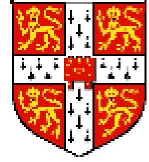
Addenbrooke's pgm Centre Postgraduate Medical Education



Communication Skills Station 3

9 minutes with up to 1 minute for feedback

You are in your first week as an ST3, and on call at night, and it's 01.00. You have been asked by the FY1 to review a patient that they have seen in A&E that they are a little concerned about. The notes of the patient are provided.

When you see the patient, you find him to be in severe pain, despite analgesia. Vomiting has continued, and he has yet to open bowels/pass flatus.

On examination, his pulse is now 105, blood pressure 100/45, Respiratory rate 26, Temperature 37.9^{o}C

His abdomen is distended, and very tender, with guarding.

In view of the deterioration you decide to call the on-call consultant, Mr Carroll

26/09/2010 21:00

Alan Jones
Date of birth: 12/4/1968
Hospital number: 123456

PC

Abdominal pain and vomiting

HPC

3 day history of worsening abdominal pain
  Central abdomen
  Colicky
  Not relieved by anything
  Currently 8/10, and has become more continuous over last few hours

Began vomiting 2 days ago,
  Every 3-4 hours,
  Quite large volumes of bilious vomit.
  Today the vomit has become browner and tastes foul.
  Continuously nauseous.

No diarrhoea reported. Has not opened bowels for 4 days – usually opens bowels once a day.
Denies passing flatus for last 48 hours

Noticed abdomen has become distended.

No recent travel, noone else unwell in household

No urinary symptoms, No other symptoms on systems review

PMH

Tonsillectomy - 1975
Open appendicectomy – 1985 – complicated by pelvic abscess requiring drainage
Asthma

DH

Nil regular
No allergies

SH

Director of IT company
Smokes 15 a day for last 20 years
4 units alcohol a week

Examination

Alan Jones
Date of birth: 12/4/1968
Hospital number: 123456

- **Cardiovascular:**
  - Pulse 98
  - 110/55
  - Normal heart sounds

- **Respiratory**
  - Respiratory rate 20
  - Saturations 98% on air

- **Gastrointestinal**
  - Abdomen distended
  - Tender +++ all over
  - Unable to palpate organomegaly
  - Tympanic bowel sounds
  - No inguinal hernia

Impression

Bowel obstruction

Plan

- Bloods
- Abdominal radiograph
- Senior review
- IV fluids

Dr Smith
FY1

26/09/2010 23:00

Bloods:

Parameter	26/09/2010
Haematology	
White cell count (4-11 x10^9/L)	18.6
Haemoglobin (13-17g/dL)	12.6
Platelets (150-400 x10^9/L)	387
Prothrombin Time (10-14s)	14.9
Activated Partial Thromboplastin Time (35-45s)	38

Alan Jones
Date of birth: 12/4/1968
Hospital number: 123456

Biochemistry	
Sodium (135-145 mmo/L)	138
Potassium (3.5-5 mmol/L)	3.0
Urea (2-7 mmol/L)	16
Creatinine (50-130 µmol/L)	159
Bilirubin (3-17 µmol/L)	15
Alkaline phosphatase (30-120 iu/L)	100
Alanine Transaminase (3-35 iu/L)	25
C- related peptide (<5)	174

Blood Gas	
pH (7.35-7.45)	7.31
P_aO_2 (>10.6)	12.8
P_aCO_2 (4.7-6)	3.8
BE (+/- 2)	-4
Lactate (<2.3)	3.6

Abdominal radiograph

- Report: Small bowel obstruction

Dr Smith
FY1

Communication Skills Station 3 – Phone call regarding small bowel obstruction

Topics/ objectives

- **Organisation and objective Setting**
- **Dealing with Seniors**
- **Assertiveness**

Brief

The faculty member should be unhelpful and sleepy ('What time is it?, Am I on call?, Is this my patient?')

The patient clearly requires laparotomy to relieve obstruction and may need small bowel resection.

The patients deterioration is likely to be due to ischaemic bowel or possibly perforation, secondary to obstruction.

However, the faculty member might suggest ,

- that an anaesthetist be involved,
- that fluids are continued,
- that he calls in at 7.00 o clock to see how the patient is doing

Or might simply misunderstand some of the things that the ST3 is saying to indicate how sleepy he is.

Whatever is done should be realistic.

Discuss

In this case the candidate should have considered, before making the telephone call, what his objective was.

This objective should be expressed at the beginning of the call. For example, it might be that the objective is:

- to inform the consultant that there is a problem,
- to ask the consultant for advice on management,
- to request the consultant to come in and carry out a procedure or assess the patient personally.

Most candidates will not have clarified their objective and will get lost fairly early in the telephone call.

Appropriate assertiveness is requires to handle their consultant. They should most certainly not be aggressive, but they should manage to obtain the end required.

The candidates should be guided by questioning, to the fact that the patient requires theatre if this is not appreciated initially. The candidate should be asked to suggest management in preparation for surgery: e.g. NG tube, catheterise, warn ICU for post-op care, book the patient for theatre, consent the patient, discuss with the anaesthetist etc.

Overall impression of the candidate Please encircle your mark

FAIL BOREDERLINE FAIL BORDERLINE PASS PASS

If you have any specific comments about this candidate please write them in the box.