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VTS Residential
Colwall Park Hotel
7/ 8th February 2007

Aims

- Re form the group and have lots of fun
- Plan the term
- Deepen our knowledge of and develop our communication skills in particular with more challenging situations

Objectives

- By the end of the residential the group will have a clear vision for the term
- Each group will have an outline structure for their individual session
- Each person will have experienced skills to use in a challenging situation

Day 1

09.00 Coffee / Tea and Registration
09.30 Welcome and sign posting
09.45 Ice Breaker Game – theme of communication
10.15 Communication issues with people in whom Alcohol causes a problem
10.45 Coffee / Tea
11.15 Communication issues with people in whom Alcohol causes a problem
13.00 Lunch
14.00 Walk
16.00 Tea
16.15 Challenging Situations: Communication issues with people in whom use of recreational drugs is a problem – Jon Shorrocks and Debbie Fowler
18.00 Belly Dancing
20.00 Dinner

Day 2

09.00 Wake up game
09.15 Stereo types
10.30 Written communication exercise
11.15 Coffee
11.45 Communicating with the Deaf
13.00 Lunch
14.00 Planning the Term
15.30 Tea
15.45 Telephone Skills Donald Worthy MDU
16.30 Evaluation and close

The New Curriculum Learning Outcomes for the Consultation

The following learning objectives relate specifically to the general practice consultation. In order to demonstrate the core competencies required for effective consultations, the general practitioner will require the ability to conduct patient-centred consultations.

The General Practitioner must, therefore:

Demonstrate understanding of the context in which the consultation happens:

With **patients** this means:

- Recognising that patients are diverse: that their behaviour and attitudes vary, for example, by age, gender, ethnicity, social background and as individuals
- Responding flexibly to the needs and expectations of different individuals
- Understanding the process by which patients decide to consult, and how this can affect consulting outcomes
- Recognising the general practitioner's roles and responsibilities towards the patient
- Negotiating a shared understanding of the problem and its management with the patient, so that they are empowered to look after their own health
- Demonstrating commitment to health promotion, while recognising the potential tension between this role and the patient's own agenda
- Managing the potential conflicts between personal health needs, evidence-based practice and public health responsibilities

With the patient's relatives, friends and supporters this means:

- Recognising that episodes of illness may affect more than merely the patient
- Understanding the patient's right to confidentiality
- Negotiating whether and how relatives and others might be involved

With other professional colleagues this means:

- Working successfully as a member of the Primary Care Team
- Working successfully with colleagues in secondary care and elsewhere
- Working successfully with a range of other professionals such as Social Services
- In all cases, recognising that "working successfully" involves:
 - understanding the role of professional colleagues, and where their expertise lies
 - drawing on this expertise as appropriate
 - treating colleagues with consideration and respect
 - understanding inter-professional boundaries with regard to clinical responsibility and confidentiality

Demonstrate understanding of the structure of the consultation:

- Demonstrating familiarity with the common models of the consultation that have been proposed, and how these models can be used to reflect on previous consultations in order to shape future consulting behaviour
- Demonstrating in the consultation:
 - o an awareness that consultations have a clinical, a psychological and a social component, with the relevance of each component varying from consultation to consultation (this is the triaxial model of the consultation proposed by the RCGP)

- o an ability to deploy successfully the characteristics represented by the MRCGP assessment criteria
- o an ability to use techniques to limit consultation length when appropriate
- Recognising that achieving a successful overall structure involves appropriate use of communication skills, and therefore:
 - o demonstrate in the consultation an appropriate use of the skills typically associated with good doctor–patient communication (see for example Silverman *et al*⁶ and Maguire and Pitceathly⁸)
 - o demonstrate in the consultation an ability to adapt communication skills to meet patient needs
- Demonstrating the ability to formulate appropriate diagnoses, rule out serious illness and manage clinical uncertainty
- Demonstrating effective use of patient records (electronic or paper) during the consultation to facilitate high-quality patient care
- Demonstrating effective use of time and resources during the consultation
- Recognising how consultations conducted via remote media (telephone and email) differ from face-to-face consultations, and demonstrating skills that can compensate for these differences

Demonstrate awareness that good consultation requires good professional attitudes:

- demonstrating familiarity with basic concepts in medical ethics such as confidentiality, consent, resource allocation and truth telling, by:
 - o demonstrating an ability to reflect on how particular clinical decisions have been informed by these concepts
 - o understanding the need to share information with patients in an honest and unbiased manner, in order to educate patients about their health (doctor as teacher)
 - o demonstrating ethically sound practice in consultation performance
- demonstrating an understanding of the importance of good professional behaviour, and how it is manifest in successful consultations, for instance by:
 - o demonstrating respect for patients, colleagues and others
 - o demonstrating good team-working skills – encouraging and assisting colleagues
 - o keeping accurate, legible and contemporaneous records
 - o making timely and appropriate referrals, using relevant information
 - o good time-keeping
- demonstrating an understanding of the importance of reflective practice for good consultation technique by:
 - o recognising the limits of one’s own abilities and expertise
 - o undertaking self-appraisal through such things as reflective logs and video recordings of consultations, and seeking out opportunities for educational development based on this
 - o recognising, monitoring and managing personal emotions arising from the consultation
 - o recognising how personal emotions, lifestyle and ill-health can affect consultation performance and the doctor patient relationship (This is important not just to achieve good single consultations but to achieve good continuity of psychological care)

Balint groups

The Balint group is a highly developed and tested method of small group consultation analysis which aims specifically to focus on the emotional content, not just of single consultations but of ongoing doctor-patient relationships.

Many doctors who have had the experience of Balint training attest to the life long benefits that it can bring in terms of interest in patients' lives, self knowledge, job satisfaction and prevention of 'burn out'. A growing body of research evidence supports the effectiveness of Balint training in many countries^{16,17,18,19}

The aims of a Balint group (as recognised by the Society) are:

- To provide a safe environment where group members are able to talk in confidence about the feelings aroused in them by their patients.
- To encourage the doctors to see their patients as human beings with a life and relationships outside the surgery and a history going back to childhood which has helped to determine what they have become.
- To help the doctors to explore in detail the emotional content of their interaction with a particular patient: to understand how their behaviour and reactions have been unconsciously affected by the feelings projected by the patient and resonating with those of the doctor.
- To help them to learn how to contain a patient's feelings even when these are uncomfortable and to tolerate feelings such as helplessness and anxiety.
- To help them to understand how a distressed patient may need to be held and supported in ongoing therapeutic relationship in a series of consultations with the same doctor over a period of time.

Michael Balint was a psychoanalyst; the first Balint groups were led by psychoanalysts or psychotherapists, but, although their insights can be invaluable, the Balint Society no longer requires group leaders to have had psychotherapy training. Groups are organised and regulated by the Balint Society whose founder members were GPs trained by the Michael and Enid Balint. They also contributed to the ranks of the first generation of GP course organisers and helped to establish the tradition of small group work in Vocational Training Schemes.

Balint Society leaders are trained to respect the emotional safety and integrity of all group members. They do not go in for psychological intrusiveness and they protect the group from any activities of this sort from group members. They establish a culture of confidentiality, safety and respect. The focus is always on the doctor patient relationship and not on the doctors' personal lives. Everyone is free to use their imagination to explore the meaning of the clinical material presented. Interpretations based on a particular theory are rarely heard. Jargon is discouraged. Everything is very down to earth.

Issues around Communication and Alcohol Use

Key Issue for GP's

Avoid tackling

Feel out of our depth

Worry about the consequences

Disruptive patients

Worries about patient motivation and compliance

May be we like a drink ourselves – where is the boundary?

Often complex problems that are masked by drugs and alcohol 25% have underlying anxiety, 20-40% underlying depression

But remember that 15-30% of patients seen in General practice have hazardous harmful or dependent alcohol use.

>30% of patients admitted to hospital -alcohol problem

Need

Clear boundaries - set out at the beginning. Some times people with alcohol problems are dependant characters so better to set clear boundaries from the start

Confidentiality

Discuss Crime risk behaviour

Non judgemental – non compliance is same as for diabetic or hypertensive not taking Rx but not always judged the same.

Gp Role

Help Identify the problem even when the patient does not.

Think about CAGE

Recognise minor withdrawal Sx that may alert you to fact that patient has alcohol problem

Recognise when some one at risk of DT's. Remember that DT's carry mortality of 15% if left untreated

Deal with the medical consequences

Minor Withdrawal

Occur within 24 hours of last drink Peak on days 2-3 and majority subside by days 4-5. May include some of the following:

Mild tremor

Anxiety

Tachycardia

Restlessness

Raised BP reading

Headache

Sweating

Difficulty sleeping

Nausea

Bad dreams

Reduced appetite

DT's

Occur in individuals who have been drinking weeks / months and usually pattern of heavy drinking for > 5 years. May have had particularly heavy session for preceding two weeks. Rare under the age of 30. Occurs in less than 5% of alcoholic patients

Agitation	Paranoia
Disorientation	Visual hallucinations
High Fevers	Sweats

Protracted withdrawal may present with:

Anxiety	Craving
Irritability	Insomnia
Hostility	Depression

(Acamprosate is thought to help maintenance by abolishing these symptoms)

History taking

Useful opening Gambit

“We often find that peoples eating, smoking and drinking habits have a significant effect on their health and how they feel about themselves, so I would like to ask you some questions about....”

Do you feel a strong desire or craving for alcohol once you have started?

Have you experienced that you were not able to stop drinking once you had started?

Do you skip meals after your drinking?

Have you failed to do what was expected of you because you were drinking?

Have you needed more alcohol than previously to get the desired effect?

Do your hands shake a lot in the morning, after you have been drinking?

Have you needed a first drink to settle things down the morning, after drinking the night before?

Have you tended to continue drinking even though you knew it caused you to be unwell or experience problems?

CAGE questionnaire

- 1) Are you or your friends concerned about your drinking? Are you considering **Cutting** down?
- 2) Do you get **Angry** when I ask you or others ask about your drinking? What other sort of trouble is your drinking causing you?
- 3) Do you feel **Guilty** about drinking? Do you have bad feelings about problems that drinking has caused?
- 4) Do you take an "**Eye-opener**" - a drink first thing in the morning?
- 5) When, what, how much do you drink?

If patient ambivalent about drinking then ask them to make a list of the good things about drinking and a list about the not so good things. Help patient to consider how he might replace the benefits of drinking with other activities.

Proceed to stage when your patient in readiness to change his/ her behaviour. Find ways that work for the patient in partnership rather than impose "orders from above"

Remain optimistic- Don't let the patients sense of failure become your own.

Pitfalls to avoid

- Failing to discuss alcohol at all
- Trying to rescue or blame the patient
- Perpetuating the myth that an addict has no choice about his/her behaviour.
- Deferring to AA or other agencies without trying to help Drs have a role too.

Brief interventions 3- 5 mins

- Current Update on alcohol use
- Motivational interviewing techniques
- Advice on cutting down
- Safe drinking guidelines
- Self Help manuals

As little as 5 mins advice to a non dependent person, from a health professional, can significantly reduce drinking 6 months later.

Brief intervention technique can be summarised by the acronym **FLAGS**

FEEDBACK- on the risk to impairment caused by drink/ drugs.

LISTEN- to the patients concerns.

ADVISE patients about the consequences of continued use of alcohol or drugs

GOALS should be defined for example to reduce or cease alcohol consumption

STRATEGIES for treatment should be discussed and implemented e.g. define triggers that make you start drinking and ideas for overcoming them.

<p><u>Low Risk</u> <=14 units per week for women <=28 for men</p>	<p><u>Risky or harmful behaviour</u> Between 15-28 units per week for women and 28-42 units per week for men</p>	<p><u>Alcohol Dependent Range</u> >29 units per week for men and 43 units per week for men</p>
<p>Feedback Reinforce safe drinking</p>	<p>Feedback results of AUDIT Listen to patients concerns Advise about consequence of continued alcohol use Goals of Rx should be defined e.g. reduce alcohol intake to safe limits and aim for 2 alcohol free days per week. Strategies for Rx Gain greater understanding of situations that trigger drinking Offer self help booklet Offer follow up</p>	<p>Feedback results of AUDIT Listen to patients concerns Advise about consequence of continued alcohol use Goals of Rx should be defined e.g. advise on the importance of period of abstinence Strategies for Rx Consider the need for detox Consider the need for pharmacotherapy to support withdrawal Advise on the need for compliance with Rx Encourage self help Gain greater understanding of situations that trigger drinking Consider referral to specialist Feedback results of AUDIT Listen to patients concerns Advise about consequence of continued alcohol use Goals of Rx should be defined e.g. reduce alcohol intake to safe limits and aim for 2 alcohol free days per week. Strategies for Rx Gain greater understanding of situations that trigger drinking Offer self help booklet</p>

Alcohol Use Disorder Identification Test (AUDIT)

1. How often do you have a drink containing alcohol?

Never < / =Monthly Once a week 2-4 x / week >5 x weekly

2. How many standard drinks do you typically have when you are drinking?

1 2 3-4 5-6 7 or more

3. How often do you have 6 or more drinks on one occasion?

Never < monthly Weekly ~Daily

4. How often in the last year have you found that you were not able to stop drinking when you tried?

Never < monthly Weekly ~Daily

5. How often have you failed to do something that was normally expected of you because of your drinking?

Never < monthly Weekly ~Daily

6. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session the day before?

Never < monthly Weekly ~Daily

7. How often in the past year have you had feelings of guilt or remorse after drinking?

Never < monthly Weekly ~Daily

8. How often in the past year have you been unable to remember what happened the night before because you had been drinking?

Never < monthly Weekly ~Daily

9. Have you or someone else been injured as a result of your drinking?

No Yes, but not in last year Yes, in the last year

10. Has a relative, friend, Dr, or health care worker been concerned about your drinking or suggest you cut down?

No Yes, but not in last year Yes, in the last year

Audit Scoring

Questions 1-8 score Left to Right 0,1,2,3 or 4.

Questions 9 +10 are scored 0, 2 or 4

Audit scores are interpreted as follows

Women		Men
0	Abstainer	0
1-5	Non hazardous safe drinking	1-6
6-12	Hazardous or harmful alcohol use	7-14
13+	Alcohol dependence	15+

Motivational Interviewing

Active listening is essential.

Listing the benefits of drinking helps counter the belief that the Dr is judgmental

Respond to negative comments by reframing e.g. "so you don't think there are any downsides to drinking.."

Make the link between known health problems and alcohol e.g. hypertension and alcohol (~30% of patients with raised BP have a significant alcohol problem.)

Readiness to change

Depends on what's important to the patient and how they feel about the problem.

The likelihood of success is thus dependent on the:

- Importance
- Confidence of the patient that they will succeed
- Readiness to change

Negotiate what is on the agenda e.g.

"There are various things such as drinking alcohol, smoking, your weight and your lack of exercise which may be affecting your health. How do you feel about... Is there anything that you would like help with today? Are you ready to think about changing any of them"

Deal with what is **important** to the patient.

"How important is it to you to personally to change?"

Assess **readiness**

"How do you really feel about...?"

How ready are you to change?

Or "Some people don't want to talk about drinking at all, others are unsure and some people don't mind at all . How do you feel about this?"

Assess how **confident** they are about tackling the issue.

"How do you feel at the moment about....?"

"What would have to happen for you to become more confident that you could cut your drinking down?"

The health belief model

This is the most researched and validated description of patients' beliefs about health and related matters, and it has five main elements.

Health motivation

People's interest in their health and the degree to which they are motivated to change it varies enormously.

Perceived vulnerability

When considering specific health problems, people think very differently about how likely they are to be affected. For example, people who think that they are at high risk of developing lung cancer are more likely to follow advice about give up smoking than those who do not think they are at risk.

If a patient already has a health problem, then the perceived vulnerability relates to the degree to which they believe in the diagnosis and its possible consequences. For example, a patient is diagnosed as having irritable bowel syndrome and it is suggested that tension may be contributing to the condition. However, if the patient is convinced that pelvic inflammatory disease is the cause, they may fail to comply with subsequent management. This disbelief in what they are told may not be explicit and needs to be searched for. They do not see themselves as being susceptible to tension and conclude there must be another cause.

Perceived seriousness

Patients vary in how dire they believe the consequences of contracting a particular illness would be and what would happen if it were left untreated. Heart disease or lung cancer can be seen as too far in the future to concern a teenage girl starting to smoke through peer pressure. Her attitude may be "And anyway by the time I get to 40 they'll have a cure for it, won't they?"

On the other hand, the publicity about skin cancer resulting from ozone depletion has meant that, in recent years, anxious patients have flocked to doctors with a wide range of minor skin blemishes. Most people regard cancer as very serious; some, if they suspect it, may even be too frightened to go to the doctor. Particularly sad examples of this, which unfortunately are not uncommon, are the older woman with a slowly growing fungating carcinoma of the breast or the young man with a treatable testicular growth.

Perceived costs and benefits

Patients weigh up the advantages and disadvantages of taking a particular course of action. They do not necessarily take all the relevant factors into consideration, but feel able to make an evaluation. This cost-benefit analysis is unique to every individual and can be influenced by outsiders, including doctors. However, for the doctor to be able to influence the equation in the patient's favour, they need to know which factors have already been included. Think

about Mrs Arthur and her fears about possible ¹³¹I treatment. Her fear that radiation would prevent her conceiving might stop her from complying with the treatment because, in her mind, the risks of treatment outweigh the benefits. The doctor needs to seek out such fears and talk them through with the patient.

Cues to action

Patients' beliefs do not already exist pre-packaged. They are prompted or created by a number of stimuli and triggers such as physical sensation, what Granny said, a TV programme or what just happened to the man down the road.

The Di Clemente model of change

Stages of Change

Most people who make changes in their lives do so without professional help. Professionals are more likely to be effective in engendering change by going with the grain of the patient rather than strictly following a professional agenda.

Studies of the process of change suggest people go through **five natural stages** when they consciously make changes to their lives. Each stage has a different frame of mind about the behaviour concerned and a different kind of motivation:

Pre-contemplation

People in this stage feel little concern about their behaviour, even though other people may be very concerned. *"What's the problem?" "No-one's perfect." "We all have our vices" "If you listen to everything you hear, you'd think that everything was bad for you."* Change is not an issue.

Contemplation

In the contemplation stage people experience conflict about the behaviour; they are drawn to it but unhappy about it; they are not sure whether they really want to or can change it. *"I want to but I don't want to"*. It is helpful to see motivation as a pair of scales with reasons for change on one side and reasons for not changing on the other. In contemplation the two are fairly evenly balanced; hence motivation can shift and sway dramatically over a short period of time.

Action

In the action stage people are ready and committed to change their behaviour.

Maintenance

Maintaining and consolidating changes is an active process that might need effort for many months. Change can only be stable after the person has met old situations associated with the behaviour and responded to them in new ways. Change can often be challenged by negative moods (anxiety, depression, boredom) and temptations to return to old habits.

Relapse

Relapse means returning to the way things were before any changes were made.

The Stages of Change model

The Stages of Change model shows that people are motivated for different things at different stages and cannot be seen as simply motivated or not motivated.

It recognises that at different stages people have different needs and that professionals are more likely to be successful if their help is more closely meeting these needs. Professional help should be directed towards nudging the person along to the next stage, not trying to do too much.

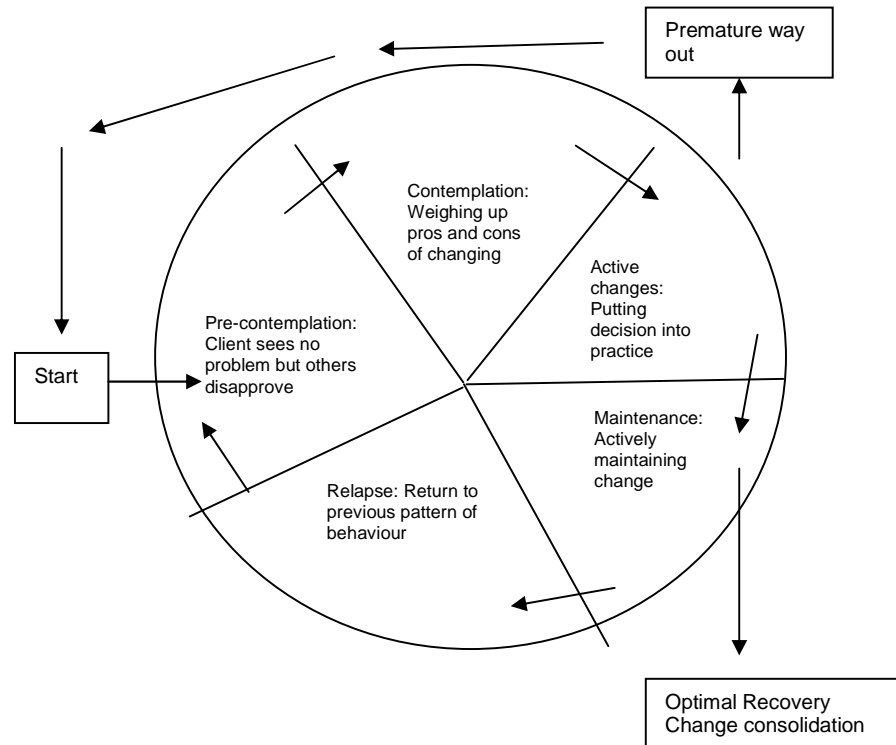


Figure 1.2 The stages of change

Source: Adapted from the work of Prochaska and Di Clemente

In the course of making change people may be round the circle of change several times, before reaching lasting success. Previous failures may make present success more likely. A temporary success on this attempt may make the person more successful in the future.

Motivational Interviewing strategies

The process of motivational interviewing consists of three distinct stages or phases.

Eliciting phase

This is the beginning of the interview. The goal of this phase is to get the patient to state as clearly as possible his concerns about particular area(s) of his life and to lead him to convince you that change is necessary.

In this phase, the practitioner uses open questions, reflections and summarising/structuring to elicit statements of concern from the patient.

The technique for dealing with statements of non-concern is also employed here using restructuring and *devil's advocate* to elicit more positive statements and to move the patient forward in the process of making the desired decision.

Information phase

In this phase, the practitioner and the patient are mutually engaged in an 'active quest for information'. The patient is now actively interested in his health.

Here, the goal is to help the patient to gather and assimilate relevant information and look at its implications for change.

Negotiating phase

The focus of this phase is on what (if anything) the patient wants to change – the goal of change, the means of achieving it, and where to begin.

By the end of the information phase, the patient will have become more aware of what needs changing and what choices are before him. He may have made a decision to change. If this is the case the practitioner will discuss what options are open to him, agree a realistic target and invite him back for follow up and support.

He may decide on no change. His decision must be respected. Let him know you respect his choice and keep the door open for him to come back another time should he wish to.

Examples of response for 'no change':

"I appreciate that for the time being, this seems to be the right decision for you to make. However, if you should like to discuss this again in the future, I would be happy for us to meet again."

Or

"You have clearly decided that now is not the right time to try to make a change. I can understand that and respect your decision. If you would like to discuss this further at another time, I would be very pleased to see you again."

Intervention Process using the Stages of Change Model

The difference between the intervention process using the Health Belief Model alone, and that using the Stages of Change model, is that the practitioner establishes not only the patient's health beliefs but also their readiness for change. Having used the appropriate techniques to determine

the stage of change that the patient is at, the practitioner then acts accordingly. Figure 1.3 shows that the practitioner starts with exploring health beliefs and determining the patient's stage. If he is at the pre-contemplation stage he will feedback the patient's views and create cognitive dissonance by use of provoking statements. In the contemplation phase he will reflect back the positive statement to enable the patient to make a decision about change. If the patient decides not to change, then he can return to start the cycle again as he wishes. If the patient decides to change, then the practitioner actively supports him to plan and sustain the change through the maintenance phase. Patients who relapse can be invited back and the practitioner will then explore with them their difficulties in maintaining the change.

Patients may be at any stage of change when they come for screening. They may be at different stages for different behaviours. They may proceed through some of the motivational stages during the course of the interview or over months during repeat visits. The practitioner's goal is to move the patient towards a positive decision to change, and then to provide him with the means to make and sustain that change until it is consolidated in his everyday life.

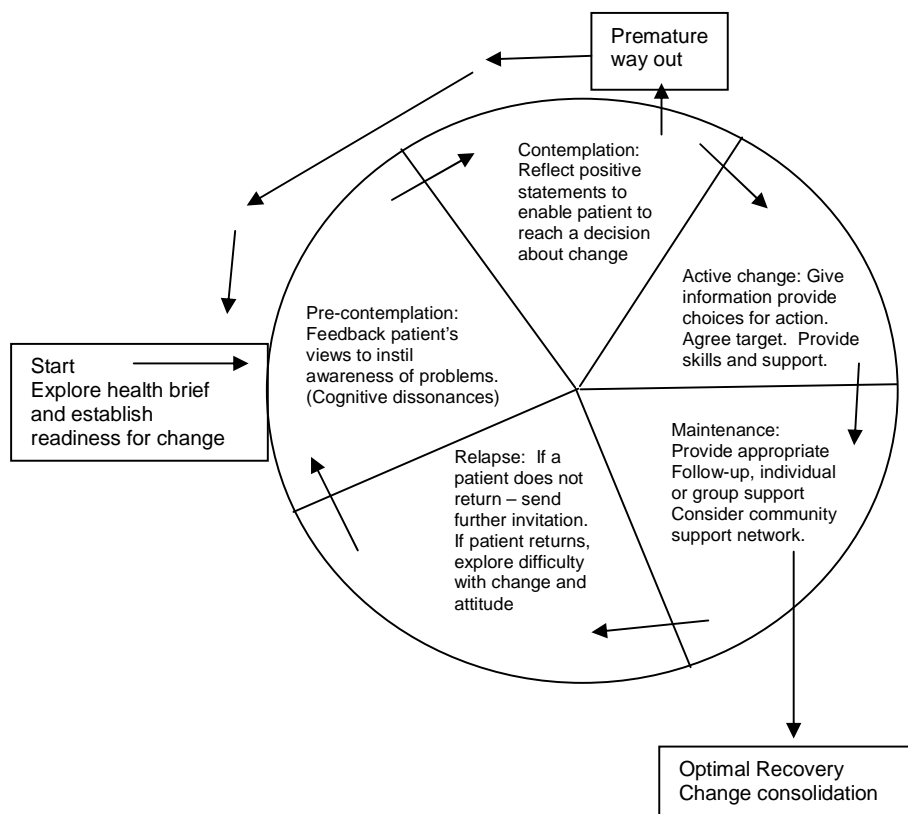


Figure 1.3 Intervention process using the Stages of Change model

Decision Balance: To Change or not to change

Considering Change	Reasons not to change	Reasons to change
<p>What is that you are thinking about changing?</p> <hr/> <p><i>Write in the behaviour</i></p> <p style="text-align: center;">Stay the same</p>	<p>Benefit</p> <p>What do you like about _____?</p>	<p>Concerns</p> <p>What concerns do you have about _____?</p>
<p><i>Write in the new behaviour / goal for change</i></p> <p style="text-align: center;">Change</p>	<p>Concern</p> <p>What concerns would you have if you were to change?</p>	<p>Benefit</p> <p>In what ways would your life be better if you were to change?</p>

Patient's Perceptions About Change

Assess what you think are the patient's perceptions about change, using this scale:

0 = no importance 1 = slight importance 5 = moderate importance 10 = very important

Select any number from 0 – 10 what score would you give to:

- the benefits of your unhealthy behaviour?
- the concerns about your unhealthy behaviour?
- your concerns about changing?
- your benefits of changing?

Initial Assessment

Behaviour change	Reasons not to change (cons)	Reasons to change (pros)
Unhealthy behaviour	Score for overall benefits =	Score for overall concerns =
Healthier behaviour	Score for overall concerns =	Score for overall benefits =
Force of Change	Resistance (average score) =	Motivation (average score) =

Task 1: Clarify Issues About Change

Ask about Readiness-to-change
<i>"Where are you in terms of your smoking?" [Select one or more of these questions] "Are you really not thinking about changing?" "Are you thinking about it?" "Are you willing to make a change?"</i>
Provide a Stage-specific Rationale for Using the Decision Balance
<i>Precontemplation: "You just told me that you are just not interested in quitting. Would you mind if we did a decision balance together? It can help me understand better why you do not want to quit."</i>
<i>Contemplation: "You told me that you are thinking about quitting. Would you mind if we did a decision balance together? It can help you think more about whether to quit."</i>
<i>Preparation: "You're thinking about setting a quit date. Would you mind if we did a decision balance together? It can help you decide on a quit date."</i>
Explain what a Decision Balance is
<i>"Let me show you what a decision balance looks like. On the left-hand side, it says that you can either smoke or quit. First, I would like you to list as many benefits as possible that you get from smoking cigarettes. Is it okay to use this decision balance?"</i>

Draw a Decision Balance for the Patient and Ask These Questions		
Smoke	1. Benefits of smoking <i>“What do you like about smoking? And what else?”</i>	2. Concerns about smoking <i>“What, if anything, concerns you about the effects of smoking on your health?” “Does anyone else have any concerns about your smoking?”</i>
Quit	3. Concerns about quitting <i>“Do you have any concerns if you were to quit?” “What effects would quitting have on you?” “What questions do you have if you were to quit smoking?”</i>	4. Benefits of quitting <i>“How do you think your health would improve if you were to quit?” “In what way would you benefit from quitting?”</i>
Explain How to Use the Decision Balance		
<i>“The middle column represents your reasons not to change and the right-hand column represents your reasons to change. At the moment, your reasons not to change seem more important than the reasons to change. On the other hand, if you feel /believe that the reasons to change are more important than the reasons not to change, then you might change. What do you think?”</i>		

Task 1: Observer Checklist

Fill out the checklists. See how your responses compare to the patient's and practitioner's assessment.

The practitioner did the following:	Yes	No
1. Assessed readiness to change		
2. Provided a rationale for using a decision balance		
3. Explained what a decision balance is		
4. Showed the patient what the decision balance looks like		
5. Itemised at least two benefits of the risk behaviour		
6. Itemised at least two concerns about the risk behaviour		
7. Itemised at least two concerns about adopting a healthy behaviour		
8. Itemised at least two benefits of adopting a healthy behaviour		
9. Explained how to use the decision balance		
10. Gave the decision balance back to the patient		

To what extent do you agree with these statements? 0= Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
The practitioner provided a rationale that helped the patient understand the reasons for using the decision balance	
The practitioner explained what a decision balance is to the patient in a way that he / she really understood	
The decision balance helped the patient think more about the possibility of change	
The practitioner explained to the patient how to use the decision balance for future purposes	
The patient wanted to keep the decision balance	
What do you estimate is the patient's resistance score? (0=none, 10=very high)	

Task 1: Practitioner checklist for Self-Assessment

Fill out the checklists. Then look at your patient's form to clarify the reasons for any differences. Please do not change your checklist after discussing your differences.

I did the following	Yes	No
1. Assessed readiness to change		
2. Provided a rationale for using a decision balance		
3. Explained what a decision balance is		
4. Showed the patient what the decision balance looks like		
5. Itemized at least two benefits of the risk behaviour		
6. Itemized at least two concerns about the risk behaviour		
7. Itemized at least two concerns about adopting a healthy behaviour		
8. Itemized at least two benefits of adopting a healthy behaviour		
9. Explained how to use the decision balance		
10. Gave the decision balance back to the patient		

Ask your patient why his / her scores were higher or lower than your scores

To what extent do you agree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
I provided a rationale that helped the patient understand the reasons for using the decision balance	
I explained what a decision balance is to the patient in a way that she really understood	
The decision balance helped the patient think more about the possibility of change	
I explained to the patient how to use the decision balance for future use	
My patient wanted to keep the decision balance	
I estimate the score of my patient's resistance to be: (0=none, 10= very high)	
I estimate the score of my patient's motivation to be: (0=none, 10= very high)	

Task 1: Patient Checklist

Fill out the checklists. Then look at your practitioner's form to clarify the reasons for any differences. Please do not change your checklist after discussing your differences.

My practitioner did the following	Yes	No
1. Assessed readiness to change		
2. Provided a rationale for using a decision balance		
3. Explained what a decision balance is		
4. Showed me what the decision balance looks like		
5. Itemized at least two benefits of the risk behaviour		
6. Itemized at least two concerns about the risk behaviour		
7. Itemized at least two concerns about adopting a healthy behaviour		
8. Itemized at least two benefits of adopting a healthy behaviour		
9. Explained how to use the decision balance		
10. Gave the decision balance back to me		

Let your practitioner ask questions about differences in the scores

To what extent do you agree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
My practitioner provided a rationale that helped me understand the reasons for using the decision balance	
My practitioner explained what a decision balance is to me in a way that I really understood	
The decision balance helped me think more about the possibility of change	
My practitioner explained to me how I could use the decision balance in the future	
I wanted to keep the decision balance	
My resistance score is (0=none, 10= very high)	
My motivation score is (0=none, 10= very high)	

Task 2: Lower Patient Resistance

Select Two or More Non-direct Interventions to Practice with Your Patient
Use simple reflection to elicit resistance, ambivalence, or indifference. <i>“So, smoking helps to relieve your stress”</i>
Probing priorities to generate ambivalence: <i>“So, what do you like most about smoking?” “And what concerns you most about your smoking?” “What concerns you most about quitting?” “What do you think would be the most important benefit of quitting?”</i>
Use double-sided reflection to summarise ambivalence. <i>“On the one hand, you said that smoking helps you relieve your stress, but on the other hand, you are concerned about how smoking stresses your heart.”</i> [Let patient respond]
Acknowledge ambivalence to validate patient’s experience: <i>“You seem to have mixed feelings about your smoking. You smoke to relax from the stresses of being a single parent, but you are concerned about its effects on your children at home”.</i>
Emphasize personal responsibility and choice (useful when the patient is being resistant). <i>What you decide to do about smoking is entirely up to you, but I’ll help you if you would like me to.”</i>
Use time-line questions to understand patient’s perspectives about their risk behaviours: <i>“So, what was your heart like five years ago when you were smoking, as compared to now? What do you think your heart will be like in five years?”</i>

Task 2: Observer Checklist

Fill out the checklists. See how your responses compare to the patient’s and practitioner’s assessment.

The practitioner used the following non-direct interventions:	Yes	No
1. Simple reflection to understand more about the patient’s:		
a) benefits of the risk behaviour	{ }	{ }
b) concerns about the risk behaviour	{ }	{ }
c) concerns about changing	{ }	{ }
d) benefits of changing	{ }	{ }
2. Probed priorities to explore ambivalence		
3. Double-sided reflection to summarize ambivalence		
4. Acknowledged ambivalence		
5. Emphasized personal responsibility		
6. Time line questions		

Options Used	How much do you agree or disagree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
	1. The practitioner helped the patient understand better the	
	a) benefits of the risk behaviour	
	b) concerns about the risk behaviour	
	c) concerns about changing	
	d) benefits of changing	
	2. The practitioner helped the patient understand better his / her priorities about change	
	3. Double-sided reflection helped the patient think more about ambivalence	
	4. Acknowledging ambivalence helped the patient feel more understood	
	5. The practitioner helped the patient understand better his / her responsibility about making change	
	6. The practitioner helped the patient think more about the time-line course of his / her risk behaviour	
	Reassess patient's perceptions about change: The resistance score is now	
		The motivation score
	is now	

Task 2: Patient Checklist

Fill out the checklist first. Then look at your practitioner's form to clarify the reasons for any differences. Please do not change your checklist after discussing your differences

My practitioner used the following nondirect interventions:	Yes	No
1. Simple reflection to understand more about:		
a) the benefits of my risk behaviour	{ }	{ }
b) my concerns about my risk behaviour	{ }	{ }
c) my concerns about changing	{ }	{ }
d) the benefits of changing	{ }	{ }
2. Probed priorities to explore ambivalence		
3. Double-sided reflection to summarize ambivalence		
4. Acknowledged ambivalence		
5. Emphasized personal responsibility		
6. Time line questions		

Fill out the whole questionnaire even though your practitioner used only a limited number of interventions. Let your practitioner ask questions about your differences in scores

Options Used	How much do you agree or disagree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
	1. My practitioner helped me understand better a) benefits of my risk behaviour	
	b) my concerns about my risk behaviour	
	c) my concerns about changing	
	d) the benefits of changing	
	2. My practitioner helped me understand better my priorities about change	
	3. Double-sided reflection helped me think more about ambivalence	
	4. Acknowledging my ambivalence helped me feel more understood	
	5. My practitioner helped me understand better my responsibility about making change	
	6. My practitioner helped me think more about the time-line course of my risk behaviour	
Reassess my perceptions about change: My resistance score is now		
My motivation score is now		

Task 3: Practitioner Checklist for Self-Assessment

Fill out the checklist first. Then look at your patient's form to clarify the reasons for any changes. Please do not change your checklist after discussing your differences.

The practitioner used the following non-direct interventions:	Yes	No
1. Simple reflection to understand more about: a) the benefits of the patient's risk behaviour b) the patient's concerns about her risk behaviour c) the patient's concerns about changing d) the benefits of changing	{ } { } { } { }	{ } { } { } { }
2. Probed priorities to explore ambivalence		
3. Double-sided reflection to summarize ambivalence		
4. Acknowledged ambivalence		
5. Emphasized personal responsibility		
6. Time line questions		

After discussing your differences, please fill out this questionnaire. After completing it, ask your patient why their scores were higher or lower than your scores

Options Used	How much do you agree or disagree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
	1. I helped the patient understand better the a) benefits of the risk behaviour	
	b) concerns about the risk behaviour	
	c) concerns about changing	
	d) benefits of changing	
	2. I helped the patient understand better his / her priorities about change	
	3. Double-sided reflection helped the patient think more about ambivalence	
	4. Acknowledging ambivalence helped the patient feel more understood	
	5. I helped the patient understand better his / her responsibility about making change	
	6. I helped the patient think more about the time-line course of his / her risk behaviour	
Reassess patient's perceptions about change: resistance score is now		
motivation score is now		

Task 3: Enhance Patient Motivation

Select Two or More Direct Interventions to Practice with Your Patient
Use back-to-the-future questioning: <i>“If you had a heart attack now, would you quit smoking?”</i> [Provided that the patient shows some interest in prevention, continue with...] <i>“Do you want to wait and see if this happens before deciding to quit?”</i> [If the patient is ambivalent, or not interested in prevention...] <i>“Would you mind sharing with me why you don’t want to quit?”</i>
Use benefit substitution: <i>“In what kind of stressful situations do you smoke?”</i> <i>“How can you relieve your stress instead of smoking?”</i> <i>“Could you write down four or five ways of relieving stress for each situation and bring the list in next time?”</i>
Clarify values: <i>“So, what is more important in your life than smoking? Is smoking and reducing your stress more important to you than your heart? If you say that your health is more important than smoking, you’re saying one thing and doing another. What would convince you to do what you say?”</i>
Identify and use discrepancies: <i>“You say that smoking relieves your stress,”</i> [Let patient acknowledge your comments non verbally.] <i>“but it also stresses your heart ... and your family because they worry about your health.”</i> [Let patient respond].
Change perceptions: <i>“you say that smoking gives you pleasure, but it makes you feel worse when you smoke too much, and it makes your cough worse in the morning.”</i>
Use differences in motivational reasons: <i>“What would it take for you to quit smoking and take care of your health in the same way that you take care of your family (or any other activities that the patient is highly motivated to do)?”</i>

Task 3: Observer Checklist

Fill out the checklist first. See how your responses compare to the patient’s and practitioner’s assessment.

The practitioner used the following direct interventions:	Yes	No
1. Back-to-the-future questioning		
2. Benefit substitution		
3. Clarification of values		
4. Discrepancies		
5. Change perceptions		
6. Differences in motivational reasons		

Options Used	How much do you agree or disagree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
	1. The practitioner helped the patient think about what his/her life would be like if he/she developed a future complication now.	
	2. The practitioner helped the patient see that he/she could obtain the benefits from his/her risk behaviour in alternative ways.	
	3. The practitioner helped the patient think about his/her values in terms of risk behaviours, health, and other aspects of his/her life.	
	4. The practitioner pointed out some discrepancies or differences between what the patient does and says that made him/her really think about change in new ways.	
	5. The practitioner helped the patient change his/her perceptions about the benefits and concerns on his/her decision balance.	
	6. The practitioner helped the patient think about how he/she could use the experience of his/her achievements in life and apply the same motivation to address behaviour change.	
Reassess patient's perceptions about change: The resistance score is now		
		The motivation score is now

Task 3: Practitioner Checklist for Self-Assessment

Fill out this checklist first. Then look at your patient's form to clarify the reasons for any differences. Please do not change your checklist after discussing your differences.

I used the following direct motivational interventions:	Yes	No
1. Back-to-the-future questioning		
2. Benefit substitution		
3. Clarification of values		
4. Discrepancies		
5. Change perceptions		
6. Differences in motivational reasons		

After discussing your differences, please fill out this questionnaire. After completing it, ask your patient why their scores were higher or lower than your scores.

Options Used	How much do you agree or disagree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
	1. I helped my patient think about what his/her life would be like if he/she developed a future complication now.	
	2. I helped my patient see that he/she could obtain the benefits from his/her risk behaviour in alternative ways.	
	3. I helped my patient think about his/her values in terms of risk behaviours, health, and other aspects of his/her life.	
	4. I pointed out some discrepancies or differences between what the patient does and says that made him/her really think about change in new ways.	
	5. I helped my patient change his/her perceptions about the benefits and concerns on his/her decision balance.	
	6. I helped my patient think about how he/she could use the experience of his/her achievements in life and apply the same motivation to address behaviour change.	
Reassess patient's perceptions about change: The resistance score is now		
		The motivation score is now

Task 3: Patient Checklist

Fill out this checklist first. Then look at your practitioner's form to clarify the reasons for any differences. Please do not change your checklist after discussing your differences.

My practitioner used the following direct interventions:	Yes	No
1. Back-to-the-future questioning		
2. Benefit substitution		
3. Clarification of values		
4. Discrepancies		
5. Change perceptions		
6. Differences in motivational reasons		

Fill out the whole questionnaire even though your practitioner used only a limited number of interventions. Let your practitioner ask questions about your differences in scores.

Options Used	How much do you agree or disagree with these statements? 0 = Feel neutral 1 = Slightly 5 = Moderately 10 = Strongly	Score (0 to 10)
	1. My practitioner helped me patient think about what my life would be like if I developed a future complication now.	
	2. My practitioner helped me see that I could obtain the benefits from my risk behaviour in alternative ways.	
	3. My practitioner helped me think about my values in terms of my risk behaviour, health, and other aspects of my life.	
	4. My practitioner pointed out some discrepancies or differences between what I do and say that made me really think about change in new ways.	
	5. My practitioner helped me change my perceptions about the benefits and concerns on my decision balance.	
	6. My practitioner helped me think about how I could use the experience of my achievements in life and apply the same motivation to address behaviour change.	
	Reassess my perceptions about change: My resistance score is now	
	My motivation score is now	

Dealing with conflict

References

Field guide to the Difficult Patient Interview

Teaching and Learning communication skills in medicine Silverman and Kurtz

Dealing with Anger

Theory

Anger is a *secondary* emotion , it always occurs along with a *primary* emotion e.g. when we are frightened, frustrated or hurt.

Anger does not progress in a linear emotion but escalates suddenly.

Anger may leap from a focus re a problem to a focus re a person and move into an ego conflict.

Understanding the above gives us ideas about to how deal with anger and conflict.

Try to deal with the anger before it takes an exponential leap. The moment you sense the anger, acknowledge its presence and deal with it.

If possible if the anger has escalated, allow time out to cool off, before trying to resolve it.

Try to identify the primary emotion and deal with this rather than focussing on the anger alone.

Managing conflict

Conflict is part of human life and it is important to have some insight into how we deal with it and how we feel about it and how it affects our behaviour – and how others perceive our behaviour.

Conflict can be seen as good?

- necessary for personal/organisational growth?
- ensures progress
- creates internal unity
- challenges established beliefs and norms

Or bad?

- destructive tensions
- breakdown of normal decision making
- social and personal cost
- absorbs high levels of energy

In situations where 2 people appear to be in conflict, we can describe their behaviour in terms of 2 basic dimensions:

- **Assertiveness** – satisfying own concerns
- **Cooperativeness** – satisfying other persons concerns

What is the right or best way of handling conflict? There is no right or wrong answer, it depends on what is situationally appropriate and how skilfully you use it.

A technique for dealing with conflict situations can be summarised by the abbreviation CUDSA:

- Confront the conflict
- Understanding
- Define the problem
- Search for a solution
- Action

Remember that 'behaviour breeds behaviour'. You can use your behaviour to help or hinder a consultation. Marshall Rosenberg was the founder of a technique known as non-violent communication, a system of communication based on the premise that negative emotions arise from unmet needs. Understanding a person's feelings, and the needs that drive them, allows you to empathise, rather than fight. As a result they feel understood and anger melts away.

Tips on dealing with angry and aggressive patients.

Causes of anger

- Long wait before a consultation
- Receiving bad news such as terminal cancer or an unexpected death
- Perceived delay in diagnosis or treatment
- Patients may feel they have no options
- Dashed expectations
- Loss of control; people in powerful positions finding themselves dependent

Warning bells

Recognise them before things get out of control

- Voice – suddenly slow, soft or loud, boisterous, and abusive
- Face – loss of eye contact; frowning; red face and red eyes
- Physical – coming too close; sudden threatening movements in upper limbs

Do's

- Keep a safe distance – neither too close nor too far
- Stay cool, calm and composed
- Correctly acknowledge the emotion that the patient is projecting. Never mistake anger as anxiety or irritable behaviour
- Acknowledge legitimacy, when appropriate, without blaming anyone
- Listen actively by making good eye contact and nodding appropriately
- Identify intensity of anger- 'How angry have you been?'
- Ask open questions: 'What makes you feel so?'
- Explore the reasons for anger and identify focus of anger
- If complication is due to a surgical intervention, explain the options for treating the complication
- acknowledge imperfections of diagnosis, investigations and treatment
- Apologise, where appropriate
- Finally, if all of the above fails to work, take a break, but do come back
- Assertive, non-aggressive communication about what is OK and is NOT OK is important

Don'ts

- Interrupt a patient's or relative's outburst
- Caution a rude patient for rude language
- Deny reality, no matter how cruel
- Talk to a patient from behind
- Get angry, especially when the patient questions your credentials or competence
- Challenge the patient's interpretation and criticise them for their reaction
- Make defensive responses such as, 'We have been doing our best, don't you realise how hard we have been trying?'
- Try to pacify them by touching them
- Block their way

Stereotypes

What processes in medicine contribute to stereotypes?

Several processes may contribute to the development of stereotypes, even among those who consider themselves well intentioned and egalitarian. These can be divided into the 'formal curriculum' which is what doctors are taught at medical school and the 'informal curriculum' which they observe during training and practice.

The informal curriculum: clinical training and practice environment.

Based on training or practice location, doctors may develop certain perceptions about race/ethnicity, culture, and class that may evolve into stereotypes. For example, many medical students and residents are often trained—and minorities cared for—in academic health centers or public hospitals located in socioeconomically disadvantaged areas. As a result, doctors may begin to equate certain races and ethnicities with specific health beliefs and behaviors (i.e., "these patients" engage in risky behaviors, or "those patients" tend to be noncompliant) that are more associated with the social environment (like poverty) than a patient's racial/ethnic background or cultural traditions. This conditioning phenomenon may also occur if doctors are faced with certain racial/ethnic patient groups who don't frequently choose aggressive forms of diagnostic or therapeutic interventions. The result over time may be that doctors begin to believe that "these patients" do not like invasive procedures and thus they may not offer them as options very ardently, if at all. In the case of African Americans, for example, one could understand how this interaction can become a cyclical and self-fulfilling prophecy. Based on historical factors of segregation and medical experimentation, African Americans have been shown to be more mistrustful of the health care system than any other racial or ethnic group (with Latinos not far behind). This mistrust may contribute to wariness in accepting or following recommendations, undergoing invasive procedures, or participating in clinical research. This in turn may lead doctors to continually believe the African-American population is less adherent or less interested in aggressive treatments. Again, this stereotyping is a natural and expected—but no less dangerous—phenomenon that may affect the way doctors make decisions and offer specific interventions to different patients based on their race or ethnicity.

The Formal Curricula: Medical Education, Race, Ethnicity, and Culture

The formal curriculum plays a role, but to a lesser extent. In medical schools, for the most part, teachings about race, ethnicity, and culture—if done at all—focus on providing knowledge regarding the attitudes, values, beliefs, and behaviours of certain groups of patients. For example, methods to care for the Asian, African-American, or Hispanic patient might present a list of common health beliefs, behaviours, and key clinical practice do's and don'ts. Given intragroup diversity, it is impossible to teach a set of unifying facts or cultural norms (such as fatalism among Hispanics, or passivity among Asians) about any particular population that can be applicable in every clinical setting, everywhere. Although well meaning, these efforts can lead to stereotyping of patients and oversimplification of culture. Research has shown that teaching such "cultural knowledge," when not done carefully, can be more detrimental than helpful.

Clinical Scenarios: How Can Stereotypes Lead to Disparities?

One can imagine a training environment where it was exceedingly difficult, for a variety of reasons, to convince African-American patients to undergo invasive surgical procedures. Perhaps it was because the patients were afraid they could not afford the procedure, they were not able to miss work, they were mistrustful of the health care system, or they had different conceptualizations of their conditions and did not think they required surgery. Whatever the case, the end result was that the doctors developed "priors" over time; that is, a pretest probability in their minds that led them to believe African Americans do not like invasive surgical procedures. How might this affect a doctor's choice to offer—or how aggressively to offer—an invasive surgical procedure to his or her 200th African-American patient who needed one? How about the 250th? Because we know that a patient's decision is very much dependent on the doctor's presentation of the treatment option, might it not be easier, with those priors, to chose medical management of a condition in favour of spending a lot of time trying to convince a patient to do something you really do not think they are going to agree to in the first place? Might the doctor then become susceptible to stereotyping African Americans as not being interested in invasive surgical procedures and thus sacrifice the optimal for the acceptable?

Although this is a hypothetical situation, consider closely the daily clinical experiences where doctors are constantly making choices on how much time and effort to spend on particular issues with patients. We should also consider how our own priors shape our actions, affect our clinical decision making, and make us susceptible to stereotyping. Could the process of stereotyping be a working hypothesis to explain the racial/ethnic disparities in referral rates of African Americans for catheterization, angioplasty, or bypass surgery when all the usual suspects (e.g., insurance status, socioeconomic status, comorbidities, appropriateness) are controlled for? Our first response might be that the doctor may have offered the patient the procedure yet the patient refused it. Although that is plausible, the IOM report went through various studies (e.g., renal transplantation) where patient preferences were examined and, although occasionally different by race/ethnicity, rarely did they account for the disparities identified. Both the IOM report and the social cognitive theory literature suggest that we give the stereotyping theory more than just a passing consideration in this instance.

What Can We Do?

There are several strategies that might allow us to counteract, both systemically and individually, our normal tendency to stereotype.

Systemic Interventions

Cooperation Toward a Common Goal: Diversity in Health Care. It has been shown that when racially/ethnically/culturally/socially diverse teams are assembled (in which each member is given equal power) and are asked to achieve a common goal, a sense of camaraderie develops that prevents the future development of stereotypes based on race/ethnicity, gender, culture, or class. This research supports the development of diverse clinical care teams as a method of promoting greater understanding among individuals from different sociocultural backgrounds.

Practice Setting Changes: Improving Our Environment. Certain incentives, such as those related to productivity or cost-control, could be adjusted or realigned to prevent an environment that leads to increased stereotyping (one in which doctors are forced to work under extreme time pressure, multitask without support, and participate in stressful environments), in favour of one that favours quality across racial/ethnic groups.

Individual Interventions

Education and Awareness: Improving Communication. As opposed to solely teaching the prescriptive theory of decision making in medical education and training, new curricula should include a more detailed analysis of how we make decisions and what nonmedical factors influence that process. Furthermore, curricula in cultural competence, which focus on preparing doctors to more effectively communicate and care for patients from diverse sociocultural backgrounds, may also be helpful. Because stereotyping develops from cognitive shortcuts, priors, and incomplete information, curricula that focus on teaching doctors how they make decisions, and how they can more effectively communicate with diverse patient populations, may be a useful preventive strategy against stereotyping.

Increased Self-Monitoring: Constantly Checking Ourselves. Research has shown that simply being aware of the operation of social cognitive factors allows one to actively "check" or "monitor" behaviour. For instance, one can constantly make sure that the same things are being offered, the same ways, to all patients.

Conclusion

The fact that racial/ethnic disparities in health care exist is now undeniable, indisputable, and extremely well detailed in the IOM report. True progress in eliminating them will only occur when doctors get past the "Not me!" phase and begin to understand the role they play in the problem, and perhaps more importantly, in the solution. This is not an indictment of physicians, but instead a call to action and open-mindedness. Our review highlights that stereotyping is a normal process with potentially unfortunate consequences. We must do everything in our power to identify and avoid it if we hope to eliminate racial and ethnic disparities in health care.

Referral letters – Written communication

“The things that ought to have been said in referral letters are not said, letters that ought to have been written are not written, and people go into hospital without letters and, even more, in the GP’s experience, come out without them”
Julian Tudor Hart

Make your referral letters work for your patients

What’s in a good referral letter?

Administrative content

- GP’s name, address, phone number
- Consultant’s name, department and address
- Patient’s name, address, phone number, date of birth, sex, NHS number
- Request transport and translators if needed

Clinical content

- Reason for referral
- Outline of history or statement of problem
- Important medical history
- Examination findings
- Investigations
- Treatment or medication
- Socio-psychological matters
- Allergies
- How the patient or relative was involved in the referral and what they expect
- What they have been told
- What the GP expects
- Whether a new referral or re- referral

Other referral methods

Templates

Advantages

Agreed sections which make the writer summarise the problem, describe what has been done and what needs to be done
Useful for electronic booking and paperless referrals

Disadvantages

Finding one
Seems like backward step to revert to handwriting

Referral management centres

Advantages

Manage waiting lists to achieve fairness and efficiency

Disadvantages

Unable to match needs of individual patients with skills of a known consultant

The patient's referral letter

"Keep falling on left side, dizziness/ feeling sick. Permanent pain over my right eye, sleep between 12-14 hours a day. Co-ordination not very good, takes at least 4 hours to get ready to go out. Fear of going out too far from home. Bedwetting and myself. Bathing very difficult. Memory short term affected, very forgetful keep burning food etc. No energy or strength."

Shortly after writing this letter, she had a craniotomy which revealed a large metastatic deposit, which was de-bulked. She died a few weeks later, and this letter fell from her notes.

With patient letters that are this good, who needs referral letters

BMJ filler 2003: 326:206

CURRICULUM STATEMENTS FOR USE IN PLANNING

1. WOMEN'S HEALTH

Rationale for this curriculum statement

Women-specific health matters, including contraception, pregnancy, menopause and disorders of reproductive organs account for over 25% of a GP's time. In addition, women present with non-gender related issues in specific ways that the GP registrar will need to become sensitive to: domestic violence, depression and alcoholism can all present differently in women. In society, women tend to take the larger role in caring for dependents - children, parents, ill or disabled spouses. This also brings special considerations.

Lifestyle aspects of women's health

Cigarette smoking is the most important modifiable, non-genetic risk factor for coronary heart disease, and accounts for 11% of all heart disease deaths in women. Smoking during pregnancy is associated with an increased risk of spontaneous abortion, haemorrhage, premature birth and low birth weight as well as many problems with the infant following birth. Smoking is also associated with infertility and subfertility in women as well as men¹.

There are increased health risks from obesity and the United Kingdom has the fastest growing rate of obesity in Europe, almost trebling in the past twenty years. Thirty three per cent of adult women are overweight and another 20% are obese².

In the general UK population only a fifth of women (21%) (compared to a third of men) meet the current guidelines for physical activity – of moderate or vigorous activity for at least 30 minutes at a time, on five or more days a week.

Approximately 3000 new cases of cervical cancer are diagnosed each year in England and Wales, leading to about 1,200 deaths. About half of the women who present with late stage cervical cancer have never had a cervical smear. The presence of Human Papilloma virus (HPV) types 16 and 18 (and less commonly some of the other types of HPV) has been shown to be associated with the development of cervical cancer. The risk of acquiring HPV increases with having larger numbers of sexual partners, or a partner who has had many previous sexual partners.³

UK health priorities

As yet there is no specific National Service Framework for Women's Health in the UK to guide training or service development. There are however several sources that demonstrate Government priorities:

In England, the Department of Health's *National Service Framework for Children, Young People and Maternity Services*⁴ emphasises woman-focused care and considers birth, post-birth care for mothers as well as planning and commissioning maternity services and contains two relevant standards:

Standard 11: Maternity Services

Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.

Standard 2:: Supporting Parenting

Parents or carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe

As part of the Government's commitment to reduce health inequalities, a target has been set to increase breastfeeding initiation rates by 2% points per annum through the NHS Priorities and Planning Framework 2003 - 2006 focusing especially on women from disadvantaged groups.

Teenage conception rates in the UK continue to be the highest in Western Europe at 90,000 per year, 7,700 of these in girls under 16, and 2,200 in girls under 14. Teenage birth rates in the UK are twice as high as in Germany and six times higher than those in the Netherlands. Tackling teenage pregnancy is a national priority and is central to the Government's work to prevent health inequalities, child poverty and social exclusion. Girls from the poorest backgrounds are ten times more likely to become teenage mothers than girls from professional backgrounds. One in every ten babies born in England is to a teenage mother. These children are at high risk of growing up in poverty and experiencing poor health and social outcomes. Infant mortality rates for babies born to mothers under the age of 18 are twice the average⁵⁶.

The Department of Health is working to modernise sexual health services¹, halt the spread of sexually transmitted infections and reduce the numbers of unintended pregnancies. The Independent Advisory Group on Sexual Health & HIV was established by the Public Health Minister in March 2003. Screening programmes such as cervical cytology, mammography and the National Chlamydia Screening Programme (NCSP) are still government priorities. (For more details please refer to the Curriculum Statement on Sexual Health)

Breast cancer and gynaecological cancers are also important NHS priority areas. ² Breast cancer is by far the most common cancer in women, accounting for 30 per cent of all new cases. Large bowel and lung cancer are respectively the second and third most common cancers in women. As with men, the top three cancers in women account for over half of all newly diagnosed cases. (Figure 1 below)⁷

Figure 1 UK Incidence of cancers in women 2001

Breast cancer is the most common cancer in England and Wales. In 2000 there were almost 36,000 new cases diagnosed, 30 per cent of all cancers in women and a rate of 114 per 100,000 women. Around 11,500 women died from breast cancer in England and Wales in 2002, a rate of 30 per 100,000 women. It is the most common cause of cancer death in women.

The breast screening programme was introduced in 1988 with the aim of reducing the number of women dying from breast cancer; over 1.5 million women are screened each year. Incidence rates have continued their upward trend, increasing by 70 per cent since 1971, and by 15 per cent in the ten years to 2000.

Earlier detection and improved treatment has meant that survival rates have risen. Five year survival was 73 per cent for women diagnosed in 1991-95, and 78 per cent for women diagnosed in 1996-99. Survival from breast cancer is better than that for cervical cancer and much better than for the other major cancers in women - lung, colorectal and ovarian. Death rates gradually increased up to the mid 1980s and then began to fall around the time that screening started. By 1998 mortality was around 20 per cent lower than it would have been (based on predictions of pre-screening rates in various age groups). Falls occurred in all age groups, but were greatest in women aged 55 to 69⁸.

Each year, there are almost 3,000 new cases of cervical cancer in the UK, just 1% of new cases diagnosed. Although there is a higher chance to develop cervical cancer later in life, it is the second most common cancer in women under the age of 35. The NHS Cervical Screening programme across the UK screens women between the ages of 20 and 64 every 3-5 years. The screening programme has been very effective in reducing the number of cases diagnosed in the UK. Ovarian cancer is the fourth most common cancer among women in the UK. Each year, there are around 6,900 new cases. Cancer of the uterus, is the fifth most common cancer in women in the UK. Each year, there are around 6,000 new cases. There are no NHS screening programmes for carcinoma of the ovary or uterus.

The GP and the primary health care team have important roles in raising awareness about breast and gynaecological cancers, promoting and participating in screening programmes, detecting early signs, referring quickly and then supporting the patient along their journey. The Department of Health have indicated the importance of the GP and primary care in their specific referral guidelines which are available for downloading from the Department of Health main website⁹.

Women's health issues are similar in the other UK countries; The public health strategy for **Northern Ireland**, *Investing for Health*, published in 2002¹⁰ and their Chief Medical Officer's reports have raised similar concerns but have also highlighted their worries about mental health, the increasing caesarean section rate, the poor uptake of breast and cervical screening, and the high teenage pregnancy rate ¹¹. The strategy advanced a number of key aims and goals to address those problems.

In **Wales**, the Welsh Assembly Government, whilst not targeting women's health specifically as one of their main areas for health improvement have ensured that aspects of women's health problems are covered in their public health strategies e.g. '*A healthier future for Wales*,¹² '*Promoting health and well being..*'¹³, and '*a strategic framework for promoting sexual health in Wales*.'¹⁴

In **Scotland**, despite gradual improvements in life expectancy and the implementation of specific initiatives - such as the cervical and breast cancer screening programmes which have led to earlier detection and treatment and improvements in survival¹⁵ there are worrying trends in Scottish women's health. Work published in 2002¹⁶, comparing Scotland's health in an international context have shown that despite mortality rates from all causes among working age Scottish women declining over the last 50 years, in comparison with 16 other Western European countries, the decrease in Scotland has been less marked and Scotland has been ranked with the highest mortality in this age group since 1958.¹⁷

Trends in individual causes of death from the same study show that, for many causes, Scotland's position in a European context is worsening. Scotland had the highest mortality rate and thus the highest ranking among working age women for oesophageal cancer (a rate which has risen since the 1970s), lung cancer (consistently ranked highest since the 1950s) and ischaemic heart disease (where the rate is falling but still lags behind other countries). Perhaps the most striking is the trend for lung cancer mortality. Mortality due to liver cirrhosis has risen steeply among Scottish working age women since the mid 1990, in contrast, the trend in mortality from 'external causes' (i.e. injuries, drowning, violence) shows a marked improvement for Scottish women.

Smoking among adult women did decrease considerably between the late 1970s (42% in 1978) and mid 1990s (29% in 1994) but has since remained relatively static.¹⁸ Scotland still appears to have one of the highest smoking prevalence among women of any country in Western Europe and one of the highest, if not the highest, levels of obesity.¹⁹ Alcohol consumption among women in Scotland is also increasing. The proportion of women exceeding the recommended maximum weekly intake of 14 units a week increased from 13% in 1995 to 15% in 1998²⁰.

New Curriculum Learning Outcomes for Women's health

The following learning objectives describe the knowledge, skills and attitudes that a GP requires relating to women's health.

Primary care management

- Demonstrate knowledge of women's health problems, conditions and diseases

- Describe how practice management issues impact on the provision of care to women including choice and availability of female doctors
- Maintain patient records that are accurate, facilitate continuity of care, and respect the patient's confidentiality (particularly in relation to family issues, domestic violence, termination of pregnancy, sexually transmitted infections and 'Partner Notification');
- Be familiar with local support services, referral services, networks, and groups for women (e.g. Family Planning, Breast Cancer Nurses, domestic violence resources)
- Describe the importance of informing patients of results of screening, and ensuring follow up

The knowledge base

Symptoms

- breast pain, breast lumps, nipple discharge,
- pruritis vulvae, vaginal discharge
- dyspareunia, pelvic pain, endometriosis
- amenorrhoea, menorrhagia, dysmenorrhoea, inter-menstrual bleeding, irregular bleeding patterns, post menopausal bleeding, pre-menstrual syndrome, menopause, menopausal problems
- infertility - primary and secondary
- urinary malfunction: dysuria, urinary incontinence,
- faecal incontinence
- emotional problems, including low mood and symptoms of depression

Common and/or important conditions

- abnormal cervical cytology,
- vaginal and uterine prolapse
- fibroids
- gynaecological infections including Bartholin's abscess and sexually transmitted infections (*covered in detail in the RCGP Curriculum Statement on Sexual Health*)
- gynaecological malignancies
- miscarriage & abortion
 - ectopic pregnancy
 - trophoblastic disease
 - normal pregnancy and pregnancy problems including hyperemesis, back pain, symphysis pubis dysfunction, multiple pregnancy, growth retardation, pre-eclampsia, ante-partum haemorrhage and abruption, premature labour, polyhydramnios, abnormal lies, placenta praevia, deep vein thrombosis and pulmonary embolism, post dates, reduced movements, intrauterine infection, intrauterine death, foetal abnormality
 - sexual dysfunction including psychosexual conditions
 - mental health issues including anxiety, depression, suicide, eating disorders³ and the relationship between these, pregnancy and the menopause

Investigations

- Pregnancy testing
- urinalysis, MSU and urine dipstick
- blood tests including renal function tests, hormone tests

- bacteriological and virology tests
 - knowledge of secondary care investigations including colposcopy and sub fertility investigations

Treatment

- primary care management of the conditions listed above (*Note: sexually transmitted infections and contraception are dealt with in depth in the Curriculum Statement on Sexual Health*)
- menopause management including Hormone Replacement Therapy
- knowledge of specialist treatments and surgical procedures including: laparoscopy, D&C, hysterectomy, oophorectomy, ovarian cystectomy, pelvic floor repair, medical and surgical termination of pregnancy, sterilisation
- understand the risks of prescribing during pregnancy
- palliative care, including management of pain, vomiting, anxiety

Emergency care

- bleeding in pregnancy
- suspected ectopic pregnancy
- domestic violence

Prevention

- health education regarding lifestyle and sexual and mental health
- pre pregnancy issues discontinuing contraception, folic acid, family & genetic history and lifestyle advice

- pregnancy care including health promotion, social and cultural factors, smoking and alcohol, age factors, previous obstetric history, diabetes and obesity, rhesus problems and use of anti d, hypertension and other medical problems, anaemia, acid reflux, leg ache and varicose veins, haemorrhoids, rubella testing and immunisation
- Risk assessment, screening and management of osteoporosis

GPs should take responsibility for the initial assessment and coordination of care of eating disorders, including the determination of the need for emergency medical or psychiatric assessment.

Person-centred care

- Communicate sensitively with women about sexuality and intimate issues (particularly in recognising the impact of past sexual abuse and genital mutilation)
- Recognise that many women consult for lifestyle advice, and that GPs should not over-medicalise these issues

- Recognise the issues of gender and power, and the patient-doctor relationship, and know how to prevent these issues adversely affecting women's health care
- Recognise the needs of lesbian or bisexual women i.e. understand that the partners of some women are women and understand the need not to make assumptions such as the need for contraception
- Describe the importance of confidentiality and informed consent
- Describe the issues relating to the use of chaperones
- Describe the impact of gender on individual cognition and lifestyle, and formulate strategies for responding to this. For example, some women, such as those from low socio-economic groups, or living with an addiction, may have limited control over lifestyle choices.
- Detect whether the female patient wishes to see a doctor of the same sex and arrange this where practical and appropriate.

Specific problem-solving skills

- Demonstrate a reasoned approach to the diagnosis of women's symptoms in a manner that is comfortable for both the patient and the GP using history, examination, incremental investigations and refer appropriately
- Recognise the prevalence of domestic violence and question sensitively where this may be an issue
- Intervene urgently with suspected malignancy and have a low threshold for the referral of breast lumps
- Recognise and intervene immediately when patients present with a gynaecological emergency
- Demonstrate an understanding of the importance of risk factors in the diagnosis and management of women's problems.

A comprehensive approach

- Outline screening strategies relevant to women (e.g. cervical, breast, other cancers, postnatal depression) and discuss their advantages/disadvantages;
- Outline prevention strategies relevant to women (e.g. safer sex, pre-pregnancy counselling, antenatal care, immunisation, osteoporosis)
- Understand the importance of promoting health and a healthy lifestyle in women, and in particular the impact of this on the unborn child, growing children and the family
- Understand the impact of other illness, in both the patient and her family on the presentation and management and of women's health problems.

Community orientation

- Understand the issues of equity and access to health information and services for women
- Evaluate the effectiveness of the primary care service you provide from the female patient's point of view.
- Appraise the role of well-woman clinics in primary care.

A holistic approach

- Discuss the psycho-social component of women's health and the need, in some cases, to provide women patients with additional emotional and organisational support (e.g. in relation to pregnancy options, hormone replacement therapy, breast cancer, and unemployment)

Contextual aspects

- Be familiar with legislation relevant to women's health (e.g. abortion, contraception for minors)

Attitudinal aspects

- Recognise their own values, attitudes and approach to ethical issues (e.g. abortion, contraception for minors, consent, confidentiality, cosmetic surgery)
- Describe the impact of culture and ethnicity on women's perceived role in society and their attendant health beliefs, and tailor healthcare accordingly

Scientific aspects

- Be aware of tensions between science and politics of screening
- Describe and implement the key national guidelines that influence healthcare provision for women's problems (and note that the documents will vary across the UK following devolution)

Psychomotor skills

- Perform a gentle and thorough pelvic examination, including, digital and speculum examination, assessment of the size, position and mobility of the uterus and the recognition of abnormality of the pelvic organs paying attention to professional etiquette, patient consent, comfort and information
- Competently perform a cervical smear with sensitivity and care, providing a positive, informative experience for the woman that allows her to control the process and enhances her view of herself and her body.
- Perform a competent and sensitive breast examination, paying attention to explanation, informed consent, professional etiquette and comfort
- Catheterisation
- Change a ring pessary

2. DERMATOLOGY

New Curriculum Learning Outcomes Skin Conditions

UK health priorities

In the UK, **15 per cent of consultations in primary care relate to problems with the skin**, and skin problems are a common reason for injury and disablement benefit or periods of certified incapacity to work.^{6,78} In 1991–92, they were the fourth commonest reason for people consulting with their GPs in England and Wales.⁹

The vast majority of skin problems can be managed in primary care, relieving pressure on secondary care services. Some general practitioners will wish to develop a special interest in the subject, enabling them to provide an enhanced service in the community and improve the patient's experience.

The following learning objectives describe the knowledge, skills and attitudes that a GP requires when managing patients with skin problems.

Primary care management

- Manage primary contact with patients who have a skin problem.
- Work with patients to empower them to look after their own health and take responsibility for managing their skin problems.
- Promote skin well-being by applying health promotion and disease prevention strategies appropriately including sun protection, occupational health advice and hand care.
- Co-ordinate care with other primary care health professionals, dermatologists and other appropriate specialists, leading to effective and appropriate acute and chronic disease management including prevention and rehabilitation.
- Make timely appropriate referrals on behalf of patients to specialist services, especially to rapid access pigmented lesion (sometimes called skin cancer, mole or melanoma) clinics.

The knowledge base

Symptoms

Key issues in the diagnosis of skin problems will be eliciting of the appropriate signs and symptoms and subsequent investigation and / or referral of people presenting with:

- rashes
- hair loss
- a disorder of their nails

- itch (also known as pruritus)
 - pigmented skin lesions
 - signs of infections of the skin
 - bruising or purpura

- lumps in and under the skin
- photosensitivity and the red face

Common and/or important skin conditions

- Eczema
- Psoriasis
- Generalised pruritus
- Urticaria and Vasculitis
- Acne and rosacea
- Infections (bacterial, viral and fungal)
- Infestations including scabies and head lice

- Leg ulcers and lymphoedema
 - Skin tumours (benign and malignant)
 - Disorders of hair and nails
 - Drug eruptions
 - Other less common conditions such as the bullous disorders, lichen planus, vitiligo, photosensitivity, pemphigus, pemphigoid, discoid lupus, granuloma annulare and lichen sclerosis

Investigations

- Ability to take specimens for mycology from skin, hair and nail
- Basic interpretation of histology reports
- Skin biopsy

Treatment

- Those commonly used in primary care (including an awareness of appropriate quantities to be prescribed and how to apply them)
- Principles of protective care (sun care, occupational health and hand care)
- An awareness of specialised treatments, such as retinoids, ciclosporin, phototherapy and methotrexate
- The indications for and have the skills to perform curettage, cautery and cryosurgery

Emergency care

- Acute treatment of people presenting with skin problems or symptoms thought to be due to skin problems and appropriate referral if necessary. Including:
 - Angioedema and Anaphylaxis
 - Meningococcal sepsis
 - Disseminated herpes simplex
 - Erythroderma
 - Pustular psoriasis
 - Severe nodulo-cystic acne
 - Toxic epidermal necrolysis
 - Stevens-Johnson syndrome
 - Necrotising fasciitis

Prevention

This will involve the following risk factors

- Sun exposure
- Fixed factors: family history and genetics
- Occupation and care of the hands

Genetics

- Describe how genetic factors influence the inheritance of common diseases such as atopic eczema and psoriasis

3. DIABETES

For the purpose of this RCGP Curriculum Statement, metabolic problems include obesity, diabetes mellitus, thyroid disorders, hyperlipidaemia, hyperuricaemia, and endocrine problems.

Rationale for this curriculum statement

Obesity is a risk factor for a variety of medical problems, including type 2 diabetes, hypertension, hyperlipidaemia, coronary heart disease, stroke, osteoarthritis, gout, sleep apnoea, gallstones, and cancer of the breast, prostate and colon.^{1,2} People who are overweight have a higher all-cause mortality than average, which increases with greater obesity.² The prevalence of obesity in children and adults is increasing in the UK and elsewhere across all gender, age, race and ethnicity groups.³

The following UK statistics have been compiled by the National Audit Office:⁴

- 1 in 5 adults are obese
- The prevalence of obesity has trebled over the last 20 years
- Nearly two thirds of men and over half of women are overweight or obese
- The estimated human cost:
 - o 18 million sick days a year
 - o 30,000 deaths a year, resulting in
 - o 40,000 lost years of working life
 - o Deaths linked to obesity shorten life by 9 years on average
- The estimated financial cost:
 - o £½ billion a year in treatment costs to the NHS
 - o Possibly £2 billion a year impact on the economy

Diabetes Mellitus is a disorder of glucose metabolism with associated disorders of lipid metabolism and hypertension. Each type of diabetes (type 1 and type 2) has profound daily and life-long effects on the well being of individuals. In 1998, around 1.8 million people in the UK were diagnosed as having diabetes.⁵ At least a million more - 'the missing million' - are thought to have diabetes but do not know it yet.⁶⁻⁸ The prevalence of type 2 diabetes is increasing in the UK⁹⁻¹² and, as a result, there will be increasing demand on the resources of the nation. Some research suggests that as much as 9% of the total NHS budget is spent managing diabetes.¹³ Studies have demonstrated that the management of the modifiable risk factors associated with diabetes reduces both morbidity and mortality from the common chronic complications of diabetes.¹⁴⁻¹⁶

UK health priorities

National Service Framework for Diabetes sets out twelve standards covering the identification of people with diabetes, clinical management, emergency and secondary care, pregnancy and the detection and management of long-term complications¹⁹. It was later adapted for use in Wales, the Diabetes NSF Standards (Wales) were published on 29 April 2002. The Delivery Strategy was launched in Wales in Spring 2003. The Scottish Diabetes Framework was published in April 2002.

Learning Outcomes for Diabetes

The following learning objectives describe the knowledge, skills and attitudes that a GP requires when managing patients with metabolic problems.

Primary care management

- Manage primary contact with patients who have a metabolic problem.
- Co-ordinate care with other primary care health professionals, such as diabetes nurse specialists, dietitians, district nurses, community matrons, chiropodists and opticians to enable chronic disease management.
- Explain the indications for referral to an endocrinologist for management of complex metabolic problems or investigation of endocrine disorders.

The knowledge base

Symptoms

Patients with metabolic problems are frequently asymptomatic or have non-specific symptoms, such as tiredness, malaise, weight loss or gain etc.

Certain symptoms raise clinical suspicion of metabolic problems:

- Diabetes mellitus – tiredness, polydipsia, polyuria, weight loss, infections

Common and/or important conditions

- Obesity
- Diabetes mellitus – type 1 and 2
- Impaired Glucose Tolerance

Investigations

- Body mass index calculation
- WHO diagnostic criteria for diabetes mellitus
- Near patient capillary glucose measurement (including patient self-monitoring)
- HbA1c and fructosamine to assess glycaemic control
- Albumin: creatinine ratio or dipstick for microalbuminuria
- Interpret serum electrolyte and urate results

- Interpret lipid profile tests – total cholesterol, HDL, LDL, triglycerides
- Visual acuity and retinal photography
- Knowledge of secondary care investigations including the glucose tolerance test,

Treatment

- Understand principles of treatment for common conditions managed largely in primary care – obesity, diabetes mellitus,
 - Chronic disease management including specific disease management, systems of care, and multidisciplinary team work for people with established metabolic problems

- Communication with patients and their families and inter-professional communication both within the PHCT and between primary and secondary care

Emergency care

- Acute management of diabetic emergencies – hypoglycaemia, hyperglycaemic ketoacidosis and hyperglycaemic hyperosmolar non-ketotic coma.

Prevention

- Health promotion activities include dietary modification and exercise advice
- Obesity and diabetes mellitus are risk factors for other conditions, so optimal management is preventative

Person-centred care

- Recognise that non-concordance is common for chronic metabolic conditions (e.g. diabetes) and respect the patient's autonomy when negotiating management.
- Communicate the patient's risk of complications from obesity and diabetes mellitus clearly and effectively in a non-biased manner.
- Develop a flexible approach to health promotion which reflects that certain groups with obesity or diabetes mellitus require different approaches e.g. children, adolescents and young adults, pregnant women, ethnic minorities, elderly and housebound patients.
- Negotiate a programme of weight reduction sensitively with patients, giving appropriate health promotion advice regarding diet, exercise and pharmacological therapies.
- Utilise disease registers and data recording templates effectively for opportunistic and planned monitoring of metabolic problems to ensure continuity of care between different health care providers.

Specific problem-solving skills

- Intervene urgently when patients present with a metabolic emergency e.g. hypoglycaemia and hyperglycaemic conditions.
- Recognise that patients with metabolic problems are frequently asymptomatic or have non-specific symptoms, and that diagnosis is often made by screening or recognising symptom complexes and arranging appropriate investigations.
- Demonstrate a logical, incremental approach to investigation and diagnosis of metabolic problems.

A comprehensive approach

- Recognise that patients with diabetes often have multiple co-morbidities and consequently polypharmacy is common.
- Develop strategies to simplify medication regimes and encourage concordance with treatment.
- Advise patients appropriately regarding lifestyle interventions for obesity, diabetes mellitus, hyperlipidaemia and hyperuricaemia.

Community orientation

- Recognise that environmental and genetic factors affect the prevalence of metabolic problems e.g. Diabetes is more prevalent in the UK in patients of Asian and Afro-Caribbean origin²¹ Hyperuricaemia is more common in prosperous areas and is associated with obesity, diabetes, hypertension and dyslipidaemia²².
- Recognise that public health interventions are likely to have the largest impact on obesity and diabetes mellitus and support such programmes where possible e.g. exercise on prescription

- Describe the exemptions from prescription charges for patients with metabolic conditions

A holistic approach

- Recognise the psychosocial impact of diabetes and other long-term metabolic problems e.g. risk of depression, restrictions on employment and driving for diabetes, sexual dysfunction.
- Recognise that stigma is associated with obesity.
- Empower patients to self-manage their conditions as far as practicable.

Contextual aspects

- Recognise the central role of primary care in managing diabetes.
- Understand the key government policy documents that influence healthcare provision for metabolic problems.
- Understand the systems of care for metabolic conditions, including the roles of primary and secondary care, shared care arrangements, multidisciplinary teams and patient involvement.

Attitudinal aspects

- Ensure that a patient's weight does not prejudice the information communicated or the doctor's attitude towards the patient.
- Ensure that the risks of diabetic complications are not over-stated in order to coerce a patient into complying with treatment.

Scientific aspects

- Describe and implement the key national guidelines that influence healthcare provision for Diabetes

4. DRUGS & ALCOHOL

<p>Asking about drugs</p> <ul style="list-style-type: none"> • Ideally doctors should ask all patients about their drug use (prescribed and non prescribed) e.g. 'do you smoke cigarettes, what about alcohol, and do you use any other drugs' • Given the opportunity many patients will volunteer problem drug use • The doctor should then ask: <ul style="list-style-type: none"> o What do you use? o How much per day? Per average week? o What route? (oral, injecting, smoking), o Longest period of abstinence? o Treatment history <p>Brief intervention for alcohol problems</p> <p>Brief intervention involves the following:</p>	F	feedback
R	responsibility	
A	advice	
M	menu	
E	empathy	
S	self-efficacy	

assessment and evaluation of the problem
 emphasizing that drinking is by choice
 explicit advice on changing drinking behaviour
 offering alternative goals and strategies
 the role of the counsellor is important
 instilling optimism that the chosen goals can be achieved

Harm minimization for alcohol

Harm minimization interventions include advising where drinking should be avoided, these include:

- before or during driving;
- before swimming;
- generally, before or during active physical sport;
- before working or in the work place when appropriate functioning would be adversely affected by alcohol;
- when taking medication, where alcohol is contra-indicated.

Planning Sheet

Topic

Aims

What are the key messages that you want to get across? What are the learners needs around this topic? Do my aims cover this? Remember that last term people wanted to know about red flags and prepare themselves for the exam. Could I find an old exam question around the subject to give as homework the week before?

Objectives

What specifically will the learners learn by the end of this session?

Methods

What would be the most appropriate way to teach about this subject?

Resources

Should we do this in house or invite an outside resource? If so, how much will they cost? Can we afford it? Have I swapped email address with my co organisers so we can email each other to co-ordinate our preparation?

Worcester Vocational Training Scheme