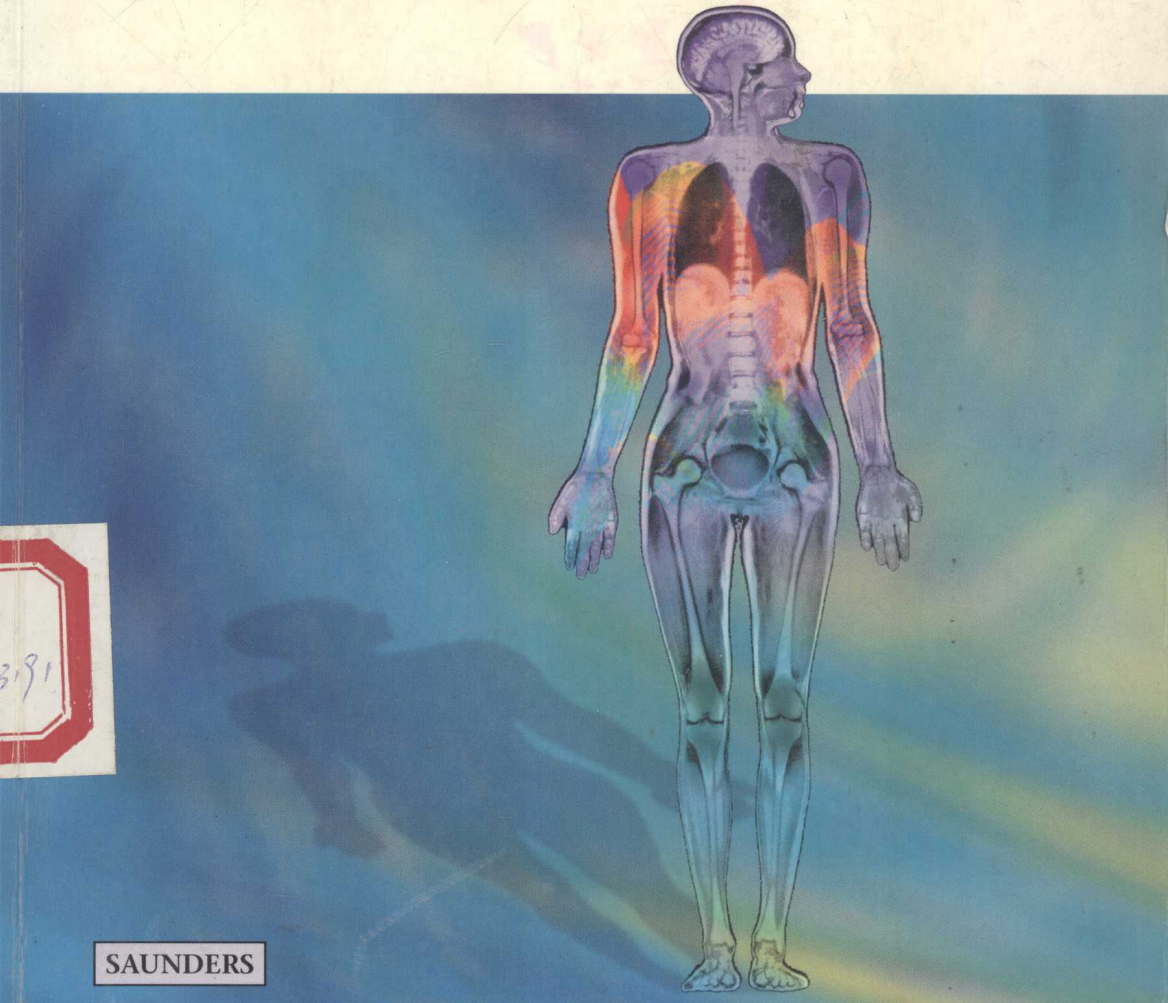
Third Edition

Ragavendra R Baliga

Self-assessment in CLINICAL MEDICINE



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Self-assessment in Clinical Medicine

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EDINBURGH LONDON NEW YORK OXFORD PHILADELPHIA ST LOUIS SYDNEY TORONTO 2004

SAUNDERS
An imprint of Elsevier Science Limited

First edition 1994
Second edition 1999
Reprinted 2000, 2001, 2002
Third edition 2004

ISBN 0702026662

ELSEVIER SCIENCE your source for books, journals and multimedia in the health sciences
www.elsevierhealth.com

Printed in China

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging in Publication Data
A catalog record for this book is available from the Library of Congress

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Cover image
Coloured MRI scan of a whole human body (female)
Credit: Simon Fraser/Science Photo Library

Self-assessment in Clinical Medicine

Dedicated to my wife Jayashree,
son Anoop and daughter Neena

For W. B. Saunders
Commissioning Editor: Ellen Green
Project Development Manager: Helen Leng
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Preface

Best of fives, extended matching questions (EMQs) and multiple choice questions (MCQs) are popular with examining bodies because they allow accurate ranking of examinees in a convenient manner. They are used for both undergraduate (MB BS, LRCP, PLAB, USMLE) and postgraduate (MRCP Part I and MRCGP) examinations in general internal medicine. Merely reading a medical text may not necessarily prepare students for such examinations. This book, which contains best of fives, EMQs and MCQs, derived from the 5th edition of Kumar and Clark's *Clinical Medicine*, should meet the needs of aspiring candidates. Limited explanations accompany the answers and candidates can refer to the main text for a better understanding of the material.

To make best use of the book I would recommend that the student reads the corresponding chapter in the original text before answering these questions. However, candidates using other texts should also find this book a useful revision guide. None of these questions have hidden meanings and are not meant to confuse the reader. To prepare for postgraduate examinations I recommend that the original textbook be read several times until the reader gets over 99% of the questions right.

Acknowledgements

I thank Professor Parveen Kumar and Dr. Michael Clark for allowing me to use *Clinical Medicine* 5E to derive the questions and answers.

I thank Prof. James Scott, FRCP, FRS for writing the Foreword.

I thank Thea Hulen-Picklesimer for taking on many of my responsibilities while I wrote this book, and Marsha Xedos for helping me to proofread this book.

I would like to thank Ellen Green, Commissioning Editor, and Helen Leng, Project Development Manager, at Elsevier. Finally I would like to thank Stephanie Pickering for painstakingly copyediting this book.

I dedicate this book to my wife Jayashree, my son Anoop and my daughter Neena for their support throughout the book's preparation.

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Ann Arbor, Michigan

Foreword

Best of fives, extended matching questions (EMQs) and multiple choice questions (MCQs) in general internal medicine are now an integral part of both undergraduate (MB BS and PLAB) and postgraduate (MRCP Part 1 and MRCGP) examinations.

Examining bodies use such questions to test more than factual recall; they are used to assess the understanding and application of essential facts. Simply reading a medical text will not prepare a candidate adequately for these examinations and to be well prepared the individual will have to solve several best of fives, EMQs and MCQs. These questions can also be used to determine areas of weakness and of expertise in general internal medicine. Although no bank of questions can be all-embracing, this book, which contains over 900 best of fives, EMQs and MCQs, should be a valuable revision guide for aspiring students.

Prospective candidates, however, must be forewarned that merely solving these questions is not a satisfactory method of enhancing their medical knowledge. Sincere and dedicated students should use both this book and the clinical text on which it is based, Kumar and Clark's *Clinical Medicine*, as complementary approaches to enhance their understanding of clinical medicine.

Professor James Scott FRCP FRS
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Technology and Medicine,
Hammersmith Hospital,
London

Contents

Ethics and communication

Q1.1

Which one of the following is the most common factor associated with failure of adherence to clinical advice following discharge from hospital?

A. No named doctor in charge of their care
B. No named nurse in charge of their care
C. Presence of pain most of the time
D. Being told on discharge when to resume normal activities
E. Scheduling of follow-up visits in outpatient clinics on discharge

Q1.2

Which one of the following qualities is seen in physicians who have never been subject to legal proceedings?

A. Normalizing ('Everyone feels that. Forget it!')
B. Jollying along ('Worse things happen at sea!')
C. Orientating patients to the process of the visit ('We are going to do this first, and then go on to do that.')
D. Passing the buck ('Nurse will tell you all about that.')
E. Switching the topic ('A headache? Tell me about your feet.')

Q1.3

'Patient-centred' communication improves the following

A. Incidence of acute urinary retention following surgery
B. Length of hospital stay following surgery
C. Blood pressure in hypertensives
D. Blood glucose control in diabetics
E. Pain following surgery

Q1.4

When a clinician learns about a patient complaint they should

A. Alter medical records to prevent lawsuit
B. Avoid offering a personal apology because this is an expression of guilt
C. Explain the reasons and circumstances behind the facts
D. Explain how things will improve
E. Avoid giving a written account, even though it is a clear account, because it could be used in a court of law later

Q1.5

When communicating with patients who are hard of hearing, the following are acceptable

A. Avoid speaking normally; mouth slowly
B. Put your face in a good light
C. Stay still and don't put things in your mouth

D. Trim moustaches and beards, avoid sunglasses, big earrings or background activity
E. Do not hesitate to say 'forget it' if the patient cannot follow you

Q1.6

1. **Respect patients' privacy and dignity**
2. **Competence when making diagnoses and when giving or arranging treatment**
3. **Listen to patients and respect their views**
4. **Do not refuse or delay treatment because you believe that a patient's actions have contributed to his or her condition, or because you may be putting yourself at risk**
5. **An adequate assessment of the patient's condition and where necessary, an appropriate examination**
6. **Give patients the information they ask for or need about their condition, its treatment and prognosis**
7. **Provide or arrange investigations or treatments where necessary**
8. **Do not allow views about a patient's lifestyle, culture, beliefs, race, colour, sex, sexuality, age, social status or perceived economic worth to prejudice treatment**

Select the best category for each of the above

A. The importance of protecting life and health
B. The importance of respect for autonomy
C. The importance of fairness and justice

Q1.7

1. **Battery**
2. **Bolam test**
3. **Competent refusal**
4. **Negligence**
5. **Explicit consent**
6. **Implied consent**

Select the best match for each of the above

A. Verbal or written consent
B. A doctor is not negligent if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular case
C. Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so notwithstanding the very strong public interest in preserving the life and health of all citizens
D. Patient accepts treatment without question, protest or any other physical sign that might be associated with rejection
E. To intentionally touch a competent person without their consent
F. Breach of professional duty to obtain adequate consent through not providing a reasonable amount of information about the risks of proposed treatment

Q1.8

1. Rhetorical leading question
2. Open screening question
3. Open question
4. Open directive question
5. Closed question
6. Reflecting question

Select the best question for each of the above categories

A. 'What has brought you to see me today?'
B. 'Is there anything else you want to tell me?'
C. 'How did the treatment for your headache go?'
D. 'Could you tell me a bit more about that?'
E. 'What date exactly did the headache start?'
F. 'The headache has got better on my treatment, hasn't it?'

Q1.9

1. The patient experiences being heard
2. The patient experiences being accepted
3. The patient experiences being seen
4. The clinician shows self-disclosure

Select the statement that best matches each of the above demonstrations of empathy

A. 'That last point made you look worried. Is there something more serious about that point you would like to tell me?'
B. 'I can tell you that most people in your circumstances get angry at some point, even with the people who have helped them.'
C. 'I'm a bit like you. Whenever I get heartburn I think it's a heart attack.'
D. 'I notice that you have talked about the death of your mother, but could I ask you to tell me something about how your brother died?'

Ethics and communication

A1.1

B

Problems identified as causing failure of adherence to clinical advice

In a random sample of 8303 patients from 66 hospitals in England and Wales (1994):

- 22% reported that no named doctor was in charge of their care
- 64% reported that no named nurse was in charge of their care
- 20% reported that they were in pain all or most of the time
- 62% were not told on discharge when to resume their normal activities

A1.2

C

Qualities leading to good relationships with patients

Primary care physicians who had never been sued:

- orientated patients to the process of the visit, e.g. introductory comments: 'We are going to do this first, and then go on to do that'
- used facilitative comments
- asked patients their opinion
- used active listening
- used humour and laughter
- conducted slightly longer visits (18 versus 15 minutes)

A1.3

A) T B) T C) T D) T E) T

Results from studies of communication and health outcomes

Condition	Outcome improved with better communication
Surgical operations	Shorter stay; less urinary retention and analgesia
Hypertension	Blood pressure control improved
Diabetes mellitus	Blood glucose control improved
Myocardial infarction	Rehabilitation improved, readmission rates reduced
Headache	Long-term symptom resolution

A1.4

A) F B) F C) T D) T E) F

When clinicians learn of a complaint they should: a) remain objective, not resentful or defensive – remember that there is a duty of care to the patient in this as every way; b) allow all the facts to speak through a clear account, verbal or written; c) explain the reasons and circumstances behind the facts; d) express regret (a personal apology is, as medical defence organizations emphasize, not an expression of guilt but a common courtesy, nor should it be wrapped up so carefully as to become a worthless token); e) explain how things will improve; f) remember that the patient is still a patient; g) leave all medical records strictly unaltered.

A1.5

A) F B) T C) T D) T E) F

Dos and don'ts of communicating with people who are deaf or hard of hearing (from RAD – Royal Association in Aid of Deaf People)

Smile and use eye contact
If you are stuck write it down
Speak normally, don't mouth slowly
Put your face in a good light
Stay still and don't put things in your mouth
Trim moustaches and beards, avoid sunglasses, big earrings or background activity
Never say 'forget it'

A1.6

1) B 2) A 3) B 4) C
5) A 6) B 7) A 8) C

General Medical Council, Good Medical Practice: 2–4

1. The importance of protecting life and health:
   a) 'an adequate assessment of the patient's condition ... (and) ... where necessary, an appropriate examination'; b) 'providing or arranging investigations or treatments where necessary'; c) 'competence when making diagnoses and when giving or arranging treatment'
2. The importance of respect for autonomy:
   a) 'listen to patients and respect their views'; b) 'respect patients' privacy and dignity'; c) 'give patients the information they ask for or need about their condition, its treatment and prognosis'
3. The importance of fairness and justice:
   a) '... (not allowing) ... views about a patient's lifestyle, culture, beliefs, race, colour, sex, sexuality, age, social status, or perceived economic worth to prejudice ... treatment'; b) '... (not refusing or delaying) treatment because you believe that patients' actions have contributed to their condition, or because you may be putting yourself at risk'

A1.7

1) E 2) B 3) C 4) F 5) A 6) D

Explicit consent may be either verbal or written, usually through the patient signing a consent form. Consent is explicit when it is given in relation to specific information about the proposed treatment. Consent may also be implied by the fact that the patient accepts treatment without question, protest or any other physical sign that might be associated with rejection. Clinicians may also be in breach of their professional duty to obtain adequate consent through not providing a reasonable amount of information about the *risks* of proposed treatment. It is unlawful intentionally to touch a competent person without their consent. To do so is battery. The Bolam test refers to the following judgement: 'A doctor is not negligent if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular case'. Competent refusal refers to the following: 'Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so notwithstanding the very strong public interest in preserving the life and health of all citizens.'

A1.8

1) F 2) B 3) A 4) C 5) E 6) D

Questioning style determines whether it is the clinician or the patient who talks more. The clinician will obtain more information by starting with open

questions (e.g. 'What has brought you to see me today?'), then guiding the history by using closed questions (e.g. 'What date *exactly* did the headache start?') for further detail. If the clinician sits in complete silence, the patient will flounder and lose confidence. Eye contact or a smile show the patient that the clinician is listening attentively. Reflecting questions (e.g. 'Could you tell me a bit more about that?') allow the clinician to take up unexpected points as they arise or expand topics. As the history unfolds, detail can be brought into focus by using screening questions (e.g. 'Is there anything else you want to tell me?') and closed questions. Leading questions may be helpful but they should not end in the rhetorical 'isn't it?', or 'wouldn't it?' challenge (e.g. 'The headache has got better on my treatment, hasn't it?'), which makes the statement difficult to for the patient to discuss or contradict, even when it is completely wrong. This type of question is a major cause of misunderstanding. With certain patients (e.g. with organic brain disease or severe mental disease), clinicians require energy and imagination to make the best of the limited lines of communication. Open questions are often impossible for these patients; open directive questions (e.g. 'How did the treatment for your headache go?') have to be adjusted to the ability of each patient and non-verbal gestures used if necessary. Just as much ingenuity may be called upon to confirm the meaning of the responses. Third parties involved in the care of the patient can help. Much can be learned by watching a specialized speech therapist at work.

A1.9

1) D 2) B 3) A 4) C

Empathy has been described as 'imagination for others'. An empathic response is one which demonstrates a genuine interest in patients' experiences. This is a key skill in building the patient–clinician relationship and is highly therapeutic. Like other communication skills, it can be taught and learned and it cannot be counterfeited by a repertoire of routine mannerisms. Techniques which demonstrate empathy are:

- Seeing (e.g. 'That last point made you look worried. Is there something more serious about that point you would like to tell me?')
- Hearing (e.g. 'I notice that you have talked about the death of your mother but could I ask you to tell me something about how your brother died?')
- Accepting (e.g. 'I can tell you that most people in your circumstances get angry at some point, even with the people who have helped them')
- Using appropriate self-disclosure (e.g. 'I'm a bit like you. Whenever I get heartburn I think it's a heart attack')
- Acknowledging facial and bodily expressions, mode of dress and notable physical characteristics
- Avoiding physical barriers; sitting or standing at the same level as the patient without objects between
- Reflecting what the patient is feeling as they talk and what the patient sees as important and what the patient may be thinking
- Using the patient's own words and ideas
- Letting the patient correct any misunderstanding that arises
- Evaluating behaviour not judging the person.