Family Medicine Osce Station

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Communication and the Health Professional

- Verbal Communication – Effective use of language skills to explain and present ideas clearly without the use of jargon; appropriate use of open and closed ended questions.
- Non-verbal Communication – body language, facial expression, gestures, pictures.
- Listening Skills – cues, silence (pause), interrupts inappropriately, attentive to answers and concerns.

Critical use of Communication Skills include:

- Explaining diagnosis, investigation and treatment.
- Breaking bad news.
- Seeking informed consent.
- Advice on lifestyle, health promotion or risk factors.
- Difficult or anxious patients or relatives

Family Medicine and the Osce

Scenarios which you encounter daily:

- Breaking bad news – abnormal pap smear, abnormal mammogram.
- Counselling – HIV pre-test, birth control.
- Lifestyle/Health promotion – Smoking cessation, screening tests.
- Difficult Patients/Relatives – Medical ethics, Confidentiality, Consent

Checklist/Marking Scheme

- Points earned according to checklist.
- If checklist item not mentioned or not dealt with appropriately point cannot be given.
- Read scenario appropriately and stay focused on given objective, eg smoking cessation, don't ramble on about stages of lung cancer etc.
- Nothing new, what you do daily with each patient encounter.....Relax !

Structure

- The structure of the patient encounter should be tailored towards the scenario as well as to the individual patient however certain aspects are basic, allowing quick and easy earning of points.
- Greet patient appropriately.
- Introduce yourself and ascertain patients name, maintain good rapport throughout the encounter.
- Establish reason for visit.

Structure Cont'd

- Patients understanding of test/procedure, disease, previous attempts at lifestyle modifications. (Also illicit fears/concerns and pass experiences if any).
- Risk assessment where appropriate – eg. Smoking cessation- length of years smoking, number of cigarettes smoked daily, other drugs; HIV pre-test - sexual practices and other potential at risk practices.

- Important not to be abrupt when breaking bad news.

Structure Cont'd

- Manner in which news is given if breaking bad news. Build up to the result, eg. "*As you know we took a biopsy* (reason for visit already established), *and the results are not as we hoped*, (PAUSE…..pausing and waiting allows patient to reflect and formulate questions which may lead the consultation) *Unfortunately/I'm sorry to tell you its* …..

Structure Cont'd

- Establish support system.
- Illicit patients understanding eg may ask patient to summarize what they have understood.
- Allow questions and answer, if unable to answer do not be afraid to say you will find out.
- Address concerns
- Management plan when appropriate (eg. Next steps etc. start date to smoking cessation)

Structure Cont'd

- Do not reassure inappropriately.
- Summarize the patient encounter, including what was discussed, understanding, items to follow up on.
- Set an early follow up appointment.
- Make yourself accessible to discuss with patient and patients support system IF it is the patients wish.
- Thank your patient.

Practice Scenarios

- Counselling – HIV Pre-test
- Health Promotion/Lifestyle Modification – Smoking Cessation
- Breaking Bad News – Abnormal pap smear or mammogram
- Difficult Patient/Relative

HIV Pre-Test

Counselling for an HIV test

Checklist	P	MP	F
Introduces self and explains reasons for consultation			
Identifies patient correctly (uses at least two identifiers)			
Gains consent			
Ensures that setting is private and dignified (bleep off, door closed)			
Establishes rapport			
Explains purpose for consultation, obtains consent			
(E – expectations) Establishes patient's reason for attending			
(I – ideas) Establishes patient's understanding of situation and need for pre HIV test discussion, and if patient has ever had an HIV test before			
(I – ideas) Establishes patient's understanding of HIV and what it is: • Destroys immune system • Makes sufferers susceptible to bacteria/viruses • If not treated, can lead to AIDS			
Establishes sequence of events leading to this consultation			
(C – concerns) Establishes and acknowledges any underlying concerns that patient may have about the HIV test and explores possible sociocultural impact of being stigmatised			
Mentions confidentiality (separate notes from medical notes			
• One-third of those HIV-positive in the UK are unaware of their status			
Patient's perception of own risk and expectation of result (responds appropriately)			
Benefits of testing			
• If positive:			
• Treatment available			
• Normal life expectancy with proper antiretroviral treatment			
• Able to have children (HAART and sperm-washing) but not able to breast-feed			
• Explains difference between HIV and AIDS			
• Reduction of further transmission			
• Counselling available if needed			
• If negative:			
• Can end a period of not knowing			
Basics of testing:			
• Point of care test (POCT): low risk. Not used for West African contacts due to insensitivity to HIV-2			
• Antigen/antibody blood test: high risk and also used to confirm reactive POCT			
• Explains window period clearly (3 months) and checks patient's understanding			

HIV Pre-Test Cont'd

test and explores possible sociocultural impact of being stigmatised			
Mentions confidentiality (separate notes from medical notes if is a genitourinary medicine clinic, insurance company, GP)			
• Has the patient ever been tested before (when? result?)			
Explains why patient needs HIV test			
Risk assessment – mentions risk factors:			
• Other sexually transmitted infections (increases risk of HIV-positive status and HIV transmission)			
• Partner known to be HIV-positive			
• Men who has sex with men (MSM), especially high-risk sex acts such as unprotected anal intercourse			
• Bisexual partner (if female)			
• Partner from high-risk country (e.g. sub-Saharan Africa and Caribbean)			
• Intravenous drug user			
• Blood transfusion abroad or before 1985 in UK			
• Is patient a sex worker or has patient had contact with a sex worker?			
Assess patient's knowledge of HIV, AIDS and transmission (sex, vertical transmission, blood, needles)			
• Most HIV-positive patients are asymptomatic			

• Explains window period clearly (3 months) and checks patient's understanding			
• Emphasises need for follow-up testing in 3 months			
• Asks when last exposure was (<72 hours + high risk – may give post-exposure prophylaxis. May be mentioned earlier)			
• Arrangements for how result will be given (usually given in person)			
Asks whether patient has support if they are found to be HIV-positive and who they would they disclose to			
Explores how patient may feel or react if HIV test is positive			
Remains empathetic and non-judgemental throughout the consultation			
Mentions documentation of discussion			
Gives patient information leaflets			
Discusses importance of avoiding spreading HIV • Condoms/safe sex			
Discusses need to test for other sexually transmitted disease			
Explores **psychosocial** aspects • Explores home situation (who patient lives with, activities of daily living, work) • Disruption to lifestyle as a result of the situation			

HIV Pre-Test Cont'd

Identifies and addresses any '**hidden agenda**'			
Works in partnership with patient, exploring their ideas and preferences with respect to possible solutions to any issues/ problems, negotiating and compromising where necessary			
Obtains informed consent for test (written consent is usually unnecessary)			
If patient is unsure after discussion, gives them time to consider and return			

If patient refuses, tries to carefully explore the reasons why. May be misinformed (e.g. criminal prosecution, insurance). The reasons for refusing a test should be documented			
Summarises and checks understanding			
Offers to answer any questions the patient has			
Acknowledges any gaps in own knowledge, and offers to seek advice from seniors/colleagues			

http://bcs.wiley.com/he-bcs/Books?action=mininav&bcsId=7645&itemId=0470659416&assetId=304427&resourceId=29970&newwindow=true

Smoking Cessation

Checklist

History

History

The student asked:

1. Age of onset smoking.
2. Number of packs per day.
3. About attempts to quit.
4. Length of abstinence.
5. Reason relapsed.

Communication:

The student:
6. Introduced him/herself to me.
7. Advises smoking cessation.
8. Assesses willingness to quit.
9. Appears to correctly identify stage of change.
10. Discusses relevance of smoking cessation to patient's current problem.
11. Identifies appropriate risks.
12. Asks or discusses rewards of not smoking.
13. Asks or discusses roadblocks to quitting.
14. Acknowledges difficulty to stop smoking.
15. Avoids argument.
16. Asks permission to continue discussion on next visit.

http://academicdepartments.musc.edu/fm_ruralclerkship/curriculum/osle.htm

Breaking Bad News

Process grid	*Good* *Yes (2)*	*Adequate* *Yes but (1)*	*Not done/ inadequate* *No (0)*
1 Greets patient and obtains patient's name			
2 Introduces self, role			
3 Explains nature of interview (reason for coming to talk to patient)			
4 Assesses the patient's starting point: what patient knows/understands already/is feeling			
5 Gives clear signposting that serious important information is to follow			
6 Chunks and checks, using patient's response to guide next steps			
7 Discovers what other information would help patient, attempts to address patient's information needs *(2 if attempts to address – student does not need to know answer)*			
8 Gives explanation in an organised manner *(2 if uses signposting/summarising)*			
9 Uses clear language, avoids jargon and confusing language			
10 Picks up and responds to patient's non-verbal cues			
11 Allows patient time to react (use of silence, allows for shut-down)			
12 Encourages patient to contribute reactions, concerns and feelings *(2 if explores these effectively once stated)*			
13 Acknowledges patient's concerns and feelings; values, accepts legitimacy			
14 Uses empathy to communicate appreciation of the patient's feelings or predicament *(2 if verbal and non-verbal empathy)*			
15 Demonstrates appropriate non-verbal behaviour (e.g. eye contact, posture and position, movement, facial expression, use of voice – including pace and tone)			
16 Provides support (e.g. expresses concern, understanding, willingness to help)			
17 Makes appropriate arrangements for follow-up contact			

Content grid	*Yes (1)*	*No (0)*
1 Appropriate gravity of explanations: avoids inappropriate reassurance		
2 States clearly the level of amputation		
3 In response to patient question about smoking, makes empathic non-judgemental comment		
4 Discovers patient is a coach driver		

http://www.radcliffehealth.com/sites/radcliffehealth.com/files/books/samplechapter/6584/21-app4-1b575c6ordz.pdf

Difficult Patient

- Scenario - Joan Lavis is the mother of your 17 year old patient, Sandra Lavis, she came to your office asking to see you. Please talk to her in the next 5/ 10/15 minutes. (***Confidentiality/ Demanding/*** *in this scenario you will discover that the mother found an appointment card in her daughter pocket while doing the laundry. She demands and insists to know the reason of her daughter's visit. Note: no reason was given for the visit in the stem question*).

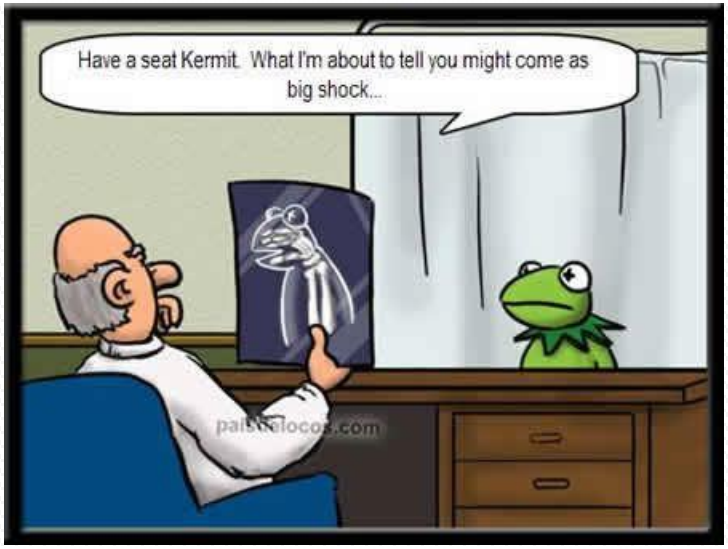
Difficult Patient Cont'd

- Approach
  - Explain Doctor/Patient Relationship ethically bound in confidentiality.
  - Competence established.
  - Suggest mother and daughter speak, other factors, lack of trust.
  - Offer group session.
  - Maintain professionalism, calm demeanour.

References/Links

- http://bcs.wiley.com/he-bcs/Books?action=mininav&bcsId=7645&itemId=0470659416&assetId=304427&resourceId=29970&newwindow=true
- http://www.radcliffehealth.com/sites/radcliffehealth.com/files/books/samplechapter/6584/21-app4-1b575c60rdz.pdf
- http://academicdepartments.musc.edu/fm_ruralclerkship/curriculum/osle.htm

Questions ???


Have a seat Kermit. What I'm about to tell you might come as big shock...