Cancer Communication Toolkit

Brought to you by North West London Cancer Network Patient User Group, The London Deanery and Macmillan Cancer Support.

MENU:

Introduction

The Cancer in Primary Care project is a collaborative venture between the North West London Cancer Network Patient User Group, The London Deanery and Macmillan Cancer Support.

The Patient User Group at the North West London Cancer Network identified the problems they experienced with GP communication around their personal journey of cancer diagnosis.

Patient voices are powerful and reflect the true experience of GPs in general practice. It is stories like these that motivate and inspire us. Together with Macmillan and the London Deanery, these experiences are provided here as videos of their personal journeys.

This education resource is aimed at supporting GP trainees with the diagnosis and appropriate referral of patients with suspicious symptoms of cancer. It offers a range of scenarios pertaining to the themes of good and bad experience of patients when they present to their GP. The aim of this resource is to build on existing communication skills, encourage the 'suspicion of cancer' conversations and in turn reduce non attendance rates and encourage appropriate referrals via the Two Week Wait process.

In order to activate the video links, you will need Adobe Reader 10 which can be downloaded for free from:
http://get.adobe.com/uk/reader/

Before embarking on the toolkit, please take a moment to think about how you currently manage cancer in primary care and how you assess patients who have symptoms suggestive of cancer. Please click here to complete a survey and to give us some indication on your current confidence levels.

MENU:

How to use

This interactive PDF can be used for:

- Self directed study
- One to one teaching
- Facilitated group teaching (e.g. within speciality half day release training or residentials)

Overview

This toolkit is divided into two sections:

The first section has four clinical cases: bowel, breast, brain and prostate cancer. Each case has a GP consultation video scripted to demonstrate different aspects of cancer diagnosis and care. They have been divided into smaller sections followed by opportunities for learning and reflective practice. The patients are played by actors and the GPs are being themselves. If used in a group, clips can be followed by discussion of these themes. Each case also has an individual patient story at the end. A case should take approximately 30 minutes to complete, longer if used for group discussion.

The second section contains web links to eight further patient stories relating to GP communication and their cancer.

By the end of this toolkit you should be able to:

- Discuss red flag symptoms of the featured cancers
- Confidently think through ideas, concerns and expectations of a patient concerned about cancer
- Negotiate onward investigations and management plans with patients
- Discuss screening
- Practice dealing with the distressed patient
- Understand the process from the patients perspective

MENU:

Clinical case 1

A 46 year old man with bowel trouble

Relevant MRCGP Curriculum Statements:

1) Communication and consulting skills, 2) Practising holistically, 4.1) Management in primary care, 12) Cancer and palliative care, 15.2) Digestive problems

Main symptoms

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Main symptoms

What are the main symptoms of bowel cancer?

Select the current answers from the options below. Once you have finished, click submit to find out what the correct options are.

- ☐ Anaemia
- ☐ Weight loss
- ☐ Constipation symptoms for 2 weeks
- ☐ A change in normal bowel habit
- ☐ Lethargy
- ☐ Abdominal or rectal mass
- ☐ Abdominal cramps
- ☐ Blood in stools
- ☐ Abdominal bloating
- ☐ Vomiting
- ☐ Loose stools for 6 weeks
- ☐ Abdominal or rectal pain
- ☐ Rectal bleeding
- ☐ Tenesmus

Correct

Rectal bleeding

Blood in stools

A change in normal bowel habit

Loose stools for 6 weeks

Abdominal or rectal mass

Tenesmus

Weight loss

Lethargy

Abdominal or rectal pain

Anaemia

Incorrect

Constipation symptoms for 2 weeks

Abdominal cramps

Abdominal bloating

Vomiting

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Ideas, concerns and expectations

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Ideas, concerns and expectations

In the video, which questions establish the patient's ideas, concerns and expectations?

Please type your answers below:

The doctor asks the patient to tell her what he thinks is going on – in his own words.

She acknowledges his assessment of the situation which helps to build rapport.

She takes time to discuss his concerns about stress at home and work.

Finally, she gains a good understanding of the patient's expectations by asking him if he thinks there is any other reason to look into his symptoms further, apart from a change in medication.

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Negotiation

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Negotiation

What is effective in how the GP negotiates with the patient?

Select from the options below you think are correct. Once your finished, click submit to find out what the correct options are.

- ☐ Pushing doctors agenda in the patients ‘best interests’
- ☐ Telling the patient what the management plan will be
- ☐ Taking time to understand the patients concerns
- ☐ Interupting
- ☐ Explaining the doctors concerns
- ☐ Having a shared management plan
- ☐ Asking open questions
- ☐ Listening
- ☐ Agreeing with the patient and leave further discussion about concerns until next appointment

Correct

Listening

Asking open questions

Taking time to understand the patients concerns

Having a shared management plan

Explaining the doctors concerns

Incorrect

Interupting

Telling the patient what the management plan will be

Pushing doctors agenda in patients ‘best interests’

Agreeing with the patient and leave further discussion about concerns until next appointment

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The GP reflections

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The GP reflections

What the GP thought about this case and how she managed it.

What are your thoughts? How would you have managed this consultation?

If in a group, why not try role playing the end of this consultation, negotiating with the patient about the need for further investigations and referral?

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Patient centred consulting

David Pendleton described a number of tasks for a doctor within the consultation (Pendleton et al. 1984) and one of these included assessment of: (Click to reveal)

Establishing ideas, concerns and expectations will often be incorporated into basic history taking. Asking about expectations is a higher-order skill and usually the starting point for negotiating and sharing a management plan.

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Simon's story

Simon's personal experience of bowel cancer.

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Simon's story

Questions for personal/group reflection:

Click buttons to reveal questions.

MENU:

Clinical case 2

A 56 year old requesting a PSA test

Relevant MRCGP Curriculum Statements:

1) Communication and consulting skills, 3.5) Evidence based practice, 10.2) Men's health, 12) Cancer and palliative care

Patient history

MENU:

Clinical case 2

A 56 year old requesting a PSA test

Relevant MRCGP Curriculum Statements:

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History

What are the qualities of an effective screening test?

Select from the options below you think are correct. Once your finished, click submit to find out what the correct options are.

- ☐ Should not involve secondary care
- ☐ Cheap test
- ☐ Natural history well understood
- ☐ Suitable and acceptable test
- ☐ Clear protocols required
- ☐ Result should be available straight away
- ☐ Can be used to plan palliative management
- ☐ Treatable condition

Correct

Treatable condition

Clear protocols required

Suitable and acceptable test

Natural history well understood

Incorrect

Cheap test

Result should be available straight away

Can be used to plan palliative management

Should not involve secondary care

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PSA test, false positives and false negatives, use of leaflet

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PSA test, false positives and false negatives, use of leaflet

What do you understand by the terms Sensitivity and Specificity?

Write your answer below and then click the buttons on the right to reveal the correct answers.

Please type your Sensitivity answer below:

Please type your Specificity answer below:

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The GP's reflections

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The GP's reflections

What are the symptoms that might suggest an enlarged prostate?

Select the correct answers from the options below. Once you're finished, click submit for answers.

- ☐ Dribbling
- ☐ Hesitancy
- ☐ Poor stream
- ☐ Dysuria
- ☐ Frequency and urgency
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Haematuria
- ☐ Poor emptying

Correct

Poor stream

Hesitancy

Dribbling

Poor emptying

Frequency and urgency

Incorrect

Haematuria

Abdominal pain

Constipation

Dysuria

An enlarged prostate can narrow the first part of the urethra causing obstructive symptoms. It can also make the bladder irritable leading to symptoms of irritability.

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Screening programmes

The National Screening Committee criteria for appraising the viability, effectiveness and appropriateness of a screening programme are based on the criteria developed by Wilson in 1968 and address the condition, the test, the treatment and the screening programme.

Wilsons Criteria for a screening test or programme:

A mnemonic has been provided to summarise these (Clarke & Croft 1998): "TRAP WILSON"

Four main points: (Click to reveal)

Plus six other criteria: (Click to reveal)

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Peter B

Peter's experience of prostate cancer.

MENU:

Clinical case 2

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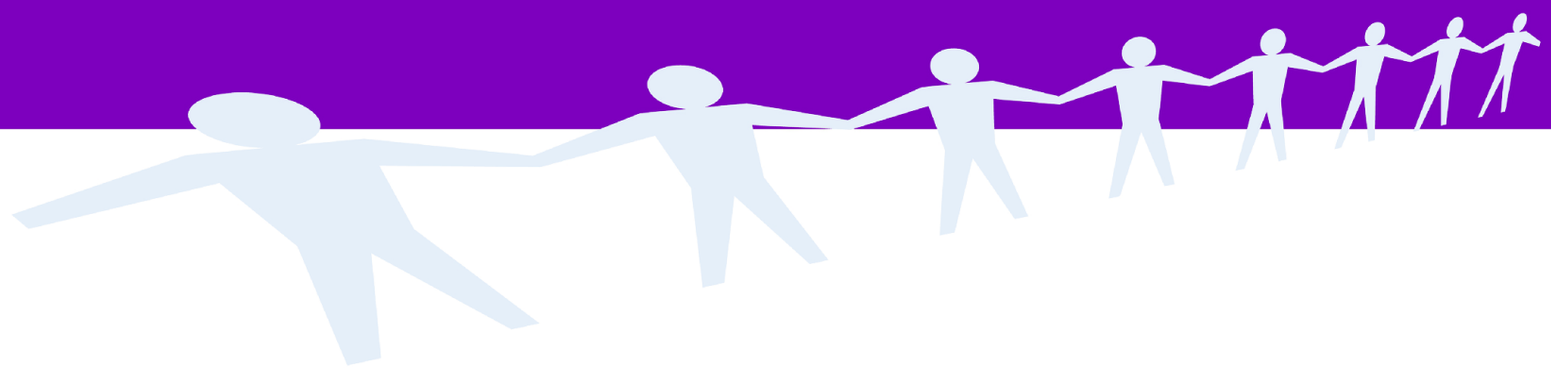
Reflection

When counselling a patient on the pros and cons of having a PSA test, think of the words and skills you use, and compare to those that the GP has used here.

How detailed should we be for our patients?

If in a group, spend 5 minutes explaining the PSA test to the person next to you and then change roles.



MENU:

Clinical case 3

A middle aged woman with a worrying mammogram

Relevant MRCGP Curriculum Statements:

1) Communication and consulting skills, 3.5) Evidence based practice, 10.1) Woman's health, 12) Cancer and palliative care

The presenting problem, and patient fears and expectations

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The presenting problem, and patient fears and expectations

What consultation skills can help with dealing with a distressed patient?

Please type your answers below:

The GP uses a variety of skills in dealing with this obviously distressed patient. She has an open posture and actively encourages the patient to speak and 'offload' with active listening techniques. She asks the patient to explain what her fears are and what the physical and emotional effects these fears are having on her life. She speaks calmly and slowly which helps to reassure the patient.

In situations such as these, openly acknowledging the patients distress allows them to speak more freely about it.

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GP outlines issues with screening and early detection

MENU:

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GP outlines issues with screening and early detection

What are the disadvantages of screening programmes in primary care settings?

Click 'Reveal' to view answers.

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A middle aged woman with a worrying mammogram

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Discussion of coping strategies, planning follow-up

Watch how the doctor discusses a range of coping strategies with the patient.

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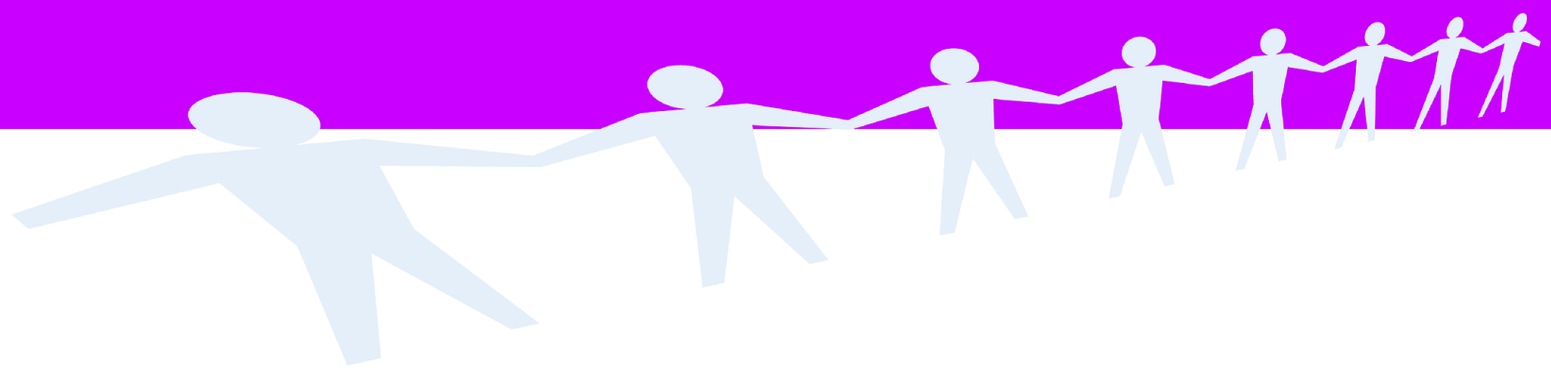
Discussion of coping strategies, planning follow-up

Watch how the doctor discusses a range of coping strategies with the patient. Keeping the patient at the centre of the consultation is key. The strategies will only be effective if they have been decided by the patient and deemed acceptable to them.

If in a group, replay this case from the point where the patient becomes distressed and reflect on how you managed this.



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How can you help a distressed patient?

The Six Category Intervention Analysis (Heron 1990), is a conceptual model for understanding interpersonal relationships. It is used as a tool to identify a range of possible therapeutic interactions between two people.

Three Authoritative Interventions:

Three Facilitative Interventions:

MENU:

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Anna's story

Anna's experience of breast cancer.

Reflections Points: How did the GP help her? What skills did he use?

Clinical case 4

A young woman with bad headaches

Relevant MRCGP Curriculum Statements:

1) Communication & consulting skills, 2) Practising holistically, 4) Making a diagnosis/decision, 4.1) Management in primary care, 15.7) Neurological problem

Main presenting symptoms

MENU:

Clinical case 4

A young woman with bad headaches

Relevant MRCGP Curriculum Statements:

1) Communication & consulting skills, 2) Practising holistically, 4) Making a diagnosis/decision, 4.1) Management in primary care, 15.7) Neurological problem

Main presenting symptoms

What are the red flag symptoms that suggest raised intracranial pressure?

Select from the options below you think are correct. Once your finished, click submit to find out what the correct options are.

- ☐ Altered mental state
- ☐ Abdominal symptoms
- ☐ Watering eyes
- ☐ Morning headaches
- ☐ Pupillary changes
- ☐ Widened pulse pressure
- ☐ Worse at the end of the day
- ☐ Blurred vision
- ☐ Facial pain
- ☐ Vomiting

Correct

Morning headaches

Vomiting

Blurred vision

Altered mental state

Pupillary changes

Widened pulse pressure

Incorrect

Worse at the end of the day

Watering eyes

Facial pain

Abdominal symptoms

MENU:

Clinical case 4

A young woman with bad headaches

Relevant MRCGP Curriculum Statements:

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Clarifying questions, personal and drug history

MENU:

Clinical case 4

A young woman with bad headaches

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Physical examination

What examination would you normally perform on a patient with headache?

MENU:

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Fear of cancer, examination, explanation, reassurance and planning

MENU:

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A young woman with bad headaches

Relevant MRCGP Curriculum Statements:

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Fear of cancer, examination, explanation, reassurance and planning

Questions:

1. How do you manage patients presenting with somatic symptoms of emotional distress?

2. How would describe the ‘heartsink’ patient?

Please type your answers below:

Please see the next slide for more information.

MENU:

Clinical case 4

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'Heartsink survival'

Mather and Gask (1995) created a 3 stage model which can be useful in helping doctors to manage certain patients who present with somatic symptoms of psychological distress.

Stage 1: Acknowledge ("The pain is real"):

1. Take a full history of symptoms – explore possibility of organic pathology and reassure patient they are being taken seriously
2. Explore emotional cues – notice verbal/non verbal cues to emotional problems
3. Explore social and family factors
4. Explore health beliefs – ask the patient what they think the symptoms may be due to
5. Brief focused physical examination

Stage 2: Explain (eg "The pain is due to tension in the muscles of the scalp"):

1. Feedback the results of the examination
2. Acknowledge the reality of the symptoms - crucial
3. Reframe the complaints: link physical, psychological and life events. E.g. 'you've told me about the stomach pains you've had for the last month, and how you've had headaches and feeling tense and worried, and about the death of your father a month ago. I wonder if these are all linked in some way..'
4. Give the patient a chance to discuss and negotiate.

Stage 3: Making the link ("Stress sometimes causes this sort of tension in muscles. I wonder whether the problems at work might be contributing"). There are a number of ways the doctor can do this:

1. Simple explanation – most commonly used. E.g. 'If you are depressed or sad you feel pain or discomfort more and start worrying that you may be sick'
2. Demonstration – symptoms can be linked in time to stressful life events, or to events in the day
3. Projection or identification – ask the patient if any other people they know have suffered with similar symptoms. If known contacts have had similar symptoms at stressful times it may be possible to get the patient to understand their own symptoms more clearly.

It may not be possible to move through all three of these stages in one consultation. Approaches will need to be modified according to symptom presentation or availability of investigation results. Evidence of some pathology may complicate the picture, but the same principles of honesty with the patient about findings, acknowledgement, negotiation and clear explanation will apply.

Clinical case 4

A young woman with bad headaches

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Nick's story

Nick's experience of throat cancer.

Reflection Points: What safety netting measures can you use when giving 'good news' after a normal test result? If in a group role play the conclusion of this case (after examination). Think through how the doctor reassured the patient.

MENU:

Patient voices

These interviews last around 10 minutes and are intended to be used to stimulate thinking about the initial diagnosis, referral and support of patients with symptoms suggestive of cancer. Using patients own experiences are a powerful way of thinking through these steps and something all clinicians can relate to. Feel free to go through all or some of these stories. You can also return to them again at a later date.

If this is used for self directed learning, please think through the prompt questions beneath each video link.

For group work, it may be appropriate to show only a few clips since discussion time of at least 20 minutes should normally be allowed if participants are to explore the issues raised in any depth.

Some programmes may invite participants to view a video clip as part of pre-course preparation. When this approach is taken, it may be helpful to use a “purposeful observation” approach in which viewers are invited to comment on specific aspects of the video. Again, we suggest using the prompt questions provided.

The videos can be used in different ways:

- By cancer type eg examples of patients with breast cancer or prostate cancer
- To illustrate important themes about cancer diagnosis using examples of patients with different types of cancer eg: Holistic care or cultural factors in disease.

MENU:

Patient voices

Title: Alison's story
Cancer type: Breast cancer
Theme: Communication skills
Duration: 10 minutes 42 seconds

View Video ›

Summary

Alison was told the likely diagnosis when she first attended the GP with nipple inversion. "I am so grateful she was so honest". Although she reacted with fear and anxiety, she felt her GP treated her as an adult and was non-judgemental about the delay in her presentation. She also mentions the importance of her faith in helping her cope and discusses the emotional aspect of the diagnosis: "Fear is a really strong component… You need to know what you're dealing with and then you get on with it".

Prompt questions

How can we support patients through the emotional adjustment involved in a cancer diagnosis?

How do you address cultural and spiritual issues with your patients?

Alison says "I'm sure I didn't hear all that she was saying" What are the implications for practitioners?

MENU:

Patient voices

Title: Govinda's story
Cancer type: Colonic cancer
Theme: Breaking significant news, Cultural factors in disease
Duration: 10 minutes 21 seconds

View Video ›

Summary

Govinda is a 79 year old man who missed out on screening because of his age and presented with anaemia. He says that he never thought be would be suffering from cancer and emphasises that "lack of awareness on the patient's part" needs to be addressed. He walked out of the hospital clinic when the news was broken to him - feeling that the consultant was talking about someone else and going into a state of being "deaf, dumb and blind". Cultural and spiritual aspects are also mentioned towards the end of the interview.

Prompt questions

What issues around breaking significant news does this raise?

How do you address cultural and spiritual issues with your patients?

Patient voices

Title: John's story
Cancer type: prostate cancer
Themes: Screening and ethics
Duration: 11 minutes 54 seconds

View Video ›

Summary

John is a man in his 50's who presented with a borderline PSA result. He valued the holistic care provided by his GP, which included great support for both him and his wife, and the fact that he felt empowered to make decisions.

Prompt questions

How did his GP provide holistic care?

How did the GP empower him?

What are the guidelines for follow up of a man with a borderline PSA?

What is the role of the internet in providing information to patients recently diagnosed with cancer?

MENU:

Patient voices

Title: Sadja's story
Cancer type: Her mother had a gynaecological cancer
Themes: Cultural factors, the "missed diagnosis", spotting red flags
Duration: 7 minutes 58 seconds

View Video ›

Summary

Here a daughter describes how her mother was finally diagnosed with endometrial cancer after four attendances at the Accident and Emergency department. She talks about screening red flag questions that can be used by doctors to try to eliminate a possible cancer diagnosis.

Prompt questions

Are there any ways in which this case could have been managed differently to have made the diagnosis earlier on?

MENU:

Patient voices

Title Simon's story
Cancer type: Colonic cancer
Themes: Patients awareness of red flags, Accurate information giving
Duration: 9 minutes 34 seconds

View Video ›

Summary

Simon tells the story that although he noticed a change in bowel habit and PR bleeding up to a year before, he only presented to his GP after a significant PR bleed. He was told "good news" initially by the surgeons that there wasn't anything wrong, then "bad news" that they had in fact found a cancer.

Prompt questions

How can we increase patient awareness of red flag symptoms, and how can we encourage them to present to us?

What public health measures could be effective of raising such awareness?

What effects do you think breaking falsely good news has on a patient and their adjustment to their diagnosis?

MENU:

Patient voices

Title: Jack's story
Cancer type: Colonic cancer and prostate cancer
Theme: effective sharing of information, danger of over-diagnosing depression/anxiety
Duration: 7 minutes and 17 seconds

View Video ›

Summary

Jack presented to his GP with dizziness and the GP attributed this to anaemia and depression. Jack protested that he was "a happy bloke", but the GP did not take the hint and was rather dismissive, but did refer him. He turned out to have both colonic and prostate cancer. Jack makes some interesting observations about his GP surgery: "They are too busy to get the right diagnosis… They try to get you in and out. It's not their fault- they're under pressure" As a result, he feels guilty taking up the doctor's time.

Prompt questions

What questions would you ask to explore further with a patient in whom you suspect depression?

How can you make our patients feel that we are not "too busy" to listen to their concerns?

MENU:

Patient voices

Title: Chonette's story
Cancer type: Chronic lymphocytic leukaemia
Duration: 11 minutes 34 seconds
Themes: adult–adult relationships; communication and respect

View Video ›

Summary

Chonette consulted the practice nurse 3 weeks after noting a node in her armpit. She turned out to have CLL and eventually needed a stem cell transplant. Her GP was "wonderful", helped her understand the system and Chonette felt that she "could trust somebody". Even more importantly, a conversation with the GP was like a conversation between "two normal people". Chonette felt that the behaviour of some doctors she had met before was arrogant and superior.

Prompt questions

What was it about the relationship with the GP that worked so well?

What practical things did the GP do that helped facilitate this patient's cancer journey?

MENU:

Patient voices

Title: Indy's story
Cancer type: Colo-rectal cancer
Duration: 5 minutes 42 seconds
Themes: spotting red flag symptoms in younger patients

View Video ›

Summary

Indy was treated for haemorrhoids for nine months and felt that he ought to have had a "finger test". Unfortunately this resulted in late stage cancer, extensive surgery and a colostomy bag. Indy blames the original GP, comments that his new GP "listens to me" and does a "thorough check" and concludes "I hope no one goes through what I've been through".

Prompt questions

What could the original GP done differently?

How often should haemorrhoids be diagnosed positively (with a proctoscope)?

MENU:

Patient voices

Title: Peter's story (Peter C)
Cancer type: Prostate
Duration: 10 minutes 58 seconds
Themes: Discontinuity of care, safety netting, risk management of investigations

View Video ›

Summary

Peter C attended his GP with nocturia three times and had a PSA test. He heard nothing so assumed it was normal. After discussing with a friend, he rang the surgery a month later and was asked to attend urgently as his PSA result had come back at 60. "My doctor hasn't given me 100%.....I think they should have called ME". "I've never seen the same doctor twice" Peter reflects that part of the problem is that he has always been in good health, rarely sees the doctor and "I don't know how to be ill?"

Prompt questions

How can we help patients who do not know "how to be ill"?

How much responsibility should we have for giving patients abnormal results?

MENU:

Key learning points of this toolkit

- This toolkit has been designed to improve the communication skills and clinical knowledge of GP trainees around cancer.

- It has covered clinical symptoms, as well as exploring in detail the different communication skills available to GPs to discuss this often emotive differential diagnosis.

- It has also provided focus on the patient perspective, enabling clinicians to understand the need to individualise their approach to cancer.

We would welcome feedback on any aspect of this project and are particularly keen to hear how different people have utilised these resources. Please click here to complete a quick survey and/or send feedback to Dr Pawan Randev: pawan.randev@nhs.net or sarita.yaganti@nwlcn.nhs.uk

References and additional resources

References

Clarke, R. & Croft, P. (1998) Critical reading for the reflective practitioner, Oxford: Butterworth Heinemann.

Greenhalgh, T. (1997) How to read a paper, London: BMJ Publishing Group.

Heron, J. (1990) Helping the client: a creative practical guide, London: Sage Publications Ltd.

Mant, D. & Fowler, G. (1990) Mass screening: theory and ethics, BMJ, 300: 916-918.

Mathers, N. & Gask, L. (1995) Surviving the heartsink experience, Family Practice, 12: 176-183.

Pendleton, D., Schofield, T., Tate, P., & Havelock, P. (1984) The consultation: an approach to learning and teaching, Oxford: Oxford University Press.

Sackett, D., Haynes, R., Guyatt, G., & Tugwell, P. (1995) Clinical epidemiology: a basic science for clinical medicine, Second edn, London: Little Brown and Company.

References and additional resources

Additional resources: General

www.spotcancerearly.com - A general resource with information for patients and professionals

Cancer Diagnosis in Primary Care [Paperback] - W. Hamilton and T Peters (Editors)

www.healthtalkonline.org - A patient experience website covering a wide range of conditions from a patient perspective with video and audio material

http://www.ncbi.nlm.nih.gov - Alarm symptoms in early diagnosis of cancer in primary care - Cohort study using the GP Research database - BMJ research paper from 2007

Predictive value of cancer symptoms in primary care - BJGP September 2010 Editorial and paper

www.macmillan.org.uk - Macmillan Cancer information - A lot of general and specific information for patients and professionals about communication and cancer

www.cancerscreening.nhs.uk - Comprehensive resource with link to prostate cancer risk management programme

www.thinkaboutyourlife.com - is about dealing with the journey. The focus is on breast cancer but applicable to any cancer

www.ncin.org.uk - Routes to cancer diagnosis

References and additional resources

Additional resources especially relevant to each of the “Four cases”

Prostate

1. NHS screening information - www.cancerscreening.nhs.uk/prostate
2. Prostate decision aids on NHS direct - www.nhsdirect.nhs.uk
3. NICE Guidance - www.nice.org.uk
4. BMJ Learning module on prostate cancer - www.learning.bmj.com
5. BMJ Learning Communicating risk to patients - www.learning.bmj.com
6. Principles of screening RCGP elearning module - http://e-lfh.org.uk
7. 2 week referral proforma - http://www.nwlcn.nhs.uk

Bowel

1. National screening programme - www.cancerscreening.nhs.uk/bowel
2. When to refer suspected lower GI Cancers: BMJ Learning - http://learning.bmj.com
3. Colorectal cancer: diagnosis and treatment BMJ Learning - http://learning.bmj.com
4. 2 week referral proforma - www.nwlcn.nhs.uk
5. Book on negotiation skills: “Getting to yes” (Fisher, Ury and Patton 1991; London: Century Business Press)

(continued...)

References and additional resources

Additional resources especially relevant to each of the “Four cases”

Breast

1. National Breast screening programme - www.cancerscreening.nhs.uk/breast / http://learning.bmj.com
2. When to refer suspected Breast Cancer: BMJ learning - http://learning.bmj.com
3. Principles of screening RCGP E learning module - http://e-lfh.org.uk
4. RCGP e-learning module on breast lumps - http://e-lfh.org.uk
5. 2 week referral proforma - www.nwlcn.nhs.uk
6. Book on a woman’s journey with Breast Cancer: “Before I say Goodbye” by Ruth Picardie

Neurological

1. BMJ learning on: Update on tension headache - http://learning.bmj.com
2. Two week referral proforma - www.nwlcn.nhs.uk
3. Distress thermometer - www.nwlcn.nhs.uk

References and additional resources

Additional resource
Adjustment to physical illness and the theory of cognitive adaptation

Shelly Taylor et al in 1984 interviewed a series of patients with breast cancer; this led to the model below about how we cope with threatening events such as illness.

1. Search for a meaning
2. Search for mastery
3. Self enhancement

Movement through these stages of the model allows an individual to maintain their much needed status quo of cognitive adaptation.

1. Search for Meaning

When the women with breast cancer were interviewed they had all asked themselves at some point questions to try and find meaning in all that had happened. Such as “why did it happen”, with many finding answers in diet and stressful life events being the main trigger to their cancer. They also asked themselves “what effect has it made on me” and many reported positive changes such as an improved self knowledge and self change.

2. Search for Mastery

There were also beliefs that in some way the illness was controllable “how can I prevent it from coming back”? Indeed 66% percent believed they could themselves prevent a recurrence by attention to diet or their psychological wellbeing by taking up meditation etc.

(continued...)

References and additional resources

Additional resource
Adjustment to physical illness and the theory of cognitive adaptation

3. Self enhancement

Taylor found that interestingly 53% of women after diagnosis reported positive shifts in their self esteem, the Social comparison theory (Festinger 1957) was developed to try and explain this further. We all try and make sense of our world by making comparisons with other people. They can be downward “at least I don’t have advanced cancer” or upward “why did I need a full mastectomy and she didn’t”. Most of the women engaged in downward comparisons, so comparing themselves with those worse off and so improving their self esteem.

Further reading on cognitive adaptation

Ogden J (2000) Health psychology: a text book Open University Press 2000

Taylor, S.E. (1983). Adjustment to threatening events: A theory of cognitive adaptation. American Psychologist, 38, 1161-1173

http://taylorlab.psych.ucla.edu

MENU:

Acknowledgement

This project has been led by a steering group including Dr Pawan Randev, Dr Afsana Safa, Sarita Yaganti, Daniel Callanan, Dr Bob Clarke and Dr Sonia Kumar. We are grateful for encouragement and advice from our colleagues, particularly Dr Sanjiv Ahluwalia, Dr Penny Trafford and Dr Ishani Patel; and to Watling Medical Centre for the use of their premises for filming the four cases.

We are grateful to the Mulberry Centre at West Middlesex Hospital for allowing us to film the patient voice interviews on their premises and for all their support of the project. Dr Pawan Randev was the interviewer on each of the 12 patient voice films.

We are particularly grateful to the North West London Cancer Network user group for encouraging us to include “Patient voices” within the material available for educational projects and specifically to the twelve people who kindly agreed to be interviewed.