STATION 22

Information given to candidates

Candidates note: this station is an out-of-hours **home visit**. You will be escorted by one of the invigilators to a room made to look like a patient's sitting room. The consultation will take place there.

You are working a Saturday morning session for the local out-of-hours provider.

Your first call of the day is a home visit to see Ben Wayne, a 74-year-old patient at a neighbouring practice to your own.

You do not have access to his GP medical records.

The information provided by the out-of-hours triage service states:

Patient	Ben Wayne
Age	74 years old
Problem	Patient describes chest pain at approximately 2 am last night. Not sure how long it lasted. Patient thought it was indigestion. Did not radiate to arms or neck. No shortness of breath. Patient says he feels fine now.
History	No history of heart problems. Has had 'camera test of stomach' due to indigestion last year.
Medication	Lansoprazole 15 mg OD
Management	Patient advised to call 999 and go straight to hospital for investigation and treatment. Patient refused admission, stating he is now well and just wants 'checking over'. Agreed to home visit.

The first words from the patient as you enter the room are, 'I'm sorry about all the fuss, doctor, I know they wanted me to go to hospital but I'm feeling fine now and there's no way I'm going to miss seeing my new granddaughter.'

- What do you think this station is testing?
- Make notes or discuss your thoughts with a colleague before you read on.

Plan your approach to this station:

Information given to simulated patient

Basic details – You are Ben Wayne, a 74-year-old retired plumber.

Appearance and behaviour – You are a little flustered at the events of last night together with your planned trip by train to see your new granddaughter.

History

Freely divulged to doctor – You woke up at 2 am earlier today with chest pain. The pain was constant and lasted about 45 minutes. Initially you thought it was indigestion, but it did not go away or change when you sat up or moved around. You had a glass of water and some paracetamol, but nothing seemed to make any difference to the pain. You started to get worried when the pain was still there after half an hour. By then you thought that it might be a heart problem, but now you think it was probably due to stress.

Divulged to doctor if specifically asked – The chest pain felt like severe heavy pressure over the middle of your chest. You felt nauseous and short of breath with the pain. The pain did not radiate to your neck or arms, or go through to your back. You have never experienced a pain like this before. The pain was not worse as you breathed. You have not had any pain in your calves or any leg swelling. You do not have a cough. You felt fit and well until last night. You did not experience any heart palpitations (feeling your heart beating in your chest or a rapid heart beat). The pain gradually started to ease after about 40 minutes and had gone within a further 5 minutes. You were able to go back to sleep after another half an hour. You woke up feeling a little tired, but otherwise ok. There has been no recurrence of the pain. You do not want your daughter to know what has happened.

Ideas, concerns and expectations – You have not told your daughter what happened as you know she will tell you not to travel and you really want to see your first grandchild. You think the pain was probably due to stress over all the travel arrangements. At one point you did think the pain might be coming from your heart, but because it went away and you now feel absolutely fine, you do not think it could be anything serious like a heart attack. But you thought you should speak to someone about it, so you rang your GP surgery in the morning and were transferred through to the out-of-hours service. When they said you should dial 999 and go straight to hospital you thought they were being over-cautious. You told them you did not think you needed to go to hospital, but agreed to a home visit from the doctor. The idea of going to hospital is also distressing as it reminds you of when your wife was very ill. You expect that once the doctor sees how well you are, they won't say that you should go straight to hospital. If the doctor does ask you to go now, you will strongly resist this request. Even if the doctor says you may well have had a heart attack and could risk your life without immediate treatment, you will simply refuse to miss your planned trip. However, if you feel confident in the doctor's abilities then – after some discussion – you will offer to go to see your own GP on your return on Monday morning, and immediately seek help if you have any further episodes of chest pain over the weekend. You will be happy to take any medication that the doctor wants to give you now.

First words spoken to doctor – The first words from the patient as you enter the room are, 'I'm sorry about all the fuss, doctor, I know they wanted me to go to hospital but I'm feeling fine now and there's no way I'm going to miss seeing my new granddaughter.'

Medical history – As far as you know, you have never had high blood pressure or any heart problems. You suffered from quite severe indigestion last year, but after having a 'camera test' and taking some tablets to get rid of 'a bug in my stomach', you have been much better. You do not recall having had your cholesterol checked.

Drug history – You take one tablet every morning for indigestion – lansoprazole 15 mg. You have no allergies.

Social history – You live on your own. Your wife died 10 years ago from breast cancer and you are very close to your only daughter who moved last year and now lives 60 miles away. You worked as a plumber until retirement 10 years ago. You gave up smoking 2 years ago but had been a heavy smoker for 30 years (about 40 cigarettes a day). You want to cut down on fried foods and eat a healthier diet.

Family history – Your father died from a stroke aged 62 and your older brother had a heart attack aged 53.

- Having read the information given to the simulated patient, what do you now think this station is testing?
- Make notes or discuss your thoughts with a colleague before you turn the page.

Review your approach to this station:

Tested at this station:

1. Understanding the patient's perspective and respecting patient autonomy.
2. History-taking skills.
3. Physical examination.
4. Recognition and management of a potentially life-threatening condition.
5. Negotiating a management plan.

Domain 1 – Interpersonal skills

Understanding the patient's perspective and respecting patient autonomy

Competent, fully informed patients have a right to refuse treatment, even if this puts them at risk of serious harm. Eliciting the patient's ideas, concerns and expectations will help you understand his perspective on events:

- The GP curriculum states that GPs should be able to deal sensitively and in line with professional codes of practice with patients who may have a serious diagnosis and refuse admission.
- You need to try to find out why the patient is so reluctant to go into hospital. Is it just about missing his trip to see his granddaughter or are there any other concerns? In this case, he has distressing memories associated with hospital visits when his wife was ill.
- This scenario is designed to see whether you can respect patient autonomy where a competent patient refuses to comply with your request for his immediate admission to hospital.
- There is a tension between your judgement of what is in his best interests and his strongly held preference to travel to see his new granddaughter, whatever the risks.
- Although you should be frank with the patient about the potential consequences of going against medical advice, you need to be careful not to be coercive or bullying in your approach.

Domain 2 – Data gathering, technical and assessment skills

History-taking skills

You may feel that from the information given by the out-of-hours triage service, this patient is unlikely to have a serious condition. However, be wary of second-hand histories – these can often change dramatically when you hear the first-hand account (as in this case):

- Any complaint of chest pain needs a thorough history to try to identify life-threatening conditions such as myocardial infarction (MI), pulmonary embolus or dissecting aortic aneurysm.
- In an out-of-hours setting, without access to the patient's medical records, taking a careful history becomes even more important.

- You need to ask various questions about the pain itself (see Knowledge base) as part of a comprehensive cardiovascular history, including risk factors for ischaemic heart disease.

Physical examination

Owing to time constraints at this station, you will not have to examine the patient. However, you would be expected to attempt to examine him, at which point the examiner will tell you the findings – namely, that cardiovascular examination is normal.

Domain 3 – Clinical management skills

Recognition and management of a potentially life-threatening condition

The GP curriculum states that GPs should be competent in the recognition and immediate management of emergencies encountered in primary care (see Knowledge base):

- The history of what happened in the night should alert you to the strong possibility that the patient has had an MI.
- In addition, this patient has a number of risk factors for heart disease, including a family history of cardiovascular disease, 60 pack years accumulated as a smoker and a high-saturated-fat diet.
- You need to make it clear to the examiner that you consider this a potentially life-threatening situation requiring immediate action (see Knowledge base).
- In this case, the management is complicated by the patient's refusal to be admitted to hospital.
- You need to treat him – as far as he will permit – to minimize the risk of cardiac damage.

Negotiating a management plan (overlap with domain 1)

It is essential that you elicit the patient's ideas, concerns and expectations, to allow you to engage with him in a meaningful way and negotiate how to proceed:

- You must not collude with the patient in downplaying the potential seriousness of the current situation.
- You need to be very clear about the fact that he may well have had a heart attack and that he needs immediate assessment in hospital.
- If he is adamant that he does not want to go to hospital, you need to ensure that he understands that this is a potentially life-threatening situation.
- Even though he feels well now, you can explain that he is at very high risk of a further episode, and without appropriate treatment this might prove fatal.
- Would he allow you to contact his daughter, or another member of the family, to discuss what has happened?
- If he continues to refuse to go straight to hospital, even though he is aware of the risks, would he be prepared to go to his daughter's local hospital, once he has seen his granddaughter? Or agree to see his own GP as soon as he returns?
- If he has any further chest pain, your advice must be to seek immediate medical help. Will he agree to this?

- Would he allow you to give him some aspirin now and a spray to use under his tongue if he has any further chest pain? You need to explain why these are important.

Knowledge base

References: include RCGP curriculum statement 7, appendix 3; National Institute for Clinical Excellence (NICE) CG95 – see Further reading below.

'Dangerous' diagnoses	• Certain conditions encountered in primary care require urgent action, including:
	• Acute coronary syndrome, i.e. MI or unstable angina
	  • pulmonary embolus
	  • carbon monoxide poisoning
	  • subarachnoid haemorrhage
	  • appendicitis
	  • limb ischaemia
	  • intestinal obstruction or perforation
	  • meningococcal and other bacterial septicaemia
	  • aneurysms
	  • ectopic pregnancy
	  • acute psychosis/mania
	  • visual problems that could threaten blindness:
	  • retinal detachment and haemorrhage
	  • temporal arteritis

Cautious approach	• If you suspect any of the diagnoses above, in a primary care setting, you should arrange for the patient to be transferred to a secondary care centre, to allow a more thorough assessment. • At times, you may be seen to be over-cautious, but without the ability to conduct a range of investigations and close monitoring it can be difficult to exclude such life-threatening conditions in primary care.

Immediate management of suspected ACS	• Do not routinely administer oxygen, but if available, offer if:
	  • Spot oxygen concentration (SpO_2) <94% and not at risk of hypercapnic respiratory failure (aim for SpO_2 of 94–98%)
	  • Chronic obstructive pulmonary disease (COPD) and risk of hypercapnic respiratory failure (aim for SpO_2 of 88–92%)
	• Give aspirin 300 mg
	• Pain relief: GTN and/or an intravenous opioid
	• A resting 12-lead electrocardiogram (ECG) (but do not delay transfer to hospital to perform)

Pain history	• A useful mnemonic when obtaining a detailed history of chest – and other – pain is: **SSS, OPD, RAAT**
	  • ***S***ite – where exactly is the pain?
	  • ***S***ort – what does the pain feel like – sharp, dull, tight, etc.?
	  • ***S***everity – on a scale of 1 to 10, how bad is the pain?
	  • ***O***nset – when did the pain start and what was the patient doing?
	  • ***P***eriodicity – does the pain come and go or is it constant?
	  • ***D***uration – how long does the pain last?
	  • ***R***adiation – does the pain radiate anywhere?
	  • ***A***lleviating or worsening factors – what makes the pain better? What makes it worse?
	  • ***A***ssociated symptoms – e.g. nausea, sweating, breathlessness
	  • ***T***ime off work – how has the pain affected the patient's life?

Take-home messages

- You need to take a detailed history for all complaints of chest pain.
- Patient autonomy must be respected in competent, fully informed patients.
- You should feel confident in the initial management of life-threatening conditions seen in primary care.

Tasks

- Re-run the scenario with the patient's chest pain occurring >72 hours ago (see NICE guidance).
- Re-run the scenario with the patient collapsing as you take the history. For example, a manikin may appear – do you know the current Basic Life Support guidance? Can you demonstrate it?
- Re-run the scenario as a telephone consultation. Think what other options you might present to the patient if he continues to refuse to go to hospital.
- Re-run the scenario with the patient attending your practice with chest pain but refusing to go to hospital.

1-minute explanations for patients

- Explain what a heart attack is.
- Explain why you need to give aspirin.
- Explain how a GTN spray works.

Ideas for further revision

Learning objectives in the GP curriculum, which the Clinical Skills Assessment (CSA) will base scenarios around, include the immediate management of acutely ill people. In this context, the curriculum states that specific psychomotor skills you should be able to demonstrate include:

- cardiopulmonary resuscitation of children and adults including use of a defibrillator
- performing and interpreting an ECG
- using a nebulizer
- passing a urinary catheter
- controlling a haemorrhage and suturing a wound.

Although these skills may be assessed in a workplace-based setting, you could be presented in the CSA with a scenario that requires candidates, as part of the station, to demonstrate one of these skills on either a simulated patient or a manikin. Make sure you feel confident in being able to perform such tasks competently.

Further reading

Committee of General Practice Education Directors (COGPED). *Out of Hours (OOH) Training for GP Specialty Registrars* Revised Position Paper. London: COGPED, 2010

NHS Evidence Clinical Knowledge Summaries – Angina www.cks.nhs.uk/angina

NICE guidelines CG95 – Chest pain of recent onset. March 2010 http://guidance.nice.org.uk/CG95

RCGP curriculum statement 7 – Care of acutely ill people www.rcgp.org.uk (see Appendix 3: 'Dangerous' diagnoses)

Simon C, Everitt H, Van Dorp F, Schroeder K. *Oxford Handbook of General Practice* (3rd edn). Oxford: Oxford University Press, 2010

Thomas J, Monaghan T. *Oxford Handbook of Clinical Examination and Practical Skills*. Oxford: Oxford University Press, 2007