

COMMUNICATION SKILLS AND ETHICS

Steps in preparation for communication skills and ethics station:

Step 1: Learn the ethical and legal issues in medicine

Step 2: Learn the general principles of communication with patient/family

Step 3: Practice an approach to the station (how to listen and respond to the patient's concerns and impart information in a clear and sensitive manner)

STEP 1: ETHICAL AND LEGAL ISSUES IN MEDICINE

Principles of medical ethics

- Protect the patient's life
- Respect the patient autonomy
- Fairness and justice
- Duty to do good (beneficence)
- Avoiding doing harm (non-maleficence)

Good medical practice principles (GMC)

- Show respect for human life
- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
- Keep your professional knowledge and skills up to date
- Recognise and work within the limits of your competence
- Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
- Treat patients politely and considerately
- Respect patients' right to confidentiality
- Work in partnership with patients
- Listen to patients and respond to their concerns and preferences
- Give patients the information they want or need in a way they can understand
- Respect patients' right to reach decisions with you about their treatment and care
- Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession.
- You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions
- In summary, good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity

Hospital records

- Patients have the right to see their medical notes and computer records, which are subject to the Data Protection Act 1998.
- If a patient asks to review their notes it should be done with a member of the medical team, to explain medical terms.

Consent

- Patients have the right to self-determination and, after an informed two-way discussion, can refuse any suggested treatment
- In order to obtain consent, an individual must be deemed competent to understand and retain the information, using it to reach a reasonable decision
- It is not always deemed to be in the best interests of the patient to discuss extremely unlikely side-effects, as it may lead to undue anxiety and poor decision-making.

Special situations in consent taking:

- **Unconscious patients:** doctors can give emergency treatment for unconscious patients (who are unable to give consent) if it is in the best interests of the patient (doctrine of necessity). If relatives are available they should be informed rather than opinions canvassed
- **Patients with impairment of mental function:** If mental impairment is suspected a psychiatrist must be consulted to make the diagnosis “the patient is unable to give consent” - defined as any disability or disorder of the mind or brain, whether permanent or temporary, which results in impairment or disturbance of mental function. In these situations, medical staff may be required to make decisions which are deemed to be in the best interests of the patient, without obtaining informed consent. Guardians and relatives have no legal rights
- **Patients who are danger to themselves or to others:** detainment of patients against their will under the 1983 Mental Health Act is aimed at controlling patients who are a danger either to themselves or to others due to temporary or permanent mental illness. They can be detained/restrained for varying periods, depending on the clause of the Act, and can be given treatment, but only for their mental illness, which is deemed in their best interests or the best interests of the public.
- **Advance directives** are recognized in law and must be respected, as long as they are completed by a competent, witnessed, adult.
- **Relatives** have a legal influence with regard to giving consent in only two situations: (1) In minor who are not “Gillick competent” and (2) after death
 - The Family Law Reform Act of 1969 defines a minor as below 18 years of age. However, for the purpose of medical treatment a patient achieves adult status at 16.
 - A competent child above **16** years of age can therefore give valid consent to any surgical, medical or dental treatment, regardless of parental opinion. Where in case of mental incompetence, a parent can act for the child until he (she) is of age **18**.
 - Children under the age of 16 years can give consent for medical intervention, or refuse it, if they are deemed to be of sufficient maturity and intelligence to understand the implications of the treatment. This is referred to as “**Gillick competence**”
 - Parents must act in the best interests of their child in order to give valid consent. If it is deemed by the medical staff this is not the case, the child can be made a ward of court and treatment given without the parent’s consent.

Confidentiality

- In order to maintain a good patient relationship, consultations should be carried out in confidence. This respect of confidentiality also applies after the patient has died (I will respect the secrets which are confided in me even after the patient has died – Declaration of Geneva as amended in Sydney 1968)
- **Situations where confidentiality must be broken (by law):**
 - Notifiable diseases (e.g. TB, plague and food poisoning)
 - Under section 18 of the Prevention of Terrorism Act 1989
 - If a warrant from a circuit judge has been obtained
 - A doctor who suspects a patient has been involved in a road traffic accident is under a duty to give information to the police, but only in order to identify the driver
- **Situations where confidentiality can be broken:**
 - Where one is acting in the best interests of the patient (only if unconscious or confused). For example, if a patient is unconscious it may be in his (her) best interests to disclose information to the relatives, not only to obtain more information, but also to relieve the anxiety of the relatives.
 - Acting in the best interests of society. For example, AIDS is not a notifiable disease and patient has the right to confidentiality. However, patient should be strongly encouraged to inform others at risk, and in exceptional circumstances, where it is considered to be of benefit to society, disclosing information can be done without the express consent of the patient, i.e. to prevent potential harm to other individuals. As a general rule, doctor must not ignore the risk to others created by a patient, but weigh up one's duty to society against one's duty to an individual
- **Situations where confidentiality should not be broken:** in cases of sexually transmitted disease and abortions confidentiality must be maintained.

Negligence: a successful claim of a doctor's negligence requires the presence of the following items:

- A duty of care between the doctor and patient must be established. For example, a doctor is not obliged to help someone in distress on the street because no duty of care has been established
- A breach of this duty of care must be demonstrated. The patient must show that the treatment was not in accordance with a reasonable body of medical opinion.
- This breach of duty of care caused harm.
- The claim should be brought within 3 years of the action occurring, unless under exceptional circumstances

Gynaecological issues

- The 1976 Abortion Act states that a pregnancy can be terminated if the pregnancy has not exceeded 24 weeks, providing continuing the pregnancy poses a risk to the mental or physical health of the mother, or existing children.
- Pregnancy can be carried out up to term if the baby is physically or mentally handicapped

Resuscitation

- Discussing resuscitation status with the patient is strongly encouraged, a view supported by the GMC. However, common sense governs the timing of such a discussion.
- Resuscitation should be attempted if there is any uncertainty about the decision of the patient or nature of the disease.
- If a competent patient does not wish to be resuscitated this should be respected
- Resuscitation should not be performed if it is deemed futile, or not in the best interests of the patient
- If a decision not to resuscitate has been made, it should be clearly documented in the medical notes
- If the patient is unconscious, discussion with the relatives may give an impression of what the patient might have wanted. The opinion or wishes of relatives regarding resuscitation has no legal standing.

Death issues

- **Diagnosing brain death** requires the following
 - Deep coma with absent respiration
 - Absence of hypoxia, hypothermia, hypoglycaemia, acidosis, abnormal biochemistry and sedative drugs
 - The following tests should be performed by a consultant or his deputy in the presence of another doctor, and should be repeated after at least 24-hour interval:
 - Fixed dilated pupils, absent corneal response and vestibulo-ocular reflex
 - No gag reflex or motor response in the cranial nerves
 - No respiratory effort on stopping the ventilator and allowing the PaCO₂ to rise to 6.7 kPa
 - In USA, an EEG is required to confirm brain death
- **Persistent vegetative state (PVS):** Patients, whose brainstem function persists despite loss of cortical function, are described as having a “PVS”. Their quality of life is at best uncertain, and their life depends on artificial feeding. However, it is only possible to withdraw this feeding via a court order
- **Euthanasia** – the process of accelerating death by active intervention artificially is illegal in the UK. The only country to allow active euthanasia is Holland, but it is subject to strict guidelines.
 - In the UK, doctors performing an intervention to terminate life are guilty of manslaughter, despite the wishes of the patient. However, competent patients have the right to refuse any active treatment that may prolong their life.
 - Doctors can administer symptomatic treatment acting in the best interests of the patient (e.g. increasing doses of opiates to control the pain of terminally ill patients), even if this treatment has known adverse side-effects and may hasten the process of death. This is the principle of double effect.

Organ donation

- After death, the next of kin have lawful possession of the body. If someone dies and there are no next of kin then the hospital has possession.
- If the patient expressed a wish to donate organs after death this should be respected. However, relatives must give consent for donation; they can refuse donation even if the deceased wishes were well known and even in the presence of organ donor card.
- Organ donation from a live donor must not be detrimental to the health of that individual
- The donor need not be an adult, e.g. matched related bone marrow donation
- Once donated, the organ is the possession of the recipient
- Organs cannot be legally bought or sold in the UK. If a donation is to take place between two unrelated individuals it must be referred to the Unrelated Live Transplantation Authority

Research

- Research projects should only commence after the approval of a research and ethics committee has been given
- It is unlawful to carry out research on patients who are unable to give consent.
- Samples taken cannot be used for research retrospectively if consent was not given specifically when the samples were taken, although these samples are not deemed the property of the patient

Driving and epilepsy

- Candidates in PACES should review the “at a glance guide to the current medical standards of fitness to drive” issued by the Driver and Vehicle Licensing Agency (DVLA) at its official website
- **Diagnosing epilepsy**
 - One seizure does not make the diagnosis of epilepsy
 - Epilepsy is by definition the continuing tendency to have such seizures, even if a long interval separates such attacks
 - An EEG may support the diagnosis, but its main function is to ensure the seizures are correctly classified to enable precise treatment.
- **General regulations** regarding medical restrictions on driving (For updated regulations review DVLA website)

Group A (motor cars and motorcycles)	Group B (Lorries and buses)
Simple faint (faints of benign nature with definite provocation factors, associated prodromal symptoms and are unlikely to occur whilst sitting or lying): No driving restrictions	
Unexplained syncope with low risk of re-occurrence (These have no relevant abnormality on CVS and neurological examination and normal ECG): can drive 4 weeks after the event.	Can drive 3 months after the event
Unexplained syncope with high risk of re-occurrence (abnormal ECG, clinical evidence of structural heart disease, syncope causing injury, occurring at the wheel or whilst sitting or lying, or more than one episode in previous six months) Can drive 4 weeks after the event if the cause has been identified and treated. If no cause identified, then require 6 months off.	Can drive 3 months after the event if the cause has been identified and treated. If no cause identified, then licence refused/revoked for one year .
<p>Unprovoked seizure</p> <ul style="list-style-type: none"> • A person who has suffered an epileptic attack whilst awake must refrain from driving for one year from the date of the attack before a driving license may be issued • A person who has suffered an epileptic attack whilst asleep must also refrain from driving for one year from the attack. However, if they have had an attack whilst asleep more than three years previously and have not had any awake attacks since that original asleep attack then they may be licensed even though asleep attacks may continue to occur. • If the seizure is related to alcohol withdrawal, the licence will be revoked for a minimum of one year from the event • Withdrawal of anti-epileptic medication is associated with a risk of seizure recurrence. The current Epilepsy Regulations require a period of 1 year free of any manifestation of epileptic seizure or attacks occurring whilst awake during this therapeutic procedure, before resuming driving. Special consideration is given where sleep only attacks have occurred 	<ul style="list-style-type: none"> • Bus and lorry drivers who has suffered unprovoked seizure, must demonstrate 10 years freedom from further seizures, without anticonvulsant medications at that time • Following a solitary seizure associated with either alcohol or substance misuse or prescribed medication, a 5 year period free of further seizures, without anticonvulsant medication in that time, is required)
<p>Provoked or acute symptomatic seizures may be dealt with on an individual basis by DVLA if there is no previous seizure history. Seizures associated with alcohol or drug misuse, sleep deprivation or a structural abnormality are not considered provoked for licensing purposes. Similarly, reports of seizures as a side-effect of prescribed medication do not automatically imply that such events will be considered as provoked.</p> <p>• The same DVLA rules apply to taxis drivers as to other motor vehicle users, although they are additionally subject to restrictions from the Public Carriage Office or the local authority. Current best practice advice is contained in the “Medical Aspects of Fitness to Drive” published by the Medical Commission on Accident Prevention in 1995. This recommended that medical standards applied by DVLA in relation to bus and lorry drivers, should also be applied by local authorities to taxi drivers</p>	

- **Notification to DVLA**

- It is the duty of the licence holder or licence applicant to notify DVLA of any medical condition, which may affect safe driving. The DVLA is legally responsible for deciding if a person is medically unfit to drive.
- Therefore, where patients have such conditions, you should make sure that the patients understand that the condition may impair their ability to drive. If a patient is incapable of understanding this advice, for example because of dementia, you should inform the DVLA immediately.
- Explain to patients that they have a legal duty to inform the DVLA about the condition. Before discussing legal issues it is often beneficial to discuss the ethical context in which the law arises. Individuals are more likely to comply with legislation if they understand the reasoning behind it.
- If the patients refuse to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patients seek a second opinion, and make appropriate arrangements for the patients to do so.
- You should advise patients not to drive until the second opinion has been obtained.
- If patients continue to drive when they are not fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin, if they agree you may do so.
- If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA.
- Before giving information to the DVLA you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made.

STEP 2: GENERAL PRINCIPLES OF COMMUNICATION WITH PATIENT/FAMILY

General rules

- Always introduce yourself and explain your role
- keep eye contact and show interest and rapport
- Always ask before telling
- Establish the expectations and knowledge of the patient
- Allow the patient to speak openly and freely, but be prepared to direct the consultation
- Provide a frame work for your explanation
- Keep statements short and simple
- Repeat important information
- Check understanding
- Try to give the patient choices rather than instructions
- Allow pauses for the patient to digest information
- Encourage feedback
- Be honest and ready to admit uncertainty
- Be optimistic but realistic (always give hope and emphasis the positive points)
- Acting against the patient/family wishes should be the last course of action even if you have the legal right to do so. This will usually result in a breakdown in the doctor-patient/family relationship, and may ultimately compromise the healthcare of the individual.

Special situations

- **Explaining procedure (investigation or treatment)**
 - Explain the purpose of the procedure using short statements
 - The purpose of this procedure is to ...
 - This will help us to ... (mention all the expected benefits)
 - Otherwise... (Mention all the sequels of not doing the procedure)
 - Explain the nature of the procedure (In this procedure the specialist doctor will...)
 - Explain the risks (A lot of patients undergo this procedure daily safely, however as any medical procedure, it has its risks which may occur in small percentage of patients such as...eventually weighing the great benefits against the low possibility of risks makes this procedure an advisable option for you from the medical point of view).
 - Check understanding at each step (is it alright/clear up till now).
 - Seek consent (so far you are supposed to sign consent for this procedure. This will include the main points that I have already explained to you. You should read it again and if you have any further questions you may ask me, and even after signing this consent you have the right not to undergo the procedure if you changed your mind for any reason before the scheduled time for the procedure)
- **Discussing prognosis**
 - Establish facts about diagnosis and results of investigations
 - Discuss the prognosis with and without treatment
 - Discuss the complications of the disease and treatment (common and serious complications)
- **Diagnostic uncertainty**
 - Outline the possibilities including the most serious
 - Discuss the plan and when further consultation is required
 - Be honest and professional
 - Keep a safety net (exclude serious causes, arrange follow up...)
- **Non-compliant patient**
 - Explain the importance of treatment
 - Explore the patient concerns
 - Explain that the doctor and patient should work together as a team (we are one team and our goal is to give you the best chance to go over this situation and you are the most important player in this team)
 - Keep options clear and simple
 - Confirm understanding

- **Sharing bad news / discussing Do Not Attempt Resuscitation order**
 - Having a relative or friend present may be helpful (If you want anyone else relevant to you to attend this meeting, he or she is welcomed)
 - Establish what the patient knows (do you understand why we have been doing this test or suspect what might be wrong?)
 - Disclose what the patient wants to know (Are you that kind of people who wants to know well about their illnesses?)
 - Build up news layer by layer preferably starting from the beginning of the problem and giving warning statement before telling the facts in short clear statements then giving realistic hope
 - (You know your father had) → (The result of the test was not as we hoped, it showed...) → (however, this is now a manageable condition and we have a lot of things to do to help you cope with this situation)
 - (I know you have been suffering from this illness for long time now...) → (I know it is difficult for you to give me an answer but let me ask you, if your heart stops do you want us to resuscitate you) → (however, we are going to provide all other available treatments and keep you free of pain and in a good shape)
 - Pause frequently to allow the patient time to think and ask questions
 - Be ready to answer questions related to life expectancy and chance for cure (No one knows what will happen in the future, and so I do not like to give figures) (Everybody is different and some people do much better than others, and I know a lot of people who had the same condition and enjoyed a reasonable life for a relatively long time) (I do not think this disease will ever go away completely, however we can do a lot of things to help you cope with it and make you free of pain and in good shape)
- **Request for autopsy or organ donation**
 - acknowledge that it is a difficult time
 - explain the reason for autopsy or organ donation
 - Discuss arrangements about the body: confirm that there will be no delay in funeral arrangements, standard invisible incisions will be used, and body can be viewed afterward.
- **Dealing with angry patient / Admitting medical error**
 - Acknowledge patient's feeling (I understand your feeling and I am sorry for this)
 - Explore patient's concerns (now let me ask you what does concern you most?)
 - Be honest and apologetic. However, stay away from areas of conflict and avoid confrontation, do not incriminate colleague and take constructive actions (I will find out what went wrong and actions will be taken to stop it happening again, but that now you must try to focus on the future and the current medical problem)
 - Explain what the options are in the future (including seeking a second opinion)
- **Patient resisting legal breach of confidentiality**
 - Explore patient's concerns
 - Explain importance of disclosure for the safety of the patient, family and society
 - Emphasise his (her) responsibility towards others
 - Inform the patient about your intentions
- **Daughter knows her mother has serious illness but does not want you to tell her mother**
 - Explain that you appreciate that she knows her mother much better than the doctors (I appreciate that you know your mother much better than the doctors. However, having seen this situation many times before, telling the mother the truth is usually what she wants and is best in the long term)
 - Explain that telling the mother the truth is usually what she wants (most people know when there is something seriously wrong, and finding out can be a relief)
 - Explain that you need to be sure that her mother does not want to know her diagnosis (How do you know that your mother does not want to know?) (I would like to be sure that your mother does not want to know her diagnosis) (I will talk to her and give her a small amount of information, and if she does not want to know I will not tell her)
 - Ask for the daughter's cooperation in the treatment plan (we are one team and our goal is to give your mother the best chance to go over this situation)

STEP 3: APPROACH TO THE STATION

Part 1: in the 5 minutes before the interview

- Establish your role and patient/relative name and location
- Establish the key issues, which must be conveyed (medical, social and medico-legal)

Part 2: The interview:

1. **Introduce** yourself and confirm the patient/relative identity
 - Good morning Mr., I have got the right person haven't I? I am Dr...
 - If he is the patient, ask how are you today?
 - If son/daughter, ask: does your father know that you're coming to see me today?
 - If pregnant wife, ask: why your husband doesn't attend this meeting? After we finish we may arrange for second meeting and invite him. I think this would be useful for both of you
2. **Listen**
 - Assess the patient Knowledge and expectations of their condition (Now let me start by asking you what do you know about your illness?)
3. **Inform**
 - Give simple information about the medical condition (let me give you a simple idea about this condition)
4. **Explore**
 - Explore the patient's worries (now let me ask you what does concern you most?)
 - Explore any social/psychosocial or ethical/legal problems (I need to ask you some rather personal questions, is that OK?) (How does this problem affect you in your job?) (How does this problem affect your marital status?) (Do you feel depressed because of this problem?)
5. **Answer** the patient's questions/worries
 - If you do not know the answer (I will attempt to find the correct answer for the next consultation or later today)
 - Ask about further questions (I hope you have found our discussion useful to you. do you have any further questions?)
6. **Management plan**
 - Ask for patient's cooperation in the treatment plan (we are one team and our goal is to give you the best chance to go over this situation and you are the most important player in this team)
 - Seek consent if needed for the procedure/treatment (so far you are supposed to sign consent for this procedure. This will include the main points that I have already explained to you. You should read it again and if you have any further questions you may ask me, and even after signing this consent you have the right not to undergo the procedure if you changed your mind for any reason before the scheduled time for the procedure)
 - Provide written information, telephones and addresses (I will provide you with pamphlets for further information and instructions regarding your condition, contact numbers of the hospital, contact numbers and addresses of support groups which may be of great help, and also addresses of respectable websites for further information)
 - Suggest additional help if needed (home visits, home nurse, occupational therapist, social worker)
7. **Summarize**
 - Before finishing, summarize the consultation (now I want to emphasize the important points in our discussion)
 - Agree a management plan for the future (our plan...)
 - ask if they want anything repeated or if they have any questions (do you want me to recover any issue)
 - arrange another appointment (I will arrange for the next appointment in couple of days to review our plan and see what's going on)

Part 3: discussion with the examiners

Question: How do you think it went?

Answer: I have explained.... The patient digested the information...I think he needs time to absorb the situation...in follow-up consultations I would readdress the issue of...