself. Within an hour you were aware of a feeling of breathlessness and developed a sharp pain low down on the right side of the chest. The pain was made worse by bending and deep breathing, and your pulse was going a mile a minute. You had never experienced anything like this before. Your spouse called an ambulance.

Since arriving at the hospital yesterday, you have had an X-ray and some other tests ['vq scan' and 'pulmonary angiography']. You had radioactive material injected into your arm and pictures taken of your chest. For half the pictures you had to breathe in a special gas, 'to check your lungs'. This all took about an hour. Then you had a needle in your groin, and had pictures taken on a big machine, then had to lie down for three hours, and the nurse had to press down quite hard on the groin area afterwards, which was quite uncomfortable.

Today, you feel a bit better, but still a bit dizzy. Your chest also aches when you breathe.

Past medical history

In recent years your activity has been limited by low back pain and arthritis of your knees. You also have varicose veins. You are *not* taking any medication. You don't smoke, but you did from your late teens until your late 30s. You have a reasonably good diet. You drink a couple of bottles of wine a week.

Family history

Your father died last year of old age, at 87 years. Your mother died three years ago, aged 77 years, of bowel cancer. Nothing major runs in your family.

Ideas, concerns, expectations, wishes

You are afraid you might have had a heart attack. One of your friends had a heart attack last year, having had pain in their chest. Your friend has been back and forth to the GP and hospital since, and still doesn't seem well.

The doctors haven't told you much so far. They seemed to pay quite a lot of attention to your varicose veins, but you don't understand why. They also asked you a lot of questions about your recent flights. You are baffled and concerned.

[based on APA-04A]

Kim / Ken Matthews (35-55 years) (Block 2)

Instructions for student

You are attached to a GP surgery. You have been asked by Dr Scott to see this next patient (Mr/Ms Matthews) to find out what has brought him/her in today.

You can see from the notes that the patient had attended the surgery a couple of months ago. There is a brief entry, which states: "Intermittent abdominal pain, ?anxiety, symptoms resolved, reassured.'

Instructions for the patient

Presenting complaint and background

Over the past couple of weeks your bowels have been irregular. For several days it was loose and frequent, not quite diarrhoea, and with a lot of wind. Now it is difficult to have a bowel motion at all. You are now passing 'rabbit pellets'.

You get cramp-like pain in different areas of your abdomen, that can last up to a few hours. The pain doesn't seem to be related to meals or to any foods. You feel 'bloated' and your waistband feels tight. You have less appetite, but wouldn't say you'd lost weight. Occasionally you feel nauseous, but you haven't been sick. You don't get indigestion or heartburn, and haven't passed any blood.

You've had this before: last summer (after returning from holiday in Thailand) and a few months ago (when you were changing jobs). By the time you got to see the GP, about a fortnight later, it had pretty much resolved.

Lifestyle factors

You don't smoke and hardly drink. You keep very fit (jog or swim four times a week). You eat a healthy diet. You have a busy job, arranging deliveries at a computer firm. You can't do this if you have to keep running to the 'loo'. You've been promoted recently, and are worried about taking too much time off.

Past medical history

Hay fever: you take antihistamine tablets/nasal sprays. It's 'murder in the summer' and you have to 'watch the pollen count religiously'.

Family history:

Your parents are both still alive although frail; brothers and sisters are healthy. No-one in the family has had an ulcer or gallstones, cancer, or any major operation.

Ideas, concerns, expectations, wishes

You want to get back to work, but are worried. You have a friend (early 50s) who has ulcerative colitis and has a colostomy bag. A male friend (mid-50s) has bowel cancer.

Patient style

You are very chatty and have difficulty sticking to the point (use the 'unending sentence technique'). You are keen to point out that you look after yourself. You will be defensive if you feel you are being thought of as 'neurotic'. Use colloquial terms to describe your bowel problems.

[based on DUN-03A]

Student handout

Communication Skills in Year 3 2011-12

Block 2 – Responding in different types of consultations

Learning objectives
By the end of this session you should be able to:

- introduce yourself appropriately and seeking consent to obtain a medical history
- establish good rapport
- gather information about a person's health problems, which includes:
    - establishing a problem list
    - conducting detailed questioning
- explore the patient's ideas, concerns and expectations
- summarise and conclude effectively
- adapt your style of communication to respond to the needs of the consultation, which includes:
    - responding appropriately different communicative styles and emotions
    - establishing and taking account of patients' concerns, preferences and perspectives

Aims
The aims of this session are for you to further **develop your skills in gathering information from patients** and to practise **adapting your communication style** to the needs of the consultation. You need to be able to conduct consultations with patients of all ages, from different social and cultural backgrounds, to listen to patients, and to respond to their concerns and preferences (Good Medical Practice, General Medical Council, 2006).
This is session is designed to *hone and refine* your skills, in the light of your experiences in talking with patients on the wards. Regardless of which attachments you have attended so far, you should be able to **apply the basic principles** of **initiating a consultation, providing structure, gathering information, building a relationship, and effectively concluding a consultation**, appropriately as a clinical student (Skills for Communicating with Patients, Silverman, Kurtz & Draper, 2005).

Responding in different types of consultations
Consultations are affected by patients' expectations and goals, any barriers to communication, and patients' normal communicative styles. There are certain key principles to follow in any consultation:

- You always need to show that you are **interested** in what the patient has to say and that you are **willing** to overcome any barriers to communication.

- Always begin a consultation with a **smile, a clear introduction and agenda setting**.

- Identify patients' **goals and expectations**. Ask the patient what they want from attending this clinic/hospital/GP surgery (e.g. 'Why did you come today?' or 'Was there anything in particular you hoped the doctor would do today?'). Remember that medical facilities are usually unfamiliar places and many patients will not know what to expect, so give clear explanations before you do anything (e.g. physical examination).

- You need to have strategies to deal with a variety of **barriers to communication**, which include: disabilities (e.g. hearing, sight or language impairments, learning disabilities), language issues, social and cultural differences, and strong emotions. Some of these will be addressed in this session. Others you will need to gain experience of on your attachments when they arise – ask the staff who are training you about what works and does not work in their experience.

- **Adapt** your manner and style of the consultation to the communicative style of the patient. E.g. a reticent or taciturn patient might need encouragement and extra time to answer questions; a talkative patient might need gently redirecting (but should not feel that you are uninterested or frustrated) and may need extra 'signposts' to explain what you most need to know about.

- When any barriers to communication are present, consultations **take more time** – you have to slow the pace and expect to cover less ground. Be **creative** (e.g. use of gestures or pictures to supplement your verbal questions when a patient speaks little English). Patients appreciate you taking the time to seriously consider how to communicate effectively with them.

Responding to emotions

Many patients you see will be worried, anxious, frightened, upset, or even frustrated or angry. You need to become comfortable with patients expressing emotions, to show that you understand, and be able to avoid further inflaming the situation.

- Firstly, it is important to **acknowledge** patients' emotions, as they are always an important part of the consultation. This applies even if emotions are only expressed non-verbally (e.g. the patient looks or sounds sad without saying that they are). E.g. 'I can see that this is upsetting for you' or 'You look worried'.

- Give the patient **time** to describe how they are feeling, or to cry if they are upset.

- Avoid empty reassurances (e.g. 'I'm sure it will all be alright') or giving advice. The most important thing you can do is **listen**. Patients *do not expect you to solve all their problems* for them.

- Be aware of your own emotional responses and think of the impact of *your* reaction on the consultation. **Keep calm**, do not panic when strong emotions are present, and do not become defensive when patients are angry.

- **Recognise** that the patient's responses to a given situation may be different from yours. You are not there to judge whether their emotional response is appropriate.

- Telling someone *not* to feel an emotion (e.g. 'Calm down' or 'Don't worry') is counterproductive – it indicates that you are not taking them seriously. Identifying **why** a patient is feeling like they are (e.g. what is the source of the worry or why exactly are they so frustrated) is the first step – you can then pass this information on to someone who can do something about it (e.g. give them information or deal with practical issues).

- It may not be appropriate for you to continue taking a history when someone is very overwrought for whatever reason. Consider the use of **'time-out'**: either offering to give the patient some time to collect their thoughts, to take a break, or meeting with them on another day.

- Alternatively, sometimes patients are reassured by the **routine** of a consultation (this applies even when patients are upset, frightened or angry) – because it shows that *something is being done*. Ask the patient if they would like to continue, and if so, try to establish a normal 'history-taking' consultation fairly quickly.

- It helps patients to know exactly what you are going to do with the information at the end of the consultation (e.g. are you about to discuss it with the consultant?).

- One final point about angry patients - do not put yourself **at risk**. If you *are* threatened or *feel* threatened at any point you must terminate the consultation (if necessary, just leave) and inform someone who can deal with the situation or alert security staff.

Course lead:
Dr Lorraine Noble, Senior Lecturer in Clinical Communication
lorraine.noble@ucl.ac.uk

UCL Medical School
MBBS Year 3
Communication Skills Course
2011-12

Information for tutors

Block 3: Sharing information and discussing treatment

Member of:

UK Council of clinical communication

Block 3 – Sharing information and discussing treatment

Aims

The focus of this session is to give students a taste of the skills of **sharing information** and how it feels to have the **responsibility to discuss** information about diagnosis, treatment options, and decision-making with patients.

Year 3 students will not have had experience of doing this themselves, although they may have seen examples on their attachments. It is important to consider why this is an important topic at the beginning of the session.

Learning objectives for this session

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

- describe the principles of sharing information in a consultation with a patient or relative
- demonstrate (e.g. by role playing in the role of a junior doctor) how they would provide information to a patient or relative – this includes discussing diagnosis, prognosis, and treatment
- demonstrate how to conduct appropriate, effective and sensitive discussions with patients or relatives within the boundaries of their role (as a junior doctor)

As ever, please refer students to the Calgary-Cambridge Guide to the Medical Interview as a structure for the consultation. The Silverman et al. 2005 book *Skills for Communicating with Patients* has a chapter on Explanation and Planning which is essential reading.

Information given to students

The handout is on the Moodle webpage:

- ***Block 3: Sharing information and discussing treatment.***

Course lead:
Dr Lorraine Noble, Senior Lecturer in Clinical Communication
lorraine.noble@ucl.ac.uk

Suggested lesson plan

2.30 Introduction
Welcome students, take register, query any reasons for previous non-attendance.
Explain the aims and learning objectives. Explore with students:
- **why it is important** to develop their skills in this area
- consider **strategies** that they have **seen on the wards** that may help in this session
- also **pitfalls** that they imagine they will need to avoid.

Note that the next session in this course (Breaking bad news) further develops these skills. Also note that there are elements of **bad news** in today's scenarios (in the sense that news of any condition or need for treatment is not what the patient hopes to hear).
Explain the **format** of the session: the focus is giving students the opportunity to practise and to discuss which strategies are effective and where consultations can be improved. This is to:
- give **individual students feedback** about their own communicative style
- to identify **general take home messages** for these types of consultations.

Refer students to the handout for this session on the Moodle webpage.
2.45-3.45 Consultations 1 and 2 (first actor)
Half an hour per consultation: to prepare, do the consultation and feedback. Usually use one scenario split into a pair of consultations, with students practising handover between (highlights issues of continuity of care).
Explain time constraints (i.e. that they will have 6-8 minutes) and check that students understand the time-out rule. Give information about the scenario to the students who will see the patient.
Encourage students to use the 6-point plan handout when preparing. Ensure that students have considered:
(1) how to prioritise the information in each consultation
(2) what to include now or leave for a later consultation
(3) how to translate jargon
(4) the concept that 'information-giving' involves checking what the person already knows, understands, suspects or is worried about (it is a dialogue, not a lecture)
(5) pace: not rushing, allowing the patient or relative time to digest what is likely to be new and scary information
(6) what information the patient *wants* and *needs*.
The aim is for students to feel prepared and have a successful consultation.
3.45 Swap actors between groups
3.45-4.45 Consultations 3 and 4 (second actor)
As before.
4.45 Ending
Review learning objectives. Ask students each for:

- one thing they have learned from the session that they will do on the wards

Give information about Block 4 session: breaking bad news.
If asked, note that any aspects of this 4-session course may appear in the summer OSCE.
4.55-5.00 Finish

Summary of roles

- Sam / Samantha Tate, parent of Andy, 7 year old boy. Strangulated inguinal hernia. Emergency department.
- Fred / Frieda Carr. Diabetes. General Practice.
- Gerald / Geraldine Patterson. Ulcerative colitis. Gastroenterology.
- Kenneth / Katharine Andrews. Aortic stenosis. Cardiology outpatients.
- Dave Turner. Accident at work. Emergency department.

Information for actors

Playing the roles

Over the course of the session, tutors are requested to give **four** students the opportunity to have a consultation with a simulated patient.

Usually a scenario is split into two consultations, where one student, playing a junior doctor, explains the diagnosis to the patient/relative, and then, following a brief handover, their colleague discusses treatment.

When a scenario is being split up into a pair of consultations (diagnosis then treatment), please help the first student focus on their task by *allowing the first student to talk only about the diagnosis* (i.e. do not spontaneously ask questions about treatment or get side-tracked onto a discussion about treatment if the student leaps ahead into their colleague's territory). The student should make it clear that their colleague is going to come in immediately to discuss treatment with you, but you should *not* look like you are anxious to get on with that.

The second student should check your understanding of the diagnosis and should not proceed with a discussion about treatment until it is clear *you understand about the condition and your queries have been addressed.*

As ever, *do not lead* the discussion (in either consultation) by asking a series of questions or by using statements to rephrase what the student is saying in order to move the consultation onwards. Do not correct the student when they use jargon during the consultation itself – mention it during feedback.

Sam / Samantha Tate, parent of Andy, 7 year old boy. Emergency Department.

Scenario

You are a junior doctor in the Emergency Department.

Andy Tate is a 7 year old boy. He is normally fit and well, but today he suddenly developed a lump in his left groin after opening his bowels. A short while later he began to vomit and complained of a pain in his abdomen. Over the past couple of hours the pain has been intermittent and the lump has become more red, painful, and tender. He was sent to the Emergency Department by his GP and has been examined.

Andy has a strangulated inguinal hernia, which means that a piece of his bowel has become trapped. He needs an operation to repair it this evening. If not he will become progressively more ill as he develops septicaemia as the trapped part of the bowel dies and releases micro-organisms from the intestines into the abdominal cavity. If no action is taken he will die within 48 hours.

The operation involves removing any dead tissue and it might be necessary to remove a piece of the bowel and rejoin its ends. The operation will provide a complete cure and the condition, which is congenital, will not return. After the operation Andy will be in hospital for five days and then will be off school for a week and off games for a month.

Task

Doctor 1: Explain Andy's medical condition to the parent. Explain that your colleague will discuss the treatment.

Doctor 2: Discuss the proposed treatment and respond to the parent's queries.

The surgical team will meet with the parent later to obtain consent for the operation; you are *not* required to do this.

Notes for simulated patient

You are the parent of Andy Tate, aged 7 years. Andy, who is normally a fit and healthy boy, suddenly developed a lump in the left side of his groin after going to the toilet. A short while later he was sick and complained of a pain in his tummy. The pain came and went several times over a couple of hours and the lump became more red, painful, and tender. You rang his GP, who sent Andy to Casualty. He has been examined, and you are now anxiously awaiting the results.

You are understandably very worried about your son, but you are coping with the situation. You need a clear explanation of the problem and reassurance that your son will be alright. The doctor should start by acknowledging your concerns about your son. The doctor's manner will be important in whether you feel confident that your son is in safe hands. The doctor should explicitly reassure you that Andy will be fine, but that they need to discuss treatment.

The nature of the problem should be explained clearly: often the use of gestures or drawing a picture is helpful. The reasons for Andy's symptoms (lump, sickness, pain) should be explained as a consequence of this. The doctor should also explain why this has happened to Andy: this should include why it happened today and whether it will happen again.

The doctor should explain the problem about the condition worsening and that this can be life-threatening unless acted upon quickly. You will need reassurance that the solution – an operation – is straightforward and routine, and will cure the problem. You will need acknowledgement

that this is a big shock for you and that you are understandably worried. You are a 'normal' person and will not over-react when given the news about your son's condition and proposed treatment.

As your son has never had an operation before, you would like to discuss this with your spouse. However, he or she is currently en route to Scotland, having left their mobile phone at home, and will not be contactable for another eight or nine hours. Do not make a huge deal about this; it should not distract from the big picture about your primary concern for your son. The point is that your spouse is out of the picture and so the responsibility for the decision falls to you. The doctor should find a way round this, as it is too long to wait. Any indication of 'we can go ahead without your consent' will worsen the situation.

Fred / Frieda Carr, 40s-50s. General practice.

Scenario

You are a junior doctor at a GP surgery.

Mr/Mrs Carr recently presented with blurred vision. The results of the investigations have now come back.

Blood pressure is 170/115 and a random blood sugar is 18 millimoles per litre. The diagnosis is type II diabetes mellitus. The patient has a number of risk factors for heart disease (smoking, diabetes mellitus, high blood pressure, high cholesterol level) and it is extremely likely that he/she will have a heart attack. Other complications of diabetes mellitus include cataracts, retinopathy, renal failure, and peripheral arterial disease.

The visual disturbance is due to fluctuating high blood sugar levels that affect the volume and hence the refractory power of the lens by osmosis.

In terms of treatment: changing diet, stopping smoking, and drastically reducing alcohol consumption are all vital. Perhaps an oral hypoglycaemic tablet twice a day for the blood sugar level. It might be helpful to refer this patient to an outpatient diabetes service.

Task

Doctor 1: Explain the diagnosis to the patient. Explain that your colleague will discuss treatment.

Doctor 2: Discuss your recommendations for treatment and respond to the patient's queries.

Notes for simulated patient

You have recently noticed your sight has been getting blurry from time to time. You didn't want to go and see a doctor: your wife/husband nagged you to go. The last time you were here you had a blood test. You don't see how a blood test can tell you anything about your eyes, and the doctor (Dr Smith) did not really explain anything.

You think that all you need is a pair of stronger glasses. You have had this pair of glasses for four years and have been putting off going for another eye test. You think you are wasting the doctor's time. You promise to go and see the optician this week.

You eats lots of fatty foods and smoke 20 a day. You go to the pub most nights each week, but 'don't drink much' (three pints of Guinness and a couple of whiskies for Mr Carr/two pints and a couple of Baileys for Mrs Carr). You are happy with your lifestyle and don't want to change.

Your mother had diabetes in her later years, starting in her mid-fifties. She was very ill in later life (problems with her heart, poor circulation, problems with her eyes), and she had to go back and forth to the hospital and the eye clinic. It was a difficult and upsetting time towards the end. She died aged 75 of a stroke, which you think is a good age.

The key to this consultation is for the doctor to focus on what you think about the problem with your eyes, and your health in general, before either launching in to give an explanation about blood sugar/diabetes or talking about 'lifestyle' change. You don't understand why you had a blood test for 'bad eyesight'. The consultation can easily go too far too fast for the patient. You need the doctor to cover a manageable amount of information and to empathise with your perspective.

In this scenario you are not starting with a concern about your own health – this concern has to be raised by the doctor. There is a balance between giving you enough information so that you

are aware of the potential seriousness of your situation and not using scare tactics. It helps if the doctor remains positive, supportive and maintains a sense of humour, because this is going to be an uphill struggle. Building a partnership tends to be more important than the doctor racing to achieve an agreement that you will change your entire lifestyle. If you feel pushed, agree with the doctor's plan in a way that is obviously insincere.

Gerald / Geraldine Patterson, 30s-40s. Gastroenterology.

Scenario

You are a junior doctor working in gastroenterology.

Mr/Mrs Patterson presented with a ten day history of bloody diarrhoea. He/she was feverish and felt unwell. He/she had previously gone to the GP surgery twice, on the second occasion being referred on to the gastroenterologist. Mr/Mrs Patterson has now had blood and fresh stool cultures, rigid sigmoidoscopy and rectal biopsy.

The results have shown that Mr/Mrs Patterson almost certainly has ulcerative colitis.

Ulcerative colitis is a long term inflammatory disease of the lining of the rectum. Sometimes it spreads to the lower part of the colon, and in a few people it spreads to the entire colon. Symptoms are usually intermittent, with many people having few or no symptoms between attacks. The severity and frequency of attacks varies due to the extent of the disease. Ulcers develop on the lining of the intestine, which may bleed, and the inflammation causes symptoms of diarrhoea. During attacks symptoms may include: diarrhoea with blood and mucus, abdominal pain, tiredness, fever, poor appetite and weight loss. The exact cause of ulcerative colitis is unknown.

The recommended medication is mesalazine. This may be the only attack he/she will have, but Mr/Mrs Patterson is likely to have further attacks if he/she does not take medication for the forseeable future. You recommend a colonoscopy in a month's time to determine the extent of the colitis (inflammation of the large bowel).

In a few people, inflammation may spread to other parts of the body (e.g. skin rashes), and a severe flare-up can lead to the whole colon becoming inflamed. This is an uncommon but serious condition, and surgery is usually necessary in the long term. There is a risk of malignant change that increases with duration of disease, and further colonoscopies may be required in the future to monitor the situation, to look for premalignant change in the mucosa and polyps.

Task

Doctor 1: Explain the medical condition to the patient. Explain that your colleague will discuss treatment.

Doctor 2: Discuss the proposed treatment and respond to the patient's queries.

The consultant will meet with the patient afterwards to answer any further questions and provide more detailed information.

Notes for simulated patient

For the past ten days you have been having diarrhoea which has blood in it. The blood is dark and mixed in with the diarrhoea. You have been going to the toilet up to 14 times a day, including 3 or 4 times at night. You are feverish and feel unwell. You have lost weight and your tummy (abdomen) is painful. You had a similar episode some months ago, albeit not nearly as bad, but it cleared up and you attributed it to a tummy bug.

You have lately been to your GP twice. On the second time you gave a sample (stool sample) and were referred to a gastroenterologist at the hospital for further tests. You are fed up waiting for something to be done.

You have had a number of investigations including what the doctor called a 'sigmoidoscopy', which was very undignified, having a tube up your bottom.

You are self-employed as a taxi-driver but cannot work at the moment due to this problem. You have never been ill really, healthy family. You have never heard of this condition, and will find it difficult to hear that you have a 'chronic condition'.

The consultation:

You are obviously worried and in pain, but are able to listen to what the doctor says.

The junior doctor should firstly ask how you are at the moment, and find out what you know so far about the situation and any concerns you have. You have probably been assuming that you caught some kind of tummy bug again, although the blood in the diarrhoea has been very worrying. You expect to be given some short course of treatment and that the problem will go away.

The doctor will need to explain clearly what the condition is, using terms you understand, and respond to your inevitable queries about how you got it and whether it will get worse. This should include an explanation that it is *not* a tummy bug that you have caught.

Then the doctor should explain that this is a condition which should respond to medication, but that you will need to continue taking medication in the long term, and that you may have further episodes like this. Obviously this has long-term implications for your job.

You really don't want to have to have that tube up your bottom again, and will say so early on in the consultation. However, the doctor will have to explain about the need for further monitoring. If the student empathises with you, it will help. The increased risk of cancer should be explained clearly – otherwise you are unlikely to agree to come back for further investigations. You do not over-react to the term 'cancer'. Ideally the doctor should frame the information positively – that monitoring should be able to catch any problems early before they take hold.

Kenneth / Katharine Andrews, 40s-50s. Cardiology outpatients.

Scenario

You are a junior doctor in cardiology outpatients.

Kenneth/Katharine Andrews has been suffering from angina. He/she exercises regularly, eats healthily, has low alcohol consumption, and smokes 10-15 cigarettes a day.

Investigations including echocardiogram, ECG and cardiac catheter have indicated that Mr/Miss Andrews has aortic stenosis. Without treatment, there is a 50% chance that in the next five years there will be a severe complication: (i) risk of sudden death (due to ventricular fibrillation), (ii) heart attack (due to occlusion of the arteries leading to death of heart muscle), (iii) heart failure (due to the increased work of the heart against a stenosed valve), (iv) stroke, or (v) the angina could worsen (due to narrowing of the coronary arteries).

Recommended treatment is a heart valve replacement, which means open heart surgery. Surgery relieves the obstruction and reduces the work of the heart. The metal valve lasts about fifteen years. The risks associated with surgery are much lower than for no surgery (about 2-5% in a person of this age). He/she will also have to take warfarin for life to prevent clots forming on the prosthetic valve.

Task

Doctor 1: Explain the medical condition to the patient.

Doctor 2: Discuss the proposed treatment and respond to the patient's queries.

Notes for simulated patient

You recently started suffering from a 'pressing' pain on your chest. It gets worse when you exercise, and goes away when you rest. You normally exercise regularly, eat healthily and drink very little alcohol (maybe a glass of wine every two weeks). You smoke 10-15 a day, which is less than several months ago when you smoked more than 20 a day. You are the head teacher in a large secondary school. You work long hours and sit on several education committees.

Being a head teacher, you are used to dealing with people on a professional basis and are (privately) dismayed at seeing a junior rather than the consultant. You won't show concern for your health: you are more worried about the time you have had to take off school for these tests.

The doctor needs to show awareness that they are giving a major diagnosis of something being wrong with your heart and that they are recommending heart surgery. You may be a head teacher but you will be unfamiliar with medical jargon. The use of percentages is also an issue. The doctor should check how you are responding to the news.

You are likely to have questions that the doctor can't answer, such as how long recovery time is, and whether the operation could wait until the summer. You should feel confident in the doctor's response, e.g. an explanation of who will provide the answers.

Dave Turner, 30s-40s. Emergency Department.

Scenario

You are a junior doctor in the Emergency Department.

Dave Turner arrived with a burn on his right hand. He had been fitting electrical ovens in an industrial kitchen when he came into contact with an open wire. He was in contact with the wire for about thirty seconds until the mains was flicked off by his workmate. He did not lose consciousness.

Having examined Mr Turner fully, a tiny burn on his left knee has been noted. His knee was in contact with the live wire and the voltage went across Mr Turner's heart. The ECG has indicated a couple of ectopic beats.

Mr Turner is in danger of cardiac arrest from ventricular fibrillation. Should this happen out of hospital he would almost certainly die.

The recommendation is that Mr Turner should stay in hospital for 24 hours, as this is the period of greatest risk. He will be admitted to the coronary care unit where he will be connected to an ECG monitor and will have a cannula in his arm in case medication is required. If he does have a cardiac arrest he will need immediate treatment (DC cardioversion).

Task

Doctor 1: Explain the medical condition to the patient.

Doctor 2: Discuss the proposed treatment and respond to the patient's queries.

Notes for simulated patient

You came into casualty with a burn on your right hand. You had been fitting electrical ovens in an industrial kitchen when you came into contact with an open wire. You were in contact with the wire for about thirty seconds until the mains was flicked off by your mate. You did not lose consciousness.

You have just come in to get checked out, but feel fine. You are keen to get back to work, because if you are late finishing the job, the people who subcontracted you will either dock your pay or just lay you off. As you are a casual worker they can just do that. You needs this job as your wife doesn't work (you have two children) and you have got to keep up with your mortgage payments.

This consultation tends to work best when the doctor takes the time to find out what you think about this situation (i.e. that you feel fine and need to get back to work), before explaining how the medical assessment of the situation is very different. If the doctor rushes the explanation and the recommendation to stay in hospital, you will simply disagree. You really want to understand the need to stay, before you will agree to it. You are likely to try to negotiate – e.g. if you start to feel unwell, can you come back into hospital to be checked out? A smart doctor will try to get your wife involved and offer a note that you are medically unfit to work. An expression of empathy with regards your situation (i.e. that you need to work so you are not laid off) will make it easier for you accept.

Giving information (1) – Discussing diagnosis

Six point plan for Block 3 simulated consultations

Introduce yourself / explain purpose of meeting today

Check the patient's understanding of the situation / condition

- establish any particular queries or concerns

Explain the diagnosis in a way the patient will understand

- *chunk* information into sections
- *check* understanding after each section

Check the patient's understanding of the explanation

Find out the patient's concerns and address these

Summarise and agree an immediate plan

Giving information (2) – Discussing treatment

Six point plan for Block 3 simulated consultations

Introduce yourself / explain purpose of meeting today

Check the patient's understanding of the situation / condition

- establish any particular queries or concerns

Discuss treatment options in a way the patient will understand

- *chunk* information into sections
- *check* understanding after each section

Check the patient's understanding of the explanation

Find out the patient's concerns and address these

Summarise and agree an immediate plan

Student handout

Communication Skills in Year 3 2011-12

Block 3 – Sharing information and discussing treatment

Learning objectives for this session
By the end of the session, you should be able to:

- describe the principles of sharing information in a consultation with a patient or relative
- demonstrate, by role playing in the role of a junior doctor, how you would provide information to a patient or relative – this includes discussing diagnosis, prognosis and treatment
- demonstrate how to conduct appropriate, effective and sensitive discussions with patients or relatives within the boundaries of your role, as a junior doctor

Aims
In this session you will develop your skills in sharing information with patients and relatives, and you will experience how it feels to have the responsibility to do this. This will include discussing information about diagnosis, prognosis and treatment.
Although in practice you only do this when qualified, practising enables you to develop your skills in readiness, and also helps you to focus on what are the features of an effective consultation.

You will be given information about each case scenario, and with your peers in the group you will identify the most helpful ways of communicating with the patient or relative in each situation. As in the previous sessions, you will also consider the boundaries of your role – this time as a junior doctor – such as the importance of being clear about the limits of your knowledge and what you can and can't do.

Communication skills to practise
'Communication is the art of being understood' (Peter Ustinov). What is important when giving information is not what you think you are delivering, but what the other person *receives*.

The following is a list of skills for you to practise in this session and future sessions with simulated patients, and to consider when you are observing consultations on your attachments.

- Make a **plan** before the consultation: know what information you need and consider how to phrase it. Be aware that the patient may want information which you *don't* have immediately to hand (for example, a comprehensive list of side effects of a medication, or certainty of the outcome when the disease progression is uncertain. Think about how you will respond if the patient asks for information you don't have.

- Patients generally expect information about: (a) what is wrong, (b) what can be done about it, and (c) what the outcome will be. In addition, they may have particular

concerns (e.g. about whether the condition is serious, or how soon they can get back to work). It helps to structure your explanation around these points.

- When you meet the patient, firstly determine:
  (a) **what the person understands** so far,
  (b) **what they expect** from the consultation or **want to know**,
  before embarking on any explanation. This helps you to calibrate your explanation, by determining what information is most needed, and where to start.

- Give an **outline** of what you plan to cover in the consultation, e.g. that you are going to explain what the problem is, what can be done about it, what the likely outcome will be, and that you will address their questions and concerns.

- Encourage the patient to guide the consultation by **asking questions**. It is helpful to give the patient 'permission' to ask questions at the outset, and then follow through with invitations to ask questions at the end of each segment. If you ask only once at the end of the consultation, people will often have forgotten their questions by then.

- Give information at a **pace** the patient can digest, in small **chunks** at a time. Remember that the information is likely to be new and scary, and seem more complicated than it is to you, as you will be more familiar it.

- Offer to **repeat** any or all of the information at key points – e.g. at the end of each segment and/or at the end. Repetition is helpful and reassuring, so don't worry if a patient takes you up on the offer to go over something (or everything) again.

- Ensure the **language** you use is understandable. It helps to give an explanation of any medical term *before* using jargon (rather than the other way round). Consider whether you need to use any jargon. Feel free to offer to write information down for the patient to take away – particularly the name of the diagnosis or treatment. It is helpful to include any terms (including jargon) that the patient may hear from other doctors or health care professionals, as well as terms that the patient can use to search on the internet.

- **Check throughout** that the patient understands, by picking up on their non-verbal cues (e.g. facial expression, eye contact), and by asking directly (e.g. 'Would you like me to go over any of that again?'). The question 'Do you understand?', tends to be less helpful, as it is a leading question to which people often feel obliged to say 'Yes' to regardless.

- Make sure the patient **understands** their diagnosis *before discussing treatment*. If you are a new doctor seeing the patient for the first time, it is helpful to check the patient's understanding of the condition, and any unresolved queries or concerns, before moving on, even if the patient is already receiving treatment.

- Respect the patient's **right to be given information**. You should not withhold information simply because you are worried it might upset the patient. Don't make assumptions about which patients are more likely to get upset. Don't assume that if the

patient wants to know something, that they will always ask. Patients often expect to be told all the relevant information *without* having to ask, as you are the 'host' of the meeting.

- Listen carefully to patients' **concerns and queries**. Non-adherence to recommendations is often the result of a difference in understanding (e.g. about the consequences of the condition, or about how the treatment works). Don't assume that information that is familiar to you is obvious. Be prepared to negotiate.

- At the end of the consultation, **summarise** the plan of action that has been **agreed** and make an immediate plan for the next step. If you have not yet reached that stage – for example, if the patient needs more information, or a decision about management has not been taken, summarise to the point you have reached, and make an agreed list of what still needs to happen. Write that down in the notes, to remind you or the next doctor of the starting point for the next consultation.

I thoroughly recommend Chapter 6 'Explanation and Planning' in Silverman, Kurtz and Draper (2005) *Skills for Communicating with Patients*, 2nd Edition, Oxford: Radcliffe, which is your essential textbook for this course.

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UCL Medical School
MBBS Year 3
Communication Skills Course
2011-12

Information for tutors

Block 4: Breaking bad news

Member of:

UK Council of clinical communication

Block 4 – Breaking bad news

Aims

This session aims to give students the **opportunity to experience** breaking bad news to patients and relatives. As with Block 3, the aim is not to expect students to be able to do this after just one session. It is helpful to practise in order to have a sense of **how it feels**, which enables students to have a better understanding of the principles and pitfalls. They should be encouraged to link this to **what they have already seen on their attachments** and to go back to these with a fresh eye after the session. Again, they have to role play as **junior doctors** for these consultations, so refer again to the points about this from Block 3 and the general points about sharing information covered in Block 3.

The scenarios address 'prototypical' bad news situations (involving cancer and death), although it should be emphasised to students that **bad news is in the eye of the beholder**, and that they should be on the lookout on their clinical attachments for situations which represent **bad news *to the patient* (or relative)**.

As with Block 3, it can be very helpful to have **two students seeing a patient/relative consecutively** (with a short handover in between), then following feedback and video review, swapping actors between the rooms and having another two consultations with a second scenario.

Learning objectives

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

- describe the principles of breaking bad news to a patient or relative
- demonstrate how to conduct sensitive and effective consultations under difficult circumstances (e.g. by role playing the breaking of bad news in the role of a junior doctor)
- demonstrate how to respond appropriately to patients and relatives within the boundaries of their role (e.g. as a junior doctor)

Further reading

Baile et al. (2000) SPIKES: a six-step protocol for delivering bad news: application to the patient with cancer. The Oncologist, 5: 302-11.

Schildmann et al. (2005) Breaking bad news: experiences, view and difficulties of pre-registration house officers. Palliative Medicine, 19: 93-98.

Silverman et al. (2005) Skills for communicating with patients. Oxford: Radcliffe Medical Publishing.

Diamond J (1998). C: Because Cowards Get Cancer Too. (Personal account of cancer).

Lynch L (2010) The C-word. (Personal account of breast cancer, at age 28).

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Overview of scenarios

There are two scenarios about diagnosis of terminal illness and one about breaking news of a death to a relative. The terminal illness roles are both about cancer – these are essentially interchangeable roles, and the issues are the same in each. They have been deliberately written to choose situations where there is *no possibility of a cure or even long-term remission.* This is to provoke the discussion about when (and how) to raise the issue of prognosis. For these scenarios, and the one about news of a death, the patient or relative is *not expecting bad news* – again, this is to ensure that the student *leads in* to the consultation (e.g. using a trail of warning shots), to give them practice in doing this.

The scenario about brain death has been included in order to give students the opportunity to really think about the importance of a clear, understandable message (rather than getting bogged down in technical jargon). It works extremely well, but is not recommended as a first scenario. The second part (raising the issue of organ donation) is another example of how to *broach* bad news – preparation is all – and also works extremely well. The Alzheimer's scenario may initially seem to be less grim, but the implications for the future are shocking to the patient as realisation sets in as the consultation unfolds.

The discussion with a relative about a 'do not resuscitate' decision has been included an example of a consultation where 'bad news' can be overlooked as an agenda - the key to this consultation is not discussing the ins and outs of how management decisions are made, but acknowledging that it is about a *bereavement* and that the first step in the situation is conveying to the relative that their parent is at the end of their natural life. (Note: the DNR scenario is not intended as the forum for a specific discussion about DNR decisions, which is a specialised topic.)

It is helpful to get students to consider other examples which raise these kind of issues – patient/relative expectations (e.g. does treatment mean cure? what is the point of treatment that does *not* cure?), how to broach the subject of 'end of life' in general (e.g. when it is a 'natural' death?), and what is the distinction between 'stopping active treatment' and 'continuing to care'?

You may wish to use other roles, but please bear in mind that: (a) other scenarios (such as amputation or diagnosis of chronic illness) will not feel as difficult to students and they may not feel the full 'bad news experience' that this session can provide, and (b) the short time available to brief actors before the session starts.

Summary of roles

- Mr/Mrs West. Terminal cancer.
- Mr/Mrs Simon. Terminal cancer.
- Husband/wife of Mr/Mrs Fitzgerald. Informing a relative of a death.
- Son/daughter of Mrs Johnson. Explaining a 'do not resuscitate decision'.
- Mr/Mrs Evans, parent of Tom. Brain death; organ donation.
- Mr/Mrs Brown. Alzheimer's disease.

Points to highlight

This session is an exercise in:

- how to determine the **starting point** of a bad news consultation (what does the patient/relative already understand/suspect)
- judging how to **break the news**, in terms of: the pace and phrasing, the appropriate amount of medical 'facts', getting across the 'main message' and the implications, discussing difficult information, telling the patient as much as they want to know
- responding to **emotionally-charged** situations
- knowing when and how to **end** a bad news consultation

Notes

- **Point the students in the direction of resources:**
  - Communication skills Block 4 handout on the Moodle webpage
  - North of England Cancer Network Video, which gives examples of patients reflecting on the consultation in which they were given bad news. This is to highlight the perspective of patients being 'on the other side'. It doesn't show examples of how to break bad news.
- **Set learning objectives**
  - Particularly focusing on 4 elements of these consultations
    - How to start
    - Warning shots
    - Breaking the news – in an understandable way
    - Exit strategy (how to leave)
- **Define tasks for Doctor 1 and Doctor 2**
- **Rehearse what they will say at each milestone above**
  - How to introduce themselves
  - Explaining the agenda of the consultation
  - How to broach the news: warning shots
  - How to explain the condition (e.g. cancer, aneurysm)
  - Specific issues: cancer is terminal, how long the patient is expected to live, explaining that a person has died
  - Immediate plan (colleague will come in shortly)
  - Taking their leave

Suggested lesson plan

2.30 Introduction
Welcome students, take register, explain the aims and format of the session, identify any issues re bad news consultations that students would like to cover as part of this session.
Note that some students may find some of these issues difficult and agree a plan with the students about how to respond to this.*
Scenario 1
2.45 Preparation for Scenario 1
Two students asked to volunteer. Give information cards for the first scenario to both students. One student reads out the information card (2 minutes).
Student 1 prepares their consultation, by defining their task and preparing how they will approach the consultation with the help of the group (8 minutes).
Student 2 prepares their consultation in the same way (8 minutes).
3.00 Consultations for Scenario 1
Student 1 consultation (8 minutes, time signal at 6 minutes).
Handover between student 1 and student 2 (4 minutes).
Student 2 consultation (8 minutes, time signal at 6 minutes).
3.20 Feedback for Scenario 1
Feedback and video review for Student 1 and Student 2 (25 minutes).
Collect information cards from both students.
Scenario 2
3.45 Preparation for Scenario 2
Actors swap between rooms.
Two students asked to volunteer. Give information cards for the second scenario to both students. One student reads out the information card (2 minutes).
Student 3 prepares their consultation, by defining their task and preparing how they will approach the consultation with the help of the group (8 minutes).
Student 4 prepares their consultation in the same way (8 minutes).
4.00 Consultations for Scenario 2
Student 3 consultation (8 minutes, time signal at 6 minutes).
Handover between student 3 and student 4 (4 minutes).
Student 4 consultation (8 minutes, time signal at 6 minutes).
4.20 Feedback for Scenario 2
Feedback and video review for Student 3 and Student 4 (25 minutes).
Collect information cards from both students.
4.45 Ending
Ask each student for one thing they have learned from the session. Check that they are all okay.
4.55-5.00 Finish

*Please also note that students in the year may have suffered recent bereavements, hence it may be prudent to negotiate choice of scenarios at the outset.

Information for actors

Block 4 – Breaking bad news

The themes of this session are:

- giving bad news about diagnosis, prognosis and treatment
- caring for distressed patients and relatives

In this session students are playing *junior doctors*.

Information about the sessions

There will be about 8 students per group. The session focuses on students having consultations with simulated patients which are videoed. Students receive feedback from each other, from the tutor and from the simulated patient. About four students will conduct a consultation per session.

Role plays

All these consultations involve the 'doctor' giving some form of bad news, either to a patient or a relative. You will be on a hospital ward, in A&E, or in a GP surgery. This is the first time that you have met this particular doctor.

Assume that you only know the information that has been given in your brief – you do not know, nor do you necessarily suspect, that there is bad news coming.

The students are pretending to be in the role of a *junior doctor*. It is their responsibility to lead the interview. Please ***do not*** 'feed' the interview by asking questions to direct the interview to the next point or to clarify what has been said. **It is specifically very important *not to ask* 'Do you mean I've got cancer?', 'Does this mean I'm going to die?', or 'How long have I got?'.** Sometimes patients and relatives give indirect indications that they would like some information (e.g. 'My wife and I were planning a trip to Australia this Christmas') to encourage the doctor to give information about prognosis.

It is equally important not to 'correct' the student throughout the interview – for example, if they use **jargon** you don't understand, or give an explanation which is unclear. Do *not* ask students to rephrase anything you haven't understood (e.g. 'What do you mean by tumour?') and **do *not* rephrase** for the student (e.g. 'So you are telling me that she has died.'). Real patients rarely say that they do not understand, ask for a clarification of an explanation, reflect back what has been said in order to achieve clarification, or ask questions. It is the student's job to make sure that their explanations are understandable and to *check* that you understand. If there are parts of the explanation that you don't understand or that don't address your concerns or queries, explain this to the student in the feedback.

In particular in these consultations, the 'doctor' should give you time to digest the information (the more serious the information, the more time is needed to digest it). They should also respond to your emotions, and again, give you time (e.g. to be upset or stunned). The tutor will give you instructions about the kind of emotional response your character is likely to make – although you should also respond according to how you are treated in the consultation. It is important that the emotional response is **real** and not overdramatic – usually people are ***not* obviously upset** when bad news is first given (and hence there are unlikely to be tears). The student also needs to be given time to give you the information they have to give, so they should

not have to spend the majority of the interview responding to a prolonged strong emotional reaction – this is *not* the learning objective of these sessions.

Each role play will last for about 8 minutes, with the student being given a time signal to wrap up at about 6 minutes. The tutor for each session will give you guidance about how they wish to run the session, however, it is usual that you will **play two scenarios per session**, and have two consultations per scenario. Normally one 'doctor' will see you for eight minutes, they will then handover to a colleague, who will see you for a second consultation for eight minutes, then you will return to the teaching room and there will be feedback about both students. After this you will probably swap rooms with the other actor, and do the same (two consultations followed by feedback) for the second scenario.

If the student gets stuck they can call time out, and then will either collect their thoughts or go back into the teaching room to ask for advice. When time out is called, sit quietly until the student indicates that they are continuing with the interview.

Particular skills to look out for

The information in scenarios gives some information about how a consultation may play out, and the types of skills that are helpful or not in a particular situation. Also there are general points about breaking bad news consultations, listed below, which may highlight aspects to be brought out in the feedback.

Breaking bad news

- Firstly, the doctor should find out what you already know and what you expect from this consultation.
- Then they should give an indication that there is bad news coming (this is called a 'warning shot'), e.g. 'I am afraid that it is serious'. Note that a warning shot can be given in a number of ways (e.g. just by the doctor's facial expression and manner). Repeated warning shots are often needed to give the patient time to realise that the news is bad – before the news is actually given.
- They should give information in small chunks at a time, and check that you are following the explanation.
- They should use clear and understandable terms to describe the situation, e.g. cancer, died, very serious, not long to live (rather than euphemisms such as malignancy, tumour, lesion, cells, passed away, we lost him).
- The explanation should cover the main points that you need to know to get the message (e.g. that it is serious, that nothing can be done) rather than getting bogged down in technical details.
- The explanation should not just focus on giving you facts in the hope that you will work out by yourself that the situation is serious.
- The students should respect your right to be given information. They should not assume that because you haven't specifically asked for a piece of information, that you do not want to know. Patients and relatives tend to wait for the doctor to tell them all the information and do not expect to have to ask. For example, they may be waiting for you to ask about how long you have left to live, but you may not even be aware that the situation is so serious that that is an issue.
- They should give you time to take the information in, and time to be upset.

- It is appropriate for them to say 'I'm sorry'. They should not say 'I'm sorry to have to be the one to tell you' (as is this about their needs, not yours).
- At the end of the consultation, they should take their leave by asking if you would like some time alone to collect your thoughts, or offer to call someone for you, or offer to bring a glass of water or cup of tea, or ask if you would like someone to sit with you. Note that they should not offer more than one option, as this will swamp you with more information than you can handle. They also shouldn't try to get you to make decisions (e.g. 'Would you like a cup of tea or coffee?') – you are more likely to be able to handle a simple statement of fact (like 'I'll get you a cup of tea').
- They should be clear about how you can contact them and agree an immediate plan (e.g. that they will come back in half an hour).

Course lead:

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Harry/Hannah West, 60s. Orthopaedic ward. (Block 4)

Diagnosis: Terminal cancer

One week ago you fell over at your daughter's house. It wasn't a hard fall, but you were a bit shaken up and your right thigh was extremely painful. You were taken to A&E (now called 'Emergency Department'), where they did an X-ray of your leg and then one of your chest. The doctors told you your bone was broken. You were surprised that you'd broken your leg given that you had fallen onto the carpet. When you mentioned this to the doctor, the doctor said that your bone seemed to be a bit weak and they were going to do some more tests on you. You were admitted to hospital there and then, to have an operation to fix your thigh bone. The doctor said that they were going to put it back together with a 'nail' (which the doctor explained was a big heavy piece of metal about eight inches long).

You have been a lifelong smoker and sometimes have had a cough. Recently your cough was slightly worse than usual, although you hadn't really thought anything of this, as you find that the cold weather gets to your chest at times.

You have now been on the ward for a week recuperating after the operation. You are just beginning to get up and about again. You have been taking each day of recovery after the operation at a time, and are the kind of person to wait to be told about the results of the tests (you have no idea why you might have had 'weak bones', perhaps it is something to do with your advancing age). You do not know or expect to be told that there is anything seriously wrong.

As the news is essentially coming out of the blue, you may not show much of an emotional reaction – other than being noticeably stunned. You are unlikely to become tearful.

Students are told this:

One week ago Mr/Mrs West presented in the Emergency Department with a painful right thigh having had a trivial fall. An X-ray showed that his/her right femur was broken and that there was an abnormally weakened area in the bone at the site of the fracture. A subsequent chest X-ray showed a large mass in the lungs. The patient was informed that the femur was broken and that s/he would need an operation immediately to nail the fracture. S/He was also told that there was an abnormal weakening of the bone and that this would have to be investigated further. The femur was nailed and the abnormal area on the bone was biopsied.

Mr/Mrs West has been on the ward for a week recuperating after the operation and is just beginning to get up and about again. The results of the biopsy have now come back and have confirmed the indications from the chest X-ray. The diagnosis is terminal lung cancer (squamous cell carcinoma). The cancer originated in the lungs and has metastasised to the bones. The patient has been a lifelong smoker.

The only treatment for this condition is palliative. Your consultant told you that he expects that Mr/s West has between six months to a year to live.

S/He will have radiotherapy to the pathological fracture and a bone scan to determine whether other sites are affected. When s/he begins to get pain, methadone or diamorphine linctus will be given. Over the next few months s/he will become more breathless and will lose weight. S/He will get weaker and towards the end is expected to lapse into a coma.

Peter/Patricia Simon, 50-60s. Medical ward. (Block 4)

Diagnosis: Terminal cancer

You went to your GP as you had been vomiting intermittently for three days and were struggling to cope with eating and drinking. In recent months you had been losing your appetite and had had a feeling similar to heart burn. You had lost weight.

Your GP sent you straight to hospital, where you had a number of tests quickly over the next couple of days. You were given an 'endoscope examination' (tube down the throat). The doctor told you that you had a growth which was causing an obstruction in your stomach. They told you that they had taken a sample of the growth, and were awaiting the results. They said they may need to do a further operation after some investigations. You had a CT scan of your chest, abdomen and pelvis.

You were given a drip (to give you fluids) and a tube placed through your nose into your stomach (to feed you). There has been little time to talk to the doctors. The main message seemed to be that they needed to wait for the test results, which reassured you.

You have been looking forward to your retirement. You attributed your recent symptoms to a heavy workload. In recent years your employer had been continually attempting to increase productivity to such an extent that the whole workforce were under pressure. Your current situation has been very sudden; you thought you were well, if a little exhausted, and then suddenly you were in hospital. Neither you nor your spouse have really taken it all in, and you are looking forward to going home.

It is now about one week since you were admitted into hospital. The tube through your nose was removed this morning and you are feeling a little better, if tired. Although you are concerned about what is wrong with you, you are not expecting bad news.

The doctor has come to see you in your private room (NHS) to give you an “update”.

You will be given an unexpected diagnosis, so you are unlikely to show much of an emotional reaction (other than being stunned) and are unlikely to become tearful.

Students are told this:

Mr/Mrs Simon went to the GP due to intermittent vomiting over a three day period. S/He was thin and pale on examination and recent symptoms included poor appetite, weight loss, and a feeling similar to heart burn. S/He was admitted to hospital that day, and over the next few days had numerous tests including endoscopy and a CT scan of the chest, abdomen and pelvis.

The endoscopy showed a bulky tumour in the stomach. Mr/s Simon was informed that there was a growth causing an obstruction, and that a biopsy had been taken.

The results of the biopsy and CT scan have now arrived. The biopsy shows a poorly differentiated adenocarcinoma. The CT scan shows seeds of the tumour all over the peritoneal cavity, the adjacent lymph nodes are involved and there are numerous small metastases in the liver. Your consultant has informed you that Mr/Mrs Simon will most likely be dead within six months.

The management options now are based on alleviation of symptoms. Neither chemotherapy nor radiotherapy will be beneficial and s/he will be discharged from hospital soon.

Mr/Mrs Fitzgerald, husband/wife of Stephanie/Stephen (60s). A&E. (Block 4)

Diagnosis: Ruptured abdominal aortic aneurysm

Your spouse begun to get a bit of back pain earlier on in the day. This suddenly turned into a very severe pain, in the back and tummy. S/He became very pale and sweaty, and looked really ill. You were extremely worried and called 999. Your spouse was taken into A&E, seen quickly, and taken straight up to the operating theatre. The doctor explained that she/he was very seriously ill. You have now been waiting for about 2-3 hours.

Students are told this:

Mr/Mrs Fitzgerald was taken into the Emergency Department by ambulance, following a 999 call by their spouse. Earlier on that day s/he had started to have back pain, which suddenly became a severe pain in the back and abdomen. Mr/Mrs Fitzgerald had become very pale and sweaty, and looked very ill.

S/he was assessed quickly and the diagnosis of abdominal aortic aneurysm was confirmed. S/He was taken straight up to the operating theatre. It was explained to the husband/wife that s/he was seriously ill.

When the abdomen was opened up in theatre, blood gushed out and blood pressure immediately plummeted. The surgeons attempted to get control of the blood loss and managed to do so, but her/his blood pressure was still very low. A blood transfusion was given and external cardiac massage was performed. However all attempts to resuscitate the patient were unsuccessful. The anaesthetist informed the team that s/he was dead.

Mr/Mrs Fitzgerald's spouse is waiting for news.

Ian Johnson/Iris Cox, 50-60s (son/daughter of Mrs. Johnson). Care of the Older Person Ward. (Block 4)

Diagnosis: Stroke / end-of-life

Your mother, Mrs Elizabeth Johnson, a widow aged 87, was brought into hospital two days ago following a deterioration in her health over the past week. She had been suffering from a urinary tract infection at home and was being looked after by you and a home nurse.

Your mother has a long history of Type II diabetes and she suffered a stroke eight years ago, which left some weakness on her left side. Last August, she had a second stroke which left her bed-bound and confused. Since this stroke, she has required constant care and attention and you have spent several hours a day helping to look after her.

She now keeps going in and out of consciousness and doesn't recognise you.

You love your mother dearly and are very worried about her. You remember how active and independent she used to be. You have noticed how helpless and frail she looks. You have been at hospital with her all morning and have been waiting to talk to one of the doctors to get a general update. You are not expecting to discuss anything in particular.

The doctor has to explain that your mother is dying. Despite the care she is receiving, she is not going to recover. The doctor will also explain that a decision has been taken that if your mother's heart stops, they will not attempt to resuscitate her (using CPR, giving an electric shock to the heart to restart it). This is a decision that the medical team make, which you are not involved in. It is, however, good practice for you to be informed. It should be clear that the medical team are still committed to providing the best care for your mother.

If you are asked whether your mother has set up a 'Lasting Power of Attorney' (LPA), or appointed anyone as an LPA, you have no idea what this is. Similarly, your mother has never written an 'advance directive' or 'advance decision' ('living will'), so you do not know what these are either, if asked. Your mother has not been able to make any important decisions or sign anything for the last couple of years.

Students are told this:

Mrs Elizabeth Johnson, a widow aged 87, was brought into hospital 2 days ago following a deterioration in her health over the past week. She had been suffering from a urinary tract infection at home and was being looked after by a home nurse and her son/daughter, Ian/Iris.

Mrs Johnson has a long history of Type II diabetes and she suffered a stroke eight years ago which left some weakness on her left side. Last year, she had a second stroke which left her bed-bound. Since this stroke, she has required constant care and attention and her son/daughter spends several hours a day helping to look after her.

Her mental state is confused, she keeps going in and out of consciousness and she no longer recognises her son/daughter.

Mrs Johnson has a very poor quality of life and is not going to recover.

The consultant, following discussion with the team, has decided that it would be futile to provide resuscitation should she suffer heart failure whilst in hospital and a DNAR order (do not attempt resuscitation) has been written. This decision has been made on the basis that further active treatment would not provide any benefits (given her quality of life and unlikelihood of recovery following resuscitation) and would only cause her more suffering.

You have been asked to tell the son/daughter that Mrs Johnson is at the end of her life and explain the decision about the DNAR order.

Josephine/Joseph Brown (early 60s). GP surgery.

Diagnosis: Alzheimer's

A few weeks ago you were taken to casualty by a neighbour, as you had hurt your head in a fall at home. You have since been attending a day hospital for tests of various sorts and you have been visited at home. You have lived alone since you were widowed three years ago.

No one has explained what all this is about, but you know that the doctors have been trying to see how well you look after yourself. You are terrified that you are going to be put into a home.

You know that you are getting very forgetful at times and that sometimes you make mistakes like forgetting to lock the back door, and forgetting people's names. At one point you even got a bit lost on your way home from the shops, and it was the same neighbour who took you home when you bumped into her. But you would rather take your chances and stay in your family home to die (at your appointed time) with all your memories of your family around you. You have two sons, twins, both married with children, who emigrated to New York some time ago.

You will be told that the tests you had point towards a diagnosis of Alzheimer's. This has not occurred to you before (surely you are too young for this), although you did realise you have been getting really very forgetful and sometimes you have felt confused and anxious. You will be horrified by this news. You had an aunt who had Alzheimer's, and you still have a clear picture of how she become totally helpless and like a child. She died a few years ago, and had been in a home for some time.

Students are told this:

Mr/Mrs Brown was widowed three years ago. A few weeks ago s/he was taken to the Emergency Department by a neighbour with a minor head injury following a fall at home. S/He was referred to the geriatrician as 'an elderly person at risk' due to concerns about 'failing skills in looking after him/herself'.

A full assessment has now been conducted of Mr/Mrs Brown's health and living conditions, and a diagnosis of Alzheimer's disease has been made.

The disease progresses at different rates in different people. The main initial signs are a deterioration in memory, and disorientation in time and place. Mr/Mrs Brown has been forgetting to lock doors and switch off kitchen appliances (such as the cooker), and often forgets to eat. S/He reportedly has got lost on the way home on at least two occasions.

In the long term, the most appropriate option for this patient is likely to be residential care.

Mr/Mrs Evans, parent of Tom Evans, 15 year old child. ITU.

Diagnosis: Brain death

Mrs Evans: You had Tom quite late (early 40's) and had not expected to have a child. The relationship had not been a good one, and you and your husband were divorced a year after he was born, so it has been just the two of you for nearly 14 years now. You have no contact with Tom's father anymore, as he moved to Canada.

Mr Evans: You married late in life, and your wife is quite a few years younger than you. The relationship had never been a good one, and you were divorced a year after he was born, so it has been just the two of you for nearly 14 years now. You have no contact with Tom's mother anymore, as she moved to Canada.

Today Tom was hit by a car whilst on his bicycle near home. You know that he had a very severe head injury and that he is now on the intensive care unit. He looks like he is in a coma and you can see that there is some breathing equipment attached, as well as lots of other machines. You feel very daunted, but you have had the impression that he is being looked after very well. You have been allowed into the room where Tom is, and to hold his hand. It is like a nightmare: it doesn't really seem real. It is now four hours since Tom was admitted.

Students are told this:

Tom has been hit by a car and has an unsalvageable head injury. He is being ventilated on ITU, but examinations (brain stem tests) have shown that he is brain dead. It is now four hours after he was admitted.

You are a doctor in ITU. You need to explain to Tom's parent that he is brain dead, and that even if kept on a ventilator, Tom's heart will stop beating within a week.

One hour later:

Another doctor from the transplant team will need to approach Tom's parent. As is usual when there is a case of brain death, a request must be made for organ donation. There are patients waiting all over the region for organs (pancreas, liver, heart, lung, corneas) some of which can be life-saving. Organ harvesting would need to be performed within 24 hours.

Notes for tutors:

This breaks naturally into two consultations:

Part 1. Student is an ITU doctor and needs to explain Tom's prognosis.

Part 2. Student is a doctor from the transplant team. This consultation takes place an hour or so later.

Student handout

Communication Skills in Year 3 2011-12

Block 4 – Breaking bad news

Learning objectives for this session

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

- describe the principles of breaking bad news to a patient or relative
- demonstrate how to conduct sensitive and effective consultations under difficult circumstances (e.g. by role playing breaking of bad news in the role of a junior doctor)
- demonstrate how to respond appropriately to patients and relatives within the boundaries of your role (e.g. as a junior doctor)

Aims

In this session you will develop your skills in sharing bad news with patients and relatives.

As with Block 3 (Sharing information and discussing treatment), in practice this is something you will do only when qualified. But *practising* these skills as a student will help you to gain an understanding of the principles of breaking bad news and will help you to learn from consultations that you observe on your attachments. As in Block 3, therefore, in this session you will be role playing as *junior doctors*.

It is difficult to draw a distinction between what constitutes a 'normal' or 'routine' situation in which you share information with patients and relatives, and what constitutes 'bad news' – in many respects it is in the eye of the beholder. It is therefore particularly important to consider the situation from the perspective of the patient or relative rather than relying on your own judgement about what qualifies as 'bad news'.

What all 'bad news' situations do have in common is a *serious loss* of some kind. In this session we will mainly be dealing with prototypical 'bad news' consultations (e.g. sharing a diagnosis of terminal illness, informing a relative of a death). However, the same principles apply to any situation where the patient experiences a loss (e.g. an amputation, a miscarriage, a diagnosis of a chronic medical condition, or a cancelled operation).

As in Block 3, you will be provided with information about each case, and the aim is that you and your colleagues identify the most helpful ways of communicating with the patient or relative in each situation. As in the previous sessions, you will also consider the boundaries of your role and what you can and can't do in these situations. You will find that this is particularly salient when faced with a situation where there is nothing further you can do 'medically' to solve the problem.

Communication skills to practise

The following is a list of skills for you to practise (with simulated patients) and to consider when you are observing consultations on your clinical attachments. Breaking bad news does not require a completely new, separate set of skills. You will need to bring to bear all the skills which you have covered in the previous sessions. However, there is also a particular sequence that it is helpful to follow when breaking bad news, and specific 'do's and don'ts' for these consultations.

- Firstly, find out what the patient or relative **already knows** and **what they expect (and want)** from this consultation (e.g. ‘Can you fill me in about what you know so far’?, 'What do you most want to know at the moment?').

- Give an indication that there is bad news coming: this is called a **‘warning shot’**. E.g. ‘I am afraid that it is serious’. Give the patient or relative *time to take this in* and to realise that you are about to break bad news. Note that a warning shot can be given in a number of ways (e.g. by your facial expression and manner). When a patient or relative does not expect bad news, repeated warning shots may be needed to enable the patient or relative to realise that the situation is serious – *before* the news is actually given. Warning shots are not blunt, but they are clear.

- Give information in **small chunks** at a time and check that you are being **understood**. It helps clarity – and to show that the situation is serious – to leave gaps between each ‘chunk’ of information. Resist the temptation to give the information as a whole paragraph and to keep going without stopping until you get to the end.

- Use **clear words and phrases** (e.g. cancer, died, very serious, we can't cure this, not long to live), rather than euphemisms (such as malignancy, tumour, lesion, not curative). Many people will not understand the term ‘palliative’ and its implications. ‘Passed away’ tends to be appropriate for expected deaths only.

- Focus the explanation on the **‘key points’** that you would like the person to understand – which in the first instance tend to be headlines about the condition and/or its implications (e.g. that it is cancer, that it is serious, that it cannot be cured). Don’t get bogged down in technical details whilst you are *breaking the news*: the aim is to give 'the big picture' first, and the details can follow later.

- Explain the **implications** of what you are saying. The explanation should not just focus on giving ‘facts’ in the hope that the patient/relative will work out that it is serious.

- Respect the person's **right to be given information**. Do not assume that because a person has not asked, that they do not want to know. Patients and relatives often wait for you to tell them all the information and do not expect to have to ask. If you are unsure whether someone is ready to move on to a particular topic (e.g. how long they have left to live), you can raise it gently (e.g. ‘There is more information I can give you about what will happen in the future. Would you like to talk about that now?’). **Be clear** when giving the key message (e.g. ‘I’m afraid this means that you don’t have long to live.’).

- Be aware that you will find breaking bad news **very difficult** and often upsetting, and that you should not avoid giving a person information because you find it difficult.

- Many people who have been on the receiving end of very bad news have said that once the ‘bombshell’ is dropped, they can remember virtually nothing about the rest of the information that was given. The more serious the news, the less information you can expect to be able to provide in a single consultation.

- Answer any direct questions with **direct answers**. Be aware that people sometimes ask questions *indirectly*, so be alert to cues that the person wants more information.

- Give the patient/relative time to **take the information in** and **time to be upset** – bear in mind that people can respond by showing any kind of emotion, or none at all.

- Patients and relatives appreciate feeling **supported**, and where possible **reassured**. The information and reassurance you give must always be **honest**. Be aware of inadvertently altering the news you have just broken, by offering false promises (e.g. of the effectiveness of further medical care).

- Simply sitting with someone in **silence** can supportive and reassuring.

- It is appropriate to say **'I'm sorry'**. Do *not* say 'I'm sorry to have to be the one to tell you' (as is this about your needs, not theirs).

- Most people are simply **not in a position** to be able to make **immediate decisions** about the next stage when you have *just broken the news*. In order to make an informed decision, people usually need time to take the information in, and often to discuss it with relatives. You can support the patient by saying something like 'We don't have to make any snap decisions at the moment. Let me give you some time to think about it. You might want to talk it over with your family first.'

- However, some patients or relatives who have been **expecting** bad news (perhaps following previous discussions whilst investigations were ongoing) may have already thought about it and may be ready to make plans and get on with practicalities.

- Be responsive to **cues** about what is a good point to end the consultation. You can usually tell when someone has reached the point where they have had enough information and when they need time to stop and digest. You can take your leave by asking if the patient/relative has **someone that they want to be phoned**, or if they want **some time to collect their thoughts**, or if they would like **someone to sit with them**. (NB Do not offer all three options.) Note that although these are technically questions, they are functioning as statements (e.g. you might say 'Shall I ask the nurse to sit with you?' in order to convey 'I am about to go and ask the nurse to sit with you') – you are not expecting that the person will be able to any kind of decision, even small ones like these.

- Be clear about how they can **contact you** and give a **brief immediate plan** (e.g. that you will come back in about half an hour).

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