SAMPLE CHAPTER ON COMMUNICATION SKILLS AND ETHICS FROM REVISION NOTES FOR MRCP PACES

The Royal Colleges have kindly made available sample scenarios for this Station: these may be viewed and downloaded using the following link:

http://www.mrcpuk.org/PACES/Pages/PACESscenarios.aspx

Introduction to the general approach of this station

Station 4 aims to assess the candidate’s ability to guide and organize a consultation with a subject who may be a patient, relative or surrogate, such as a health care worker. The candidate is expected to provide emotional support, discuss further management of the case and deal with ethical and legal implications as they arise. The inclusion of this task in the PACES examination is significant, since the medical interview is considered central to clinical practice. Doctors are thought to perform around 200,000 interviews in a professional lifetime. Communication is therefore the clinician’s responsibility, with multiple influences. It is an essential component of the physician role. Effective communication builds trust between the patient and the doctor, improves patient satisfaction, recall, understanding, concordance, decision-making and disease outcome.

The importance of communication was recently emphasised by the British Medical Association in an article entitled “Communication Skills education for doctors: an update” (November 2004) and the Royal Colleges of Physicians themselves, “Improving communication between doctors and patients” (Royal College of Physicians of London, 1997). All patients irrespective of race, gender and social class are entitled to good standards from their doctors. The essential tenets underlying this good practice are: professional competence, good relationships with patients and colleagues, and thinking ethically about decisions regarding patients and colleagues. In this chapter, we are obviously unable to cover all eventuality in the examination. Rather, we have used 24 scenarios to outline the fundamental principles of communication skills and ethics which cover the key areas of the values tested, including breaking bad news, confidentiality and consent, explaining diagnosis and treatments, different styles of patient response, and end-of-life decisions (Sections A-G of this chapter).

The RCP want a Registrar that they feel is competent to deal with such scenario so that the patient/family will be satisfied with the explanation they are given. It is not possible to try and prepare for all possible scenarios.

Instead, make sure you have:-

- A broad knowledge of general medicine
- Knowledge of (national or international) clinical guidelines and protocols: useful guidelines relevant to this station are the DVLA guidelines, NICE guidelines, details about coroner referral, and BMA guidelines on DNAR.
- Intimate knowledge of acute medical management protocols for common medical emergencies
- A management plan for all common non-acute conditions
- Knowledge of major trials that have altered clinical practice in some way
- An idea of any topical newspaper reports on medical subjects
Candidates are not expected to have a detailed knowledge of medical jurisprudence. For overseas candidates in the UK, detailed knowledge of UK law is not required, although candidates should be aware of general legal and ethical principles that may affect the case in question.

**Principles of communication skills**

**Structure of the consultation for the examination**

In the examination, five minutes are allowed for reading the referral letter, 14 minutes for talking to the patient, 1 minute for the candidate to collect his/her thoughts and five minutes’ discussion with the examiner. Read the scenario carefully before going in, decide the important issues that you are addressing and what you should stress for the patient to take home. Make sure that you write the main points you want to discuss otherwise you may forget once you go inside that room. You are given a blank sheet of paper to scribble on. If possible, use this time to decide which words are likely to constitute medical jargon and think of equivalent words a lay person would understand. When in the room, take a short time to establish rapport, and lead/direct the interview without being too controlling. See if the chair has been left a bit further away from the patient; see if there is a barrier between you and the patient. One of your colleagues tried to bring the chair around the table near the patient to break bad news and the examiner said, “It is alright. I know what you are trying to do. Point taken.” You are supposed to have, after the 15 minutes, a discussion of five minutes when they will ask you questions concerning the case and if there are any ethical dilemmas. Timing is therefore absolutely crucial to a decent performance in this Station, and time management, whilst not explicitly stated, as in real life and indeed for the clinical stations, can help to determine success. The five minutes spent reading the task is of critical importance.

You should be able to put patients at ease, particularly with regard to beginning an interview and enabling the patient to raise and discuss sensitive personal issues. In this station, you should be demonstrate your ability to adapt their interviewing style to accommodate different patient styles (overtalkativeness, reticence, depression, hostility, confusion), the communicative abilities of different patient groups (e.g. children, patients who understand or speak very little English, patients with learning difficulties), and the changing demands of the situation (e.g. within one consultation the candidate may be required to elicit information about a medical problem, discuss a psychosocial problem, deal with emotional distress, and provide education). Some of these issues are discussed in part E of this chapter.

Most of all, you must undertake the task. Do not attempt to convert the case into something that you would rather do. Each examiner also has a copy of the written instructions to the candidates, together with the written subject information and Examiners’ information. Each examiner has a structured marking schedule for the case and will examine independently and without discussion. Be frank with the patient (honesty means integrity)! You are expected to have agreed a summary and plan of action with the patient/subject before closure and discussion.

The structure suggested below is based on the Cambridge-Calgary formulation. This structure can be applied to virtually all scenarios. These scenarios may be set in any branch of adult medicine that an FY2/ST1 is likely to encounter in an in-patient or outpatient setting. The semi-structured marking schemes involves sections covering initiation of the interview, appropriate exploration
and planning, and exploration and problem negotiation, and conclusion of the interview, as well as the discussion of relevant issues of medical ethics and/or law. This marking scheme is given below (reproduced by kind permission of the Federation of the Royal College of Physicians).

This station can go easily wrong!

The new PACES format allows candidates to receive more structured feedback on why they failed this particular station. This station is an evolution of the old viva system. The easiest way to ensure that you are given a “clear fail” in this section of the exam is by saying something that is downright dangerous medical practice, or indicates a complete lack of basic understanding about a subject.
Reasons how the station could go wrong

1. Taking the station for granted.

It is very important to see as many clinical cases as possible in the run-up to the exam – both to refine one’s examination skills and to pick up key signs. Nevertheless, to ignore the communication skills and ethics station nor to devote a proportion of your time in proportion to the examination is unwise.

2. Not showing enough empathy.

It is relatively easy to distinguish those candidates who are trying to show empathy from those who do not. It is important that the candidate is seen to demonstrate empathy in dealing with their situation. Empathy is the ability to identify or understand with another person’s predicament. Synonymous words include compassion and sympathy. One useful tip in helping you develop more empathy is to try and imaging how you would feel if you or a relative were caught up in that person’s situation.


Do not use medical jargon. Remember that this station is testing your ability to communicate effectively. You are not communicating effectively if the person in front of you who has no medical knowledge cannot understand what you are saying. Bear in mind that medical jargon is not necessarily limited to medical terminology but also “medical speak”. By medical speak, we mean words that are not for the most part purely medical but convey a different meaning to health professionals.

4. Misreading the scenario given to them.

Read the scenario carefully. In addition, the information contained in the scenario may be extremely important, for example, why have they made the patient a young woman (issues of contraception, pregnancy) or why have they mentioned that the patient is attending with their relative (issue of confidentiality).

5. Being insensitive with patients/relatives

This does not need any explanation.

6. Volunteering wrong information

Although this station is not testing your clinical skills, it is important that the candidate does not communicate erroneous clinical information. This in itself may lead to the interview going in a completely different direction to that intended by the examiners. Examples include making up information, not given to the candidate either from the scenario or from the actor/actress. Another error is assuming that the patient has had tests not mentioned in the scenario. For example, although in some scenarios when it says the cancer has metastasized, it is very likely that you have performed a CT to find out where it has metastasized. However, some of your colleagues
suggested the patient’s confusion is secondary to metastases (when the primary was lung cancer). As you well know, hypoxia or secondary infection could have caused the confusion.
Section 1: Conduct of the interview

The first third of the structured marking scheme is devoted to the general conduct of the interview, in particular, an appropriate initiation followed by adequate exploration of the patient’s beliefs, concerns and expectations.

INITIATION

- Introduction of doctor to patient; introduction as Dr.
- Establish reason for the discussion/explain role clearly.
- Agree the purpose of the interview with the patient: ask the patient what he/she wants or needs
- Put the patient at ease and establish good rapport. Ways in which to develop good rapport include accepting non-judgementally what the patient says, acknowledging the legitimacy of the patient to hold their views (“I can understand that you wish to get … checked out”). It is vital not to be too judgemental, patronising or paternalistic.
- Make appropriate eye-contact early in the interview. General principles of non-verbal communication include appropriate body-posture, proximity, touch, body movements, facial expression, eye behaviour, vocal cues, use of time, physical presence, and environmental cues. Use non-verbal cues to demonstrate attentiveness and build the relationship. Patients and examiners alike are good at picking up non-verbal cues.

EXPLANATION AND PLANNING

Explanations should be tailored to the patient’s preferences in terms of the amount and timing of the information provided.

- Assess the patient’s level of knowledge,
- Assess the patient’s concerns,
- Assess the patient’s expectations and feelings.

You need to assess the patient’s starting point. Discover what the patient already knows, is fearful of, and what they are hoping for, particularly when they are frightened. The rewards of obtaining an accurate picture of where the patient and their relative is coming from before giving information about prognosis or treatment options are great. Gauging how much the patient wishes to know also requires skill. Do not fall into the trap of doing most of the talking (this is a mistake that leads to failure). Remember that the actor in front of you will have been given information that would not be initially available to you and can only be gleaned by asking relevant questions. In addition to that, it is a well known fact that listening is respectful and polite. Try not to interrupt.
Beliefs

We’re here to talk about X. Is that correct?
What do you think is causing it?
Why do you think that might be happening?
Have you had any ideas about this yourself?
Have you got any clues or theories?
You’ve obviously given this some thought; it would help me to know what you think it might be?
Is there anybody else you know who has this problem?

Concerns

What are you concerned that it might be?
Is there anything particular or specific that you were uneasy about...?
What was your worse fear or thoughts about this?
In your darkest moments ... what had been going through your mind?
Is there anything else that you would like to talk about?

Expectations

How were you hoping I might help you with this?
What were you hoping we might be able to do for this?
What do you think might be the best plan of action?
You’ve obviously given this some thought, what were you thinking might be the best way of tackling this?
What sort of information do you want to know?

Feelings

How has all of this made you feel?
How has this left you feeling?
How have things seemed to you?

In the subsequent part of the interview, you will be expected to:
• Demonstrate empathy, response and non-judgemental attitude. Empathy is the understanding and sensitive appreciation of another person’s predicament or feelings, and the communication back to the patient.
• Give the information required in simple language avoiding medical jargon, abbreviations or slang.
• Inform the patient about the options as to what can be done or should be done and what you are going to.
• Avoid patronizing the patient by talking extremely slowly or loudly, calling them “dear” or saying “sure, sure” dismissively.
• Check out non-verbal cues – this allows doctors to express empathy and compassion for the patient’s position. It also gives the doctor space to enquire about further concerns and respond to them with feeling. “I can see that you look very distressed to hear the results of the tests confirm your worst fears. I am extremely sorry (pause) you mentioned your husband is disabled; have you any other concerns you wish to discuss now?” or “The last point made you look worried. Is there something more serious about the point you would like to tell me?”
• Encourage active listening: wait time, facilitate responding (encouragement, repetition, paraphrasing), and encourage non-verbal transmission.
• Facilitate questions and answer them, but avoid distressing too much.
• Prioritise problems.
• Redirect interview as necessary with sensitivity.
• Offer support in terms of concern, understanding, willingness to help, partnership and sensitivity.

Some golden rules of things of what not to do!
• Do not talk over the patient; if it is necessary to interrupt, do it sensitively and rarely.
• Do not get angry with the patient if they cannot remember things or do not accept your views.
• Do not use “statement” questions, such as “You don’t have diabetes?”

Section 2: Exploration and problem negotiation

The next section of the marking scheme assesses the ability of the candidate to agree a clear course of action, involving achieving an appropriate diagnosis and treatment plan, and to summarise and check the patient’s understanding. It is expected that the candidate within 14 minutes concludes the interview appropriately, without overrunning. A possible way in which these goals can be achieved is suggested below:

• Use an appropriate questioning style (generally open-ended to closed as the interview progresses).

• First it is a good idea to start with encouraging the patient to contribute their thoughts first and it’s useful to be forewarned about potentially strong feelings against a course of action, before rather than after, it has been suggested.

**Doctor:** “Before I suggest a way… I’d like to hear what you had in mind – or anything you wouldn’t be keen to consider?”

**Patient:** “I’ve heard a lot about the dangers of surgery and I’m not too keen on being reliant on drugs for the rest of my life. Is there a homeopathic remedy you can recommend?”

• Next you should share your own thoughts about management - this allows patients to understand your own reasoning as well as your difficulties and dilemmas. Enlistment is a term that conveys the initiation of the physician to do this.
Doctor: “I can well understand your concerns about medication – but having a blood pressure of this level makes me think it is unlikely that you will be able to control it by diet and exercise alone. There might be a risk involved if you exercise vigorously in the meantime …I think the best ways is to…. What do you think?”

“Are these treatments acceptable to you?”

- Next, you need to provide clear and relevant information about the various approaches and options – continue by involving the patient by offering choices and making suggestions (not directives).

Doctor: “There are clearly pros and cons to each of these options … what preferences do you have?”

Patient: “Yes I agree – I’m really not sure now”

Doctor: “My suggestion is that we get an expert opinion about your gallstones…and see what this involves… what do you think?”

- Finally - actively seek and encourage their reactions, views and acceptability about what is proposed – and negotiate a mutually acceptable plan

Doctor: “Perhaps we can start with something mild and check to see if there are any problems before going on… Is this acceptable or do you have any other ideas”

- Summarise the subject’s understanding.

“Is there anything else that you are unclear about or didn’t understand?”

“From what we have talked about today, what do you think is most important?”

“I want to make sure, I’ve got everything. You are concerned about….”

- Formulate a plan of action with the patient.
- Reiterate your discussion with the patient to ensure understanding.
- Offer co-partnership and support. Overt statements such as “we need to work on this together” or “I will undertake to speak to the specialist on your behalf”, “you will not be left to cope with this on your own … how can we go forward now?” are examples of phrasing which may help patients and need to be underlined.
- Ask if there are any important issues not covered or if they have any further concerns that they would like you to address.
- Remember it is often appropriate to say that you would seek senior or specialist advice.
- Offer further information sources e.g. leaflets, societies, and support groups.
• Close the interview appropriately. Offer a clear follow-up plan, set a date for a next appointment. Offering to contact relatives or carers when the patient has expressed concern about informing others about their diagnosis or prognosis is often helping. This all arises from the need to inform the patient that the interview is over.

<table>
<thead>
<tr>
<th>Common questions that can be expected from the Examiners:</th>
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<tbody>
<tr>
<td>How do you feel that went? Did you put the patient at ease?</td>
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<tr>
<td>What could you have done differently?</td>
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<td>Which areas if you had time would you have covered?</td>
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<td>What and how do you the patient has taken from your consultation?</td>
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<td>They will then discuss legal and ethical issues (see below).</td>
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**Section 3: Medical Ethics**

In dealing with your case scenario in the examination, you must be able to communicate your argument with relation to the four fundamental ethical principles. The examiner will expect you to have some understanding of these principles which underpin the practice of good medicine, and may refer to these as part of the semi-structured oral examination which follows the interview.

**Beauchamp and Childress' principles**

These four principles derive from Beauchamp and Childress (1979), and are:

**Autonomy:** This literally means self-rule, and means in practice respecting and following the patient’s decisions in the management of their condition. Competent patients have the capacity to think, decide and act on the basis of such thought and decision, freely and independently. Respect for patient autonomy requires that health professionals (and others, including the patient’s family) help patients to make their own decisions (e.g. by providing appropriate information), and respect to follow these decisions (even when the health professional believes the patient’s decision is wrong).

**Beneficence:** This means promoting what is in the patient’s best interests. In most situations, respect for the principle of beneficence and for the principle of respect for patient autonomy will lead to the same conclusion. The two principles conflict when a competent patient chooses a course of action that is not in his or her own best interests. However, a patient can be advised that a course of treatment in her best interests if there is evidence to do so (e.g. sub-cutaneous heparin in a young pregnant lady with a suspected pulmonary embolism, who is beyond the first trimester.)

**Non-maleficence:** This means avoiding harm. The potential good and harms and their probabilities must be weighed up to decide what is in the patient’s best interests. Sometimes it means that appropriate safety measures are taken to perform certain essential investigations, e.g. using an x-ray shield for a CT scan of the chest in a pregnancy lady.

**Justice and sharing:** doing what is good for the population as a whole in terms of time and treatments. In real terms, this may mean distributing resources fairly in the provision of care; health professionals have to decide how much time to spend with different patients, and decisions must be made about limitations on the treatments that can be offered at various levels within a health care system.
In the following sections, general advice is given about the possible principles being tested, followed by specific examples of tasks which illustrate these principles.

We have organised these sample scenarios according to the broad category of their main focus: breaking bad news, giving information about diagnoses and treatments, informed consent, differing patient styles and responses, the ethical issues concerning genetic counselling, confidentiality and good medical practice, and end-of-life decisions. We have provided details for the candidate, as well as a description of a possible consultation in response to that instruction. Of course, various ethical issues are brought out in these different scenarios. In the real examination, however, any scenario can be used to examine your competence at communication skills, law and ethics (e.g. advising a nursery school teacher not to attend work, even if she wants to, because of the danger of passing on an infectious disease).

Examples of types of scenarios

A: Breaking bad news

A review of candidates’ experiences of PACES suggests that ‘breaking bad news’ has been the focus of many scenarios. Bad news is any information which is likely to alter drastically the patient’s view of the future, for example a diagnosis of multiple sclerosis or the news that a patient is brain-dead. It is the most potent cause of distress and, for the medical profession, if done incorrectly, an important cause of complaints and law suits. Genuine communication is characterised by attentiveness, listening and dialogue. The required skills can be learned. Health care professionals sometimes find it difficult to understand the physical, social, occupational and financial consequences of bad news. There are gradations of bad news: subjective, dependent on individuals’ life experiences, personality, spiritual beliefs, philosophical structure, perceived social supports, and emotional hardiness. A useful structure to this type of task is given below. We will use a few scenarios which you can use to consider how these principles may be put into practice.
A STRUCTURE FOR BREAKING BAD NEWS

Initiation
• Use a private setting, involve other health workers, opportunity for relatives to attend if they wish.
• Set your behaviour with correct positioning, eye contact, body language, listening skills. Some examiners are impressed if you physically move the chair near the patient, but obviously at a comfortable interpersonal space.
• Check there is privacy.
• Ask about attendees.
• Offer good eye contact and the patient comfort.
• Greet the patient, and obtain the patient’s name.
• Provide a proper introduction of self and role, outline plan for the consultation.
• The clinician should first find out if anything new has happened since the last encounter. Begin with a neutral question about what is happening.

Assess beliefs before giving the bad news with appropriate signposting (signals moving to information)
• It is important to hear the patient’s narrative of events to allow them to explain what has happened and where they are up to in their illness, e.g. ask “How did it all start?” and “What happened next?”
• Ask about his/her beliefs about the situation. Repeat and reflect “So you had been worried about something like that?” “Have you thought about what may be causing your symptoms?” or “What has been the most difficult part of the whole thing for you”. This way you understand the patient’s perspective and what they understand by their illness and therefore can avoid giving shocking information, if, for example, it is their belief that they have had curative treatment when you know that their prognosis is only a few weeks.
• Acknowledge what the patient has been told in the past.
• “You said you wanted me to be honest and open with you. Are you the sort of person who likes to be told about his medical condition?”
• Ask what he/she understood about why a test was done, for example, “Do you know why we did the biopsy?”
• Give clear signposting/warning shot that serious information is to follow. “I’m afraid it looks more serious than we hoped.” “Unfortunately, the test results show ... ” Give time for the patient to think about this.
• Watch your body language particularly when breaking bad news – look at the patient and lean a bit forwards, pause and acknowledge distress, recap what has been discussed and check understanding of the key facts.
• Give the bad news simply and clearly in small pieces, without fudging, in an organised manner.
• Build the news up layer by layer.

Reaction and prognosis
• Allow the patient time to respond. There is good evidence that most doctors interrupt the patient within 30 seconds of speaking. Encourage the patient to contribute reactions, concerns and feelings. Be prepared for the patient to have disorderly emotional responses of some kind and acknowledge them early on.
• If the patient is distressed acknowledge this e.g. “I can see this news has really upset you. Can you bear to tell me what distresses you most about this?” Many patients are distressed but can be uncertain what the distress is mainly about. Giving permission to discuss concerns enables
the patient to start clarifying the issues and then prioritising their concerns. This feels like a positive process to the patient and is always helpful. Avoid premature reassurance or excessive explanations which can cause dissatisfaction and frustration. Avoid the use of confusing language and jargon.

• Denial is a way of coping with fear and it should be respected as a coping strategy, especially if the patient is coping. If a patient declines further information, it should be acknowledged, but also acknowledge the discomfort of uncertainty and give permission to ask questions at a later date. Few patients adopt a stance of denial permanently, most start to ask more information once they feel more secure. Patients usually experience belief once that they are able to discuss some of their fears.

• Check understanding. “Is this making sense?” or “Have I covered what you want to talk about?”

• Repeat certain information.

• Keep pausing to allow the patient to think.

• Acknowledge the patient’s concerns and feelings through attentive listening. Allowing ventilation of feelings provides a therapeutic part of the dialogue. “How does this leave you feeling at the moment?” is the key phrase. The aim is to help the patient try to name their feelings. Encouraging the ventilation of feelings conveys empathy. Stay calm and allow time for the person to think about their feelings.

• Discuss prognosis. If the prognosis is unclear, give a range rather than leave it entirely open i.e. avoid saying “No one can tell for sure”. Be realistic and honest, but try to leave room for hope.

• Outline likely consequences in a sympathetic and empathetic manner.

Treatment
Do not rush into treatment options if it is clear the patient/relative is not prepared for the information yet.

• Explain clearly the treatment options and outcome, with an approximate time frame

• Ask for any other or new worries and deal with them systematically, bring the discussion to a close but offer an opportunity to speak again and elicit the help of other groups e.g. specialist cancer nurses or societies, offer services for the future, offer transport for the patient. Be prepared for anger and denial, despair and depression. Consider the long term implications, the importance of the support network of family, friends and agencies now and in the future. Identify problems of the patient which are fixable and make a plan.

• Identify coping strategies of the patient and incorporate them. Identify other sources of support for the patient.

• Encourage feedback and check understanding.

• Leave room for hope.

• Summarise and emphasise what can be done.

• Encourage the patient to articulate his personal goals.

• Make appropriate arrangements for follow-up contact. Some examiners like the candidates to enquire what the subject will be doing in the immediate short-term (e.g. by offering if they are travelling alone to arrange a cab to go home if the news has been devastating).

This framework can be applied to the scenarios below, but we have also included some further details specific to each scenario.
Scenario 1

Problem: Breaking bad news (brainstem death and organ donation)
Subject name: Helen Roberts (sister of the patient, Charles Roberts)

You are the FY2/ST1 for ITU. Charles Roberts is a 28 year old accountant who was admitted a week previously following a road-traffic accident. He was treated for multi-system trauma, and was being kept alive on a ventilator. The nurses have requested you to tell the sister of the patient that he has been declared brain-dead by two consultants. It is documented that he had wished his organs to be donated to medical science, in a private conversation with his parents many years’ ago (obviously without having foreseen these particular tragic circumstances). Please inform his sister that Charles Roberts is brain-dead, and approach, if appropriate, the issue of organ donation.

• Introduce yourself and establish a good rapport.

• Ask if he would like anyone else there for the discussion. Assess how much emotional support the subject has in dealing with the situation.

• Acknowledge that it must have been a very difficult time for all of the family.

• Ask what the family has been told in the past, and signpost the bad news. Explain briefly the history of admission to ITU.

• Explain the patient is brain-dead simply. “He has technically died and only the ventilator is keeping the other organs working. For all intents and purposes, Charles is dead because the parts of the brain vital in keeping someone alive are damaged beyond any possibility of recovery”. Explain that brain cells cannot be replaced once damaged and so these cells will not recover. You can also add that if the machines were to be switched off then his heart and lings would stop. It can also be helpful to volunteer to involve a neurologist to confirm the patient is genuinely brain dead.

• Explain the next appropriate step is to stop the ventilation. Explain carefully that this is not to allow her father to die but that continuing ventilation is inappropriate if a person has already died. Explain that it is the medical team who makes the decision who makes the decision as they may think that they are giving you permission to end his life (you are not actually causing death).

• Pause for reflection and allow plenty of time for reaction. Express condolence.

• Show empathy – e.g. “I realize that this must be extremely distressing for you. I only wish that I had better news for you”.

• Confirm that there is no hope of recovery.

• Give opportunity to discuss the situation with family and friends.

• According to the subject’s response, consider whether a subsequent discussion regarding organ transplantation would be appropriate. If so, outline the benefits of organ donation: the shortage of hearts, lungs, kidneys, for example, which may enable other people to live who would
otherwise die. In this case, Charles Roberts, the patient, had previously suggested the notion that his organs to be put to medical science.

- Nurses in ITU often open the discussion by asking something like “What do you think your mother/sister would have wanted in these circumstances?” “I wonder if your father/husband would have wanted his organs donated for the benefit of others”. Remember that this is not an all-or-nothing situation – relatives, who are legal guardians of the body, may specify which are acceptable or unacceptable organs for donation.

- If there is strong emotional resistance, then you should respect and acknowledge their resistance. “I can see you find the idea distasteful, so I won’t pursue it any further”.

- If, instead, the relatives are sympathetic to the idea, you should explore their reasons and determine whether their reasons are appropriate are realistic. “What exactly makes you support the idea of organ donation?”

- Offer him the opportunity to have a discussion with other members of the family; arrange to meet again in a few hours. Ask the father if there is anyone else he would like to inform. Ask if he has any questions. Ensure all staff involved in the case of the father’s decision.

- Arrange a further appointment with somebody.

Mistakes candidates have made when acting out this scenario including adding information not given to them, e.g. “The CT scan shows a very large bleed” or using graphic descriptions of injuries which are unpleasant.
Definitions: The definitions of death have to some extent varied with altering technologies. The examiners may be interested in your understanding of terms such as “brainstem death”. In 1979, the Medical Royal Colleges volunteered the definition that brain death represents the stage at which the patient truly becomes dead. There is no legal definition of death. Death is now accepted as meaning brainstem death or brain death. Brainstem death is a deep coma with absent respiration, with absence of hypoxia, hypothermia, hypoglycaemia, neuromuscular blocking agents, acidosis, abnormal biochemistry and sedative drugs. Tests include fixed dilated pupils, absent corneal response and vestibulo-ocular reflex. There is no gag reflex or motor response in the cranial nerves. There is no respiratory effort on stopping the ventilator and allowing the PaCO₂ to rise to 6.7 kPa. The definition involves two medical practitioners; with two sets of tests; the tests are repeated at an interval that is left to clinical judgement. A persistent vegetative state (Jennett and Plum, 1972) is in patients whose brainstem function persists despite loss of cortical function; there is no behavioural evidence of awareness of self or the environment. Their quality of life is at best uncertain, and their life depends on artificial feeding. There are no reversible causes present, and at least 6 months and usually 12 months have passed since the onset. The causes are severe head injury (40%), hypoxia (40%), and others. There are about 600 new cases in the UK. There is brain damage consistent with the diagnosis. These patients breathe spontaneously, open and close their eyes, swallow and make facial grimaces. However, they show no behavioural evidence of awareness.
Multiple sclerosis

Scenario 2

Problem: Breaking bad news (multiple sclerosis)
Patient name: Sarah Lewis (aged 26)

Sarah Lewis is a 26 year old lady who had noticed some numbness of her feet, with some difficulty in walking, and odd sensations when taking a bath in her upper limbs, a few weeks’ ago. You are the FY2/ST1 in clinic for Neurology. The MRI scan organised by your Consultant demonstrates multiple peri-ventricular plaques most in keeping with a diagnosis of multiple sclerosis. Miss Lewis is a local teacher. She has attended clinic today, and would like the results of her investigation. On previous occasions, the patient has never asked what the problem might be and nobody has volunteered a differential diagnosis. Please discuss with her.

• Introduce yourself to the patient and establish good rapport. Ask if she wishes for anyone else to be present.

• Explore the patient’s understanding of her symptoms and what they possibly meant – i.e. expectations/suspicions of what may be wrong.

• Ask what she understood by the tests. The patient should be given small pieces of information in a logical manner; pauses are essential and give the opportunity for questions. Patients can be given too much information in one consultation after receiving bad news. Explain that the MRI scan findings do suggest multiple sclerosis. Pause to allow this to sink in.

• Watch for her reactions, such as anger or denial. Express empathy.

• Ask what she knows about multiple sclerosis (MS). Explain that myelin is a substance that sheaths around nerves in the body for insulation. Damage to them is called ‘demyelination’ and the bare patches interfere with the smooth conduction of nerve impulses. Aim to reassure her that there are specialists who look after patients with multiple sclerosis and that they will help her with the best available therapy.

• “How many attacks will I have in a year?” Reassure her that she may have no further attacks.

• “What happens if I have an attack?”. Mention that there is treatment (iv methylprednisolone) for a ‘sudden’ attack, but that this usually requires admission for a few days.

• Tell her that there are many people with multiple sclerosis who lead very active lives. In terms of prognosis, explain that there are different forms of the disease. Tell her that patients with relapses and remissions may go on for many years without any major disability.

• Ask if she has any specific concerns; these may include her worries about future pregnancies, or her ability to hold down a particular job such as teaching.

• Tell her the causes of the condition are unknown.
• Explain that there are treatments that prevent the disease from relapsing, but that these do not affect the final outcome. Beta-interferon reduce the rate of relapse, but at this point is unlikely to be warranted.

• MS has no effect on fertility and does not affect pregnancy outcome (but may worsen in the puerperium period”).

• Offer general advice (polyunsaturated fat may be good, and hot climate may worsen the condition”).

• Reassure her that this is not hereditary.

• Tell her about the Multiple Sclerosis Society 0800 800 0800. Explain that joining such groups may allow her to come into contact with other people who have MS. It may even help her to see other people who are coping well with the condition. Other advantages of MS groups in addition to encouragement include education, tips and awareness of new discoveries.

• Ask about her support mechanisms and enquire about his social circumstances including job. Arrange early follow-up to discuss this further. Say you will refer her to a specialist and tell her you will inform her GP.

• Conclude the interview appropriately, and arrange a follow-up appointment. Give her a contact number if she wants to ring you for advice.

_A note on the term ‘multiple sclerosis’: this is normally referred to in the clinical cases as a demyelinating disorder._

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**Lung cancer**

**Scenario 3**  
**Problem: Breaking bad news (Lung cancer)**  
**Patient name: Michael George (aged 58)**

Michael George is a 58 year old architect. He has smoked 10 cigarettes a day for the last 40 years. He was admitted a week ago with cough and shortness of breath. Investigations were normal, apart from a slightly low serum sodium, and a high resolution spiral CT scan of the chest demonstrated left-sided hilar lymphadenopathy. The Radiology report states that the appearance is most suggestive of a neoplasm of the lung. You are the FY2/ST1 for General Medicine. He is feeling much better, and would like to go back to work as soon as possible. You are to discuss with him the results of his investigations, and their possible significance.

• Introduce yourself and establish a good rapport.

• Ask the patient what he thought the symptoms meant: possible symptoms include cough, shortness of breath, bloody sputum, chest pain, wheezing or pneumonia.

• “I’ve read a summary from the GP, but what have you been told?” Check what is known already. Is more information wanted? What is his concern?
• Signpost that the news is worse than may first appear (the “warning shot”, Faulkner (1998)). “I’ve had a look at your scans, and it’s not good”. Ask about why the patient thought he was having tests and what they mean in the long term, despite the fact he is currently feeling very much better.

• Break the news that he has an abnormal growth of cells in the lung, a lung cancer. Explain that diagnosis of a lung cancer is normally through imaging findings (including CXR and CT), as in his case, but further details about the type of cancer can only be obtained through further investigation (e.g. induced sputum). The spread of cancer can be ascertained through further imaging (e.g. CT of the abdomen). Pulmonary function testing may be useful for determining suitability for surgery, or safety of further investigation (such as bronchoscopy). It is very important, however, to absorb jargon.

• Ask about the beliefs about the cause. Inform him that 80% of lung cancers are related to tobacco smoke, and therefore smoking cessation is advised.

• Explain that foreseeing the likely prognosis of his condition depends upon information from these tests.

• Ask the subject if he has any questions. Explain that there will be appropriate management with the respiratory physicians and oncologists, and he will be introduced to the physicians and nurses.

• Beware of information overload (Greger, 1993) and allow denial, “I’m going to be the first person to beat this, Doctor. You’ll be proud of me!!” Give time for the news to be absorbed, and don’t be afraid of silence. Allow ventilation of feelings. Stay calm.

• Arrange a further appointment with somebody in the near future. Offer availability.

Discussion: Whilst this station is primarily an assessment of communication skills, the examiners may reasonably be interested in your understanding of the basic principles of the management of lung cancer. Lobectomy and pneumonectomy are used for non-small cell carcinoma, and can prolong life, improve quality of life and relieve pain. Adenocarcinoma is the most common non-small cell cancer, when tend to develop to the periphery. They tend to metastasize to the bone, CNS, adrenal glands, liver and opposite lung. Squamous cell carcinomas tend to be located in the more central part of the lung. Small cell carcinoma is the most aggressive type of cancer and has the worst prognosis. Radiotherapy and chemotherapy is the primary treatment for small cell carcinomas. Contraindications to surgery in non-small cell lung cancer include: metastatic carcinoma, transfer factor < 50%, severe pulmonary hypertension, uncontrolled cardiac arrhythmias, poor lung function, left laryngeal nerve palsy, malignant effusion, dysphagia, mediastinal lymph node involvement, superior vena cava obstruction, phrenic nerve palsy, rib or distant metastasis. The examiners may wish to discuss related oncology issues, such as the importance of oncology patients entering multicentre clinical research trials. It may be useful to be aware of documents such as the “Calman-Hine” report which was produced in response to concerns about variations in treatment around the country. This report recommends that cancer services should be organised at three levels. Primary care is seen as the focus of care; the commoner cancers will be treated in Cancer Units in local hospitals which have the expertise and facilities to support a
multidisciplinary team; and the less common cancers will be treated in Cancer Centres situated in larger hospitals, which will also support Cancer Units by providing specialist services such as radiotherapy.

Alzheimer’s disease

Scenario 4
Problem: Breaking bad news (a diagnosis of Alzheimer’s disease)
Patient name: Peter Matthews (aged 64)
Peter Matthews is a 64 year old man who presented with increasing memory difficulties. He himself reported an incident where he went to his local corner shop, but on arrival forgot what he had intended to purchase. Overall, he feels that his mood has been fine, and he reports that he has had no other difficulty. In light of this symptom, his GP arranged a CT head scan which demonstrates cerebral atrophy. Neuropsychology confirmed short-term memory problems. You are the FY2/ST1 for Neurology and General Medicine, and you are to see Peter Matthews in outpatients regarding his investigations. The multidisciplinary ‘memory clinic’ team have discussed Mr. Matthews, and they feel that the most diagnosis is Alzheimer’s disease.

- Introduce yourself to the patient and establish good rapport. Ask if she wishes for anyone else to be present.
- Explore the patient’s understanding of the condition and expectations/suspicions of what may be wrong.
- Discover what the patient understood about the tests (e.g. CT scan demonstrating cerebral atrophy). Explain that there is no single test for this particular condition, although results may be supportive of such a condition.
- Explain that the disease tends to be a slowly progressive disease, but the rate of progression can be unpredictable. The disease is characterised in its early stages by loss of memory. “I can see how hard your memory loss has been to deal with.”
- He should aim to optimise general health, and should use cognitive aids (e.g. clear labelling diary). Current medications include donepezil, a cholinesterase inhibitor, for mild dementia. Main side effects are cholinergic. It is a case of taking things as they happen.
- Explain that lifestyle changes can be helpful (for example, locking up any rooms in the house that are not in use, locking up any drawers that contain important documents).
- The patient may wish to know whether the condition runs in families. Alzheimer’s disease where there is a family link is called familial Alzheimer’s disease, and is more common among younger people (under the age of 65). Research has shown that even for people with a strong family history of early onset Alzheimer’s disease, only 50% of cases are caused by a genetic defect. Some cases of Alzheimer’s disease in people under 65 are, however, inherited. On average, half of the children of a person with one of these rare genetic defects inherits the disease. Probably all those who inherit the genetic defect develop Alzheimer’s disease at a comparatively early age.
• Tell him about the support offered by the Alzheimer’s Disease Society. Mention that benefits are available to patients with Alzheimer’s disease, and their carers, and these can be ascertained from the Citizen’s Advice Bureau.

• Explain that daycare may be available for the patient, giving respite for the carer.

• Ask her if he has any questions. Offer an appropriate time for follow up.

Testicular cancer

Scenario 5
Problem: Breaking bad news (A diagnosis of testicular cancer)
Patient name: William Charles (aged 21)

William Charles is a 21 year old man saw his GP because of a lump in his testes. A nurse had accidentally done a pregnancy test which was positive. However, he was unaware this had been done, and had just been told that a urine sample was needed to look for infection. A CT scan, with subsequent biopsy, arranged by his GP, demonstrates a testicular tumour. He has a girlfriend of two years, to whom he is close. You are the FY2/ST1 for General Medicine. He has attended clinic to discuss the result.

• Introduce yourself to the patient and establish good rapport. Ask if she wishes for anyone else to be present.

• Explore the history of how the patient realised that something was wrong. Once the patient’s understanding of the condition has been established, it may be possible to predict if he is expecting a diagnosis of cancer. If he is aware that cancer is a possibility, the patient should be informed of the diagnosis in a clear and sympathetic manner. He may wish to see his CT scans or the histology report, which is sometimes useful.

• Explain the nature of the disease, the need for cyclical combination therapy over a period of several weeks, and its side-effects. Explain that the treatment will give him a very good outcome. If the patient has not considered cancer as a possible diagnosis, the patient should ideally be given small pieces of information at a time, working towards the diagnosis. The doctor should be relatively positive, as the outcome is usually good with chemotherapy.

• Allow the patient time to react to the diagnosis and pause.

• He may ask why the urine sample was taken. The author of this scenario would like you to consider what ethically you would do in this scenario!

• Explain the need for subsequent cytotoxic chemotherapy: logistics (when and where) and side-effects (e.g. infection, alopecia, nausea and infertility).

• Explain the implications of the treatment of his condition: cosmetic – testicular prostheses can be inserted; fertility – unaffected by previous surgery, likely to be infertile after chemotherapy, but semen can be frozen and stored; need for future monitoring of response to
treatment: CT body and blood tests. He may wish to discuss these findings in light of his personal circumstances (such as his girlfriend).

- Emphasise the very good prognosis for testicular cancer: around 90% cure. Ask the patient if he understands what has been said. Summarise the consultation and ask if he has any questions.

- Arrange medical follow-up. Arrange a point of contact with the oncology nurse specialist. Make sure that there is someone he can talk to, or someone at home with him.

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**Hodgkin’s disease**

**Scenario 6**

**Problem: Breaking bad news (Hodgkin’s disease)**

**Patient name: Claire Barron (aged 27)**

Claire Barron aged 27 presented to her GP feeling unwell a month ago with fever and loss of appetite. A chest x-ray in the clinic showed bilateral hilar lymphadenopathy. The consultant did not discuss the diagnostic possibilities but arranged for a mediastinal biopsy (mediastinoscopy) which was performed by a thoracic surgeon 2 weeks ago. You are the FY2/ST1 for a firm that specializes in haematology and oncology. Your Consultant is away today, and Miss Barron has come back for the biopsy result. Unfortunately, this result states Hodgkin’s disease as the diagnosis.

- Introduce yourself to the patient and establish good rapport. Ask if she wishes for anyone else to be present.

- Explore the patient’s understanding of her symptoms and expectations/suspicions of what may be wrong.

- Ask her if she has heard of “Hodgkin’s disease”.

- Explain that Hodgkin’s disease is a malignant proliferation of a certain type of cells which are involved in the immune system and called lymphoid cells. Prognosis depends upon sampling these in biopsy.

- The symptoms should be explained to the patient. Patients usually present with enlarged, painless nodes, and 25% have constitutional upset, e.g. fever, weight loss, night sweats, pruritus, and lethargy.

- Explain that there are doctors who specialize in this disease and that there are well-established treatments available. The tests which need to be done should be explained, including lymph node biopsy, blood tests, CT/MRI thorax, abdomen and pelvis.

- Tell her that you will refer her urgently to the clinical oncologist for further staging, which confers a treatment plan and prognosis.
• Explain the options for treatment: radiotherapy is for stages IA and IIB, chemotherapy for IIA with >3 areas involved to IVB. Complications of treatment include hypothyroidism, lung fibrosis, nausea, alopecia, infertility, infection and secondary malignancies.

• Ascertain how much the patient has taken in regarding the information.

• Avoid giving specific times regarding prognosis, and provide hope.

• Ask who is at home to support her. It is wise to inform the GP straight away for primary care support. Check that she is not driving home on her own.

• Offer an appropriate for follow up.

Discussion: The prognosis of Hodgkin’s disease depends on the histological type of disease. Lymphocyte-depleted has a poor prognosis, the others have good prognosis (nodular sclerosing, mixed cellularity, lymphocyte rich). It also depends on the staging of disease. The examiners may expect some understanding of the staging of disease. Stage I is confined to a singly lymph node region, II involves two or more regions on the same side of the diaphragm, III involves nodes on both sides of the diaphragm, and IV involves spread beyond the lymph nodes.

Recurrence of breast cancer

Breaking the bad news of a recurrence of breast cancer is a particular example of a ‘bad news’ scenario, but there are features of this scenario which reflect that palliative care is a speciality where patients can lose hope. It is therefore essential to elicit a patient’s own specific fears, before addressing them.

• Consider the understanding of illness, the expectations and concerns about the future.

• Consider the effect of the illness physically and emotionally.

• Provide medical reassurance (their symptoms will be identified promptly, controlled as far as possible and that they will remain comfortable).

• Explore the social support (in terms of Doctors, Nurses, Church etc.)

• Explore thoughts and fears about the future, dying, worries, plans made, plans not made.

• Explore how the family is coping with the illness.

Scenario 7
Problem: Recurrence of breast cancer
Patient name: Anna Fine (aged 48)
You are the FY2/ST1 on the medical ward to which Mrs. Fine, a 48 year old lady, who was admitted a month ago with acute confusion secondary to mild hyponatraemia and severe hypercalcaemia. She was treated with intravenous fluids and pamidronate, and was then well orientated and lucid. She had a mastectomy for breast cancer 12 years ago followed by radiotherapy but no chemotherapy. She was last seen only six months ago in breast clinic, and reassured that everything was going well. She even underwent a mammogram at that stage, reported as “normal”. She had been otherwise well on this admission, until she began to complain of increasing back and sacral pain. The House Officer requested x-rays which demonstrated changes consistent with bone metastases, confirmed on a later DEXA bone scan. Her chest x-ray also demonstrates a moderate effusion and cytology confirming malignant cells. Your task is to
explain to Mrs. Fine that she has advanced metastatic cancer, and will be referred to the oncology team for further care that is likely to include chemotherapy and radiotherapy.

• Introduce yourself to the patient and establish good rapport. Ask if she wishes for anyone else to be present.

• Explore the patient’s understanding of the condition and expectations/suspicions of what may be wrong. Explore the understanding of her prognosis: she may have been convinced that she has been completely cured of cancer, but her recent admission cast may have doubt upon this.

• Explain the meaning of the tests and results (e.g. bone scan), and explain that the cancer has spread.

• Be prepared for the patient’s response. She may demonstrate denial, before being angry towards the initial therapy given. The candidate should not criticise previous treatment, and even if he is not able to understand the logic of the initial therapy, he should still find some way of reassuring the patient about the appropriateness of initial therapy.

• Explain that it is difficult to predict what course the disease will take. However, prompt investigation of the cause of symptoms, and treatment for these symptoms and side-effects can be given. Inform the patient that you will comply with her wishes. Explain that you will listen to the patient’s concerns and involve her in decision-making.

• Explain that her symptoms will be treated, but that the treatments have side effects, for example chemotherapy can cause nausea and vomiting, diarrhoea and constipation. The ‘best treatment’ may involve radiotherapy, chemotherapy or hormone therapy, either given alone or in any combination or order. Explain that the treatment will shrink the cancerous growths but it may be impossible to get rid of the cancer completely. Some patients go into complete clinical remission. The candidate should be prepared to discuss the pro’s and con’s of an optimistic versus a pessimistic approach in discussion.

• Outline that breast cancer treatment is carried out by different specialists who work together as a team, including psychologists, physiotherapists and also members of the appropriate religion. There are a number of sources of professional support. It is impossible to predict who will do well until the treatment is underway. The GP has responsibility for health care, and the District nurse can provide nursing care and organise for equipment. Macmillan nurses are available, who are specialists in pain and symptom control for people with cancer, and emotional and psychological support for carers. Palliative Care Teams have expertise in symptom control and support for patients and their carers. A social worker can assess what welfare benefits a patient may be entitled to. They can arrange social services and other practical help. Explain that there are organisations such as CancerBACUP can help, and these organisations usually have their own websites on the internet.

• Enquire further about any further expectations (for example, she may have booked a holiday abroad, in which case you would need to inform her about the possible need for assessment for a fitness to fly, and what local arrangements could be made at the place that she is flying to regarding local therapy for emergency such as cord compression).
• It is important to maintain a positive and optimistic outlook. Ask the patient if he has told other members of the family, or if he would like them to know of his decision. Ask if he has sorted things out at home. Is there anyone else who would like to be contacted? Explore the patient’s understanding of what refusal will entail. A good candidate should be able to agree a summary and plan of action with the subject. Summarise what has been discussed. Ask if he has any questions. Make appropriate follow-up arrangements.

• At some later date (guided by the scenario), it may be important to discuss resuscitation status.
B. Giving information: explaining diagnosis, treatment and prognosis to competent patients

Several scenarios used in this station involve simply explaining a diagnosis or treatment to competent patients. A definition of competence is provided in the next section C, and is not the focus of this section. A recent study by Kindelan and Kent (1987) in British general practice showed that patients placed the highest value on giving information about diagnosis, prognosis and causation of their condition. Doctors however greatly tend to underestimate their patients’ desire for information about prognosis and causation, and overestimated their desire for information concerning treatment and drug therapy. Patients’ individual information needs were not elicited.

You should explore the patient’s perception of their condition and prepare them. Consider “What have you been told about your condition?” Find out what the patient wishes to know. Bear in mind that patients are often extremely well informed, and therefore if a patient presents with a condition that you may in actual fact know not that much about, for example alpha-thalassaemia trait, listen to the patient! You should show you are listening through body language, and encourage the patient to tell their 'story' too.

**Do not forget that some scenarios will deliberately go beyond the scope of a junior doctor in a medical firm's professional experience or authority (e.g. a certain condition in a pregnant lady). In such cases, you will be expected to recognise the need to refer the matter.**

Examples of suitable scenarios for this station include:

(a) Giving information about diagnoses

This will not be a test of your knowledge of particular medical conditions, but rather an approach of how you impart information about these particular diagnoses. Some useful points to consider are:

1. Information must be related not only to the facts, but also the patient’s ideas about the condition. “Have you heard of this condition before?”, “Have you any ideas about this condition?”, or “What have you been told about this condition?”
2. Use a logical sequence to explain the cause and effect of the condition in the context of the patient’s symptoms (why it occurs, possible clinical problems, the likely natural history with/without treatment).
3. Be alert to beliefs, concerns and expectations. Establishing prior experience can help you understand any specific fears that may relate to it.
4. Tell one thing at a time and check the patient understands before moving onto the next.
5. Use simple language; translate any unavoidable medical terms and write them down.
6. Make your information direct. Repeat important information.
7. At the outset, show patients that you will write down the key words, use a simple diagram, and offer them aids to memory.
8. Acknowledge the possible need for further referral in diagnosis or management.
9. Encourage feedback, invite questions and check understanding. Be prepared to admit uncertainty if the patient asks you something you cannot answer.
Scenario 8
Problem: Giving information (a new diagnosis of diabetes mellitus)
Patient name: Tim Scott (aged 19)

Tim Scott is a 19 year old man who was referred to endocrinology outpatients after his fasting blood sugar was found to be elevated. He had noticed some transient blurring of vision, which has subsequently thought to be due to osmotic changes in the lens as a result of blood sugar problems. His glucose tolerance test supported the diagnosis of diabetes mellitus. Please discuss with him.

- Introduce yourself to the patient and establish rapport. Establish the patient’s understanding of his symptoms and their implication (e.g. “You say that you have been passing water frequently, and felt thirsty. Have you had any thoughts about what these symptoms might be due to?”), and expectations.

- Ask the patient whether he has had any experience of diabetes in other people (e.g. his father may have had diabetes and developed complications from that), and respond empathetically.

- Explain to the patient the basic mechanisms underlying the diabetes mellitus. You should then ask the patient if he would like any other information (e.g. “Would you like to know about the tests I would like to do to confirm the diagnosis and the stage of your diabetes?”)

- Explain the aims of treatment – to reduce the risk of complications: macrovascular (IHD, cerebrovascular and peripheral vascular disease) and microvascular (nephropathy, retinopathy and neuropathy). All of these can be reduced with optimal glycaemic control, but other important risk factors are smoking, alcohol excess, hypertension, hyperlipidaemia, and obesity.

- Emphasise the need for lifelong treatment.

- Explain the multidisciplinary approach: diabetic specialist nurse, dietitian, chiropodist, ophthalmologist, and need for teamwork.

- Outline possible treatments: emphasise that dietary modification is a most important aspect of treatment, combined with exercise.

- Discuss the possibility of oral medication, if this is unsuccessful.

- Discuss the possibility of insulin therapy in the future. Address other risk factors i.e. hypertension, hyperlipidaemia, smoking. Emphasise the need for compliance and regular review. Introduce him to the diabetic team.

- Point the patient in the direction of further information about diabetes. Arrange patient education sessions. State clearly that he will require follow-up for review of his diabetes to detect and treat any complications.
It is important that you check the patient’s understanding by asking, “Can you now tell me what you understand about what I have explained to you in terms of the tests needed, the extent to which we should be able to control your illness, and the likely treatment?”

Arrange appropriate follow-up with the multidisciplinary team.

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**Thyrotoxicosis**

**Scenario 9**

*Problem: Giving information (a new diagnosis of thyrotoxicosis)*

*Patient name: Annabel Smith (aged 29)*

Annabel Smith is a 29 year old lady who has lost 2 kg over the last few months, despite a good appetite and intake of food. She has become somewhat irritable at work, and slightly tremulous in both her hands which she thought was due to her anxiety. Blood tests confirms that she is hyperthyroid. Examination, apart from the tremor, is normal. Her pulse is 90, regular. You are the FY2/ST1 for Endocrinology. She has returned to clinic for the results of her blood tests.

- Introduce yourself and establish rapport.
- Explore her knowledge of the symptoms, and what they possibly meant. Ask what she understood by the need for the blood test. Explain the results of the blood test.
- Explain the nature of an overactive thyroid and the pathological consequences of an untreated disease. This might focus on current symptoms. When considering loss of weight, confirm that this weight is lost despite a good appetite and eating vast amounts. Advise about some of the manifestations of thyrotoxicosis can take: e.g. skin (warm and sweaty due to vasodilatation), cardiovascular (tachycardia, with increased cardiac output due to increased peripheral oxygen utilisation and increased cardiac contractility, atrial fibrillation, mitral valve prolapse), ocular, gastrointestinal (weight loss due to increased basal metabolic rare, increased gut motility with associated diarrhea and malabsorption), locomotor, neurological (emotional lability, insomnia, irritability, anxiety, proximal muscle weakness, tremor) and reproductive system.
- If a smoker, the patient is at greater risk of eye disease, and so therefore should be asked if there is any noticeable bulging of the eyes or double vision. Discuss the treatment options.
- Explain that her symptoms will resolve with treatment, but may take months to resolve completely. For medical therapy, warn of the potential side-effects, especially agranulocytosis. Thus must be given both verbally and in writing. Establish her last menstrual period, wishes for pregnancy and if she has any children.
- Establish the need for regular review.
- Point the patient in the direction of further information about thyroid disease. Arrange patient education sessions.
- It is important again that you check the patient’s understanding by asking, “Can you now tell me what you understand about what I have explained to you in terms of the tests needed, the extent to which we should be able to control your illness, and the likely treatment?”.
(b) Giving information about treatments

Encouraging a patient to adopt a treatment requires that the patient understands the risks and benefits of that treatment, and it is necessary before consent for a treatment can be acquired. For any procedure, treatment or operation, the doctor needs to explain the nature of the procedure. The doctor must exercise sensitivity to patient’s fears, and it is a legal requirement to inform the patient of risks, benefits and alternative treatments which demonstrate both good practice and avoidance of negligence. Doctors may be faced with litigation when patients understand the benefits of the treatment, but do not understand the risks of the procedures that they are undergoing. The duty of the doctor is to provide this information frankly to the patient. The nature by which consent is obtained is not only fundamental to the doctor/patient relationship, but is also a key way to which patient autonomy is respected. In order to obtain consent, the doctor discloses information to a patient who is legally competent. A sensible approach in which to do this is suggested below:

1. Explain the reasons for considering the treatment (Is the treatment critical, essential, elective or discretionary)?
2. Give the patient a chance to react to the need for treatment
3. Consider whether there are any likely benefits of treatment according to currently accepted medical practice, but be aware of overwhelming patients with outcomes of studies.
4. Explain what the treatment will need for the patient in terms of the frequency of dosing, the duration of therapy, any special instructions, how long the treatment will take.
5. Any requirement for any specific monitoring, e.g. blood monitoring.
6. The common, as well as uncommon, side effects and any discomfort of treatment.
7. Suggest any alternative to treatment. You should be offering support, i.e. making supportive statements but also giving practical advice such as details of counselling services and appropriate literature.
8. How soon knowledge about the effects of the proposed intervention will be made available.
9. Give ample opportunity for questions.
10. Keep it short and simple.
11. Finally seek consent. Remember that you are explaining the reason for a treatment and not telling your patient that they must have it. Following your explanation, you should seek informed consent to proceed.
12. For negotiating a management plan, clarify the task, explore concerns and explanations, keep to a framework, share management options “It might help if…”, “I wonder if…” etc.
13. Show respect for the patient’s autonomy; do not behave coercively.
14. Invite the patient to ask any questions.

Studies have consistently shown that between 10 and 90% of patients prescribed drugs by their doctors (with an average of 50%) do not take their medication at all or take it incorrectly. Walton et al. (1980) estimated the cost of wasted drugs per year in the UK is of the order of £300 million. In the scenario, you should specifically ask how the patient is with regard to symptoms. Ask any patient who appears not to be compliant with his medical regimen whether he has not been taking his medication, and, if so, enquire why, e.g. side-effects, forgetfulness, inability to get hold of the tablets, poor information about how to get the tablets, the purpose of taking the medication,
unpleasant side-effects. Consider alternative simplified drug regimens. Consider arranging with the health visitor and your Consultant directly observed therapy where ingestion of every dose is witnessed. Patient recall is increased by categorisation, signposting, summarising, repetition, clarity and use of diagrams (Ley, 1988).

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**Hormone replacement therapy (HRT)**

**Scenario 10**

**Problem: Commencing treatment (hormone replacement therapy)**

**Patient name: Laura Wood (aged 57)**

Laura Wood is a 57 year old lady who has been experiencing the symptoms of the menopause. She has read about HRT, and has considered it as a treatment for her troubling symptoms. You are the FY2/ST1 for General Medicine. Please discuss with her HRT as an option, and advise accordingly.

- Introduce yourself to the patient.
- Establish the patient’s perception of her symptoms.
- Explain the concept of HRT and explore the patient’s beliefs and concerns about it. Establish then the patient’s expectations.
- Explain the potential benefits: HRT is an effective means of controlling the vasomotor and genital symptoms associated with the menopause. It prevents osteoporosis. There is a possible decrease in the risk of ischaemic heart disease, but the evidence is unclear. It decreases the risk of uterine carcinoma and possibly colonic carcinoma.
- Explain the likely course of treatment, and related issues. Current recommendations are to stop HRT after 5-10 years of treatment, although the increased risk of breast cancer attributable to HRT is not thought to begin until around 50 years of age. Oestrogen-only HRT tablets or patches may be used in hysterectomised patients, but preparations associated with progesterone should otherwise be used to limit endometrial hyperplasia and the risk of endometrial malignancy. Amenorrhoea need not be awaited before starting HRT. Cyclical (sequential) hormone regimens are generally used in perimenopausal women and continuous combined regimens in postmenopausal women. Continuous combined treatment is associated with a high risk of irregular bleeding in perimenopausal women but should not cause induced bleeding in postmenopausal women. Postmenopausal bleeding generally necessitates investigation to exclude endometrial malignancy.
- Describe briefly the evidence concerning the risks associated with hormone replacement therapy. HRT increases the relative risk of venous thromboembolism, but again the absolute risk is low, and possibly offset by the favourable effects of HRT on lipid profiles and potential cardiovascular benefit. Studies are inconclusive as to whether HRT induces (or even increases) cardiovascular risk. There is no current evidence to support the use of HRT in either the primary or secondary prevention of coronary heart disease, and no evidence that HRT reduces stroke risk. A systematic review and meta-analysis has suggested that HRT may have a role in reducing
dementia and cognitive decline. HRT does not cause weight gain. Discuss alternatives to HRT, e.g. clonidine for hot flushes, evening primrose oil, topical oestrogens.

- Explain the need for annual mammograms and self-examination. Explain that HRT will result in her continuing to have regular withdrawal bleeds that she may find troublesome. Ultimately the decision is the patient’s, and she needs to weigh up the theoretical risks and inconvenience against her troublesome symptoms. Ensure that she understands all the issues. Finally ask if she has any questions.

**Warfarin**

**Scenario 11**

**Problem: Commencing treatment (warfarin)**

**Patient name: Jennifer Salmon (aged 34)**

Jennifer Salmon is a 34 year old lady who has recently undergone a mitral valve replacement. She was diagnosed both clinically and echocardiographically with severe mitral stenosis. She is about to be discharged having undergone the replacement, but your Consultant would like you to discuss with her the need for anticoagulation with warfarin. She has made it known to the senior CCU nurses that she and her husband had been wishing to try for a family by the end of the year. You are the FY2/ST1 for Cardiology. Please discuss with her the need for warfarin treatment, and any concerns she may have.

- Introduce yourself and establish rapport. Explore the patient’s perception of her condition, and what she has been told about it in the past. Ask about her beliefs, concerns and expectations of her valve replacement.

- Ascertain what she knows about aspects of the treatment plan, including knowledge of warfarin.

- Some people only have heard of warfarin in the context of “rat poison”. Explain that blood clots normally form to stop bleeding that has occurred as a result of injury to the tissues. Explain that the clotting process is complicated, but sometimes a blood clot can form abnormally within blood vessels and dislodge such that blood supply to a vital organ such as the heart, brain or lungs is impeded (thromboembolism).

- State that ‘loading’ with warfarin is necessary, and explain what this involves.

- Consider the need for treatment and the precautions needed. It is used for abnormal blood clots in conditions with increased risk (e.g. prosthetic heart valves, atrial fibrillation), and prevention of PE’s and DVT’S. Consider all the drug history and lifestyle factors that would impact upon taking warfarin, i.e. the patient should be warned to take extra care when participating in physical activities because minor injury can result in bleeding. Also, warfarin inhibits vitamin K, therefore eating large amounts of green vegetables can reduce the effect of warfarin and should be avoided. Large amounts of alcohol can also increase the effect of warfarin.

- The candidate should be able to give adequate information to the patient about how to take the treatment and what precautions to observe, in terms suitable for a patient to understand. If there is any bruising, bleeding, dark stools, dark urine, or fever, then a Doctor should be seen.
• Warn about common side effects including easy bruising, rash, jaundice, alopecia, skin necrosis, liver disorders, pancreatitis and nausea and vomiting. OCP and rifampicin can reduce the effect of warfarin.

• The need to monitor the INR should be explained, as too much anticoagulation can adversely increase the risk of bleeding. If there are any problems with ongoing bleeding, the patient should seek medical attention immediately. Warfarin is the long-term anticoagulant of choice in non-pregnant patients, but its great disadvantage in pregnancy is that it freely crosses the placental barrier because of its low molecular weight and can harm the fetus.

• Explain the need to carry an anticoagulation book, and the need to tell the dentist/other doctors about treatment.

• Ask for any further questions, and make appropriate follow-up arrangements.

Discussion: The anticoagulant effect of warfarin is mediated by inhibition of the vitamin K-dependent gamma-carboxylation of coagulation factors II, VII, IX and X and proteins C and S. The laboratory test most commonly used to measure the effects of warfarin is the prothrombin time. Loading is necessary because, in the first few days, factor VII is depressed, but five days are needed before factors II, IX and X are suppressed.

Adverse fetal effects from warfarin may result from the teratogenicity of the drug and its propensity to cause bleeding in the fetus. Warfarin should also not be used in pregnancy, peptic ulcer or uncontrolled high blood pressure. Difficult decisions arise when patients are on long-term warfarin therapy because of prosthetic valves or recurrent pulmonary embolism become pregnant. Any changeover to low molecular weight heparins (LMWH) must be carried out with care and under the multidisciplinary care of the obstetrician and the haematologist. Warfarin crosses the placenta with a risk of placental or fetal haemorrhage. Warfarin therapy is contraindicated in the first trimester because of its association with fetal epiphyseal haemorrhage. In the second and third trimesters, warfarin may cause fetal atrophy, microcephaly, optic atrophy, spasticity, and mental retardation. However, warfarin is safe during breastfeeding. In the initial treatment of a DVT, LMWH which does not cross the placenta may be administered subcutaneously according to body weight. LMWH is not contraindicated in breast-feeding women.

**Statins**

**Scenario 12**

**Problem: Commencing treatment (a statin)**

**Patient name: Luke Dunn (aged 48)**

Luke Dunn is a 48 year old who, despite a good BMI, has a consistently high cholesterol. He had an uncomplicated myocardial infarction 4 years’ ago, but made an excellent recovery. Recent investigations showed: plasma cholesterol 7.2 mmol/l, LDL-cholesterol 4.9 mmol/l, HDL-cholesterol 1.1 mmol/l and triglycerides 1.4 mmol/l. He is a life-long non-smoker, and his diet has been good. Despite dietary advice, his cholesterol remained high. You are the FY2/ST1 for General Medicine in clinic. Please discuss with him the possibility of commencing the statin simvastatin.

• Introduce yourself and establish rapport.
• Explore his knowledge of his condition, and the relevance of cholesterol. Explore briefly relevant risk factors: i.e. cardiovascular history, diabetes history, hypertension history, family history of ischaemic heart disease, alcohol, smoking, dietary and exercise history, concerns of patient.

• Explain the need for reducing cholesterol in terms of the future, e.g. heart attacks, stroke. There is ‘bad’ cholesterol (LDL) and ‘good’ cholesterol (HDL). Simvastatin decreases the production of LDL cholesterol (and total cholesterol) by competitively blocking the action of the enzyme in the liver that is responsible for its synthesis (HMG-CoA reductase).

• Explain that, as the body produces most cholesterol at night, statins are generally more effective at night.

• Explain the likely benefits of the therapy (cause regression of coronary atheromatous plaques, may ameliorate peripheral vascular as well as coronary artery disease, slightly reduce the risk of stroke), and explain what the treatment will mean for the patient in terms of frequency of dosing, the duration of therapy, any special instructions (e.g. the tablet should be taken with meals), any requirements for blood monitoring.

• Advise that excessive amounts of alcohol should not be taken, and grapefruit juice should ideally be avoided in excess because it can increase the amount of medicine in the blood.

• The patient should see the doctor if there is pain or tenderness in the muscles, particularly if accompanied by symptoms of generally feeling unwell. Blood tests should be monitored before treatment (e.g. LFTs), and during it. It should be used with caution in the elderly and in patients with hypothyroidism, or history of liver disease. It should not be used in pregnancy.

• Explain the side effects which are common or serious, and explain how the side effects weigh up against the benefits. These side effects are abdominal pain, constipation, flatulence, headache, dizziness, pins and needles, indigestion, nausea and vomiting, anaemia, liver disorders, hair loss and muscle disorders.

• Common medications that increase side effects are amiodarone, verapamil, diltiazem, itraconazole, and erythromycin. Explain what should be done when a side effect occurs.

• Give ample opportunity to react to the information, and ask for questions. Seek consent to proceed. Explain that other health professionals may be involved, such as dietitians. Arrange appropriate further information if necessary, and follow-up.

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**Steroids**

**Scenario 13**

**Problem: Commencing treatment (steroids for rheumatoid disease)**

**Patient name: Sarah Collins (aged 37)**

You are the Rheumatology FY2/ST1 in clinic in outpatients. You have just discussed the case of Mrs. Collins, a 37 year old woman, with your consultant who feels that she should start steroids. She has had rheumatoid disease for three years. So far, her main symptoms have been stiff hands,
and she required NSAIDs to control her symptoms. However, over the last few months, she has worsening disease, and your team decision is that she should start prednisolone 30 mg od to control her symptoms. Please discuss with her.

- Polite introduction and establish rapport.

- Establish the patient’s understanding of her disease and the need for steroids.

- Try to get some feel of the impact of the disease on her life, including the use of her hands (eating, washing) and other aspects of a routine functional assessment (for example, managing stairs, using a telephone, cooking, shopping).

- Explain that corticosteroids are hormones produced naturally by the adrenal glands which have important functions including the control of inflammatory responses. Explain that prednisolone is a synthetic corticosteroid that is used to increase inflammation in various diseases.

- Explain the need for steroids to prevent attacks and the consequences of poorly controlled disease. Explain that steroids should be taken after food. A steroid card will be needed if prednisolone taken for more than three weeks, which contains details of prescriber, the type of steroid, dose taken and duration of treatment. There will also be a need for medic alert bracelet and a hydrocortisone pack (for parenteral self-administration if she’s unable to take oral medication). If there is any illness, trauma or surgery, the steroid dose may need to be temporarily increased.

- A good candidate should be able to explore the impact of disease on the patient’s daily activities and quality of life, and explain the need for further treatment and advantages of using steroids.

- Warn that the steroids should also not stopped suddenly, as long-term use suppresses the natural production of steroids by the adrenal glands. She should therefore not miss a dose. There may be increased susceptibility to infections.

- Common side-effects are difficulty in sleeping, depression, skin thinning, weight gain, irregular menstrual cycle, osteoporosis, diabetes, acne, increased susceptibility to infection, high blood pressure.

- Your role in discussing the adverse effects should not be confined to reeling off a long list of adverse effects but rather to have a balanced discussion. Remember you are automatically making (or should be making) risk-benefit calculations in your everyday jobs when considering investigations and treatments.

- She may mention weight gain. You can say, “Yes, these steroids can cause weight gain and they do this not only by causing the retention of fluid but also by increasing appetite. So knowing this you can plan ahead and try to eat more sensibly with smaller portion sizes (although offer her a dietitian appointment to help her plan the strategy more effectively). She could also exercise more frequently. By saying this, you are offering back some control of the situation.

- She might have heard that steroids will thin her bones. Again explain that this is a possibility but that as a young person she is likely to have strong bones to begin with. Reassure
her that you will be ordering a (DEXA) scan that will monitor her “bone strength”. Explain that there are effective treatments she can take that will prevent bone loss and that exercise can also help.

- “What about the blood pressure doctor?”. Steroids tend to cause retention of water and this may cause an increase in blood pressure. Reassure that regular measurements of blood pressure can be taken, and that treatments are available to counter the rise in blood pressure.

- “What about the blood sugar doctor?”. Corticosteroids do not precipitate high blood glucose (say “sugar” instead of glucose) in everyone who takes the tablets. Some people are more susceptible especially if there is a family history of diabetes and if they are overweight. Again, there are effective ways of monitoring for this and treating if necessary.

- State that these will be minimised by ensuring her dose is tailored to her condition. Osteoporosis can be minimised by concomitant bisphosphonate therapy. The effects of steroids are reduced by anti-epileptics, rifampicin, barbiturates and aminoglutethimide. When taken with NSAIDs, there is an increased effect of adverse effects on the gut. Ensure that the patient understands what has been said and ask if she has any questions.

- It is very important to ask the occupation of the patient in certain situations. If you are not given this information, it is a good idea to ask. If the person has never had chickenpox, close personal contact should be avoided. If exposed, the patient should see his/her doctor urgently, as these diseases can be threatening. This would be especially important if, for example, she was working as a nanny.

- Summarise what has been discussed. Arrange appropriate follow-up.

Surgical treatments for medical disorders

Benefit and risk of a CABG in a patient with triple vessel disease

Scenario 15

Problem: Proposing treatment (coronary artery bypass graft)
Patient name: Andrew Foster (aged 53)

Andrew Foster, a 53 year old man, was admitted with his third episode of chest pain at rest this year. This pain was cardiac sounding in history, and the ECG demonstrated dynamic changes. His troponin was elevated 12 hours after the onset of the pain. A coronary angiogram was arranged on this admission, which demonstrated multiple narrowings in the coronary circulation. He had hoped that these vessels would be amenable to stenting, but the Cardiology Consultant on review of the angiogram data feels that he ought to be referred to Cardiac Surgery. You are the FY2/ST1 for Cardiology. Please discuss the possibility of coronary artery bypass grafting as an option for him.

- Introduce yourself and establish good rapport.

- Establish the patient’s beliefs and concerns of understanding the disease, its severity and likely expectations. Ask about smoking behaviour, but avoid being judgemental about his smoking.
• Explain the results of the recent angiogram. Establish the patient’s understanding and expectations of possible treatment options. Explain the need for the procedure, e.g. none of the vessels are amenable to stenting.

• Explain that coronary artery bypass graft (CABG) surgery, sometimes just called bypass, is the procedure that enables a blocked area of the coronary artery to be bypassed so that blood flow is not hindered. During bypass surgery, a healthy artery or vein is taken from the leg, arm or chest and transferred to the outside of the heart. The new healthy artery or vein then carries the oxygenated blood around the blockage in the coronary artery. Explain why CABG surgery is performed, i.e. to relieve symptoms of coronary artery disease, reduce the possibility of more heart problems, and to prolong life.

• As with seeking consent for any procedure, explain explicitly that there are complications and risks associated with CABG procedures. Complications associated with coronary artery bypass grafting may include stroke, damage to the aorta, the potential damaging effect of emboli, bleeding, vein graft occlusion or stenosis, arrhythmias, acute myocardial infarction, angina, or death. After the procedure, the patient spends 5-7 days in hospital. After a day in the ICU, the patient normally moves to a hospital wound, and the incision heals. Recovery from any surgery varies for each patient. Most patients start feeling better within 4-6 weeks. It is important in the post-operative phase to follow doctor’s instructions and to report any problems (abnormal pain, signs of infection) immediately.

• Arrange for the patient to meet the surgical team, and arrange appropriate follow-up.

Renal transplant

Scenario 16
Problem: Proposing treatment (renal transplant)
Patient name: Elaine Cook (aged 58)

Elaine Cook is a 58 year old lady who has polycystic kidney disease. Four years ago, she commenced continuous ambulatory peritoneal dialysis, but her renal function has remained poor. She now has end-stage renal failure, and requires further support. Haemodialysis has previously failed. You are the renal SHO. Mrs. Cook would like to discuss with you the possibility of a renal transplant, and what practicalities will be involved.

• Introduce yourself to the patient and establish rapport.

• Explain the patient’s understanding of the condition requiring renal transplant. A candidate should be able to explain to the patient that the kidneys are not working and why. They should be able to explain the significance of this and what would happen if left untreated. This should be done in an empathetic manner in terms the patient would be able to understand, avoiding technical terms.

• The candidate should be able to ascertain the current level of functioning and quality of life of the patient in a sensitive way, to determine the appropriateness of dialysis. (See Station 1 for a description of types of dialysis.)
• Discuss the reasons for not coping with other renal replacement therapy, e.g. CAPD.

• Explore the patient’s expectations of CAPD and transplantation. Explain that he has endstage renal failure and requires support. If he is not managing CAPD, renal transplantation is the only alternative, as haemodialysis has previously failed.

• Explain the practicalities of obtaining a transplant: cadaveric vs. live donor, the waiting list is long, the length of wait for transplant depends on finding an acceptable HLA match, explain the complications of transplant: i.e. short-term (surgical risks), medium term (immunosuppression and risk of rejection) and long-term (immunosuppression – secondary malignancy and infection; recurrent renal failure – 5-year graft survival).
• Ensure the patient understands what has been said. Ask if he has any questions. Arrange a follow-up.

Lifestyle adjustments

To illustrate two discussions of lifestyle, scenarios 17 and 18 tackle the issues of smoking cessation and lifestyle adjustments following a MI respectively.

Smoking cessation

Scenario 17

Problem: Smoking cessation
Patient name: Ken Wood (aged 59)

Ken Wood is a 59 year old bar manager who has been smoking 10 cigarettes a day for the last 20 years. His previous medical history is otherwise unremarkable. His wife has mentioned to you that he would like to give up smoking, and he has attended clinic today to discuss this with you. You are the FY2/ST1 for General Medicine.

• Introduce yourself and establish rapport.
• Explore his knowledge of the effects of smoking on health. Ask about current smoking status. Explain that smoking cessation reduces the risk of many diseases, including stroke, coronary artery disease, peripheral vascular disease, COPD, cancers of the lung, mouth, throat, larynx, oesophagus, pancreas, bladder, and peptic ulcer disease (and in women ca of cervix and complications of pregnancy).
• Explain also the risk of smoking to others; that adults are at risk of developing heart and lung disease from passive smoking.
• Emphasise that there are social and cosmetic benefits from stopping smoking.
• Ask whether she has been given any “quitting smoking” leaflets.
• Explain symptoms of nicotine withdrawal (such as tremor and nausea). Inform about the benefits of stopping smoking. Involve family and friends. Nicorette products and ‘zyban’ (buproprion) may help to avoid these withdrawal symptoms, but consider contraindications include hepatic cirrhosis, seizure, CNS tumours, EtOH withdrawal, benzodiazepine withdrawal.
• Advise the patient to aim to stop completely rather than cut down. Ask your patient if he/she really wants to stop smoking and if he/she would be prepared to stop now or within the next few weeks.
• Say that it may be useful to get rid of all ashtrays, lighters and cigarette holders etc.
• Find out whether previous attempts have been made, and what measures helped/hindered.
• Discuss ways of assisting, including setting a date and stopping completely, enlisting the help of family and friends, enlisting the help of health promotion services, and amfebutamone.

• Watch out for relapse. Amfebutamone is a possible medication. Advise the patient that he has access to specialist counsellors and/or psychotherapists. Make appropriate follow-up arrangements.

**Lifestyle adjustments after an uncomplicated acute myocardial infarction**

**Scenario 18**

**Problem: Lifestyle adjustments after an uncomplicated acute MI**

**Patient name: Chris Goddard (aged 48)**

Chris Goddard is a 48 year old computer programmer who has just sustained an uncomplicated anterior myocardial infarct. He was successfully thrombolysed, with complete resolution of his ST changes. You are the FY2/ST1 for Cardiology. He smokes about four cigarettes a day, and drinks around ten pints of beer a week. He is about to be discharged. He has been happily married for 15 years. He is keen to discuss with you the lifestyle adjustments that will be necessary. Please discuss with him, and advise accordingly.

• Introduce yourself and establish rapport.

• Explore his knowledge of the term “heart attack”. Explain in simple language what a heart attack is, i.e. it is caused by a blockage of a blood vessel that supplies blood to the heart, but reassure him he has the correct and best treatment available and that he is on the road back to health. Reassure him that many people do well after a heart attack and that the reason for the tablets is to offer some prevention from a second attack.

• A patient’s specific concerns can be overlooked when giving advice after a myocardial infarction (e.g. a flight to somewhere abroad in a month’s time), because there are usually standard areas that are usually discussed. Patients do not always voice their concerns.

• Explain the need for tablets. Explain that he should change his lifestyle, and tackle exercise, smoking and weight. Activity may be restricted by an overprotective spouse. Returning to work depends on the type of work and completeness of recovery. With less physical jobs, 4-6 weeks off work is advisable. With physical jobs, defer the return to work until after stress testing. Anxiety is common. Most exercise programmes recommend at least three types of aerobic exercise (e.g. brisk walking, jogging, swimming, aerobics classes). Point out that regular exercise has benefits for preventing further heart attacks and encourage him to go for walks.

• Speak that you will speak to the cardiac rehabilitation nurse who will arrange rehabilitation programmes. Offer pamphlets from the rehabilitation team and the British Heart Foundation.

• Say that he should not drive for a month and that he can have sexual intercourse only after increasing his activity level, say to going up briskly two flights of stairs. Explain the need for moderate amounts of alcohol at maximum (e.g. around 21 units/week), as heavy drinking can increase the patient’s weight and ‘weaken’ the heart muscle.

• Ask if he has any questions. Offer appropriate follow up.
C. Informed consent

This section takes further some of the issues discussed in the previous last section, namely, one aspect of medical practice is the approach a doctor takes to obtain consent from a patient regarding investigation and treatment for a given condition. Consent is only valid when the individual is competent (or in legal terms has “capacity”). A patient is not incompetent because they act against their best wishes. For consent to treatment to be valid, the patient must be legally competent to give consent, the patient must have sufficient information to make a choice, consent must be given freely.

A competent patient can refuse any, even life-saving, treatment. For example, in the case of Jehovah’s witnesses, you may ask to explain the benefits of blood transfusion, but you should allow the patient to explain religious beliefs with respect. The use of components such as albumin, immunoglobulins and haemophilia preparations may be allowed on an individual basis. For normal blood transfusions, non-haemolytic febrile transfusion reactions may occur, acute haemolytic transfusion reactions, bacterial and viral contamination, wrong blood group, iron overload, and circulatory overload (see “Better Blood Transfusion”, 1998). Capacity is not a global term but is specific to each decision, i.e. a patient may be competent to make a will but at the same time incompetent to consent to treatment. A clinician does not have to prove beyond all reasonable doubt that a patient has capacity, only that the balance of probability favours capacity. The critical stages in assessing capacity are: comprehension and retention of information needed to make a decision, ability to believe the information, ability to weigh the information, consider the degree and severity of risk to the patient, the risk to benefit ratio of the treatment, the patient’s mental state, and ability make the decision. Patients under 16 years of age can consent to treatment if they are deemed ‘Gillick competent’, i.e. are deemed mature enough to understand the implications of their actions.

A patient has a right therefore to refuse treatment ordinarily, but not where there is an issue of public health. Section 37 of the Public Health Act magistrates orders to allow compulsory treatment of a patient with notifiable disease. This is almost never needed if appropriate negotiation with the patient is undertaken.

Consent and the law

This PACES station is not intended as a test of medicolegal issues, but obviously candidates need to be roughly aware of them. The main issues candidates are expected to know about are expressed consent (consent either oral or in writing), statutory requirements (where law requires particular consent for particular treatment), and implied consent. At present, consent forms are used if a patient is exposed to any invasive procedure. After providing the patient with adequate information about the procedure, as well as risks and benefits, doctors should document what has been said on the consent form. The patient then reads the consent form with the doctor and signs accordingly. The consent form provides a mechanism to ensure that consent is obtained, and also to communicate the fact to other members of the health team. Consent forms are not, themselves, absolute proof that valid consent was obtained to the treatment specified on the form. These tasks may be delegated to a person who is suitably trained and qualified, with appropriate knowledge.
From a legal point of view, lack of consent engages two key aspects:

- **Battery/assault**: non-fatal offences against the person. A procedure or treatment that is performed without consent.
- **Negligence**: Harm caused by a doctor acting outside accepted medical opinion or practice (the Bolam principle). If a patient does not receive certain relevant information when consented for a procedure, a doctor may be found negligent. It is advisable to tell the patient of all potential serious complications and those with an incidence of at least 1%.

**Situations where consent is not possible**

A doctor, by acting in the patient’s best interests, can treat a patient against their will under common law. The “doctrine of necessity”, which underpins the treatment of patients lacking capacity, is made up of the necessity to act and the action being in the best interests of the patient, where a patient is unable to give the necessary consent required for treatment. If relatives are available for discussion, they should be informed rather than opinions canvassed. It is advisable that they remain well informed. The patient has the right to be free from discrimination, have privacy, have confidentiality of personal health information with information disclosed only to the nominated next of kin, liberty (i.e. free from interventions that inhibit liberty), and continue dignity (according to social and cultural views). Legally, when consent is not available and there is no advanced directive, the responsibility for emergency operations rests with the consultant in charge particularly if the team believes this is in the patient’s best interests.

An advance directive is that a person can anticipate losing the mental capacity to decide or communicate how she wishes to be treated by drawing up a formal advance statement of her values and preferences or by naming a person who can be consulted. Whilst advance directives may not always be legally binding or unambiguous, it will be increasingly unwise to ignore these directives, and they can be helpful to clinicians. If there is disagreement, a second opinion can be arranged. Views about the patient’s preferences given by a third party who may have more knowledge of the patient should be taken into account. There are different types of advance directive.

If mental impairment is suspected, a psychiatrist may be consulted to make the diagnosis. Medical staff may be required to make decisions which are deemed to be in the best interests of the patient.

Be aware of the meaning of the following specific terms used in relation to consent:

- **Proxy consent**: a relative cannot consent on behalf of an incompetent patient.
- **Implied consent**: by going to hospital a patient should expect a nurse to take their blood pressure and therefore consent for this procedure should not necessarily be sought.
- **Emergency consent**: where consent cannot be obtained, medical treatment can be provided to anyone who needs it.
- **Advanced directives or living wills**: a patient makes a choice on their future medical care before they become incompetent. A doctor that treats a patient in the face of an advanced directive could be liable in battery.
• Power of attorney: a patient nominates a person (usually a relative) whilst competent to make decisions on their behalf if they were to become incompetent. However, this does not include medical management decisions. With an increasingly elderly population, there is growing need for people to delegate control of financial and legal affairs to others close to them. A power of attorney is a legal document enabling this to be done, allowing, for instance, someone to sign cheques and letters on another's behalf if he or she were going abroad for some time; or if you became seriously ill, or were mentally incapacitated, business and personal interests could be looked after.

• Ward of court: a doctor may apply to a judge to make medical decisions on behalf of the patient. This is advisable if it is not clear what the correct course of management should be and there is opposition from colleagues or relatives against the intended treatment.

Mental Health Act

The Mental Health Act [1983] (but please note Mental Health Act [2007]) can be used to treat psychiatric illness in non-consenting patients. This may be useful in patients who present with deliberate self harm either due to a temporary or permanent illness. Factors suggesting suicidal intent include act in isolation, precautions to avoid discovery, preparation made in anticipation of death, active preparation for the event, leaving a suicide note; consider the events preceding the act, concomitant psychiatric illness, personal and family history, coping resources and the risk of suicide (male,<19,>45, separate, living alone, chronic physical health, problems with alcohol and drugs, psychiatric disorder including depression, schizophrenia and alcoholism). They can be detained/restrained for varying periods, depending on the clause of the Act, and can be given treatment, but only for their mental illness, which is deemed in the best interests for themselves or the public.

Section 5(2): emergency doctor’s holding power
Applied by one physician or an inpatient to enable a psychiatric assessment to be made. 72 hours’ duration. Good practice to convert this to a Section 2.

Section 2: admission for assessment order
Applied by two written medical recommendations (usually a psychiatrist and a GP) and an approved social worker or relative, on a patient in the community. 28 days’ duration. May be converted to a Section 3. The patient has a right of appeal to a tribunal within 14 days of detention.

Section 3: admission for treatment order
Applied as in a Section 2 on a patient already diagnosed with a mental disorder. 3 months’ duration and then reviewed.

Section 4: emergency admission to hospital order
Applied by one doctor (usually a GP) and an approved social worker or relative. Urgent necessity is demonstrable. May be converted to a Section 2 or 3.
Mental Capacity Act [2005]

This is an Act of the UK that came into force in April 2007. It applies to everyone over the age of 16 in England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of individuals who lack the capacity to make particular decisions for themselves. The five principles are outlined in Section 1 of the Act. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

Please note that this Act was amended by the Mental Health Act [2007] in July 2007.

Examples of common ‘consent’ scenarios:

Acquiring consent for autopsy

Scenario 19  
Problem: Acquiring consent for autopsy
Relative name: Winnifred Thomas, wife of the patient Edward Thomas (aged 84)

Edward Thomas, 84, was admitted yesterday with acute confusion. He was tachypnoeic with a respiratory rate of 30/minute, and cyanosed. His urea was 13 mmol/l, but his C-reactive protein was <8 g/l. He was admitted to ITU, where an initial chest x-ray was unremarkable. At 2 am this morning, he died suddenly. He had been thought to have been suffering from a pneumonia, but this cause of death was not certain. You are the ITU SHO. Your objective is to inform his wife of his sudden death, and to acquire consent for an autopsy if appropriate.

The principles of the breaking of bad news are outlined above.

• Ensure that you will not be disturbed. In real life, you will also ensure that you are appropriately dressed (e.g. not in blood-stained theatre clothes).

• Introduce yourself to the patient and establish rapport. Ask her if she would like anyone else present at this point.

• You must break the news about her father’s death early on. You must provide the necessary background for the grave news e.g. the seriousness of the pneumonia, the expectation of her father’s illness. Explain that attempts were made to contact her, but he deteriorated suddenly and resuscitation was attempted. Avoid making assumptions about the direct causes of any incident (e.g. a drink-driver going off a road into the river) if there is a risk of being
judgmental. Mention that the death was swift and painless. Avoid euphemisms for the death. Be prepared for the emotional response, and be prepared to repeat information patiently.

- Tell her how sorry you and all the staff who have looked after him are.
- Check if the relative has come alone or is with others – if possible, know who they are at least in general (the family).
- If the relative would like to go on, explain that the doctors looking after her father would like to know exactly what caused the sudden deterioration. This can be done by performing a post mortem examination. Ask if she knows if the patient himself had any known objection towards a post mortem before his illness.
- The relatives need a general understanding of the procedure. The pathologist first carries out an external examination of the body, before proceeding to an internal examination. Reassure her that the body will not be disfigured.
- Explain that she will be asked to sign a consent form.
- Tell her that she can obtain the results of the post mortem as the results are sent to the consultant looking after her father, and she can arrange an appointment with him to have the findings explained. Explain that the body can be viewed by relatives after the post mortem if necessary.
- Ask if she has any questions. Ask if she would like to contact someone. Ascertain how much emotional support the subject has in dealing with the bereavement.
- If agreed, the medical certificate is issued before the post-mortem so that the funeral arrangements can be made. Express condolence and appreciate that the subject has maintained a major loss.
- Allow the subject to speak and ask questions which should be answered with sensitivity and empathy. Make follow-up arrangements to speak to her or other members of the family again. Offer to put them in touch with the transplant coordinator once the family members have been consulted before reaching a decision. Arrange immediate follow-up: e.g. further meetings with a Doctor, including a GP.

**Discussion**

Organ and tissue retention at hospital post mortem examinations is currently an issue attracting much public attention and is subject to independent enquiries. Post mortems are introduced as a way of discovering the cause of deterioration and are carried out by a histopathologist according to standards set by the Royal College of Pathologists, and may be full or limited in nature; if something suspicious is found, consider objection to retaining of organ part for educational or research purposes which can be kept indefinitely, or disposed of in a legal and proper manner if the relatives change their mind. Autopsies are useful where the cause of death is unclear, where the disease is rare and an autopsy can shed new light on the disease, and where information may shed light on other family members who suffer from the condition. Coroners’ post mortems are required for sudden unexplained death, deaths from an operation, suspicion of unnatural cause of
death (e.g. violence, neglect, drug poisoning). An autopsy should not delay funeral arrangements, and relatives can view the body afterwards. Finally, it is now widely accepted that specific consent is required for organ/tissue retention. This issue is an area of intense debate and legislation is likely to be forthcoming.

The Human Tissue Act [1961] does not mention the requirement for relatives of the deceased to consent to post-mortem examination. A donor card is sufficient legal authority to proceed; however it is good practice to assess the relatives’ wishes and few centres would proceed if the relatives did not assent to organ donation. Contraindications are infections such as HIV, prion disease, metastatic tumours, severe atherosclerosis. Time delays involved prior to the certification of death and the release of the body.

Regarding live organ donations, a donation may be obtained from a non-genetically related person provided no payment is expected. The Human Organ Transplants Act [1989] restricts transplants between persons who are not genetically related. All proposals are referred to Unrelated Live Transplant Regulatory Authority (ULTRA). Living donor kidney transplantation is only considered if the risk to the donor is low, the donor is fully informed, the consent is freely given, the donor can withdraw his consent anytime before the operation, the offer of the organ is voluntary, and the transplant procedure has a good chance of success. To sell an organ is illegal (under s.16(1)). Please note that the UK currently does not operate a system of presumed consent, where consent is assumed unless notification is given otherwise. This is in contrast to some jurisdictions.
Consent for a HIV test

This is a relatively common examination scenario. We will therefore attempt to consider the component parts of this discussion carefully.

Scenario 20
Problem: Acquiring consent for a HIV test
Patient name: Hannah Jones (aged 22)
Hannah Jones is a 22 year old journalist who has a sore throat and a rash. You have a clinical suspicion of HIV seroconversion. She has recently returned from a trip abroad to SE Asia. Discuss this possibility with her, and counsel her regarding an HIV test.

A suggested plan for this consultation is:

• Introduce yourself and try to establish a good rapport. The patient must be aware that confidentiality will be respected.

• Ask how the patient feels and explain that you are now in a position to be able to tell her what the cause of the problem is.

• A good candidate should consider a brief history of the current illness as an introduction to the issue, and explore risk factors for HIV infection so as to go onto sensitively introduce HIV infection as a possible diagnosis. Ask her if she has been prone to infection in the past.

• The risk factors for HIV include current state of health, sexual orientation, sexual behaviour (e.g. numbers of partners, type of intercourse, use of condoms), partners, ethnic background (HIV-2 is common in parts of Africa), history of sexually transmitted disease, sexual behaviour whilst overseas, history of drug abuse (has she shared needles either now or previously), history of blood or blood product transfusion here or overseas, or organ donation. Review HIV risk reduction measures.

• Discover the patient’s knowledge about HIV, how it is transmitted and its prognosis. Avoid being judgemental. Review the natural history of HIV infection.

• Distinguish between anonymous and confidential testing, availability of rapid-home-testing kits, and lab-send away from home kit.

• The candidate should be able to discuss the implications of a positive test including who to tell and implications for employment. Include that you can test for HIV infection, and not for AIDS. The window period between infection and seroconversion is normally no more than three months during which a false negative result may be obtained. The course is usually transmission, primary HIV infection, seroconversion, the asymptomatic period when lymphocyte counts fall and then AIDS.

• State explicitly that the test is for HIV antibodies, and it involves talking a small amount of venous blood, tell the patient when the result will be vailable, and tell the patient that the result will be given verbally, ideally by you. The tests are ELISA and Western Blot. Strict protection of client confidentiality must be maintained for all persons offered and receiving HIV counselling services.
• Explain that HIV is lifelong infection. Without treatment, there is a relatively short life expectancy due to immune suppression. New drugs have revolutionised the treatment with a marked improvement in life expectancy. HAART treatment can now prolong life of sufferers for up to 30 years. New treatments are being researched all the time.

• When applying for a mortgage, the patient may be asked whether she has had an HIV test. If the test is positive, the patient will be strongly encouraged to give consent for his GP and dentist to be notified and the result will then be permanently be in his GP records. The patient may be asked about his HIV status at employment medicals, although they are not legally obliged to divulge information. If positive, the patient’s partner(s) should be informed. Say that you will not divulge details of the HIV test (even if the test was negative) to any insurance company without the patient’s consent.

• You should assess the patient’s ability to cope with the implications of a positive test and prepare them for it. Some implications of a positive test are: it would need to be repeated to confirm its positivity; it would give the patient greater uncertainty albeit of an unpleasant nature; there might be social discrimination and adverse psychological reaction; the patient would be offered continued medical support including anti-retroviral therapy and follow-up including prophylaxis of opportunistic infections including appropriate vaccinations; it should motivate the patient to practise risk minimization (decrease the number of partners, condoms and spermicide, detoxification regarding i/v drugs, use sterile needles, do not share razors or toothbrushes).

• If the test is positive then all insurance policies taken out prior to this will be honoured, although he may find difficulty in taking out future policies; all prior policies will be honoured. There are specialist companies for mortgages (and group-employment schemes and opt-outs).

• If the test is positive, it has to be considered that she may be at risk of other transmitted viruses. For example, Hepatitis B and hepatitis D which requires co-infection with Hepatitis B to replicate successfully.

• Ask who else needs to be told the result. Assess the personal and social support, and advise the patient where to obtain information about other services.

• If negative, the possibility of a false negative has to be considered, it might give the patient reassurance, and the patient will still have to behave responsibly to minimise her risk of HIV. Explain about seroconversion but dispel the false beliefs about immunity.

• Having weighed up the pro’s and con’s, the patient should be encouraged to make a decision, and appropriate follow-up made.

(This question has featured in a number of different guises, including oesophageal candidiasis, and hypoxia and abnormal CXR.)

Discussion: Causes of a false negative ELISA (0.2%) Multiple pregnancies, blood transfusions, liver disease, parenteral substance abuse, haemodialysis, hepatitis B vaccination, rabies, influenza.
Causes of a false negative Western Blot (0.00001%)
Clerical error, contaminated sample, misinterpretation of results.
Jehovah’s witness

Scenario 21

Problem: Jehovah’s witness requiring blood transfusion

Patient name: Kirsty Fox (aged 42)

Kirsty Fox is a 53-year old church volunteer. She presented with a history of tiredness, palpitations, raised blood pressure 180/110 mmHg. CT of the abdomen revealed that she has a large phaeochromocytoma on the right side adjacent to the aorta. She is about to undergo an operative procedure to remove the phaeochromocytoma. She has a past medical history of having three TIA’s within the last year. However, in view of the position of the tumour, there is a high risk that the patient may bleed, making blood transfusion a critical matter.

• Jehovah’s witnesses refuse to take any blood or blood products, they refuse any blood to be reintroduced to their body. They regard this as a sin.

• This patient needs the operation. There is a high risk that the patient will bleed. And if the patient continues to refuse the surgeons may have the right to cancel the procedure if he/she feels the risk is more than the benefit. So you are left with a dilemma if he/she feels the risk is more than the benefit. So you are left with a dilemma that you need to convince the patient of the necessity for the blood.

• It is difficult if you know little about their beliefs. “Tell me a little more about your faith”. Your best option is first to build a rapport and find out how much the patient knows about the condition.

• Their confidentiality is paramount; it is up to them if they take blood and does not inform the church. Explain the options: EPO but the patient is hypertensive. Another possibility is reintroducing one’s own blood (amount-limited and the period to save it in the fridge is also limited). Offer her the option of discussing this with the elders of the Church.

• Bring to her attention the watchtower policy. “When it comes to fractions of any of the primary components, each Christian, after careful and prayerful meditation, must conscientiously decide for himself”. Refer to the Bloodless Surgery Centre (the Watch Tower Society has lists).

• Be aware of patients’ refusal or childrens’ consent – best interests principle/only one parent’s consent required.

D. Ethical issues regarding genetic counselling

Consent is clearly crucial in situations regarding genetic counselling. This type of task poses particular problems.

The principles of genetic counselling whatever the condition
The subject should be encouraged to select a companion for the stages of the testing process: the pretest stage, the taking of the test, the delivery of the results and the post-test stage. The tests performed are:

**Carrier-testing:** Usually for AR/XLR conditions to base reproductive decisions. Give information regarding reliability of test, implications of carrier status. Children are advised to delay this until old enough to make personal decision.

**Predictive testing:** Presymptomatic tests: usually for complete penetrance AD conditions, e.g. HD. If no useful treatment, the value of testing is questionable. This has profound implications regarding insurance, etc.

**Predisposition testing:** Increased risk, not certain of disease (e.g. BRCA for breast cancer, APO for Alzheimer’s disease).

The aim of genetic screening is to identify people who might benefit from the new medications, help genetic researchers understand the disease better and so lead to improved treatment, and help people plan for the future. However, the disadvantages are that a genetic defect cannot be repaired. Neither prevention or cure is possible. The test may not accurately predict who will develop the disease; testing positive does not necessarily mean that a person will definitely develop the disease and testing negative does not guarantee they will not. There could also be an effect of a positive test on buying property, getting insurance and financial planning for the future. Alternatives the applicant can consider are not to take the test for the time being, to deposit DNA for research, and to deposit DNA for possible future use by family and self. Discuss how the diagnosis relates to others, e.g. mother: social aspects, legal aspects. Counsellors and multidisciplinary team (such as a geneticist, neurologist, social worker, psychiatrist, or medical ethicist) are important. Consider socioeconomic consequences on potential employment, social security, data security etc. Reassure the patient that there will be time to decide if he is unsure about proceeding and that at the next appointment you will provide information about addresses of support services. Say that you could refer him to a regional genetic centre if he wishes to go ahead with the testing.

**Discussion**

The subject must choose freely to be tested and must not be coerced by anyone. Extreme care should be exercised when testing would provide information about another person who has not requested the test. This issue arises when an offspring with a 25% risk requests testing with full knowledge that his or her parent does not want to know his or her own status. Ownership of the test result remains with the subject who requested the test.

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**Huntington’s disease and genetic counselling: explaining a test result**

**Scenario 22**  
**Problem:** Explaining a test result (genetic test for Huntington’s disease)  
**Patient name:** Anne Wood (aged 37)

Anne Wood, aged 37, has attended clinic following the recent diagnosis of her mother with Huntington’s disease five years’ ago, which followed a two year history of psychiatric disturbance and choreiform movements. She agreed to have a genetic test for Huntington’s
disease. You are the FY2/ST1 for Neurology. She has returned to clinic to discuss with you the results of the test.

- Introduce yourself to the patient and establish rapport. Ask if she would like someone with her.

- Establish the patient’s beliefs about the disease (Huntington’s disease), her concerns and expectations. She must be aware of the seriousness of the condition and its untreatable nature. If she is not fully aware, the doctor should discuss the nature of the disease at length with her, including its inherited nature. Before moving on, ask if she has any questions about the disease.

- Explore why she has decided to have the test now. Explain that the test is positive.

- At this point wait for the patient’s reaction.

- If the patient is not emotionally well prepared, listen and answer questions. The patient may not wish to talk about siblings or children at this point although she may already be aware of the inherited nature of the disease.

- If the patient is well prepared, ask if she has thought about telling other members of her family, the implications of inheritance and who may or may not be affected.

- Discuss support groups. Ensure that the patient has adequate emotional support at home.

- Summarise the discussion. Ask if she has any questions. Arrange follow-up.

E. Differing patient responses

In real life, we have to acknowledge that people, in response to certain situations, all tend to react differently. This is reflected in the description of the station provided by the Royal Colleges of Physicians in Station 4. Candidates are expected to react to these different patient responses appropriately. In real terms, in the exam, do not allow the actors to wind you up – you need to show that you can keep calm even when stressed. Consider the following examples:

1. If the patient is angry, acknowledge the anger and plight. Listen without interruption. Avoid being defensive. Check how intense the anger is. Keep calm and do not raise voice. Empathize. Advise of complaints procedure. Offer to meet later.

2. If the patient is depressed, ask her to tell you more about “feeling low” and the extent of it (severity, frequency, comparison with how the patient feels normally). Direct questions may be aimed at particular symptoms, for example, sleep, concentration, loss of interest, loss of energy, loss of appetite, loss of weight.

3. If the patient is confused, check their orientation according to time, place and date, and assess their short-term memory by giving them a name and address to remember and check their recall immediately. Assess whether they are having any abnormal experiences (e.g. misinterpretations, hallucinations), and whether there is any evidence for false beliefs such as delusions. Give the patient a clear explanation of their confusional state, and to reassure them that
this is why they are having a confusional state. It is important to explain that every effort will be made to determine the cause of the confusion.

4. If communicating cross-culturally, ask him if there is anything special about his culture (e.g. sense of family) or religion that might be affecting him. Show acceptance of this cultural or religious dimension, and explore the patient’s views. Avoid the danger of stereotyping in cross-cultural communication, by accepting that each person has their own particular view of culture or religion. Express solutions and involve other agencies if possible.

5. If communicating through an interpreter, address both the patient and the interpreter, and communicate simply in “chunks”. Be aware of some problems involved with using interpreters (e.g. incorrect transmission or misunderstanding of information, avoidance of delicate topics, domination of the patient by the interpreter).

6. When talking to someone who is over-talkative, avoid interrupting too much because the more you interrupt the more your patient will tend to have to say; ‘steer’ the patient by selectively reflecting, paraphrasing and summarising aspects of the narrative, avoid resorting to closed questions until you have developed some sort of rapport, and, most of all, remain calm and courteous.

A medical mistake and an angry patient

Scenario 23
Problem: Medical mistake (omission of a gentamicin level)
Patient name: George Ellis (aged 48)
George Ellis is a 46 year old man who was commenced on ciprofloxacin and gentamicin on this admission for an acute exacerbation of bronchiectasis, but who has previously been admitted on multiple occasions with infective exacerbations of bronchiectasis. His previous medical history included multiple respiratory infections as a child. The drug chart indicated that he was supposed to have a gentamicin level on the 3rd dose, but this was accidentally omitted. He has found out about the error. This is the first time such a mistake has happened. He had been told yesterday that his renal function was normal. You are the FY2/ST1 for Respiratory Medicine. He would like to discuss the problem with you.

• Introduce yourself to the patient and establish rapport. Explain involvement in the case.

• Tell the patient that there has been a problem with one of the drugs. Explain the concept of a therapeutic range and the need to monitor levels.

• Explain what happened and how.

• Apologise for the error. Emphasise openness and truthfulness.

• Allow the patient to voice anger. Empathise and give legitimacy to the patient’s feelings. Show your empathy verbally and non-verbally.
• Say that you are disappointed.

• Explain the side-effects of the drug (e.g. problems with deteriorating kidney function), and that therefore appropriate monitoring will be necessary (for example, blood tests).

• Explain the steps that you have taken to determine the cause and to prevent it from happening again. Explain the need for continuing medical care.

• Deal with emotions before facts; put the emotions into words and offer them back to the patient. Seek to understand the emotions. Be clear what the patient is feeling and identify the source of these feelings.

• Encourage the patient to elaborate on the background of his emotions. Avoid disagreement.

• Explain the possibility of further action for him to take in the future, e.g. formal complaint, and identify constructive actions that you and the patient can take.

• State that you will discuss the mistake openly with your consultant, an adverse incident form will be completed, and that the conversation will be documented in the medical notes.

• Ask the patient for any further worries.

The conditions for negligence are that the doctor owes a duty of care, that the doctor was in breach of the appropriate standard of care imposed by the law, and that the breach in the duty of care caused harm in question.

**Bolam v Friern Hospital Management Committee** [1957] is the English case that lays down the typical rule for assessing the appropriate standard of reasonable care in negligence cases involving doctors. The Bolam test provides that where the defendant has represented him or herself as having more than average skills and abilities, this test expects standards which must be consistent with a reasonable body of medical opinion (**De Frietas v O’Brien** [1995] which suggests that this can be as low as 11 in 1,000 doctors). It is intuitive, and the common law position, that this standard of care must not be palpably wrong (**Bolitho v City and Hackney Health Authority** [1997]), although the law does allow for different, nut valid, possible management decisions.

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**F. Confidentiality and Good Clinical Practice**

Under common law, doctors are obliged to maintain confidentiality, and MRCP(UK) candidates are expected to respect that confidentiality forms the core of any doctor/patient relationship. In terms of ethical principles, confidentiality therefore supports the principle of respect for patient autonomy, a principle that emphasises the patient’s right to have control over his own life. The fundamental concept of medical confidentiality is that patients have a right to expect that information about them will be held in confidence by their doctors. Without assurances about confidentiality, patients may be reluctant to give doctors the information that they need to provide good care. The doctor must also respect requests by patients that information should not be
disclosed to third parties, except in specific circumstances, where the health or safety of others
would otherwise be at serious risk. The issue of when it is lawful, and when it is not lawful, for a
doctor to breach confidentiality is often a question of balancing public interests, and of balancing
private and public interests. The General Medical Council provides professional guidelines on the
issue of confidentiality for practising doctors. Whilst these do not have the force of the law, they
are taken seriously by the courts.

Obligations for doctors to breach medical confidentiality

The GMC(UK) states that patients have a right to expect that doctors will not disclose any
personal information which they learn during the course of their professional duties unless they
give permission. Indeed, several acts of Parliament allow access of patients to material kept about
them (the Data Protection Act, the Freedom to Health Records Act (1990) and the Freedom of
Information Act (2005)). When a doctor is responsible for confidential information, it is the duty
of the doctor to ensure that the information is effectively protected against improper disclosure
when it is received, transmitted, stored or disposed. When patients give consent to disclosure of
information about themselves, you must ensure that they understand what is being disclosed, the
reasons for disclosure, and the likely consequences. You must also ensure that patients are
informed whenever information about them is likely to be disclosed to others involved in their
healthcare (sharing information with other members of the health-care team is not generally
viewed by the law as breaching confidentiality), and that they have the opportunity to withhold
permission. Confidential information must be disclosed in the following situations. If confidential
information is disclosed, the doctor should release only as much information as is necessary for
that purpose.

• When legally required by a court order
• In a communicable disease notification, and the reporting of births, deaths, abortions and
work-related accidents (Public Health Control of Diseases Act 1984; Abortion Act 1967; Births
and Deaths Registration Act 1953). This is a statutory duty.
• Identification of patient undergoing in vitro fertility treatment with donated gametes (The
Human Fertilisation and Embryology Act, 1990)
• Identification of donors and recipients for transplanted organs – Human Organ
Transplants Act 1989
• Drug addiction (Misuse of Drugs Act, 1973)
• In cases of national security, such as terrorism or major crime prevention or solution
(Prevention of Terrorism Act, 1989).
• Police on request – name and address (but not clinical details) of driver of vehicle who is
alleged to be guilty of an offence under the Road Traffic Act 1988

Confidential information may be disclosed at a doctor’s discretion:

• when a 3rd party is risk of harm, for example at risk of contracting a serious infectious
disease,
• when it is in the public interest, e.g. patient with seizures known to be driving illegally,
• through sharing information with the health care team
• other than for treatment only with express consent (e.g. lawyers, Insurance companies).
In terms of public interest, the doctor is advised to disclose information promptly to an appropriate person or authority. Examples of this include a situation where a medical colleague who is also a patient is placing the patient at risk as a result of illness or another medical condition.

No information that might identify a patient examined or treated for any sexually transmitted disease should be provided to a third party, except for in a few specific situations where that third party may be in a situation of contracting a life-threatening disease, such as HIV infection. Furthermore, doctors should not write reports or disclose any confidential information which may be requested by insurance companies or employers without the patients’ prior written consent.

Even after a patient has died, the obligation to keep the information confidential remains. If an insurance company seeks information about a deceased patient to decide whether or not to make a payment under a life insurance policy, information should not be released without the prior consent of the patient’s executor, or a close relative, without being fully informed of the consequences of disclosure.

Possible consequences of breach of confidentiality are loss of trust, disciplinary action by the GMC, civil legal action, and investigation of serious professional misconduct by the General Medical Council.

**Disclosure of information and public versus private information**

**A road traffic offence**

In road traffic offences, the doctor must breach confidentiality and provide the police constable with the name and address of the patient (*Road Traffic Act* [1988]). The doctor must explain that he cannot without the patient’s consent divulge any other information which can be used to prevent minor crime, or help conviction in minor crime. Most crimes against properties are considered to be minor crimes now. Details should not include clinical details. You are duty bound by a duty of confidentiality not to give any clinical information without the consent of the patient. Most crimes against properties are considered to be minor crimes now. Similarly, the doctor cannot breach confidentiality to prevent minor harm to another individual.

**Fitness to drive**

The DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when holders of a driving licence have a condition which may now in the future affect their safety as a driver. The following situations illustrate the steps taken in discussing this with patients. The ethical areas in the fitness to drive scenarios are respecting confidentiality, recognising the need to inform others when a patient refuses to take responsibility, recognising that failing to act may put others at risk, and recognising that a doctor’s duty may involve doing something to which the patient has not consented.

**Epilepsy**

*Scenario 24*

*Problem: Epilepsy and DVLA*
Patient name: Terri Warner (aged 21)

Terri Warner is a 21 year old night club dancer who was admitted yesterday with a second tonic-clonic seizure. She had a similar seizure a month previously. Both seizures occurred whilst at work, in the presence of strobe lighting. She had been working the “night shift”, and had felt relatively tired on both occasions. She has undergone a MRI which is normal, and an EEG demonstrated abnormal activity in relation to light stimuli. Her only medication is the oral contraceptive pill. She normally drives to work. Please discuss with her the results of her investigations. She is keen to carry on driving, especially “off road” driving, a competitive sport which is not governed by the DVLA.

- Introduce yourself, explain your role clearly, and agree the purpose of the interview.
- Explain epilepsy in a way that a layperson would understand. “A seizure is a sudden, unpredictable attack of electrical activity of the brain resulting in shaking of part of the body (or all four limbs). It may cause you to lose consciousness. Epilepsy is a term we use when somebody is having seizures”.
- Establish the patient’s level of knowledge of precipitating factors, including alcohol and recreational drugs, lifestyle and late nights. Inform her that alcohol will lower the fit threshold, and the medication given to avoid further fits may not work properly.
- Avoid swimming, bathing alone, cooking alone with gas cookers, heights. Ask about understanding of medication: important issues are compliance and pill-failure, and continue anti-epileptic medication with folate cover during pregnancy.
- Ask about her occupation. Remember that with every epilepsy scenario, it is very important that you ask what the person’s occupation is since their medical condition may prevent them from safely carrying out their job.
- Ask about driving and state how this would affect the person’s life and job. Make sure that the patient understands that the condition may impair his ability to drive.
- Provide information about the law in relation to epilepsy. A patient can drive (on and off drugs) when they have been free of fits for 12 months, provided that they do not have continued high likelihood of seizures (e.g. a known brain tumour). If he/she has purely nocturnal (sleep) seizures he can drive, provided this pattern has been established for 3 years. Advise the patient about his responsibilities to himself and other drivers.
- The onus is on her to report the condition to the DVLA. The patient must be aware that you have the right to inform the DVLA if you think that the patient is going to continue to drive despite careful consideration of the position. Mention lack of insurance cover if they drive and safety issues. Remain calm in the face of mild aggressive and emotional behaviour by the patient.
- If the patient refuses to accept the diagnosis or the effect of the condition on driving, you can suggest that the driver seeks a second opinion. You should advise that the patient should not drive until the second opinion has been obtained.
- Notice that she is a young woman of childbearing age. You need to tell her that certain anti-epileptics can make the oral contraceptive pill less effective and that a doubling or even tripling of the dose of oestrogen may be required. It is important to also inform her that pregnancy can ina percentage of women result in fetal teratogenic side effects. Explain that the risk is around 7% compared to 3% for the “normal” population and that there are ways of minimizing the risk, e.g. taking folic acid, using one instead of two anti-epileptics and possibly using the newer agents.
- Inform about the British Epilepsy Society. Agree a plan by the end of the interview. Advise her about the need to inform her partner. Arrange for appropriate follow-up.
The framework for the interview is likely to include: respect of the patient’s autonomy (i.e. the capacity of the patient to make deliberated or reasoned decisions for himself and to act on the basis of these decisions), disclosure of confidential information (i.e. it is in the best interest of the public if this information is handed to the relevant authorities).
Table 10. Summary table of the DVLA and common medical disorders. For further information, please see consult [www.dvla.org.uk](http://www.dvla.org.uk) for current guidelines.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Private vehicle license</th>
<th>HGV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy</td>
<td>1 year fit free</td>
<td>Fit free, off medication</td>
</tr>
<tr>
<td>MI</td>
<td>1 month</td>
<td>3 months. Symptom-free. Completes 9 minutes of Bruce-treadmill test</td>
</tr>
<tr>
<td>Stroke</td>
<td>1 month</td>
<td>Banned</td>
</tr>
<tr>
<td>IDDM</td>
<td>Notify DVLA</td>
<td>Banned</td>
</tr>
</tbody>
</table>

Public health

A patient may refuse treatment ordinarily, but Section 37 of the Public Health Act 1984 magistrates orders to allow compulsory treatment of a patient with notifiable disease. This is almost never needed if appropriate negotiation with the patient is undertaken, which is a good thing as it is very difficult to work.

Compulsory treatment of TB

The *Public Health Act (Control of disease)* [1984] states that, in exceptional circumstances where a person with TB of the respiratory tract poses serious risk of infection to others, a CDC and Respiratory Physician can enforce compulsory admission of the patient.

Needlestick injury

If you or another health care worker has suffered a needlestick injury or other occupational exposure to blood or body fluids and you consider it necessary to test the patient for a serious communicable disease, the patient's consent should be obtained before the test is undertaken. If the patient is unconscious when the injury occurs consent should be sought once the patient has regained full consciousness. If appropriate, the injured person can take prophylactic treatment until consent has been obtained and the test result is known. If the patient refuses testing, is unable to give or withhold consent because of mental illness or disability, or does not regain full consciousness within 48 hours, you should reconsider the severity of risk to yourself, or another injured health care worker, or to others. You should not arrange testing against the patient's wishes or without consent other than in exceptional circumstances, for example where you have good reason to think that the patient may have a condition such as HIV for which prophylactic treatment is available. In such cases you may test an existing blood sample, taken for other purposes, but you should consult an experienced colleague first. It is possible that a decision to test an existing blood without consent could be challenged in the courts, or be the subject of a complaint to your employer or the GMC. You must therefore be prepared to justify your decision. If you decide to test without consent, you must inform the patient of your decision at the earliest opportunity. In such cases confidentiality is paramount: only the patient and those who have been exposed to infection may be told about the test and its result. In these exceptional circumstances neither the fact that test has been undertaken, nor its result, should be entered in the patient's personal medical record without the patient's consent. If the patient dies you may test for a serious communicable disease if you have good reason to think that the patient may have been infected, and a health care worker has been exposed to the patient's blood or other body fluid. You should usually seek the agreement of a relative before testing. If the test shows the patient was a carrier
of the virus, you should follow the guidance in paragraphs 21 - 23 of this booklet on giving information to patients' close contacts.

G. End of life decisions

This chapter concludes with the area in medical ethics that raises probably the most strong and diverse views: those concerned with end-of-life decisions. Indeed, topics such as euthanasia, do not resuscitate orders, and even advance directives (living wills) concern many outside the medical profession.

Who makes end of life decisions?

Doctors, patients and families may face the question of how actively life-sustaining treatments should be pursued. In making these decisions, there should be respect for the patient autonomy, knowledge about the limitation of the treatment and promotion of the patient’s best interests. Patients are deemed to act autonomously if they act with intent, with understanding and without controlling influences. Patients of this calibre may refuse life-prolonging treatment. If the patient knew all the relevant facts, there is reason to limit life-prolonging treatment. If the desires are regarding treatment, then it needs to be clear whether the decision was formed with an adequate understanding of alternatives and their consequences, and that these decisions were made when the patient was competent, and formed without coercion. If this is the case, there is no reason to limit life-prolonging treatment. In some situations, the opposite scenario may arise when a patient requests life-prolonging treatment which may prove harmful or futile. If the patient has made this decision, having been fully advised, there is no reason to satisfy the request.

Doctrine of double effect

The principle of double effect permits an act which is foreseen to have both good and bad effects. This doctrine distinguishes actions that are intended to harm versus those where harm is foreseen but not intended. Frequently, doctors set out to relieve pain and suffering but see that life may be shortened. Foreseeing is not necessarily the same as intending. This is in keeping with duties of a doctor. Consider, for example, patients dying from cancer. These patients are often given heightened dosages of opiates to relieve pain by their medical care teams who will have foreseen that these actions may shorten the patient’s life by their effects on respiratory depression. Although it would be morally wrong to inject morphine into the patient’s blood stream with the intent of hastening death, it may not be necessarily wrong to inject it if the foreseeable consequences of it were to hasten death if the doctor’s intention was to relieve pain.

Euthanasia and assisted suicide

Euthanasia is intentional killing, i.e. murder under English law, and therefore illegal. Assisted suicide, i.e. helping someone take their own life, is a criminal offence.

Arguments for: respecting a patient’s autonomy over their body, beneficence (i.e. mercy killing may prevent suffering), suicide is legal but unavailable to the disabled.

Arguments against: good palliative care obviates the need for euthanasia, risk of manipulation / coercion/ exploitation of the vulnerable, undesirable practices when constraints on killing are loosened.

Physician-assisted suicide is where the physician provides the patient with the means to commit suicide.
Euthanasia and assisted-suicide are illegal.

*Best interests*

Options for treatment or investigations are contemplated by the Medical Team which are clinically indicated are in line with the patient’s expressed preferences, and the patient’s background (cultural, religious or employment), or the patient’s preferences given by a 3rd partner.

*Advance directives*

Advance directives are not covered by legislation. In cases of conflict with other legal provisions, advance statements are superseded by existing stature. A person can anticipate losing the mental capacity to decide or communicate how much he or she wishes to be treated by drawing up a formal advance statement of her values and preferences or by naming a person who can be consulted. These are statements usually written and formally witnessed made by a person when they are fully competent about the medical care he/she does or does not want to receive should they become incompetent in the future. It will be increasingly unwise to ignore these directives, and they can be helpful to clinicians. Advanced consent is not legally binding, e.g. to be kept alive as reasonably possible using whatever forms of treatment are available. Advanced refusal is legally binding if adult and competent when made, the decision was informed, circumstances have arisen which were envisaged, and the patient was not unduly influenced.

*Withholding medical treatment*

The primary goal of medicine is to benefit the patient’s health with minimal harm, and this should be explained to those close to them so that they can understand why treatment is given, and why a decision to withhold or withdraw life-prolonging treatment may be considered. Balance should be in favour of treatment if there is doubt. On the other hand, treatment may prolong suffering and there is no absolute ethical or legal right to a treatment that may prolong suffering. When a patient lacks capacity to make decisions and there is uncertainty about the appropriateness of treatment, treatment that may be of some benefit should be started until clearer assessment can be made. This is particularly important in emergencies, when more time is needed for detailed assessment. Although it may be emotionally easier to withhold treatment, rather than to withdraw that which has already been started, there are no legal or necessarily moral distinctions between the two. The BMA considers that where a particular treatment is no longer benefitting the patient, continuing to provide it would not be in the patient’s best interests and maybe morally wrong. Greater emphasis on the reasons for providing treatment including artificial nutrition and hydration, rather than the justification for withholding treatment, may challenge this perceived difference. (British Medical Association, Withholding and withdrawing life-prolonging medical treatment: guidance for decision-making. 1999).

Whilst the nature of the withdrawal of medical treatment will depend on the particular context, we hope that the possible structure to this difficult area below is a useful guide:

- Introduce yourself and establish rapport.
• In withholding treatment, you may start by suggesting you wish to share some thoughts on the next step if the outlook is poor.

• Explain that the team feels that continuing active treatment will not achieve the desired result and introduce the concept of withdrawing active treatment. This does not mean the same as withdrawal of all treatment. Explain that, rather, the emphasis will change from treatment with the aim of cure or prolongation of life to that of the relief of symptoms and for the promotion of the patient’s comfort and dignity. The quality of care will remain the same.

• In explaining this situation, it can be helpful to go back over the past history and place the severity in historical context. Ask if any members of the family have had views on this, or whether the patient had views on this when well.

• Explain that the patient is not in pain and well sedated. Explain that if the family allows the withdrawal of treatment, he may deteriorate quickly and die soon after.

• Point out politely that the final decision of withdrawal of treatment does not reside with the family but the ITU staff. Explain how the withdrawal will be undertaken.

• Explain that a decision is not needed right away, and ask about any queries.

The case of *Burke v GMC* [2005] suggests that artificial nutrition and hydration (ANH) cannot be withdrawn without a court order, in other words ANH rights may reside with the patient. ANH should not be withdrawn where there is doubt/disagreement about the patient’s capacity, where a lack of consensus amongst doctors regarding prognosis or best interests, where the patient when competent may have wanted ANH to continue, where the patient resists/disputes the withdrawal of ANH, and where close others feel that ANH withdrawal is not in the patient’s best interests.
Do-not-attempt resuscitate (DNAR) order

English law does not require doctors to prescribe futile treatments, even if requested so by the patient. Therefore a DNR order is an example of limiting treatment that is futile. Cardiopulmonary arrest is the most crucial of all medical emergencies. Local Trusts have their own regional guidelines usually authored by a Resuscitation Committee and ratified by the Executive Board.

The BMA, RCN and UK Resuscitation Council (1999) state that a DNAR order is appropriate:

a) where CPR is unlikely to be successful
b) CPR is not in accord with the recorded sustained wishes of the patient if mentally competent
c) CPR is not in accord with a valid advanced directive
d) CPR is likely to be followed by the length and quality of life not in the best interest of the patient. Expected benefits are outweighed by the burdens – e.g. life-burdened by severe uncontrollable pain, permanent lack of awareness, or total dependency.

Possible definitions of futility include: the likelihood of the patient regaining consciousness following resuscitation is less than 1%, the likelihood of the patient being in hospital following resuscitation is less than 10%, or the patient will live only for a few weeks because of another untreatable terminal illness. The resuscitation decision is made by appropriate health professionals and not by the patient’s relative, but her cooperation is valued; address all concerns of the relative. This decision should be made after appropriate consultation and consideration of all aspects of the patient’s conditioning. Emphasise the need for self esteem, dignity and comfort. Ask if other members of the family need to be involved, and consider their spiritual beliefs.

Doctors should make a decision as to whether to inform the patient of the decision. It may be inhumane and distressing to raise issues of this nature with terminally ill patients. However, ideally the patient should be fully informed of any discussions about care and decisions regarding resuscitation. The order should be conveyed to all members of the multidisciplinary team, and reviewed in light of changes in the patient’s condition. A DNAR order can sometimes be made without consulting a patient if there is no likelihood that resuscitation would be successful (futility), or if the patient is not able to make such a decision (unconscious or not competent to do so), or if the patient’s quality of life is extremely poor.

DNAR

Scenario 25

Problem: Do-not-attempt-resuscitate order (DNAR)

Patient name: Tony Graham (aged 62)

Tony Graham, aged 62, was admitted with a stroke. Following management of this stroke, a palliative stent was inserted for his underlying disease, carcinoma of the head of the pancreas, but it is known that he has a very poor prognosis given that he now has metastases in the liver. He was discussed in your multidisciplinary team meeting this morning, and the Consultant signed a form to state that, in the event of a cardiopulmonary arrest, a resuscitation attempt should not be made. He has never discussed this issue with your team. You are the FY2/ST1 for General Medicine. Your Consultant would like you to discuss this resuscitation status with him.

Setting: A quiet office to ensure a lack of interruptions.
Pacing: allow yourself enough time.

Opening: Introduce yourself and establish good rapport. Call yourself Doctor. Ask how to address the patient.

Give a warning shot. “I have something important to discuss with you”.

• Establish the patient’s understanding of the underlying condition and reason for admission. Emphasise that he on maximum medical therapy which will continue, including “strong” antibiotics for the chest infection and medications to relieve any distressing or suffering.

• Ask an open question about how his symptoms have been recently. Good listening skills prepare for the most difficult part of the interview.

• What does he think will happen on the future?

• Explain there will be a decline in his function, i.e. a grave prognosis, and the reasons for this. “Somebody with a condition as bad as yours may suddenly take a turn for the worst.”

• Respond to emotions. “I see that you are distressed by the situation. I find it very hard to confront you with painful facts like this”.

• “If we were to restart your heart, we might prolong a situation which you find intolerable. We would hate to do the wrong thing for you. If your heart were to stop beating, would you want us to restart it for you?”

• If he feels strongly that he would like every medical attempt made to prolong his life, this should be respected.

• Ask what he/she feels about this. Promise support from doctors and nurses. Agree treatments to relieve symptoms.

• If he does not wish to be resuscitated, you could say something like, “I can see how distressing it is for you to face up to how ill you are. I can see that it’s a hard decision for you, but you said that life is so bad that you wouldn’t want your heart to be restarted. Have I understood you correctly?”

• If he does not wish to be resuscitated, you could explain to him that death is not a failure, and that the decision has been taken to let nature to take its course.

• Explain that the patient should be left comfortable with the aim of preserving dignity and self-esteem.

• Explain that a side-room will be organised for privacy. Ask if there are any other members of the family who need to be involved.

• Finally, address any other concerns of the patient.

• Say when you will meet again.
In most circumstances, a patient should be involved in a DNAR decision. It should be borne in mind that for every patient there comes a time when death is inevitable and cardiac or respiratory function will fail. It is essential therefore to determine for each patient whether CPR is appropriate. A DNAR order should only be given after full consultation with the patient and the medical team. Where a patient is seriously ill, decisions about CPR should be ideally made in advance. The current guidelines are that if the patient is not competent to take part in the decision, consider discussing the issue with family to help make the judgement. If the length and quality of life after resuscitation is likely to be worthwhile, do not consider a DNAR order; else DNAR. The DNAR order should be reviewed and documented at a frequency appropriate to the patient’s condition. The most senior available member of the medical team is normally responsible for entering the DNAR decision, and the reasons for it.

Medicolegal aspects of care of the elderly
Although the law applies to everyone, there are certain aspects which become particularly associated with the needs of elderly persons.

Testamentary capacity
The law requires that a person making a will has a 'sound disposing mind'. Doctors are often asked to assess a patient prior to making a Will. It is important that accurate records are taken and kept of the assessment in order that your decisions can be justified by contemporaneous note keeping.

In addition to establishing and documenting the absence of cognitive impairment it is necessary to specifically assess the following:

Does the patient understand the nature of the act of making a Will and its effects?
Does the patient know the nature and extent of his/her property?
Does the patient know which persons have a claim upon his/her property?
Can he/she form a judgement on the strength of the claims made by these people on his/her property?
Has the patient expressed him/herself clearly and without ambiguity (this need not necessarily be in writing as nods and gestures can be allowed)?

Section 47
Section 47 National Assistance Act [1948] gave the Medical Officer of Health the power to apply to a Magistrate for the compulsory removal of persons who:-

- are suffering from grave chronic disease or being aged, infirm or physically incapacitated, are living in insanitary conditions AND
- are unable to devote to themselves and are not receiving from other persons proper care and attention.

The Section 47 Act is not commonly used with only around 250 cases admitted per annum in the whole of the UK. It is good practice that Geriatricians be involved and it is probably better that patients compulsory detained are initially admitted to hospital where they can be given the full benefit of a medical assessment.

Power of Attorney
This is a legal document which gives total control of a persons financial affairs to someone else. It must be made by a mentally competent person but ceases to be valid once the patient loses the
mental capacity to withdraw it. This is only really of any use for physically incapacitated patients who wish their attorney to deal with their affairs.

**Enduring Power of Attorney**
This is a document taken out by a person when they have mental capacity, which will continue if it is subsequently lost. This is the preferred method for elderly persons to safeguard their financial affairs and property. It does not relate to decisions regarding medical treatment.

Once it is decided that mental capacity is lost the Enduring Power of Attorney must be registered with the Court of Protection. This usually requires that the document is accompanied by a doctor's opinion that the patient has now lost the mental capacity to make decisions. The patient concerned is notified and if they disagree and feel that they have not yet lost their mental capacity they may challenge the decision so providing some safeguard. It is wise that two attorneys are established, one person being a family member (usually a grown-up child) and the other to be the representative from a legal firm.

**Court of Protection**
This is an Office of the Supreme Court of Judicature under the direction of a master, deputy master and assistant masters. The Court's primary function is to safeguard the financial interests of a patient by providing for his/her maintenance and that of his/her family dependants and management of his/her property, and the Public Trustee is a specific person to whom these powers are delegated. It can take months to grant receivership which is usually granted to either a firm of solicitors or to a relative, but the Court itself has to oversee all the expenditure which it must also approve. This is really the only mechanism of controlling the financial affairs of a mentally incompetent patient if no Enduring Power of Attorney has been produced. This is extremely expensive and is not to be recommended if it can be avoided.

The family solicitor will usually arrange for the patient to be examined by a doctor who will determine whether or not the patient is capable or incapable of managing and administering his/her property and affairs by virtue of mental disorder. The patient is usually served with notice of proposed proceedings so they may protest if they feel they have not yet lost their powers. The doctor may choose to recommend that the service of notice is dispensed with if either the patient is incapable of understanding it or that service would be injurious to health or for any other reason.

The Court of Protection is usually receptive to providing things which will improve the quality of life of a patient. For example, they may well fund a holiday for both themselves and their carer and may be in a position to approve purchase of a vehicle, if funds permit, in order to allow for trips out etc.

**Conclusions**

We hope that the scenarios above help to illustrate some of the key principles underlying the communication skills and ethics which are being tested. The key mistake to avoid is to think you must have a script ready for every discussion before you attend the examination. All consultations are different, and relying on a pre-prepared formula may be dangerous if you are seen to not respond to the patient’s needs. Practice with somebody this station in advance of the examination, and consider whether the principles you apply for the examination are being appropriately applied.
in real life. It is intended that people who pass this station in the examination are performing well in their day-to-day careers.

**USEFUL REFERENCES**
Practice questions

1. Mr. Giles, a 55-year-old man, is due to be reviewed in clinic as a follow-up patient. He has been diagnosed as having type II respiratory failure, in the presence of chronic obstructive pulmonary disease. Pulmonary function tests have shown:

FEV1 is 0.95 pre β-agonist (predicted value 3.5 l)
FEV1 is 1.29 post β-agonist

He has gross ankle oedema. At present, he is on salbutamol and atrovent mdi inhalers. Please discuss future potential management strategies and Mr. Giles’ understanding of his disease process with him.

2. Mr. Johnson is a 46-year-old man who has undergone investigations for a six-month history of pain and stiffness in his joints, predominantly affecting the small joints of his hands, wrists and ankles. The blood tests have revealed the following:

Normal FBC, normal biochemical profile other than mildly elevated liver function tests and significantly elevated ESR and CRP.
The rheumatoid factor is positive at 1 in 320.
X-ray of the hands have revealed early erosions.

He does enjoy regular pints of beer with his friends at his local pub. He has returned for his follow-up appointment. Please inform him of the diagnosis and the potential of management strategies. You would ideally like to start him on methotrexate.

3. Miss Salt is a 19-year-old lady who was diagnosed as an insulin-dependent diabetic six years’ ago. She is due to be discharged following a five-day in-patient stay after her third recent episode of diabetic ketoacidosis. You are seeing her prior to her discharge. Please advise her regarding her diabetic control.

4. The son/daughter of a 74-year-old woman with severe rheumatoid arthritis has demanded to “see a doctor now” and you have complied with this request. The patient was admitted four weeks ago with a UTI but has become weaker and less mobile. She has bed-sores and today swabs have revealed MRSA.

5. Please respond to the referral letter below.

Re: Jane Francis
(aged 32)
Dear Doctor,
I would be very grateful if you could see Mrs. Francis urgently. She has attended with a itchy skin rash on her elbows, and I wonder whether she could be started on suitable treatment for this. She lives with her two children aged 6 and 4, who have also developed some itchy lesions. She has been trying to maintain a diet compatible with her diagnosis of coeliac disease. She seems anxious.
Yours sincerely,
6. You are a registrar. This patient has been diagnosed with acute renal failure, the creatinine is climbing despite appropriate treatment, and he/she is likely to need to commence haemodialysis tomorrow. He/she has a past history of nephrectomy for renal cell cancer treated at another hospital; you know few details about this, but the patient looks well and has been leading a relatively normal life until he/she became acutely ill three days prior to admission. However, his wife reports that he has also had diabetes for 10 years, treated with oral hypoglycaemic agents. The patient is in a high-care ward on a cardiac monitor with central line. You have come to explain about the need for dialysis.

7. You have just been phoned by the Nuclear Medicine department to say that a V/Q scan on a 35-year old woman gives a high probability of pulmonary embolism. Your task is to explain the prognosis, and the need for treatment with warfarin. You should give the patient appropriate information to take this drug safely.

8. Mr. Peters has had open tuberculosis. He has a young family who have all received a course of chemoprophylaxis. He, to date, has fully-sensitive mycobacteria on sputum culture. He admits to being non-compliant with therapy. This is the second time that he has had to recommence treatment. Discuss the importance of completion of treatment with Mr. Peters and how this can be achieved.

9. John Harvey is a 65 year old lorry driver who was discharged last week following a myocardial infarction. He has been found to be in atrial fibrillation (a new finding since his MI), but does not appear symptomatic with him. Please advise him about his concerns.

10. A 35-year old cyclist is referred to you, with recurrent syncope of unknown cause. He loses consciousness without warning for 30 s. He is advised not to cycle in public roads, but refuses to agree to this as he cycles as a city courier-delivery service for his job. Counsel him regarding his cycling. What legal restraints are available to prevent him from cycling?

11. You are the medical FY2/ST1 on call. You are asked to come urgently to the A&E department where Mrs. Brown has presented with 24 hours of haemoptysis and a two-month history of cough, purulent sputum and weight loss. Urgent staining of the sputum has revealed plentiful Mycobacteria (Ziehl-Nielsen staining). The A&E FY2/ST1 says that previous notes of the patient had been found and that a diagnosis of rifampicin and isoniazid resistant tuberculosis and been made 18 months previously. The patient had taken treatment for three months in an isolation unit in hospital before going home. She had been lost to follow-up and discontinued treatment after discharge. The patient is not keen to be admitted as she did not enjoy isolation and would prefer to be at home, looking after her disabled husband. Your task is to discuss with the patient:

- The need for further investigation (including contributory underlying factors)
- The need for treatment
- The need for admission
- What can be done for the household contacts?
12. Mr. Brown is a 61-year-old man who was fit and healthy until one year ago now has end-stage cardiac failure. He is not a candidate for heart transplantation because due to his age and degree of renal failure. He was admitted routinely by yourself to optimise his cardiac failure therapy but his condition has deteriorated over the weekend as your team forgot to decrease the dose of his diuretics. His renal failure worsened. The ITU team have reviewed him and refused an HDU or ITU bed due to his terminal condition. The family has requested a meeting with you, and the senior nurse looking after the patient feels a decision on resuscitation should be raised.

13. A 59-year-old man, Mr. Patel, has severe congestive cardiac failure. He has idiopathic dilated cardiomyopathy. The strict upper age group for heart transplantation is 60 years. He recently turned 62, and has developed insulin-dependent diabetes mellitus. He has been on the waiting list for three years. His cardiac function has deteriorated. He is keen to discuss the possibility of heart transplantation.

14. The son/daughter of a patient with a slowly progressive primary brain tumour has asked to discuss discharge plans. The patient has been in hospital for three weeks, can only transfer with the help of two people, and is intermittently confused. 24-hour nursing assessment suggests that discharge home would only be possible with an acre package comprising two carers three times a day. Carers are in short supply and this is not feasible. Nursing-home placement is the only option.

15. A normally fit 74 year old has suffered a dense right-sided stroke and is unconscious. You have arranged to see a spouse to discuss decision-making about intravenous hydration and whether or not to institute enteral nutrition.

16. An endoscopy is carried out on Mr. Hopkins, a 37-year-old gentleman who has presented with weight loss and epigastric discomfort. Endoscopy has revealed severe oesophageal candidiasis. The risk of immunosuppression had not been considered when he was initially reviewed. You are to review Mr. Hopkins during his follow-up clinical appointment. Please inform him of the findings of the gastroscopy and discuss the further potential management plans with the patient.

17. You are the FY2/ST1 in the Genitourinary clinic. Mr. Jones is a Consultant Surgeon in your local hospital. His wife is diagnosed as HIV positive. She does not wish her husband to be told. She is, however, concerned about the risks of his job to other people. She wants to know if Mr. Jones should be asked not to operate on patients this afternoon. Please counsel her.

18. A 30 year old man has presented with CMV colitis. He has returned to clinic for the results of a HIV test that is positive. He is married and his wife is expecting her first child. Explain the news to the man, discuss telling his wife, discuss the possible risks to the child, and introduce the idea of a multidisciplinary team approach.

19. This in-patient who is in his/her 40s presented with a short history of jaundice. ERCP has diagnosed a carcinoma of the head of the pancreas. You have come to him/her to explain the diagnosis and possible treatment options.
20. Mr. Evans is a 42-year-old man who has admitted following an episode of haematemesis and melaena. He was treated with variceal sclerosis during endoscopy and required four units of blood transfusion during acute admission. He is now no longer encephalopathic and has been haemodynamically stable for the past 48 hours. This gentleman’s liver disease has been diagnosed to be purely related to his heavy alcohol consumption. Please advise him as you feel appropriate.

21. You have just gastroscoped this patient with symptomatic acid reflux and found a hiatus hernia with oesophagitis. You now have got to see the patient to explain the results of the gastroscopy and outline the treatment options – medication, surgery.

22. Mr. Jones is a 25-year-old pharmaceutical representative. He has been referred to you by his general practitioner. Mr. Jones was involved in a road-traffic accident whilst on holiday in Spain. He suffered head injuries from which he made a full recovery. However, 6 hours’ post trauma, and on the way to the local hospital, he had a grand mal seizure. This was treated by the paramedics with lorazepam. He was discharged from the hospital on carbamazepine. He has not returned back to work yet, though it has been 3 months since the incident. He feels cognitively impaired and low in mood. He has asked to see you because he has been told he cannot drive for 3 years, and is unsure how he can regain his life back.

23. Complaints about your house officer have been made by the nursing staff. Sometimes rude, short-tempered, he/she is causing moderate friction on the ward. You need to try and sort things out.

24. You are the medical FY2/ST1 on-call and asked by the A&E staff to attend a patient who has presented with a hypoglycaemic attack. He has had some intravenous dextrose, and is now awake and orientated. This is the first hypoglycaemic episode which required hospital treatment. Your task is to convince Mr. Watkins of the need to revoke his driving licence and persuade him to inform the DVLA.

25. You are seeing the daughter of a 87-year-old lady who is ill following an extensive CVA. You wish to discuss her management, particularly nutrition, but the family seem unkeen on any further treatment. The patient has written a will with an advance directive asking to be resuscitated if required.

26. You are the SHO on the ward. You have been asked to see the son of a patient of yours, Mr. Irvine. He lives a long distance from his father and sees him only 2-3 times per year. Mr. Irvine is an elderly man with metastatic carcinoma of the lung. He is admitted with an acute episode of breathlessness and a large pleural effusion which has confirmed malignant cytology. He is very cachectic and very frail. He lives alone since his wife died 4 years ago. He claims that he has had enough and feels too unwell to undergo any further treatment. You feel that he is competent to make this decision. Your task is to discuss Mr. Irvine’s prognosis and decide with his son:

- The idea of further investigation
- Any proposed treatment
- The likely prognosis and resuscitation status
You are the medical FY2/ST1 doing a ward round. You have been told by the Nurses that the wife of one of your patients would like to speak to you before you review her husband. He has severe Chronic Obstructive Pulmonary Disease and has been admitted with an infective exacerbation. He is on home nebulisers, home oxygen and is housebound due to a combination of his lung disease and depression. On the ward, he is receiving intravenous antibiotics and an aminophylline infusion as well as his regular nebulisers and oxygen. Mrs. Smith does not want her husband to be resuscitated in the event of a cardiac arrest. Mrs. Smith is depressed, tired and fed up with her husband’s illness. She feels that whilst she would like to continue to care for him, she also cannot watch him suffer any more. She would like to discuss his resuscitation status with you, but does not want him to know, as it would upset him. She feels that he should not be resuscitated but would like this decision to be made without her husband. Your task is to explain that whilst resuscitation is likely to be futile, Mr. Smith must be involved in all decisions regarding his care and that will include discussions about his resuscitation.