JOURNAL-BASED LEARNING EXERCISES

Please select your choice of correct answers and complete the exercises online at: **www.ibms.org/cpd/jbl**

DEADLINE WEDNESDAY 1 APRIL 2020

Health and Care Professions Council. Standards of conduct, performance and ethics.
London: HCPC, 2019 (www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics). Assessment No: 010920

01	You do not need to notify the Health and Care Professions Council (HCPC) if you receive a police caution.	11	You must be completely honest about your qualifications.
02	It is important to ensure you challenge any form of discrimination.	12	You must look out for and minimise risks.
03	You have a duty of candour and openness.	13	You do not need to apologise for mistakes.
04	The standards do not cover the use of social media.	14	Everything you do professionally must contribute to public trust in the profession you work in.
05	You are expected to maintain professional working relationships with all your colleagues, working in partnership.	15	You are not obliged to cooperate with an investigation into conduct if it is not about you personally.
06	It is acceptable to develop close relationships with those using your services.	16	It is important to consider patient dignity and consent.
07	You must take responsibility for keeping thorough, accurate and secure records relating to your work.	17	Once you have delegated a task, you do not have responsibility for it.
08	Once you have raised any concerns, it is not your duty to follow them up.	18	You are absolutely required to continue your professional development.
09	It is not necessary to ask others for feedback relating to your practice.	19	You do not need to respond to a complaint about your own service.
10	You may not break confidentiality, even if it may be in the patient's best interest.	20	Conflicts of interest must be declared.

REFLECTIVE LEARNING

01	Take time to review your organisational and departmental approach to educating staff about ethics and conflicts of interest: is this effective, recorded and meeting the requirements stated in ISO 15189:2012? Could the approach and training be improved?	02	In your opinion, are the standards of ethics and conduct suitably robust to ensure the profession remains reputable and trustworthy?

DEADLINE WEDNESDAY 1 APRIL 2020

Real-world data reveal a diagnostic gap in non-alcoholic fatty liver disease.
Alexander M, Loomis AK, Fairburn-Beech **J** *et al. BMC Med* 2018; **16** (1): 130. doi:10.1186/s12916-018-1103-x
Assessment No: 010320

01	The overall (pooled) prevalence of non-alcoholic fatty liver disease (NAFLD) in the databases studied was 1.85% on 1 January 2015.	**11**	The incidence of NAFLD trebled between 2007 and 2015.
02	The prevalence of NAFLD is decreasing over time.	**12**	The formula for calculating Fib-4 uses age, aspartate transaminase (AST), platelet count and alanine transaminase (ALT).
03	Non-alcoholic fatty liver disease progresses as follows: uncomplicated steatosis, fibrosis, non-alcoholic steatohepatitis (NASH).	**13**	The prevalence of NAFLD in the Western population has been estimated as 40–70%.
04	The only available intervention for NAFLD is lifestyle change.	**14**	Non-alcoholic fatty liver disease currently meets Wilson's criteria for effective screening.
05	Non-alcoholic fatty liver disease is associated with the metabolic syndrome.	**15**	The mean body-mass index (BMI) for patients with NAFLD is greater than the upper limit of the NHS healthy weight range.
06	Between 36% and 47.5% of patients with an incident diagnosis of NAFLD also had a history of diabetes or impaired fasting glucose.	**16**	Patients with NAFLD will inevitably develop cirrhosis.
07	Non-alcoholic fatty liver disease is associated with increased risk of cardiovascular disease and cancer.	**17**	Non-alcoholic fatty liver disease can exist in patients with recorded alcohol abuse.
08	Electronic health records can be considered as complete in Europe and the USA.	**18**	Cohort studies suggest that NAFLD affects about 20–30% of the general European population.
09	The incidence of NAFLD in 2015 was highest in 40-49 year olds.	**19**	Patients with NAFLD and diabetes have a three-fold increased risk of all-cause mortality.
10	In 2015 the overall (pooled) incidence of NAFLD in the databases studied was 2.35 per 1000 person-years.	**20**	A Fib-4 score of <1.30 indicates a high risk of advanced fibrosis or cirrhosis.

REFLECTIVE LEARNING

01	What are the criteria used in your hospital to confirm a diagnosis of NAFLD?	**02**	Should NAFLD be screened for in selected populations?