Clinical Skills I (5720) Communications

STUDENT MANUAL

SEPTEMBER 2017 – FEBRUARY 2018

Undergraduate Medical Education
Memorial University of Newfoundland

Clinical Skills I - 5720
Phase I and II
2017-2018

Introduction:

This course introduces the basic skills of interviewing, the identification and analysis of issues and dilemmas within the doctor/patient relationship and also provides the opportunity to become familiar with the fundamental use of medical instruments.

The following goals will be pursued within a small group of students working with one medical doctor who will assist the group in defining its learning tasks. A Community Facilitator will be assigned to each group and resource people from the Community will be invited to present particular concerns.

Overall Course Goals

- 7031 Across all stages of healthy development and aging apply the basic skills of communication and history taking for physical examinations (Program Competencies: me-1)
- 7032 Across all age groups in healthy individuals educate a patient about healthy living and primary prevention (Program Competencies: cm-3)
- 7033 Across all age groups in healthy individuals demonstrate a patient-centered approach to interviewing (Program Competencies: cm-1 cm-2)
- 7034 Identify the roles of the various professional groups on the healthcare team (Program Competencies: co-1 co-3)
- 7035 Demonstrate the attributes of an effective small group learning environment (Program Competencies: co-3 co-4)
- 7036 Explain the importance of the interdisciplinary/team approach to patient care and its importance in patient safety (Program Competencies: ma-3)
- 7037 Discuss the evidence for effective communication skills (Program Competencies: sc-2)
- 7038 Explain the principles of doctor-patient relationships without compromising patient care and well-being (Program Competencies: pr-1)

Overall Program Competencies

me-1 Medical Expert
Take a complete and accurate patient-centered history appropriate to the patient's Presentation

cm-3 Communicator
Accurately convey relevant information and explanations to patient and families

cm-1 Communicator
Appropriately develop and maintain ethical relationships, rapport and trust with patients and families

cm-2 Communicator
Accurately elicit information and perspectives from patients and families, colleagues and other professionals

co-1 Collaborator
Collaborate effectively within the health care system

co-3 Collaborator
Participate effectively on health care teams

co-4 Collaborator
Manage conflict effectively

ma-3 Manager
Participate appropriately in the health care system

sc-2 Scholar
Apply principles of research and information management to learning and practice

pr-1 Professional
Demonstrate an understanding of the following as a medical professional:
Accountability
to self, to patients and their families, to society, to the medical profession, to other health professionals and the health care system, Integrity, and Altruism

Tutor “No Show” Policy
Phase I - III Clinical Skills

In the event that a group has come to Clinical Skills for instruction by a tutor and the tutor in question does not show up, the Clinical Experience Coordinator will page the tutor within 10 minutes. The SP Educators may take on this role in the absence of the Clinical Experience Coordinator.
Unless told otherwise, students will be expected to wait a minimum of 30 minutes for a tutor’s arrival before leaving the Clinical Skill session. Students are encouraged to do independent work and are allowed to practice their skills with the SP provided during that time. However, without a tutor, this will not be considered a session and their session will still be rescheduled.

In the event that the students are off site, (i.e. St. Clare’s, on a patient floor of HSC, etc.) and the tutor has not shown up within 10 minutes, the students need to page the tutor. If they have been not given other instruction, and the tutor does not show up, they are allowed to leave after 30 minutes.
It is the responsibility of the student to contact the Clinical Experience Coordinator via email to reschedule the missed session.

SP educators will forward via email to the Clinical Experience Coordinator the list of any tutor(s) that were not able to attend a scheduled Clinical Skills session. At the end of each month, the Clinical Skills Coordinator will send a list of “no show” tutors to the Undergraduate Associate Dean.

Dress Code for Clinical Skills

As is appropriate to a professional role, a white lab coat and student photo identification card must be worn when in contact with patients. It is required that when seeing patients, the students be well-groomed (with hair tied back) and not wearing t-shirts, jeans, tennis shoes, beach style clothing, crop tops, halter tops, stiletto heels or open-toed shoes. Clothing must be clean, proper fitting, comfortable, nonrestrictive and non-revealing. Please note that this applies to sessions involving inpatients, outpatients and Standardized Patients.

White lab coats are not required for the following Clinical Skills sessions:

- Pediatrics
- Psychiatry
- Orthopaedic Clinical Skills at the Janeway (this site only)
- Breast Screening Centre visit

Shorts & tank top (T-Shirt) are to be worn at the MSK Patient Partner session in September/October of Med II.

Neonatology - No white coats or clothing beyond the elbow, no jewelry (rings, watches, etc.), no stethoscope.

Facilitators in Terms I & II will advise re: wearing of lab coats during patient visits (usually not required).

Health Care Corporation's Scent Free Guidelines

The Health Care Corporation advises all to use fragrant free personal care products. Scented products contain chemicals which can cause severe problems for many people, especially those with asthma, allergies, and chemical sensitivities.

It is recommended that:

1. Perfume, aftershave or scented products not be worn when coming to any facility.
2. Clothing that has been dry cleaned should be aired 2 or 3 days before being worn.

NOTE:

We also ask all students to refrain from eating/drinking while in clinical encounters with either patients or standardized patients. This is required because of health, hygienic and professional reasons.
(Revised November 30, 2010)

Kalamazoo Essential Elements Communication Checklist (adapted for Memorial Medical School)

Student's Name:

Facilitator's Name:

Date of Session:

How well does the learner do the following:

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	1 Poor	2 Fair	3 Good	4 V. Good	5 Excellent
A. Builds a Relationship (includes the following):	☐	☐	☐	☐	☐

- Greets and shows interest in patient as a person
- Uses words that show care and concern throughout the interview
- Uses tone, pace, eye contact, and posture that show care and concern
- Responds explicitly to patient's statements about ideas and feelings

Comments:

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	1 Poor	2 Fair	3 Good	4 V. Good	5 Excellent
B. Opens the Discussion (includes the following):	☐	☐	☐	☐	☐

- Allows patient to complete opening statement without interruption
- Asks "Is there anything else?" to elicit full set of concerns
- Explains and/or negotiates an agenda for the visit

Comments:

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	1 Poor	2 Fair	3 Good	4 V. Good	5 Excellent
C. Gathers Information (includes the following):	☐	☐	☐	☐	☐

- Begins with patient's story using open-ended questions (e.g."tell me about…")
- Clarifies details as necessary with more specific or "yes/no" questions
- Summarizes and gives patient opportunity to correct or add information
- Transitions effectively to additional questions

Comments:

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	1 Poor	2 Fair	3 Good	4 V. Good	5 Excellent
D. Understands the Patient's Perspective (includes the following):	☐	☐	☐	☐	☐

- Asks about life events, circumstances, other people that might affect health
- Elicits patient's beliefs, concerns, and expectations about illness and treatment

Comments:

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	1 Poor	2 Fair	3 Good	4 V. Good	5 Excellent
E. Shares Information (includes the following):	☐	☐	☐	☐	☐

- Assesses patient's understanding of problem and desire for more information

- Explains using words that patient can understand
- Asks if patient has any questions

Comments:

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	1 Poor	2 Fair	3 Good	4 V. Good	5 Excellent
F. Reaches Agreement (if new/changed plan) (includes the following):	☐	☐	☐	☐	☐

- Includes patient in choices and decisions to the extent s/he desires
- Checks for mutual understanding of diagnostic and/or treatment plans
- Asks about patients ability to follow diagnostic and/or treatment plans
- Identifies additional resources as appropriate

Comments:

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	1 Poor	2 Fair	3 Good	4 V. Good	5 Excellent
G. Provides Closure (includes the following):	☐	☐	☐	☐	☐

- Asks if patient has questions, concerns or other issues
- Summarizes
- Clarifies follow-up or contact arrangements
- Acknowledges patient and closes interview

Comments:

Adapted from Essential Elements: The Communication Checklist, ©Bayer-Fetzer Group on Physician-Patient Communication in Medical Education, May 2001, and from: The Bayer-Fetzer Group on Physician-Patient Communication in Medical Education. Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement. *Academic Medicine* 2001; 76:390-393.

NOTES ON HISTORY AND PHYSICAL:

Prior to the interview, garner as much information as you can about the patient, especially in regards to full name, sex, age and occupation. This is where a previous CCP (the cumulative patient profile) is helpful.

As soon as you make contact with the patient, monitor the patient's demeanor- unless the patient is obviously disturbed or depressed looking, you should present an "upbeat", positive, confident approach. In a friendly manner, introduce yourself and make the patient feel welcome.

Unless there is an urgent, overwhelming complaint, the first few minutes should be taken "to break the ice" with the patient. During this time you should be determining the level of communication at which to converse with the patient (based on the patient's educational and/or intellectual level). By this time, you are seated comfortably, making good eye contact with the patient and although relaxed you should be totally focused on the patient and the presenting complaint. You are now ready to develop your patient-centered interview!

The "write-up" of the history should generally follow the format described but should not be the basis for history taking. This should be based on a patient-centered interview and not on an "interrogation" (which the interview would become if one were to strictly follow the "write-up" format as a question template).

The Review of Systems or Functional Enquiry consists of details of all <u>significant</u> positive or negative findings of each body system (see appendix). For this course, it is not expected that you explore all of these systems but this will be a skill that you will be developing in future clinical skills training.

Likewise, the Physical Examination write-up is not expanded at this time but will elaborate as you progress in clinical skills.

HISTORY:

CC – (Chief Complaint) This is a succinct statement, usually in the patient's own words and in one line or less; keep it short- you are going to expand on this throughout your report.

HPI – (History of Present Illness) this has a "loaded" opening statement: "This (age) (Marital Status) (race) (sex) (occupation) from (where) complains of (illness) of (duration). He/she was last relatively well etc.

Eg. This 23 year old single white male office worker from Fogo complains of a headache of one week's duration. He was last relatively well about ten days ago when he fell off . . .

This will be a concisely written short paragraph outlining the patient's problem in his/her own words. The main idea is to have a fully informative, chronological, readable account of the patient's complaint(s) written in essay-like fashion. This is not a place for your opinions or conclusions.

PMH- (Past Medical History) This is a listed concise history of all past significant illnesses and should be in chronological order with the most recent illness at the top of the list. Chronic illnesses should be placed in the order when they were first diagnosed. (Alternatively, PMH could be subdivided into "Medical" and "Surgical" categories). It is less confusing if you write the date followed by the illness and then, if necessary, a further brief description.

Eg. 1994 Diabetes Mellitus (insulin dependent)
1992 Appendectomy (at HSC- no complications)

Meds- This should list (to the best of your knowledge) all medications taken by the patient including non-prescription drugs: If you are uncertain, leave a question mark by the drug reported taken.

Eg. Glyburide 5 mg po bid
? Pill for high blood pressure

Allergies-This should be a separate category and should be in two parts: allergies to medications and allergies to other allergens (eg. Peanut butter, cat's fur, etc.); you might also consider, in addition, listing life-threatening allergies in large letters at the top of the chart in large prominent letters. It is also important to briefly describe how the initial allergy came about.

FH- (Family History) – This includes two aspects: a listing of family members relevant to the presenting complaint and the medical problems of family members, more importantly those of "blood" relations. A genogram would be ideal because of its conciseness and easy readability. Names and ages are sometimes useful to note.

PP- (Patient Profile) – This is also called the Social History; list a short sketch of the patient's life including details of occupation, hobbies, recreational interests, marital status, sexual orientation if relevant, religious affiliation if relevant. Traditionally, this is where smoking and drinking history are noted: make sure that you quantitate both of the above.

Eg. Smoker x 20 years- 1 ppd
Social Drinker- about 4 beer/wk.; no noted alcohol dependence

ROS- (Review of Systems) - also called Functional Enquiry
List all the <u>significant</u> positives and negatives of each body system
Do not clutter up your report with irrelevant material
See appendix

REVIEW OF SYSTEMS:

GENERAL: fatigue, weakness, appetite change, sleep disturbance, fever, chills, night sweats.
SKIN: itching, pallor, pigment, rash, nails, hair change, bruising
EYES: vision, glasses, diplopia, tearing, itching, redness, pain, photophobia, protrusion
EARS: deafness, tinnitus, vertigo, pain, discharge
NOSE: epistaxis, postnasal drip, discharge, obstruction
MOUTH/TEETH: sore tongue, sore throat, bleeding gums, dental condition, dentures, hoarseness, neck pain
RESPIRATORY: cough, sputum, hemoptysis, wheezing, dyspnea, pleurisy, chest pain, cyanosis
CARDIOVASCULAR: dyspnea, orthopnea, palpitations, chest pain, claudication, edema, blood pressure, varicose veins, murmurs
GASTROINTESTINAL: anorexia, nausea, vomiting, dysphagia, indigestion, gas pain, bleeding, hernia, stool (frequency, colour, volume)
URINARY: frequency (day/night), volume, dysuria, urgency, hesitancy, stones, renal colic
GENITAL (MALE/FEMALE): discharge, sores, pain, potency, libido
Menses: cycle, duration, amount, # of pads, menarche, menopause, pregnancies, dysmenorrhea, discharge, spotting, itching, post-partum hemorrhage, last menstrual period, last Pap smear (date) and result
BREASTS: lumps, pain, discharge
ENDOCRINE/METABOLIC: goitre, heat/cold intolerance, voice change, tetany, appetite, thirst, polyuria, hormone treatments
ALLERGIC: sensitivity to vaccines, eczema, asthma, hives, hay fever
HEMATOLOGIC: anemia, enlarged nodes, bleeding tendency, pain, recurrent infection, herpes
NEUROMUSCULAR: trauma, swelling, pain, arthritis, headache, convulsion, syncope, stroke, weakness, numbness, clumsiness, gait, tinnitus, tremor, dizziness, muscle wasting
PSYCHIATRIC: general behavior & appearance, speech, thought disorder, mood, suicidal thoughts, sleep, diurnality, delusions, hallucinations, memory, orientation

PHYSCIAL EXAM:

This should start off with a succinct description of the patient usually no longer than one sentence.

Eg. The patient was pale looking, appeared stated age and was in no distress.

Vitals: BP: _____ Pulse: _____ RR: _____ Temp: _____

(The remainder of the physical exam is listed and will be developed in further clinical skills training)

HEENT: (Head, Eyes, Ears, Nose & Throat)

CVS:

LUNGS:

ABDOMEN:

LYMPH:

DERM:

GU:

MSK:

CNS:

Last of all, remember that your write-up of the history and physical should be legible. Your colleagues will not appreciate the frustrating task of trying to decipher an otherwise well written report!

G.M. Tarrant MD.