Human Development Resources

This resource has been adapted from a SSC project by a former Barts and the London Graduate Talia Sagal. She created a wonderful and comprehensive bank of scenarios to help students practise common consultations that occur in GP in regards to children's and women's health.

This resource is intended to be used by Community Tutors during their weekly tutorial or it can be used by students practising in small groups (even virtually).

Please see form at the end of the document, to aid feedback.

Tutors/Students

- Please set safe and confidential space for this role play work.
- It is important to remind students playing the patient that the aim is not to be a "difficult patient" and not to try and withhold information. It is to be as realistic as possible.
- You may find it helpful, for both parties to read and discuss their brief with you in separate areas. This can help them get into character.
- We usually facilitate feedback by asking the student how they felt it went, concentrating on what went well; then the observers (if any), simulated patients and then yourself as the Tutor.
- There are "Further discussion points" which should generate interesting discussion and aid additional learning.

Scenario 1: A Child with difficulty breathing

Student instructions:

You an F1 in a GP Surgery your next patient is Mrs Johnson, she has made an urgent appointment for her 3 year old son, Oliver. She is worried about his breathing.

- Please take a history from Mrs Johnson
- Explain what you think the diagnosis is, and how you might manage Oliver.

Oliver is not present for purpose of this simulated scenario. When the history is obtained from Mrs Johnson you will be handed some examination findings.

Simulated patient instructions

You are playing the role of Mrs Johnson, mother to 3 year old Oliver. You are coming to see the GP as you are worried about his breathing.

PC	Difficulty breathing the past 2-3days but especially last night.
HPC	• Cough and runny nose for the past 7 days. • Had a mild temperature yesterday. • He doesn't seem himself. If asked specifically – It is worse at night, you think you might have heard wheezing. He is having coughing fits and then finds it difficult to catch his breath. You haven't noticed that he is breathing with this tummy muscles or see his ribs when he breaths You gave calpol yesterday but not today. Not sure how high the temp was. Poor sleep but eating well and drinking well. Seems to be going to pass water a usual amount. Opening bowels as normal. No diarrhoea of vomiting. Is clingy. You confess, sheepishly, that you tried your older son's nebuliser on him last night and it seemed to help a lot.
General	Born at term, Normal Vaginal Birth Met all milestones at correct times inc height and weight Up to date with all vaccinations No antenatal or post-natal complications
PMH	None, normally fit and well
DHx	None, NKDA
FHx	You had asthma as a child, but have not had symptoms for years Your son, aged 7, has asthma. He has a blue inhaler and a brown inhaler, as well as a nebuliser to use at home if needed
SHx	Lives at home with mum, dad and 7 year old brother. No one smokes in the house if asked. Has recently started attending nursery full time
ICE	Concerned it may be asthma as it sounds similar to when your other older son's asthma flares up. Concerned you may end up with trying to manage 2 kids with asthma when 1 is hard enough. You expect to be given an inhaler.

Tutor Notes

- Please hand the student a set of observations (below) after they have obtained the history from the Mother.

o/e temp 37.0
alert and content, clinically hydrated
R and L ear normal inc TM
Nil to see in mouth, some enlarged non tender mobile LN in anterior chain
HS normal, chest has slight polyphonic widespread wheeze. Abdo snt
Cap refil < 2 secs, RR 27 HR130 (normal)

- Prompt student to explain likely diagnosis and possible management to the Mrs Johnson
- If safety netting not discussed in consultation, please review this in the de-brief/feedback.

Further discussion points

→ Considering the differential diagnosis of difficulty breathing in a young child
→ Raising the issue of a parent administering a medication to a child that is not prescribed for them and how you might possibly do this.
→ Explaining a likely diagnosis as based on a child's age, i.e. how asthma is rarely diagnosed before a Lung Function can be performed (aged 9).

Additional reading:

→ British Thoracic Society (BTS) guidelines on asthma (2016) https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-asthma-guideline-quick-reference-guide-2016/
→ NICE guidelines on asthma (2019) https://www.nice.org.uk/guidance/ng80
→ *N.B. BTS and NICE are currently consulting on producing a combined set of new guidelines, which are due to be published in 2019*

Scenario 2: A child who isn't herself

Student instructions:

Mr Patel has come to the GP with his six month old daughter, Meera. He is worried that she is not herself and would like you to check her over.

- Please take a history from Mr Patel
- Consider what examinations you would like to perform. (The tutor will hand you the findings)
- Consider the likely diagnoses, and what management, if any, is needed.

Meera is not present for purpose of this simulated scenario. When the history is obtained from Mr Patel you will be handed some examination findings.

Simulated patient instructions

You are playing the role of Mr Patel. You have come into the GP with your six month old daughter, Meera, as she has been unwell, and you don't know what the matter is.

PC	Irritability, been off her food, poor sleep, crying, fever
HPC	Started about 12 hours ago Drinking seems to have reduced (by approx half) but having wet nappies. You have not noticed a smell. But have managed to get a sample for the GP to test. Seems to cry inconsolably without warning, but stops spontaneously If asked specifically – She is not coughing, no ear pulling or no obvious teething concerns No diarrhoea or vomiting.
PMH	Possible urine infection at 4 months – treated with antibiotics by GP but was not able to obtain a urine sample at the time. If asked: It was very hard to obtain a sample – had to wait for ages for her to pee and catch it in the urine bottle provided last time.
General	Born at 35+3/40, Mum's waters broke. Stayed in neonatal unit for a week until feeding was established. Meeting milestones almost on time, as appropriate for corrected age inc height and weight All vaccinations up to date
DHx	None, NKDA
FHx	Grandmother T2DM Older Sister has recently had a cold
SHx	Lives at home with mum, dad and older sister (4yo) Goes to childminder once a week
ICE	Do you need to go to the hospital? Why is she getting urine infections, is it because of poor hygiene.

Tutor Notes

- Please hand the student a set of observations (below) after they have obtained the history from the Father. Try to get them to think about what observations and examinations they would like to do.

Temperature 38.1°C Warm and well perfused Alert and content Cap refil < 2 secs, HR 130 and RR 32 (normal) Urine dip: leuk ++, nitrites +++, blood + Ears normal Throat normal Chest clear, although slightly tachypnoeic Abdo snt

Further Discussion Points

→ How do you obtain a clean catch sample? Quick wee method is helpful.
→ Discuss and consider the differential diagnosis of a child presenting with systemic symptoms and fever (without knowledge of previous uti of sample already obtained).
→ What is the likely management, how would you safety net?
→ Knowledge of NICE guidance on UTI in children

Additional reading:

→ NICE guidelines on UTI in children under 16 - https://www.nice.org.uk/guidance/cg54

Scenario 3: A child with a 'toileting issue'

Student instructions:

You are an F1 in a GP surgery and Mrs Bello has brought her four year old daughter Praise to see you because of a 'toileting issue'.

- Please take a history from Mrs Bello and suggest which examinations you would like to perform.
- Please advise Mrs Bello of the likely diagnosis, and what management, if any, you would recommend.

Praise is not present for purpose of this simulated scenario. When the history is obtained from Mrs Bello you will be handed some examination findings.

Simulated patient instructions

You are playing the role of Mrs Bello, mum of four year old Praise. You have brought Praise in because she has been soiling her underwear almost daily for the last two weeks. It is causing you concern and frustration.

PC	Soiling episodes, coming home almost every day with dirty underwear (small amounts)
HPC	Praise seems embarrassed by the episodes and does not want to talk about it. Eating and drinking normally – eats veg, could be better and doesn't drink enough water. Has a lower appetite of late. Slightly constipated but always is (hard and every other day) – if asked, have noticed a bit worse the last few weeks. You have encouraged plenty of fluids and fibre which usually helps. No obvious urinary symptoms. No abdominal pains. Otherwise well. NO temps or cough/cold.
PMH	None
General	If asked: Born at term, NVD Normal developmental milestones met Appropriate height and weight Up to date with vaccinations Was fully toilet trained aged 2 in daytime, and aged 3 at night
DHx	None, NKDA
FHx	None of note
SHx	Lives with mum, dad, and two older brothers, aged 11 and 9. Has recently started reception at primary school If asked: no stress at home or at school know but was nervous leaving nursery school
ICE	You are frustrated because this has been going on for the last few weeks You have tried different tactics, like promising rewards, and threatening consequences, but nothing seems to have made a difference You are worried about Praise because you know she is finding everything a bit overwhelming, starting the new school year and you think this could be the cause.

Tutor Notes

- Please hand the student a set of observations/examinations (below) after they have obtained the history from the Mother. Ask them what they would like to know first re: exam/observations.

Alert and content 36.7 Abdomen SNT, although large palpable mass in left iliac fossa

Further Discussion Points

→ How would you respond to a parent expressing frustration and how can this affect the situation
→ What are the possible other causes?
→ What would common management and safety netting be for this situation.

Additional reading:

→ NICE guidelines on constipation in young people: https://www.nice.org.uk/guidance/cg99

Scenario 4i: An unwell child

Student Instructions: Part 1:

You are an F1 in a GP surgery. Ms Fletcher presents to you her 5 year old son, Niall. She is worried that he has been clingy, sleepy and off his food.

- Please take a full history
- Suggest the relevant examinations and investigations that you wish to carry out
- Consider the likely diagnosis and management plan.

Niall is not present for purpose of this simulated scenario. When the history is obtained from Ms Fletcher you will be handed some examination findings.

Simulated patient instructions: Part 1:

You are playing the role of Ms Fletcher. You have brought in Niall, your 5 year old son because he has been clingy, sleepy and off his food.

PC	He does not seem himself and has become quite sleepy and clingy.
HPC	• Started 48 hours ago, Niall wouldn't get out of bed for school and he felt feverish. • You initially thought it was just a virus and would pass, so you gave him Calpol which helped to cool him down • He has had a slight cough and cold. Yesterday was not eating but drinking well. No problems yesterday with peeing and pooing. Today you got worried as he has not eaten or drunk anything in the last 6hours, is sleepy and you are struggling to get the temperature down. It's been 38 since the morning despite regular Calpol. You have not given ibuprofen. If asked: • Don't think he has passed urine or stool since yesterday. Vomited once this morning, mainly bile. No abdo pain. • No rash. • No foreign travel or unwell contacts. • No difficulty looking at light and his neck seems fine.
General	Normally happy, fit and well. Energetic and inquisitive child.
PMH	None of note Born at term, NVB Normal milestones inc height and weight appropriate Up to date with vaccinations.
DHx	Nil NKDA
FHx	None of note
SHx	In Year 1 of primary school Lives with Mum (works at the council)
ICE	Very worried what it could be This is very unlike Niall

Tutor notes

Ask the student what observations and examination findings they would like and then hand them the below findings.

→ Temperature 38.4°C
→ Sleepy, quiet with dry lips and cool hands/feet
→ No obvious photophobia or neck stiffness. No rash seen
→ Nil to see in ears and throat
→ HS and chest clear, abdo snt
→ HR 140bpm (94-140), RR 35 breaths/min (25-30), CRT 2 seconds

Further discussion points

→ How do you spot signs of a sick child, including the red flag signs (discuss below)
→ Responding to parental concerns in calm and confident manner to prevent distress/hysteria
→ Knowledge of the appropriate pathway for escalation of care and the practical aspects of how to arrange

Additional reading:

→ NICE Traffic Light system for identifying risk of serious illness (see below)
https://www.nice.org.uk/guidance/cg160/resources/support-for-education-and-learning-educational-resource-traffic-light-table-189985789

Green – low risk		**Amber – intermediate risk**	**Red – high risk**
Colour (of skin, lips or tongue)	▯ Normal colour	▯ Pallor reported by parent/carer	▯ Pale/mottled/ashen/ blue
Activity	▯ Responds normally to social cues ▯ Content/smiles ▯ Stays awake or awakens quickly ▯ Strong normal cry/not crying	▯ Not responding normally to social cues ▯ No smile ▯ Wakes only with prolonged stimulation ▯ Decreased activity	▯ No response to social cues ▯ Appears ill to a healthcare professional ▯ Does not wake or if roused does not stay awake ▯ Weak, high-pitched or continuous cry
Respiratory		▯ Nasal flaring ▯ Tachypnoea: - RR >50 breaths/ minute, age 6–12 months - RR >40 breaths/ minute, age >12 months ▯ Oxygen saturation ≤95% in air ▯ Crackles in the chest	▯ Grunting ▯ Tachypnoea: RR >60 breaths/minute ▯ Moderate or severe chest indrawing
Circulation and hydration	▯ Normal skin and eyes ▯ Moist mucous membranes	▯ Tachycardia: - >160 beats/minute, age <12 months - >150 beats/minute, age 12–24 months - >140 beats/minute, age 2–5 years ▯ CRT ≥3 seconds ▯ Dry mucous membranes ▯ Poor feeding in infants ▯ Reduced urine output	▯ Reduced skin turgor

Other	? None of the amber or red symptoms or signs	? Age 3–6 months, temperature ≥39°C ? Fever for ≥5 days ? Rigors ? Swelling of a limb or joint ? Non-weight bearing limb/not using an extremity	? Age <3 months, temperature ≥38°C* ? Non-blanching rash ? Bulging fontanelle ? Neck stiffness ? Status epilepticus ? Focal neurological signs ? Focal seizures
CRT, capillary refill time; RR, respiratory rate *Some vaccinations have been found to induce fever in children aged under 3 months			
This traffic light table should be used in conjunction with the recommendations in the NICE guideline on Feverish illness in children.			

Scenario 4ii: Referring an unwell child

Student Instructions: Part 2 – (can be a different student)

You are an F1 in a GP Surgery and just seen Niall (5 yrs old) with Mum (Ms Fletcher). He has a fever and was becomingly increasingly sleepy over the last day. You have conducted some preliminary findings and found:

→ Temperature 38.4°C
→ Sleepy, quiet with dry lips and cool hands and feet
→ No obvious photophobia or neck stiffness. No rash seen
→ Nil to see in ears and throat
→ HS and chest clear, abdo snt
→ HR 140bpm (94-140), RR 35 breaths/min (25-30), CRT 2 seconds

You have concluded that he is unwell and needs to be assessed urgently in secondary care.

- Please telephone the paediatric registrar on call at the hospital to arrange an admission for Niall.

You may take some time to make notes, and pick up the phone when you are ready.

The examiner will play the role of the registrar. You should sit back to back.

Simulated Registrar instructions/Tutor Notes

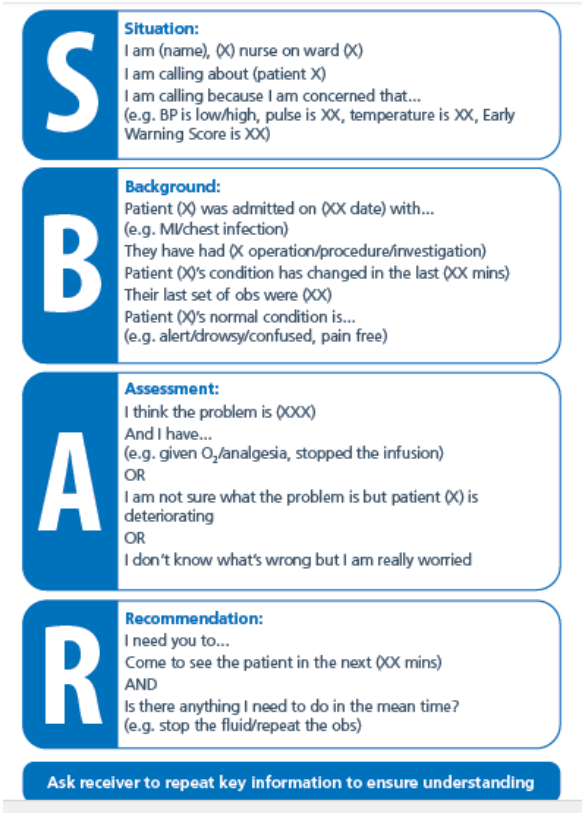
- Ask why the referring doctor thinks this is an urgent matter
- Ask about presence of red flag signs if not conveyed
- Ask about the potential loci of infection
- Ask what they think the differential diagnosis is
- Ask which investigations they may wish to request
- You may are not questioning of the referral but just wish to know the detail to provide appropriate care on arrival

Further discussion notes:

→ Use of the SBAR tool to handover
→ Discuss how telephone use has its differences with face to face discussions. E.g. due to the little non-verbal aspects of communication etc.
→ Providing the necessary information to process a referral to secondary care
→ Discuss any difficulties that might arise with trying to refer a patient (but without scarring students that every interaction is always somewhat difficult)
→ Expressing the clinical urgency of the situation over the phone, especially with Mum present
→ Prompt them to think about transportation to the hospital. How to do this e.g.?Blue light (what does this mean?)

Additional reading:

NHS SBAR Tool (see below) https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf


S
Situation:
I am (name), (X) nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned that...
(e.g. BP is low/high, pulse is XX, temperature is XX, Early Warning Score is XX)
B
Background:
Patient (X) was admitted on (XX date) with...
(e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)'s normal condition is...
(e.g. alert/drowsy/confused, pain free)
A
Assessment:
I think the problem is (XXX)
And I have...
(e.g. given O_2/analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried
R
Recommendation:
I need you to...
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the mean time?
(e.g. stop the fluid/repeat the obs)
Ask receiver to repeat key information to ensure understanding

Scenario 5: Concerns about a child's walking

Student instructions:

You are an F1 in a GP Surgery and Mr Lin has brought in his 18 month old son, Wei, as he is concerned about his walking.

- Please take a full history from Mr Lin
- Considering what actions, if any, you may wish to take.

Wei is not present but currently at nursery.

Simulated patient instructions

You are playing the role of Mr Lin, who has brought in his 18 month old son Wei because you are concerned that he cannot walk more than a few steps unaided. He is at nursery today but you are happy to bring him in for examination is necessary.

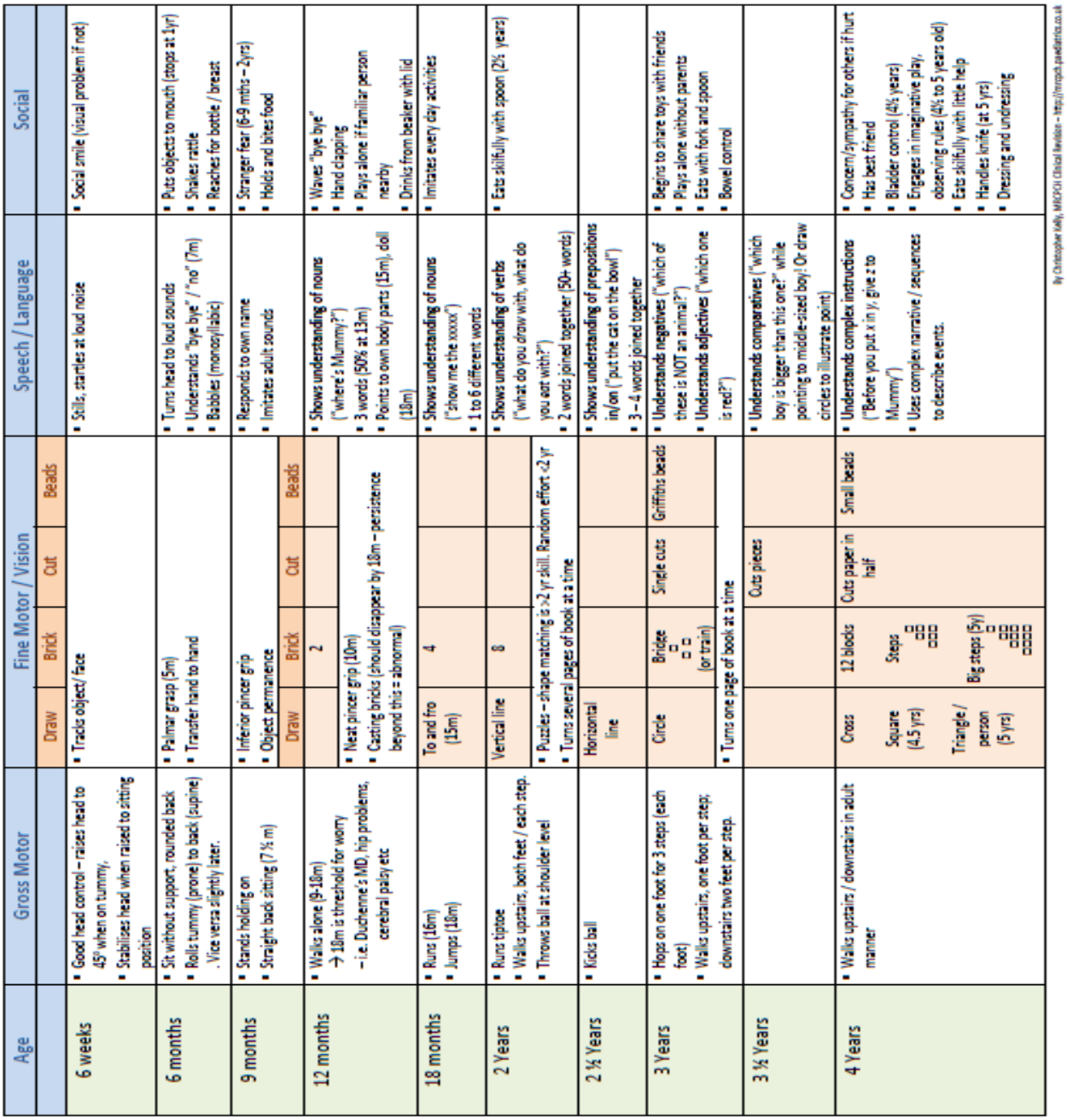
PC	"He seemed to be all fine until the last few months"
HPC	A few weeks ago, Wei started going to a playgroup in the mornings, so you have noticed that most other children his age are walking more confidently than he is. If asked: He Lifted his head up by a few weeks old Sat unaided at 8 months Bottom-shuffled at 9 months Pulled to stand aged 11 months Stood unaided at 14 months Took first step at 16 months Can now take up to 7 steps unaided before falling down Well in himself, eating and drinking well, normal numbers of wet and dirty nappies
PMH	Reflux as a baby, had to take ranitidine until 1 year old There was a question of development dysplasia of hips when he was born, but he had an ultrasound and no further action was taken
General	NVD at 41+3, breech delivery All immunisations up to date Normal height and weight
DHx	Abidec multivitamin drops. NO allergies
FHx	None of note
SHx	Lives at home with Mum and Dad Mum is 27/40 pregnant with their second child Attends playgroup 4 mornings a week
ICE	Worried that he is behind other children
Developmental	Met all other domains of milestones on time Smiled aged 6 weeks Said his first words 'Mama' and 'Dada' aged 11 months Is now putting sentences of a few words together Engages and plays happily

Further Discussion Points

- → A structure to take a development history?
- → Ability to respond to a parent's concerns
- → Possible causes and management.
- → How this is a skill in dealing and managing uncertainty.

Additional reading:

- → Table of developmental milestones in children from RCPCH (see below) http://mrcpch.paediatrics.co.uk/wp-content/uploads/2014/06/Development-Assessment-MRCPCH-Website.pdf



Age	Gross Motor	Fine Motor / Vision				Speech / Language	Social
		Draw	Brick	Cut	Beads		
6 weeks	• Good head control – raises head to 45° when on tummy. • Stabilizes head when raised to sitting position	• Tracks object/ face				• Skills, startles at loud noise	• Social smile (visual problem if not)
6 months	• Sit without support, rounded back • Rolls tummy (prone) to back (supine) . Vice versa slightly later.	• Palmar grasp (5m) • Transfer hand to hand				• Turns head to loud sounds • Understands "bye bye" / "no" (7m) • Babbles (monosyllabic)	• Puts objects to mouth (stops at 1yr) • Shakes rattle • Reaches for bottle / breast
9 months	• Stands holding on • Straight back sitting (7 ½ m)	• Inferior pincer grip • Object permanence				• Responds to own name • Imitates adult sounds	• Stranger fear (6-9 mths – 2yrs) • Holds and bites food
12 months	• Walks alone (9-18m) → 18m is threshold for worry – i.e. Duchenne's MD, hip problems, cerebral palsy etc	Draw	Brick	Cut	Beads	• Shows understanding of nouns ("where's Mummy?") • 3 words (50% at 13m) • Points to own body parts (15m), doll (18m)	• Waves "bye bye" • Hand clapping • Plays alone if familiar person nearby • Drinks from beaker with lid
		• Neat pincer grip (10m) • Casting bricks (should disappear by 18m – persistence beyond this = abnormal)	2				
18 months	• Runs (16m) • Jumps (18m)	To and fro (15m)	4			• Shows understanding of nouns ("show me the xxxxx") • 1 to 6 different words	• Imitates every day activities
2 Years	• Runs tiptoe • Walks upstairs, both feet / each step. • Throws ball at shoulder level	Vertical line	6			• Shows understanding of verbs ("what do you draw with, what do you eat with?") • 2 words joined together (50+ words)	• Eats skilfully with spoon (2½ years)
		• Puzzles – shape matching is >2 yr skill. Random effort <2 yr • Turns several pages of book at a time					
2 ½ Years	• Kicks ball	Horizontal line				• Shows understanding of prepositions in/on ("put the cat on the bowl") • 3 – 4 words joined together	
3 Years	• Hops on one foot for 3 steps (each foot) • Walks upstairs, one foot per step; downstairs two feet per step.	Circle	Bridge (or train)	Single cuts	Griffiths beads	• Understands negatives ("which of these is NOT an animal?") • Understands adjectives ("which one is red?")	• Begins to share toys with friends • Plays alone without parents • Eats with fork and spoon • Bowel control
		• Turns one page of book at a time					
3 ½ Years				Cuts pieces		• Understands comparatives ("which boy is bigger than this one?" while pointing to middle-sized boy). Or draw circles to illustrate point)	
4 Years	• Walks upstairs / downstairs in adult manner	Cross Square (4.5 yrs) Triangle / person (5 yrs)	12 blocks Steps Big steps (5y)	Cuts paper in half	Small beads	• Understands complex instructions ("Before you put x in y, give z to Mummy") • Uses complex narrative / sequences to describe events.	• Concern/sympathy for others if hurt • Has best friend • Bladder control (4½ years) • Engages in imaginative play, observing rules (4½ to 5 years old) • Eats skilfully with little help • Handles knife (at 5 yrs) • Dressing and undressing

By Christopher Kelly, MRCPCH Clinical Fellow – http://mrcpch.paediatrics.co.uk

Scenario 6: A teenager requesting contraception

Student instructions:

You are an F1 in a GP Surgery and Julie Turner, aged 15, has come to the GP (alone) to see you.

- Please take a history from Julie
- Please discuss an possible appropriate management plan

Simulated patient instructions:

You are playing the role of Julie Turner, aged 15. You have come to the GP to talk about contraception as you have recently started a sexual relationship with your boyfriend, who is 16. You are a bit shy talking about sex, as it is all new to you but you are happy to speak to the doctor as long as they appear non-judgmental.

PC	You would like to go on the pill as you have just started a sexual relationship with your boyfriend.
HPC	• You started having sex a few months ago, been using condoms ever time (with no problems). Your BF has been buying them but complaining they are expensive. If asked: • He is your first proper bf (16) and you started going out 6m ago, you met him in school. It is not secret you are in a relationship, he does not give you presents for sex. It's something you both wanted to do. • You think he has had sex before but you are not sure. You were a virgin when you met him. • You know you take it every day for 21d and then break for 7d. Most of your friends are on it. You don't think missing pills will be a problem for you. You want the pill as you are scared the condom will break. You are not really aware of any other type of contraception. You want what everyone else has. • You do not want to tell your parents as they would be angry and wouldn't understand. You may be persuaded to tell an older cousin who you are close too.
PMH	Mild acne
Menstrual history	• First period aged 12 • LMP – 1w ago (please give a date is asked) – normally 5days long (not really heavy or painful) and every month or so. • No problems with bleeding and not experiencing abnormal vaginal discharge
Sexual history	You have never had an STI test but would be happy to do one as long it is not painful.
Obstetric history	None
DHx	Duac for skin
FHx	None of note
SHx	Attends local high school, is in year 11 Drinks at parties only – 1 or 2 beers No smoking Tried cannabis once

ICE	• You do not want your parents to know you are sexually active. • If the doctor is not clear re: confidentiality you ask…. "You are not going to tell my parents are you?" • You would like the pill to prevent pregnancy • To want to get the pill today as most of your friends are on it and you don't see the problem. You get a little annoyed if it looks like they might not give it to you. If explained they might need to check with another doctor - you understand this, if explained appropriately.

Further Discussion points:

→ How do you feel about building rapport with a teenager, especially asking personal questions about relationships? Do you have an approach in mind? How do you think your age could affect the professional relationship

→ How do you assess Gillick competence

→ Discuss patient confidentiality, and how it applies to children in the UK

→ Consider safeguarding issues (e.g. grooming); including the age of the partner (plus nature of their relationship, e.g. how did they meet) and whether the sex is consensual

→ How do you take a sexual and menstrual history

→ Considering other relevant areas around the immediate consultation, including STI protection and appropriate follow up.

Additional reading:

→ Fraser/Gillick competence https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf

Scenario 7: A woman with a 'personal request'

Student instructions:

Cecile Dabbous, aged 41 has booked an emergency appointment to see the GP this morning. The reason given on the system is 'personal'. You are an F1 in a GP Surgery and she is your next patient.

- → Please take a history from Cecile
- → Consider an appropriate management plan.

Simulated patient instructions:

You are playing the role of Cecile Dabbous, aged 41, you work in finance. You have come to the GP to request the morning after pill after getting drunk at a party a few days ago. You are a little embarrassed and know you have made a silly mistake. You need to get back to work and want to just forget about the whole thing.

PC	Unprotected vaginal sex 3 days ago (80 hours if asked)
HPC	→ That night at some work drinks, a junior colleague of yours suggested some further drinks in a different bar, which lead to you going back to his and sleeping together. → You have no intention of starting a new relationship with this man. You didn't use a condom. Which you know is silly but these things happen occasionally. → You were not able to come sooner as you found it difficult to get a GP appointment If asked: → LMP – 1w ago (give exact date if asked), normally regular periods. No abnormal bleeding. → You have taken the morning after pill a few years ago. When in a relationship you use the COC for protection but have no intention of restarting this (as you are not in a relationship currently.) → Been pregnant once before in the past but miscarried. Smear was 1 year ago. STI check was 2 years ago. Have no current regular partner. → You had vaginal, anal and gave/received oral sex both ways. → You do intent to get a STI test from the GUM clinic but just need the morning after pill to make sure you don't get pregnant for now. → You do not think your colleague is high risk for HIV i.e. – a man that has sex with men, IV drug user and you know he is British born.
PMH	Menorrhagia Pre-menstrual tension Tonsillectomy 10 years ago
DHx	Allergy to penicillin Takes vitamin supplements OTC No other medications
FHx	None of note
SHx	Live in a house in Stoke Newington. Works in the city as an assistant director of a finance company. Never smoked. Drinks a bottle of wine over the week. Used to take cocaine on a regular basis in your 30s but gave that all up 2-3yrs ago. Eats well, and has a personal trainer 3/week.
ICE	You definitely don't want to become pregnant. You are slightly annoyed at all the questions being asked, and may try to hurry the doctor along so you can get to work. But you are not rude. You will get an STI test when you get a chance in the coming weeks. You expect to be given the morning after pill.

Further Discussion Points

- → Discuss the appropriate information needed to gather to prescribe emergency contraception, and discuss how to prescribe
- → Discuss types of emergency contraception and think about what would be appropriate to use in this circumstance. Where else can you get the EC?
- → Are there any other issues that need to be raised due to this encounter e.g. STI testing. How would you do this?
- → Responding to a patient who may not wish to engage fully in your comprehensive information gathering.

Additional reading:

- → Faculty of Sexual and Reproductive Health guidelines on emergency contraception: https://www.fsrh.org/standards-and-guidance/documents/ceu-clinical-guidance-emergency-contraception-march-2017/
- → British Association of Sexual health and HIV guidance on STI history taking and testing: https://www.bashh.org/guidelines

Scenario 8: Smear test results

Student instructions:

You are an F1 in a GP surgery, Katie Morgan is aged 36, has recently had her cervical smear test, she has made an appointment to discuss the results.

A letter showing the result is scanned into the notes (the patient has been CC'd in to this letter).

It shows 'borderline changes and also HPV is detected' – refer for colposcopy within 6w.

→ Please take a brief and focused history of the background
→ Please discuss what the results mean and the further steps to be taken
→ Please address any concerns she may have

Simulated patient instructions

You are playing the role of 36 year old Katie, you received your abnormal smear results in the post.

It shows 'borderline changes and also HPV is detected' – refer for colposcopy within 6w.

You were shocked as you have always had normal smears and annoyed with yourself for your smear being overdue by 2 years. You had been travelling and didn't get around to doing it.

PC	To discuss the results you have received in the post
Background	• You normally are up today with your smears but this one was 18m overdue as you have been travelling the past 2years. • You are confused and worried about the result. You do not know what this means and what a colposcopy is? • You also don't understand how you are HPV positive or what it is, you are always careful and get STI tests regularly. Do you need to tell previous partners? Is there a vaccine you could get? If asked: → LMP 2w ago – was normal. No bleeding in between period, after sex. Period normally last 5d (quite heavy) and is every 28d. → Used to be on the pill many years ago but currently has the cooper coil (since 3yrs ago). You do regularly feel the strings. → You have never been pregnant. STI test was 6m ago and normal (had chlamydia at aged 16yrs). Smear before this was 4-5years ago. → You have had 10 partners in the past (first at aged 15). If asked this is an insensitive way or in a way which isn't explained why they are asking this - you look horrified and pretty offended. "What has that got to do with this?!"
PMH	Migraine
DHx	Cooper coil inserted 3 years ago
FHx	Paternal aunt diagnosed with breast cancer aged 68. Currently in remission
SHx	Lives with friends in flat in central London Works as an events manager Ex smoker (10/day from 15yrs – stopped at age 25) Drinks a bottle of wine or two a week. No drugs.
ICE	Doctor, do I have cancer? What is a colposcopy? What is HPV, how did I get it? Am I contagious? Do I need to tell previous partners? Can I get the vaccine?

Further Discussion Points

→ What are the appropriate referral pathways in cervical screening?
→ How do you explain the results and the management?
→ Do you know about HPV testing, management and prevention?
→ How do you approach possible risk factors in a non-judgmental way? Do you need to?

Additional reading

→ NICE guidelines on cervical screening https://cks.nice.org.uk/cervical-screening
→ NICE guidelines on managing abnormal cytology results (see below) https://cks.nice.org.uk/cervical-screening#!scenario:1

Managing abnormal results

- **Women with:**
  - **Borderline change in squamous or endocervical cells, or low-grade dyskaryosis** — the laboratory will perform a reflex high-risk human papillomavirus (HR-HPV) test on the cytology sample:
    - If the HPV test is positive the woman will be referred for colposcopy for an appointment within 6 weeks.
    - If HPV test is negative, the woman will be returned to routine screening.
  - **High-grade dyskaryosis (moderate), or high-grade dyskaryosis (severe)** will be referred to colposcopy for an appointment within 2 weeks.
  - **Suspected invasive cancer or glandular neoplasia** will be referred to colposcopy for an appointment within 2 weeks.
- **Ensure the woman has received an explanation about what an abnormal result means and what further tests or treatment she may need.**
  - The NHS Cervical Screening Programme (NHSCSP) provides the leaflets NHS cervical screening: helping you decide and NHS cervical screening: having a colposcopy.
  - The NHS Choices website (www.nhs.uk) provides information on the Cervical screening test and Cervical screening - Results.

Student feedback form

Barts and The London School of Medicine and Dentistry

Feedback4You

CENTRAL LOCOMOTOR TEACHING - STUDENT OBSERVED CONSULTATION

Name of Student..... Date.....

Presenting Complaint.....

DOMAIN	STUDENT COMMENTS	ACTOR COMMENTS	TUTOR COMMENTS
Non verbal Communication			
Verbal communication			
History taking			
Exploring Ideas, Concerns and Expectations			
Decision making			