School of Medicine

Year 3 - 2011/12

**Clinical Communication**

**Spring term session guide**

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**Communicating information and**

**patient safety**

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**Clinical Communication**

**Communicating Information and Patient Safety**

**Learning objectives**

In your Clinical Communication (CC) curriculum so far we have focused on mainly the skills associated with gathering information and aimed to develop knowledge, attitudes and skills commensurate with patient-centred interviewing. We have touched on communicating information to colleagues in the form of case presentations as well as considering the role of written materials in information exchange.

In this session we aim to explore the skills associated with effective *giving* information. We will use several contexts in which we give information to patients (explaining a procedure, explaining risk, communicating during procedures) and colleagues (communicating critical information, handovers, case presentations).
We will also consider the close relationship between communication and patient safety in these areas.

After this session, you are expected to be able to:

1. Outline the GMC specified communication and patient safety learning outcomes in *Tomorrow’s Doctors*
2. Describe key principles for effective information exchange with patients
3. Describe key principles for effective information exchange with colleagues
4. Describe the impact of communication with patients and colleagues in patient safety

**Session outline**

Introduction

Activity 1: GMC competencies in communication and patient safety

Activity 2: Principles of communicating information

Activity 3: Procedural information for patients

Activity 4: Communicating risk information

Break

Activity 5: Communicating during procedures

Activity 6: Communicating with colleagues

Closure

**A note about the OSCE**

We will be making references to the OSCE at various points throughout the session. Remember that OSCE stations are designed to reflect the way doctors integrate technical, professional and communication skills. The exam will include a mix of history taking, examination, procedural and information giving stations. You will be assessed on your ability to integrate your communication skills with patients (and/or colleagues) in every station. **Activity 1: GMC guidelines for new graduates in communication and patient safety**

In the last decade, the issue of patient safety in health care has increased in importance both nationally and internationally. In the UK, the Safer Patients Initiative (http://www.health.org.uk/publications/safer-patients-initiative/) sets out a programme of initiatives and implementation strategies designed to improve patient safety at clinical level.

*Aim: To review the GMC guidelines so that you can identify areas for your own development*

The General Medical Council’s document, *Tomorrow’s Doctors: Recommendations on Undergraduate Medical Education (2003)* contains several references to learning outcomes in communication and patient safety expected of new graduates (<http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/tomorrows_doctors.asp>)

See also the appendix of this document for a summary

As educators our responsibility is to:

* Provide you with experience under supervision to achieve these outcomes
* Assess your competence in these skills
* Stress the importance of communication skills
* Raise the profile of health and safety of the public in the curriculum

The aims of this session are to:

* Provide you with an opportunity to reflect on your progress towards meeting these outcomes
* Discuss and practise ways in which you could manage a range of challenging patient safety and clinical communication scenarios

Although the focus of this session is communication, we will be making links to patient safety throughout as these two themes are inextricably linked.

In addition to the GMC document, it is worth exploring the Foundation Programme (FP) (<http://www.foundationprogramme.nhs.uk/pages/foundation-doctors/key-documents>) curriculum where there are explicit learning outcomes associated with communication and patient safety. Much of the FP is based on these concepts together with professionalism. It is critical for you to start thinking about and actively gaining clinical experience with these concepts in mind.

**Patient Safety: The research context**

A substantial amount of research into patient safety has been conducted in Accident and Emergency departments where the proportion of preventable injuries is believed to be highest when compared to the operating theatre (Wears et al 2010). Some of these studies have carefully examined the role of communication in these contexts (see for example, Woloshynowych 2007) and the implications for patient safety. Several key findings emerge from these studies: In settings like A+E there are high levels of communication activity; effective communication in such complex environments is essential to the effective transaction of medical treatment and patient safety; there are however, high levels of interruptions increasing cognitive and communication loads which potentially can lead to mistakes and patient harm; a focus on communication is, therefore, a critical focal point when examining the issue of patient safety (Redfern et al 2009).

These studies go a significant way toward highlighting the importance of communication and patient safety. There is an overriding concern to involve the patient in their own safety (Vincent 2010). However, the focus of this research tends to be on examining the relation between communication load, cognitive load and human performance among health care teams. This concentration on inter-professional communication is an important component of patient safety and will be examined in the latter half of the session. However, by and large clinician-patient communication tends to receive less attention. At a deeper conceptual level, communication is treated as a means of information transfer between participants.
As a consequence we learn little about the communication skills participants themselves rely on to handle interruptions, distractions and heavy communication loads when dealing with patients.

This session will aim to introduce you to communication skills that can be used to effectively give information and to counter interruptions, distractions and other practical contingencies when treating patients. The guide outlines communication issues in relation to clinical practice and draws on your experiences as medical students. The session will also provide you with an opportunity to consolidate your knowledge and experience in these areas, consider how the information is relevant to your forthcoming OSCE and provide a link through your remaining undergraduate programme to the FP.

**Activity 2: Communicating information**

*Aims: To review general principles of giving information*

*To review skills necessary for effective information giving*

We reviewed the Calgary-Cambridge Model for consultations and used it as a framework to develop consultation skills (Silverman et al, 2004).



The general aims of effective information giving are outlined in the “explanation and planning” stage

* Providing the correct amount and type of information
* Aiding accurate recall and understanding
* Achieving a shared understanding incorporating the patient’s illness framework
* Planning: shared decision making

The list below sets out a broad range of skills that are important for explaining information to patients. Consider what information is essential to convey and also what additional information the patient may want. Effective use of these skills contributes to achieving the broad aims laid out on the previous page.

# Skills that can be used to achieve these objectives are:

* Before giving them the information gather some first!;
	+ Check what the patient already knows
	+ Determine amount of information patient wants (just the essentials, or prefer more detail?)
	+ Is there anything in particular they want to know, what they are concerned about?
* Organise information so that it is logical and clear
* Use explicit categorisation or signposting – “chunk and check” - (E.g. “I have three things to tell you. The first is about the procedure, the second is about how you can prepare for it and the third is what happens after the procedure…”)
* Relate explanations to patient’s illness framework (ideas, concerns and expectations, need for action, motivation, perceived benefits) – based on the information gathered
* Use repetition and summarising – People are more likely to remember the first and last bits of information – primacy and recency effect
* Use language that is understandable, avoid jargon, explain medical terms
* Use visual methods of conveying information
* Check patient’s understanding
* Provide opportunities for and encourage the patient to contribute
* Pick up verbal cues and non-verbal cues
* Use active listening
* Explain causation, diagnosis, treatment, tests, seriousness, expected outcomes, short-and long-term consequences
* Check regularly if the patient has any questions
* Ask specifically about potential anxieties
* Discuss negative outcomes
* Use specific (rather than general) advice statements

**Activity 3: Procedural information for patients**

*Aims: To consider the nature of information about procedures/tests which patients require and ways in which it may be delivered*

*To consider the role of informed consent and how to achieve it*

Although you have probably developed extensive knowledge about a range of procedures, it is likely that the information is focused on your perspective as a clinician. It is important to remember that patients may require information about aspects of the procedure that are perhaps less important to you. However, you will need to be able to fill in the gaps. Of course, not all of the questions are relevant for every procedure.

What is it (test/procedure)? How do you explain this in lay terms?

When will it take place?

Where will it happen?

What preparation is necessary?

How long it will last?

How painful it will be?

Will I be awake?

Who will do it?

Who else will be present?

What happens afterwards?

What are the risks?

Are there any other risks?

What are they?

What are the side/after effects?

What happens if I don’t have the test?

Are there any alternatives?

When the result will be available?

Who will give me the results?

How will I get the result?

Do I have to sign a consent form?

Do I have to take time off work?

For the test/procedures listed below that the GMC expect new graduates to be competent in (Tomorrow’s Doctors 2003), can you correctly answer all of the above questions?

Inserting nasogastric tube

Inserting a cannula into peripheral veins

Giving intravenous injections

Inserting a urinary catheterisation

Performing venepuncture

Performing suturing

Obtaining arterial blood gases

Using a nebuliser correctly

Carrying out basic respiratory function tests

Administering oxygen therapy

In addition to the procedures in which you are expected to have competence, you are also expected to have knowledge of other procedures, including:

Flexible sigmoidoscopy

Lumbar puncture

Arthroscopy

Lithotripsy

Cervical smear

Fine needle aspiration

See the “Guide to Practical Clinical Skills” in the intranet for guidance on competencies at Year 3

<https://education.med.imperial.ac.uk/Skills/Guide-PracticalClinicalSkills-Jan10.pdf>

**Questions to consider**

*To what extent do you think you are competent in these procedures?*

*Have you practised in the clinical skills lab?*

*Have you done these on real patients?*

*Have you been observed performing them?*

*Have you been given feedback?*

*How do you know if you are doing them safely?*

*How many of these procedures have you seen?*

*Have you heard doctors explain these procedures to patients?*

*Have you explained any of these procedures?*

*What are the potential benefits of obtaining informed consent?*

*What skills are necessary for obtaining informed consent?*

*For patients undergoing procedures, what factors compromise their safety?*

*Are any of these preventable?*

*What advice would you give a patient about to enter hospital to ensure they have a good outcome and are not harmed by their care?*

**Activity 4: Explaining risk**

*Aim: To reflect on the approaches to explaining risk to patients*

Communicating with patients about risk is central to effective decision-making. However, there is evidence that this is not done well (if at all). The general principles of “giving information” apply. Consider the outcome of the previous exercise and how you may discuss mammogram or FOTB results with patients.

Standardising language does not allow the flexibility required for dealing with people with different levels of literacy, numeracy, and attitudes (Berry et al, 2003)

“The nature of risk, its burden, the context and the timeframe over which one has to live with it, are all important determinants of how individuals interpret risk for themselves, and whether they choose to accept it.” (Edwards & Elwyn, 2001)

Should I use words or numbers?

There is conflicting evidence about whether risk information is best described verbally or numerically.

Verbal information (“the risk of this side effect is low”) is retained better by patients and many patients prefer this delivery. Others patients prefer numerical data (1:10,000). However, many question the patient’s ability to make sense of this data.

Paling (2003) makes the following recommendations:

* Use absolute risks or actual numbers
* Use natural frequencies
* Use frequency statements
* Use consistent denominators
* Frame the risk both positively and negatively
* Present information visually
* Use time frames, life-time risks and compare medical with non-medical risks
* Use individualised or tailored risk estimates
* Avoid descriptive terms such as ‘high’ or ‘low’ risk

Verbal risk scale (Calman, 1996)

High >1:100

Moderate 1:100-1:1000

Low 1:1000-1:10000

Very Low 1:10000-1:100000

Minimal 1:100000-1:1000000

Negligible <1:1000000

* No empirical basis
* Considerably overestimates the risk of side-effects by lay-people, patients and doctors
* Results in judgements of increased risk to health and reduced intention
to take the medication compared with equivalent numerical presentations of risk

There are many terms used to communicate risk:

*Absolute Risk (AR):* The probability that an individual will experience the specified outcome during a specified period. It lies in the range 0 to 1, or is expressed as a percentage. In contrast to common usage, the word "risk" may refer to adverse events (such as myocardial infarction) or desirable events (such as cure).

*Absolute Risk Reduction (ARR):* The absolute difference in risk between the experimental and control groups in a trial. It is used when the risk in the control group exceeds the risk in the experimental group, and is calculated by subtracting the AR in the experimental group from the AR in the control group.

*Number needed to treat (NNT):* One measure of treatment effectiveness. It is the average number of people who need to be treated with a specific intervention for a given period of time to prevent one additional adverse outcome or achieve one additional beneficial outcome. NNT can be calculated as 1/ARR.

*Relative Risk (RR):* The number of times more likely (RR > 1) or less likely (RR < 1) an event is to happen in one group compared with another. It is the ratio of the absolute risk (AR) for each group.

It is easy for risk information to be misinterpreted. In 1995, the statement that third generation contraceptive pills “doubled the risk of thromboembolism” (relative risk) created a media-led panic resulting in many women stopping the pill and a boom in unplanned pregnancies. This doubling in risk equated to 15 cases in 100000.
The irony was that the risk of thromboembolism from pregnancy is 6-20 cases per 10000 (i.e. 10 fold higher than for the pill).

Framing

The way the data are presented can influence the patient’s interpretation and ultimately their decision.

“This procedure has a 70% success rate”

Versus

“This procedure has a 30% failure rate”

Framing can be subconscious, but in many cases doctors use it to influence the patient’s decision. Be aware of your own ideas about the options available and whether you are trying to get the patient to agree with your viewpoint rather than come to their own decision. One way of avoiding framing is to present the data both ways “this procedure is successful in 70% of patients, but the rest see no improvement”.

**Risk Information - exercise**

“The probability that a woman has breast cancer is 0.8%. If she does have breast cancer, the probability that a mammogram will show a positive result is 90%. If a woman does not have breast cancer, the probability of a positive result is 7%. ”

In other words:

 out of every 1000 women have breast cancer.

Of these , will have a positive result on mammography.

Of the who do not have breast cancer some will still have positive mammograms.”

Natural Frequencies Diagram

The standard test for colorectal cancer is the faecal occult blood test (FOTB). For symptom-free people over 50 screened using this test, the probability that one of these people has colorectal cancer is 0.3%. If they do have cancer, there is a 50% probability that they will have a positive FOTB. If they don’t, the probability of a positive test is 3%.

 out of every people have colorectal cancer.

Of these people with colorectal cancer, will have a positive FOTB test result.

Of the remaining people without cancer, will still have a positive FOTB.

So of people who have a positive test, only have cancer, which is a probability of % or 1 in .

**Activity 5: Communicating during procedures**

*Aim: To reflect on skills required for communicating during procedures*

Most of your CC teaching has focused on history-taking and giving information while the patient is in the consulting room. Communicating with patients while you are doing physical examinations or conducting procedures can demand a more complex set of communication skills – especially if you lack confidence in the technical skills needed for the procedure.

In medical curricula, communication skills are often taught separately from technical skills and by different people. However, in clinical practice you need to be able to integrate these sets of skills as well as respond to the contextual cues of your setting (e.g. unfamiliar equipment, interruptions etc) (Kneebone et al, 2006)

Clinicians respond to the challenge of integrating these skills in different ways.
They might stop talking (and listening) while they are conducting a procedure, especially if they lack confidence or experience in the technical skill. This can leave the patient confused and dissatisfied. Others provide a running commentary of what they are doing. Again, this can leave some patients irritated.

The FP has the Direct Observation of Procedural Skills (DOPS) assessment in which junior doctors are observed performing procedures on real patients. We will use this form to guide our observation in a scenario-based simulation.

What are critical *communication* issues relevant while you are conducting procedures?

Look at your patient for non-verbal cues.

* Facial expressions – grimacing
* Skin colour
* Conscious state
* Physical movement – fidgeting, stillness

Listen to your patient for verbal cues.

* “How much longer?”
* “My sister had a mole like this removed…”

Let the patient know what they need to do during the procedure.

* “It is very important that you stay still for the 10 minutes it takes to complete the procedure.”
* “If you think you will have to move, then let me know and I can stop what I am doing.”
* “This drape is *sterile* so it means that the area around the wound is clean.
It is very important that you do not touch it.”
* “If you cannot tolerate the discomfort, then just say so.”
* “The procedure should not hurt so if you feel pain, it is important you tell me.”

**Activity 6: Communicating with colleagues
- Giving information at critical moments**

*Aim: To consider approaches to effective telephone communication for critical information*

Knowing the limits of your competence is important. You need to be confident to call senior colleagues to seek help/guidance.

*Skills*

Speak clearly at all times

Appropriate volume

Offer to repeat information

Listen actively

Check that information is heard and understood

Have relevant information at hand

Clarify instructions by paraphrasing or repeating

Document call

Logical order

Brevity

*Content*

State own name (and role)

Use the name of doctor or health care professional you are calling

If the doctor or health care professional is unknown to you, check their role

State purpose of call

Give essential information in summary form

* Relevant patient details
* Current status
* Relevant history
* Concerns

Offer additional information

Make a clear request for guidance

* “I do not know what to do next…”
* “I am concerned that … because…”

Summarise received instructions and your proposed actions

Clarify if further advice is needed and how this can be obtained

See: <http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm>

**Communicating with colleagues - Case presentations**

In 2nd year you participated in a session on case presentations. This is an important aspect of clinical work that is related to handover information. Remembering that transmission of accurate information is a critical element of patient safety.

From your 2nd year Communication Programme Guide - The content of case presentations depends on their purpose and to whom they are given.
A multidisciplinary clinical case presentation might include the following (Billings & Stoeckle, 1999):

1. Description of the diagnosis (if known) and its presentation in the patient
2. Clinical reasoning (how was the diagnosis confirmed - history, clinical tests)
3. Treatment including pharmacological, surgical &/or other interventions
4. Recovery (response to treatment - psychological and physiological)
5. Discharge plan (ability of patient to manage)
6. Notable points including features of the patient’s past medical history, occupation, unique life experience etc.

Consider:

* Omission of irrelevant material (for that audience)
* Commence with a summary statement
* Present illness and relevant past medical history, social and family history and systems review
* Separate/distinguish subjective from objective data
* Concise/compress/group the amount of facts
* Present the most important information first
* Similarities with written presentations
	+ Orderly, familiar organisational format
	+ Full characterisation of symptoms
	+ Reconstruction of the patient’s narrative into a coherent description of an illness

Bullet presentations (<1 minute) are typically given either in ward rounds over the telephone. It is a very brief description often used to introduce the patient to a new audience. For example:

* “Mr Lucas is a 42-year-old journalist who presents with knee problems for three months and was found for the first time to be hypertensive. As an enthusiastic jogger, Mr Lucas is anxious to have the knee problem resolved.”
* “Mrs O’Connor is a 56-year-old widowed call centre operator with long-standing insulin-dependent diabetes and has been admitted for investigation of weekly dizzy spells during the past two months.”

There are obvious limitations with such presentations but it is important to recognise that a lot of information can be imparted in very few words. These provide minimal insight into the patients’ ideas, concerns or expectations or the impact of the presenting complaint on their functional capacity but they do provide key medical information to further explore these aspects of the patient’s experience.

A formal case presentation (sometimes called a short case) (5-7 minutes) is usually given to supervisors and colleagues at the bedside or in a sit-down conference.

A complete case presentation (sometimes called a long case) might last at least 20 minutes and will typically recapitulate the bulk of the written record. They may be used to assess a clinicians’ ability in clinical reasoning or to identify and manage unusual or complex presentations of illness. In the Foundation Programme you will be required to conduct Case based discussions which will involve this approach. After your presentation, your assessor will ask you questions about your actions and also about what you have learned from looking after the patient. It is very important that you reflect on your interactions with patients so as you can identify what works and what does not. We hope it is becoming obvious why reflective practice is so important for patient safety.

#### What are key skills for making presentation?

Verbal

* Framework for information
* Introduction
* Check identity
* Statement of purpose – “I’d like to update you on Mrs X who has been admitted for cholecystectomy tomorrow.”
* Invite clarification and checking
* Use patient’s quotes – “The patient clearly states …”
* Distinguish your judgements from others – “My concern is …”
* Emphasis – “I think the past anaesthetic history needs further investigation as there was clearly a problem several years ago.”
* If there is an overarching difficulty/issue with the patient, state this early on. “The patient has difficulty remembering details.” “The patient has reported several discrepant pieces of information.”
* If the patient has had several operations, previous admissions, medications, then quantify them. “The patient has been admitted to hospital on 7 occasions over the last 14 years. Four were associated with a motor car accident in 1990 in which the patient received a crushing injury to his right knee.
These admissions all required surgery for reconstruction. The other 3 more recent admissions were associated with angina. This is now stable and controlled by XXX.”
* “The patient currently takes 4 prescribed medications. First is XXX, second XXX, third and fourth XXX.”
* Use summaries – start with an introductory statement, finish with a collation of key points AND state that you are making a summary. “So, in summary…” “Finally, …” “In conclusion, …”
* Choose language that accurately reflects the substance of the information – urgent, critical, essential, definitive, crucial

Non-verbal

* Eye contact, body positioning, modulate your voice, hand gestures, eye contact, body positioning to make your point
* Consider the limitations of the listener – clear; uncluttered; easily grasped; guided through a reasoning process

**Communicating with colleagues - Handovers**

*Aim: To explore the purpose and content of an effective handover*

Handovers are a special example of case presentations.

* What is the purpose of handover?

The efficient transmission of information about patients between health care professionals

Provides for continuity of care through continuity of information (can avoid unnecessary repetition)

Promote patient safety

Demonstrate team rather than individual approach to care

Educative benefits for multidisciplinary teams

Can be used to identify a range of problems

* What is the content?

Depends on the purpose and to whom the handover is being given

At shift change in ward

List of patients during shift should be available

Focus on ongoing management plans especially reviewing patient or urgent investigations – Have they been arranged? What is the resuscitation status? Are there any urgent results of tests expected? When should they be followed up? Has the information been recorded?

Handovers can be either verbal/non-verbal (electronic, written information) or both

Key information is exchanged

Handovers likely to become more frequent and an essential part of patient care

* How long?

10-30 minutes

Bedside review may take longer

* Where do handovers take place?

Any clinical setting

Bedside review of all or specific patients

Brief ward round with specific staff

Preferably in space that is free from distraction and with access to necessary medical information

* When?

Sometimes fixed e.g. shift changeover

Known to medical and paramedical staff

Adequate overlap of shifts/rotas

Unplanned

Consultant anaesthetist/surgeon

Effective handovers do not happen by chance but require co-ordination of multi-disciplinary teams and organisational structures

* What are the obstacles to effective handover?

Insufficient time

Lack of preparation

Insufficient attention to the verbal handover – adjusting equipment, observing patient etc

Not reading written handover information

Incomplete written or verbal information

Imprecise role function – important information may be omitted because participants are uncertain as to each others’ roles during handover

Multidisciplinary handovers can be beneficial because all participants are aware of medical and nursing factors that may impact on patient well being

A nominated lead person can prevent multiple conversations occurring simultaneously resulting in an incomplete sharing of information or conflicting information

Two way process – the team handing over must engage the next team who are expected to ask questions and clarify uncertainties

Inadequate information technology (Junior Doctors Committee, 2004)

* What are the benefits to doctors and other health care professionals?

Educational

Professional protection

Reduction of stress

Job satisfaction (Junior Doctors Committee, 2004)

* How can you maximise your learning during handover?

Listen to clinical information – what is transmitted, why, how

“Doing” handovers, observing, interacting, reflecting

Use a structured template to help process handover information

Formal/informal interactions with more experienced staff (Royal College of Physicians Handbook, 2000)

* What are the benefits for patients of effective handover?

Safety improved

Less discontinuity of care

Decreased repetition

Increased service satisfaction (Junior Doctors Committee, 2004)

Handover during emergencies requires a specific set of skills. A study in Scotland investigating handover practices of ambulance officers to medical staff in the emergency department identified that both ambulance staff and doctors were reasonable satisfied with handover but doctors were less satisfied than ambulance officers. Doctors may have been “distracted” by presence of the patient during verbal handover so may not have completely attended to ambulance officer handover. Ambulance officers reported little formal training in handover. Only 19% had received training. The officers expressed a strong need for training in handover skills.
Further, systems were largely not in place for medical staff to give feedback to ambulance officers on handover (Thakore & Morrison, 2001)

**Further reading**

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**APPENDIX**

General Medical Council (2003) *Tomorrow’s Doctors: Recommendations on Undergraduate Medical Education* contains several references to patient safety and communication.

The following information comes from this document and this is not an exhaustive list.

The essential skills that graduates need must be gained under supervision. Medical schools must assess students’ competence in these skills.

The curriculum must stress the importance of communication skills and the other essential skills of medical practice. (p3)

The health and safety of the public must be an important part of the curriculum. (p3)

In relation to curriculum outcomes:

Doctors must practise good standards of clinical care, practice within the limits of their competence, and make sure that patients are not put at unnecessary risk. (p4)

Good clinical care (p4)

1. Know about and understand the following:
2. Our guidance on the principles of good medical practice and the standards of competence, care and conduct expected of doctors in the UK
3. How errors can happen and the principles of managing risk
4. Be able to perform clinical and practical skills safely
5. Recognise personal and professional limits, and be willing to ask for help when necessary
6. Recognise the duty to protect patients and others by taking action if a colleague’s health, performance or conduct is putting patients at risk.

Maintaining good medical practice (p5)

* 1. Be able to gain, assess, apply and integrate new knowledge and have the ability to adapt to changing circumstances throughout their professional life
	2. Be willing to take part in continuing professional development to make sure that they maintain high levels of clinical competence and knowledge
	3. Understand the principles of audit and the importance of using the results to improve practice
	4. Be willing to respond constructively to the outcome of appraisal, performance review and assessment

# Relationships with patients (p5)

Doctors must develop and maintain successful relationships with their patients

1. Know about and understand the rights of patients
2. Be able to communicate effectively with individuals and group
3. Demonstrate the following attitudes and behaviour
4. Accept the moral and ethical responsibilities involved in providing care to individual patients and communities
5. Respect patients regardless of their lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age, or social or economic status
6. Respect the rights of patients to be fully involved in decisions about their care, including the right to refuse to take part in teaching or research
7. Recognise their obligation to understand and deal with patients’ healthcare needs by consulting them and, where appropriate, their relatives or carers.

# Working with colleagues (p5)

Doctors must work effectively with colleagues

* 1. Know about, understand and respect the roles and expertise of other health and social care professionals
	2. Be able to demonstrate effective team working and leadership skills
	3. Be willing to lead when faced with uncertainty and change

20. Graduates must be able to communicate clearly, sensitively and effectively with patients and their relatives, and colleagues from a variety of health and social care professions. Clear communication will help them carry out their various roles, including clinicians, team member, team leader and teacher.

21. Graduates must know that some individuals use different methods of communication, for example, Deafblind Manual and British Sign Language.

22. Graduates must be able to do the following:

1. Communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds, or their disabilities.
2. Communicate with individuals who cannot speak English, including working with interpreters.

23. Students must have opportunities to practice communicating in different ways, including spoken, written and electronic methods. There should be guidance about how to cope in difficult circumstances. Some examples are listed below:

1. Breaking bad news
2. Dealing with difficult and violent patients
3. Communicating with people with mental illness, including cases where patients have special difficulties in sharing how they feel and think with doctors
4. Communicating with and treating patients with severe mental or physical disabilities.
5. Helping vulnerable patients

26. Graduates must be able to do the following:

1. Manage their own time and that of others
2. Prioritise tasks effectively
3. Reflect on practice, be self-critical and carry out an audit of their own work and that of others
4. Follow the principles of risk management when they practise

28. Graduates must be aware of current developments and guiding principles in the NHS, for example

1. Patient-centred care
2. Systems of quality assurance such as clinical governance
3. Clinical audit
4. The significance of health and safety in the healthcare setting
5. Risk assessment and management strategies for healthcare professionals
6. The importance of working as a team within a multi-professional environment

29. Graduates must know and understand the main ethical and legal issues they will come across

1. Make sure patient’s rights are protected
2. Respond to patient’s complaints about their care
3. Deal appropriately, effectively, and in patients’ interests, with problems in the performance, conduct or health of colleagues

30. Graduates must understand the principles of good practice set out in our publication Seeking patients’ consent: the ethical considerations. These include:

1. Providing enough information about conditions and possible treatments to allow patients to make informed decisions about their care
2. Responding to questions
3. Knowing who is the most appropriate person to ask for consent
4. Finding out about a patient’s ability to make their own decisions and to give their consent; and
5. Statutory requirements that may need to be taken into account