Health Education Thames Valley

INFORMATION GIVING CLINIC APPOINTMENT

MODULE: GENERAL SURGERY

TARGET: CT1 – ST4

BACKGROUND:

Surgical trainees work in a variety of different environments – Ward, Theatre, Accident and Emergency and the Outpatients clinic. This simulation addresses some of the skills required for a successful outpatients consultantion. This is an information giving scenario – NOT breaking bad news. Whilst some technical clinical information will be given, the focus of the encounter is on how the trainee 'controls' the consultation. The clinic appointment is a maximum of 10 minutes with a maximum of 10 minutes for feedback

RELEVANT AREAS OF THE CURRICULUM

Module 4: The assessment and management of the surgical patient

To demonstrate the relevant knowledge in assessing and managing patients including follow-up planning

Professional behaviour and leadership skills

To be a good communicator

INFORMATION FOR FACULTY

The patient is attending clinic today for a histology result after a colonoscopy 6 weeks ago at which biopsies were taken and a polyp was removed. This is a follow-up appointment. The first appointment was 3 months ago (early August), the initial GP referral was for change in bowel habit towards diarrhoea – both more frequent motions and more runny (no blood or mucus). The Registrar saw the patient last time, did a rigid sigmoidoscopy in clinic and sent him for a colonoscopy. For the colonoscopy test the patient had full bowel prep. The colonoscopy was done under sedation in the endoscopy department. The patient cannot really remember what was said at the time.

LEARNING OBJECTIVES

- Learners will reflect upon how to conduct an effective clinic consultation including time keeping and maintaining control of the consultation process.
- Learners will practice using a Dictaphone to dictate a GP letter

SCENE SETTING

Location: Outpatient clinic room

Expected duration of scenario: 15mins

Expected duration of debriefing: 15 mins

EQUIPMENT AND CONSUMABLES

Patient notes with colonoscopy report and histology report
Table and chairs
Clinical notes paper plus pen
Dictaphone

PERSONNEL-IN-SCENARIO

Colorectal nurse specialist
Patient (actor) The Harry Partnership £250

PARTICIPANT BRIEFING

You are in Mr. Huang's s outpatients clinic, he has had to leave early and has left you a follow-up patient to see.

This is an information giving scenario, you do not need to examine the patient. The clinic slot is a maximum of 10 minutes, you may be much quicker than this. You have a full set of patient notes and a clinic nurse. Please see the patient, write in the notes and dictate a clinic letter.

FACULTY BRIEFING

The trainee will start in the clinic room with the notes. They will have access to the internet should they wish to look up technical information (this will not be suggested to them it is up to them to use their initiative). The patient (actor) will be waiting outside.

After the trainee has opened the notes and read the last clinic letter the nurse will ask the trainee if they are ready for the patient to be brought through (the trainee may wish to delay in order to look up guidelines on internet – this is fine).

SIMULATED PATIENT / ACTOR

You are Mr. Brian Fleming a 67-year old computer programmer. Date of birth 02/11/46. You are otherwise pretty fit and well – only blood pressure that your GP is keeping an eye on, not currently on medication. (You can be married, children etc. if you like this is not important to the scenario so feel free to ad lib).

There is no family history of bowel cancer.

You do not remember much about the colonoscopy test, the bowel prep before hand was pretty dramatic. You know that some biopsies were taken during the procedure you do not know what of and are keen to hear any results.
Your specific questions are (in whatever order comes naturally in the consultation):

- What is the polyp? Might it grow back?
  - You are not particularly anxious, but if the trainee mentions the word cancer please pick up on this and ask them directly whether the polyp was cancerous and whether it could turn into cancer.
- What were the other biopsies of and why were they taken?
- What is the cause of your looser and more frequent motions?

Listen carefully to their answers, pause to let it sink in but be satisfied with what they say – not too much further interrogation.

Please be prepared to give face-to-face feedback to the trainee about their communication style, body language and any terminology that you found difficult to understand.

IN-SCENARIO PERSONNEL BRIEFING – COLORECTAL NURSE

You will call the patient through and then listen to the consultation.

Your role (as faculty) is to observe the trainee and to think about specific feedback on their communication, think about terminology that they use and perhaps suggest other ways of explaining what dysplasia is, give them feedback on their communication style as well as pinpointing any inconsistent clinical information that they may have given. Think also about how they 'control' the consultation.

If the trainee does not mention follow-up please ask nonchalantly at the end of the consultation 'when would you like to see him again'.

At the end of the consultation the trainee will dictate a clinic letter to the GP on a Dictaphone and will write in the notes.

ADDITIONAL INFORMATION

1. Original GP Referral Letter

Greenfields Surgery,
Westencourt Vale,
Aylesbury

3rd September 2013

Dear Colorectal Surgeon

Re: Brian Fleming 02/11/46
4, Kyle Close, Aylesbury, Buckinghamshire. HP 14 7DF

I'd be grateful if you would assess this pleasant gentleman in your outpatients clinic. He has been having diarrhoea since the summer - initially thought it was a stomach bug but has not settled. He has no blood in the motions.

There is no significant familial history of bowel disease.

Please assess and advise.

Many thanks

Dr. Geoffrey Motson MRCGP

2. Previous Colorectal Clinic Letter

Buckinghamshire Healthcare NHS
NHS Trust

Mr. Huang MB BS FRCS (Gen)
Consultant Colorectal Surgeon
Wycombe General Hospital,
Alexandra Road,
High Wycombe.
Secretary Ext 4235
Monday 29th September 2013

Dear Dr. Motson,

Re: Brian Fleming 02/11/46

4, Kyle Close, Aylesbury, Buckinghamshire. HP 14 7DF

Thank you for referring this patient to Mr. Huang's outpatient clinic with a 3 month history of looser motions. He has not noticed any blood or mucus and there is no family hsitory of inflammatory bowel disease or colorectal cancer.

Mr. Fleming describes a change in his bowel habits from opening once a day to now opening up to four times in 24 hours. He has not significantly changed his diet over this time period.

On examination his abdomen was soft and non tender. Digital rectal examination revealed an empty rectum with no masses palpable. Rigid sigmoidoscopy to 12cm visualised normal looking rectal mucosa.

I have arranged for him to have a colonoscopy test in the endoscopy department and will keep you informed of any results.

Many thanks for the referral

Yours sincerely,

Miss Alexandra Cope MB BS MRCS M.Ed
Specialist Registrar to Mr. Huang

3. Colonoscopy Report

Buckinghamshire Healthcare NHS
NHS Trust

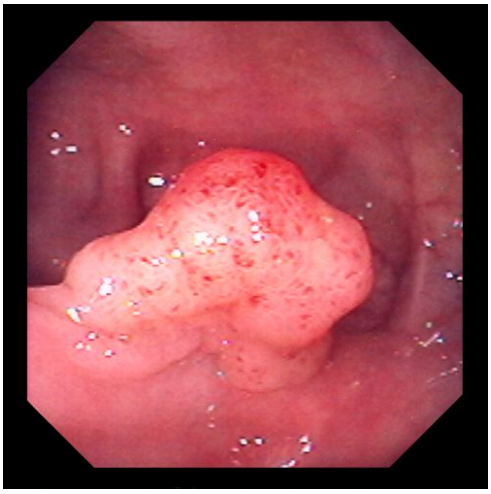
ENDOSCOPY REPORT 05/11/13
COLONOSCOPY
GP - Dr. Geoffrey Motson,
Greenfields Surgery, Westencourt Vale, Aylesbury.

Patient: Brian Fleming **Date of birth: 02/11/46** **SM4562258M**

Findings:

Timing	Examination (elective routine)
Indication	Change in bowel habit
Scores	ASA 1
Medication	3mg midazolam 50mcg pethidine
Bowel preparation	With KleenPrep
Level reached	Caecum – confirmed by ileocaecal valve
Caecum	Normal
Ascending colon	Normal
Transverse	Normal
Descending colon	Wide based polyp– completely excised
Sigmoid colon	Normal
Rectum	Normal
Action post procedure	Random biopsies taken form colon as well as descednign colon polyp excised - See in clinic

Mr. A. Huang Colorectal Surgeon
Descending colon



Descending colon

HISTOPATHOLOGY REPORT

Specimens received 06/11/13
Clinical information: Change in bowel habit

2 pots received.
Pot 1 labeled random colonic biopsies
Pot 2 labeled polyp
MACRO:
Pot 1 contains 6 fragments of tan coloured tissue
Pot 2 contains wide based polyp 6 x 8mm
MICRO: Pot 1- Specimens show features consistent with normal colonic mucosa. No evidence of crypt formation or sub-mucosal inflammation.
Pot 2: Features are consistent with a tubulovillous adenoma, evidence of dysplastic field change at base of polyp.

Authorised by Dr. John Van Guard MRCPath
12/11/13

4. Photo of Simulated Clinic Appointment

DEBRIEFING

Debriefing to be led by external surgeon observer

Use patient (actor) to give feedback on communication skills

Colorectal nurse specialist may also be involved in giving feedback

POINTS FOR FURTHER DISCUSSION

- Reliability of information on the internet
- Risk can be stratified according to findings at baseline and refined at each subsequent surveillance examination. **(Recommendation Grade B)**

  Low risk
  Patients with only 1–2, small (<1 cm) adenomas.
  Recommendation: no follow up or five yearly until one negative examination.

  Intermediate risk
  Patients with 3–4 small adenomas or at least one >1 cm
  Recommendation: three yearly until two consecutive negative examinations.

  High risk
  If either of the following are detected at any single examination (at baseline or follow up): ≥5 adenomas or ≥3 adenomas at least one of which is ≥1 cm.

- **Recommendation**
  An extra examination should be undertaken at 12 months before returning to three yearly surveillance

- **Stopping surveillance due to comorbidity or age**
  The cut off age for stopping surveillance is usually 75 years, but should also depend upon patient wishes and comorbidity.**(Recommendation Grade C)**

- **Incomplete examinations**
  Patients with failed colonoscopies, for whatever reason, should undergo repeat colonoscopy or an alternative complete colon examination. These guidelines are based on accurate detection of adenomas; otherwise risk status will be underestimated.

DEBRIEFING RESOURCES

The Association of Coloproctology of Great Britain and Ireland
http://www.acpgbi.org.uk

SURGERY > IMMERSIVE SCENARIO 5 > CLINIC

INFORMATION FOR PARTICIPANTS

- Read the patient notes before you call the patient in
- Use the resources available to you – internet, colorectal nurse specialist etc.
- Structure the clinic appointment so that there is initial rapport making.
- Do not assume that the patient already knows the result.
- Offer opportunity for the patient to ask questions

PARTICIPANT REFLECTION

What have you learned from this experience? (Please try and list 3 things)

How will your practice now change?

What other actions will you now take to meet any identified learning needs?

PARTICIPANT FEEDBACK

Date of training session:.....

Learner Grade:.....

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I found this scenario useful					
I understand more about the scenario subject					
I have more confidence to deal with this scenario					
The material covered was relevant to me					

How could this scenario be improved for future participants? This is especially important if you have ticked anything in the disagree/strongly disagree box.

FACULTY DEBRIEF – TO BE COMPLETED BY FACULTY TEAM

What went particularly well during this scenario?

What did not go well, or as well as planned?

Why didn't it go well?

How could the scenario be improved for future participants?