Primary Health Care Teaching Office
Centre for Academic Primary Care
phc-teaching@bristol.ac.uk

http://www.bristol.ac.uk/primaryhealthcare/

University of BRISTOL

2016 Report

Workshop for Year 2&3 GP Teachers

Well worth the effort and very relevant to teaching practice, Thanks!

Year 2&3 update

MB21 update

Feedback – More than a 'sandwich'?

Teaching History and consultation skills

Best teaching practice in years 2&3

Teaching clinical reasoning

Organiser	**Contributors**
Barbara Laue	Jessica Buchan
	James Seddon
	Juliet Brown

From: Primary Care Teaching Office
Centre for Academic Primary Care
T +44 (0)117 331 4546
phc-teaching@bristol.ac.uk
http://www.bristol.ac.uk/primaryhealthcare/

University of BRISTOL
SCHOOL OF SOCIAL AND COMMUNITY MEDICINE
Canynge Hall, Whatley Road, Bristol, BS8 2PS

Year 2&3 GP Teachers' Workshop

Engineers' House, Clifton, Bristol
Tuesday 11th October 2016

Morning		
9.00	**Coffee and registration**	**Mel Butler**
9.30	Welcome and Intro to the day **Update**	Barbara Laue
10.00	**Feedback – More than a 'sandwich'?**	Barbara Laue
11.10	**Coffee**	
11.40	**Teaching history taking and consultation skills** - Integrating content and process	Small groups with actors
12.50	**Lunch**	
Afternoon		
13.50	**MB21 Years 1&2 – what is happening?**	Jess Buchan
14.30	**Best teaching practice in Years 2&3**	Small groups
15.30	**Tea**	
15.45	**Teaching clinical reasoning**	Barbara Laue
16.20	Q&A	Barbara Laue James Seddon
16.30	**Home**	

Speakers

- Barbara Laue, GP lead for Years 2&3 and North Bristol Academy
- Jess Buchan, GP and Teaching Fellow, GP lead for Year 4

Objectives

- Update on teaching in Years 2&3
- Reflecting on 'micro skills' for giving feedback
- Exploring how we teach complex skills – content and process of the consultation
- Update on MB21
- Sharing 'Best Practice' for Year 2&3 teaching

Dear GP Teachers, 27.10.16

Many thanks for coming to the Year 2&3 GP Teacher workshop.

In this workshop we revisited 'Feedback' and looked beyond 'the sandwich'. We also explored how to teach clinical reasoning. This will be a prominent learning strand through all 5 years of the new curriculum. MB21 developments are ongoing and we gave you an update. We are planning MB21 roadshows for all academies in 2017. In the meantime, please do send in any comments or suggestions for the Primary Care role in MB21

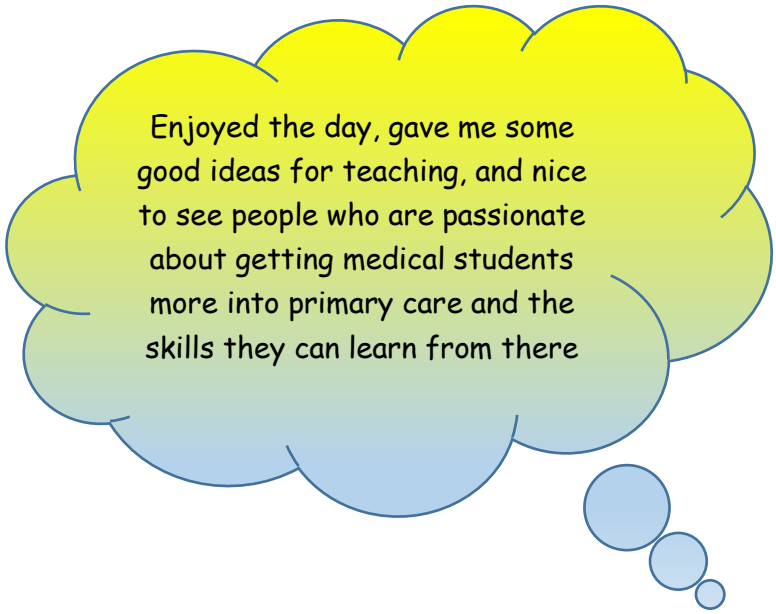
As teachers we all know that 'active' learning is the best sort and we therefore presented you with some complex role play scenarios. A big THANK YOU to all of you for engaging with the role plays, in particular to those of you who so magnificently played tutors and students. This provided the groups with rich material to discuss and learn from. We further discussed and shared teaching experiences in the 'Best Practice' session.

Please remind your students to use the Year 3 GP guidebook, especially the log of patients and templates for reflection. One group suggested that GPs could remind their students about it when they email them about a session.

We have tried to capture the key points from these sessions in this report and hope that it will be a useful resource for you.

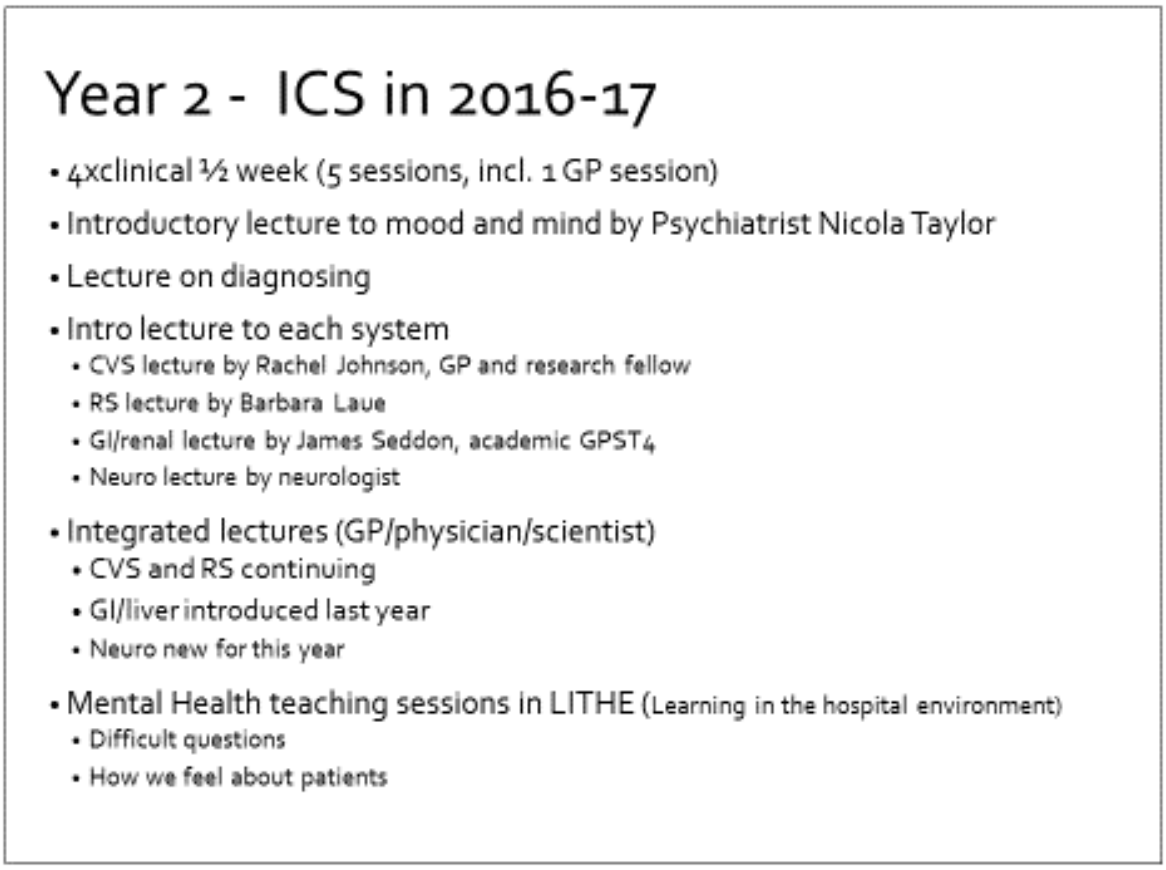
Best wishes from

Barbara and the Primary Care teaching team

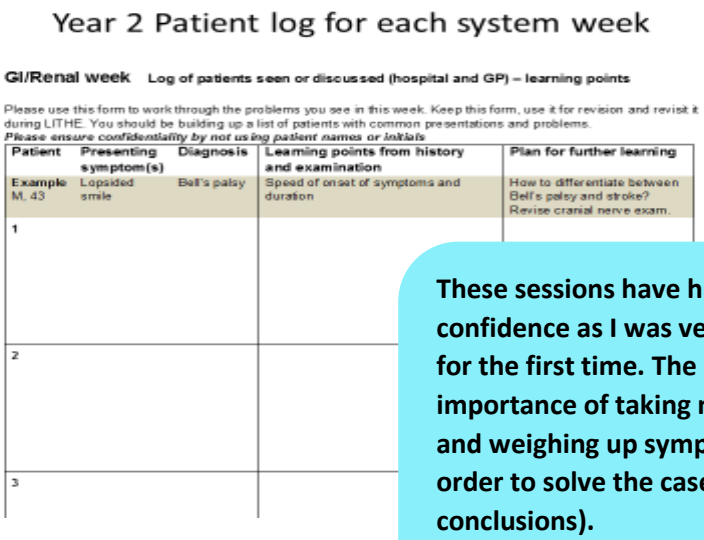


Year 2 - Introduction to clinical skills

This slide shows the clinical teaching for Year 2 students outside the clinical weeks



This year we introduced a patient log in year 2 and printed the handbooks. Many students have been bringing the handbooks to the clinical lectures and I have also had feedback from some GPs that students are bringing their ICS handbooks. Please encourage them to fill in the patient logs and to identify learning needs.


Year 2 Patient log for each system week

GI/Renal week **Log of patients seen or discussed (hospital and GP) – learning points**

Please use this form to work through the problems you see in this week. Keep this form, use it for revision and revisit it during LITHE. You should be building up a list of patients with common presentations and problems.
Please ensure confidentiality by not using patient names or initials

Patient	Presenting symptom(s)	Diagnosis	Learning points from history and examination	Plan for further learning
Example M, 43	Lopsided smile	Bell's palsy	Speed of onset of symptoms and duration	How to differentiate between Bell's palsy and stroke? Revise cranial nerve exam.
1				
2				
3				

These sessions have hugely improved my self-confidence as I was very nervous about seeing patients for the first time. The sessions have also taught me the importance of taking my time during the examination and weighing up symptoms and signs as evidence in order to solve the case as it were (without jumping to conclusions).

Year 3 – JMS, MDEMO, Pathology

These junior students could be our GP partners in less than 10 years' time

Year 3 in 2016-17

- **Return of OSCEs Fri 9th June 2017**
- GP Teacher guidebook
  - Conditions to be taught clearly identified
  - Brief summary of Year 3 teaching tasks
- Mental health teaching in Year 3 continues
  - Balint groups in JMS
  - Day with liaison psychiatrist
  - Depression in GP

Conditions to teach in Year 3 GP

- HT
- CVA/TIA
- IHD (Angina, MI)
- DM (Type2)
- COPD/Asthma

} Junior Medicine and Surgery

- Hypothyroidism
- Abnormal LFT
- Abnormal renal function (U+E/eGFR)

} Pathology

- Osteoarthritis

} MDEMO

Enthusiastic GP. Never made to feel uncomfortable or like I didn't know anything!!

Seven Aims for Year 3

History taking
Examination
Clinical skills
Begin to understand disease processes
Begin to understand appropriate investigations
Develop a professional manner
Take responsibility for your own learning and progression

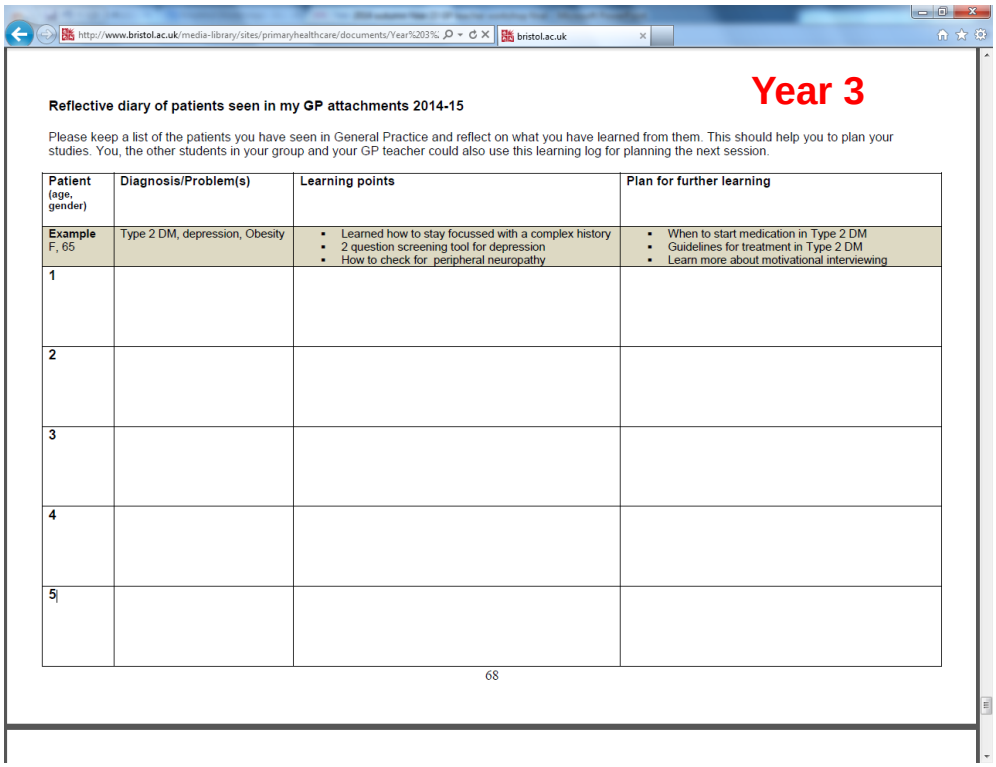
In addition, each unit has its specific aims and objectives

From the Year 3 Web Guide

University of BRISTOL

Please encourage your students to complete the patient log in their guidebooks and to identify their learning objectives

Please encourage your students to keep a log of the patients they are seeing



http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/documents/Year%203%... bristol.ac.uk

Year 3

Reflective diary of patients seen in my GP attachments 2014-15

Please keep a list of the patients you have seen in General Practice and reflect on what you have learned from them. This should help you to plan your studies. You, the other students in your group and your GP teacher could also use this learning log for planning the next session.

Patient (age, gender)	Diagnosis/Problem(s)	Learning points	Plan for further learning
Example F, 65	Type 2 DM, depression, Obesity	▪ Learned how to stay focussed with a complex history ▪ 2 question screening tool for depression ▪ How to check for peripheral neuropathy	▪ When to start medication in Type 2 DM ▪ Guidelines for treatment in Type 2 DM ▪ Learn more about motivational interviewing
1			
2			
3			
4			
5			

68

Proposed Primary Care teaching in MB21

Good to have our opinions requested about future changes

MB21 Primary Care teaching

MB16 - 67 GP sessions/student ~ 10% of the curriculum

MB21	Y	No of students	No of sessions	Teaching task
4 sessions + (4 clinical days)	1	3,4 (6)	8	Linked to theoretical learning, observing surgeries, visiting patients but more emphasis on introduction to clinical skills, first time students take a medical history and lay hands on patients
7 clinical days	2	4 (5)	4	Linked to cases. Great emphasis on clinical learning e.g. more proficient in communication skills, clinical skills and clinical reasoning by end of the year.
32	3	4 (5)	8	Clinical skills (extended), diagnosing, investigations, management, prescribing
72	4	1	30	Core curriculum of common presentations in GP Apprenticeship style learning (4 week 'clerkship'), observing and consulting
63	5	2	17	Complex patients, MUPS, $1^0/2^0$ care interface, acute care, prescribing, multimorbidities, observing and consulting, peer learning

182 GP sessions

This was the countdown to the start of MB21 at 12.49 on 27th Oct. 2016

Really important for us to understand what lies ahead with the MB21 curriculum

Like the use of simple non-medical examples - shows that anyone can give feedback even if not an expert themselves

Feedback Rules

Balanced
Well timed
Honest
Start with something positive

Specific	Not just 'That was great…'
Descriptive	'I noticed…' 'What I see…'
Non-judgemental	not 'Not your strength…'
Constructive	'What about…' **'Feed forward'**

Take home message

MEDALS **&** **MISSIONS**

- What was done well

- What can be improved
- Clear goals on how to achieve this

Processes for giving feedback

Pendleton process

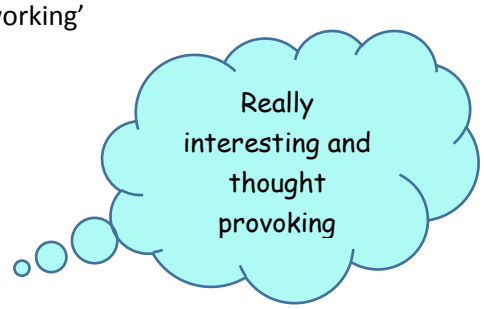
- Check the student wants and is ready for feedback
- Clarification of facts
- Student states what went well
- Observer states what was done well
- Student states what could be improved
- Observer states how it could be improved
- Action plan agreed

ALOBA Agenda led outcome based analysis

- Start with students agenda
  - Clarification of facts
  - What did they find difficult?
  - What were they trying to achieve
- Encourage problem solving
  - What would you do next time?
- Engage peers in problem solving
  - How would you like the group to help you?
  - Suggestions
- Summarise discussion and suggestions

Feedback – Taking a look inside the 'black box'

- Appreciation 'I know how hard you have been working'
- Evaluation 'Here is where you stand'
- Coaching 'Here is a better way of doing it'



Feedback has a past – looking back

- 'What I noticed…'

Feedback has a future

- Here's what you need to do…'

How objective is the feedback?

People don't give 'raw' data, they filter them through their own experiences, values, assumptions, rules etc *'I understand your life through the lens of my life'*

- We observe data
- We interpret data
- We tell a story about the data

Blocks to receiving feedback

- Truth 'I know I am good at it, I am going to ignore that comment' **Blind spot**
- Identity Two different ways how people tell their identity story
    - Fixed – FB reveals how we are
    - Growth identity – FB helps us grow
- Relationship 'I am going to ignore that comment, he doesn't like me'

Improving reception of feedback

- Need to get our purposes aligned (Appreciation, Evaluation, coaching)
- Check periodically
    - Is it right from my point of view?
    - Is it right from the receiver's point of view?
    - Evaluation may be heard more loudly than appreciation or coaching
- Need to be specific about
    - Where feedback is coming from
    - Where feedback is going
- Be aware of feedback labels
    - What is meant
    - What is heard

The goal is not to eliminate interpretation or judgement but to make judgements thoughtfully and transparently

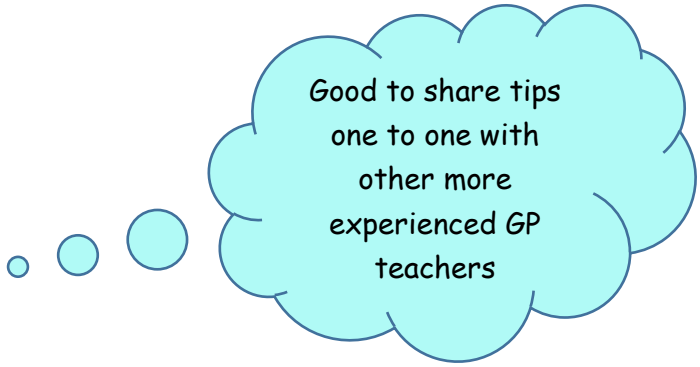
Giving feedback is not a problem solving session but an understanding session

Ability to receive feedback can be learned

Teaching tips from the role play and 'Best practice' sessions

The continuum of teaching

First we discussed the continuum of teaching and decided that most of us were somewhere in the middle, though acknowledged that our own experience of teaching as medical students was probably more didactic than our students experience. We also discussed how we changed according to the student and situation and that it may be easier to be at the less didactic end of teaching style in general practice, perhaps simply because often the situations encountered with students are less acute/the patients are less unwell. The more experienced teachers felt that they had let go of having to fill the students with knowledge and are more able to "trust the process."



Organisation

Confidentiality agreements

Most people felt that given the students are GMC registered and trained in confidentiality that this was sufficient. Many practices in the age of CQC require their own confidentiality agreements to comply with their information governance polices. Best to check with your practice manager.

The handbook and learning needs analysis

The students don't use this, especially year 3 as it is not printed for them. The students rarely use their assessment of competence to drive the selection of patients etc. and for review in the final wrap up session. We felt that signposting them to this in our introductory email when arranging times to come in would be helpful as they are supposed to read it and complete their learning needs analyses before coming.

Scheduling teaching dates

- Ideal to set them in advance
- Make sure a colleague can cover if you are booking a holiday
- Some teachers would prefer fixed teaching dates in Year 3 but would need to know them well in advance

The year 3 teachers discussed the difficulty of finding a time with the students and when they cancel or try and rearrange at short notice

- Hand this over to an administrator who is responsible for this
- Advise the students not to suggest times v close to their exams as the pressure will mount and they will want to cancel
- General preference was to be allocated dates!

Room size

Some rooms are too small to have 6 people in there – patient, teacher and 4 students

Thank you letter

We thought that it would be a good idea to send a thank you letter and to get the students to sign it

Setting up the teaching session

Setting up the group

Given that all the students were being asked to contribute and help each other during the histories we felt it important to **generate a sense of togetherness** at the beginning of the session. Setting ground rules at the beginning of the sessions that everyone might not look perfect in front of each other was important. By emphasising that through making mistakes we learn and that what happens in the room stays in the room we hoped that everyone would help each other along, especially when they didn't know each other.

- Email the students beforehand to explain about your practice and consider introducing what you will cover (briefly) in the session and remind about pre-reading e.g. we will see a patient with diabetes. Or reminder to watch the videos on clinical examination on Hippocrates.
- Invite the students to bring their lunch to the surgery so that the "settling in" can happen before the session and not use up teaching time.
- A suggested ice breaker was to ask the students to name something from lectures or recent teaching that they didn't understand. For example they might say "I heard the term *bruit* but I don't know what this is." This also sets up an atmosphere of being able to question and ask and identify learning needs
- Ask the students about their week and what they have been doing
- Set expectations that they should form clinical questions and that they should read up before the sessions and afterwards—how to learn from clinical experience.
- **Set rules about use of mobile phones** – only for the purpose to contribute to the session, i.e. looking something up on the web

We had a really dynamic and engaged group, so a big thank-you from me as a facilitator first of all. In the first role play (Asthma), the GP role-playing the tutor forgot to "set up" the session for the students at the beginning. In part this was probably my fault as a facilitator for not making the role play objectives clear, but in actual fact, it gave us a real talking point about how important it is to set the scene for both patient and students alike. Setting the scene at the beginning of the tutorial about what the students are expected to do, what they can expect from you, and priming the patient about their "role" are integral to the smooth running of a year 2 or 3 teaching session. In the second role play we were able to play this out and see how much of a difference it made.

Know your audience!

We felt this important for several reasons.

- Firstly, they are adult learners and will have their own hopes and fears for the sessions. No point in covering stuff they feel they are confident in when there are likely large areas they need help with. The students also develop rapidly through the year (3) and so one lot early in the year will need more general support than a different lot at the end of the year who are likely to have specific things they want to achieve.
- Secondly, having a bit of personal background written down allows you to connect with them as an individual and also respond should a request for a reference come along at a later date.

Planning the sessions

Make a plan for the session and discuss this with the students. Good idea to have a bit of time at the start to go over history and exam (Year 2). Could make a plan for all four sessions, which student is going to take history or examine in which session.

Time management

- Acknowledged that a lot to cover per session
- Stress the importance to time management to the students—arrive promptly, prepare beforehand
- Quality more important that rushing through everything; do less, do it well
- Assess learning needs so that you cover what the students need
- Hand responsibility back to the students for their learning—sometimes questions will take you off on a tangent and they should go home, look up the answer or topic and can report back.
- The last session in year 2 is very packed. Tip was to do cranial nerve examination on each other. It helps to have patients (esp. in neuro) who are experienced and can give a good history and have good signs.
- Allocate a student as time keeper

Patients

Well pre-prepared patients can seem artificial for history and wanted to balance this with some "real" patients. Pros and cons to this discussed—they will get plenty of acutely presenting patients in year 4 but also consider bringing back a patient seen in the last couple of days that you want to review.

Giving information about the patient

We discussed the pros and cons of telling the students the diagnosis in advance of seeing the patient. Best to discuss this with the students.

Pros

- May increase the confidence of very inexperienced students that they know which questions they should ask (early in year 2)
- Knowing the diagnosis in advance means that they can red up about the condition, for example on patient.co.uk

Cons

- May be more fun later in year 2 and also in Year 3 for students to work out the diagnosis.

Keeping the group active - Small group facilitation

By **assigning roles** at the beginning of the session we ensured it stayed active for the students watching and we allowed them to contribute at times when the student taking the history became stuck. We thought that this could be simple areas like asking one student to focus on good things and another on areas of improvement.

Assigning roles also works during the examination part of the session. One or two students could share the examination while the other two students give a running commentary of the examination for each of the examining students. 'Good cop' 'bad cop' roles could be assigned. A student could be asked to think of things that they would have done differently or additionally.

One teacher would teach examination skills with just 2 students present while the other two practice pulse, BP etc in another room. This loses some of the learning element that comes from observing others do something and hearing the feedback they are getting or the questions they are asking.

Keeping track of your students

It is easy to forget which role you assigned to whom. Make a list of their names and write the role next to the name. If you are sitting in a semicircle reflect the students' position in how you write the names down on your piece of paper.

We asked each role playing team to give pointers from their role-play perspective:

The GP tutor was worried about when to jump in if a student was floundering. Should they allow a student to have flow and "have their say". Conversely, the students felt it was ok for tutors to interrupt if they were floundering or digging themselves a hole, as they knew this was happening and really wanted help!

We concluded from this that if the GP has a gut feeling that it might be time to speak up, it probably is, and would (probably) be well received by the students.

GP tutor felt it was important if patient was giving a history of (for example) an MI which happened 6 m ago you had to be clear (to both students and patients) about whether you were expecting the students to take a history as if symptoms were happening now, or whether you wanted to hear the narrative of the experience from the patient. Important skill for GPs in particular (but also on ward rounds etc) to be able to hear and tell the story from half way through, rather than as a de novo presentation.

The observing students liked being involved. They particularly liked being asked to help their colleagues or having a task to do. They liked the idea of being told that there were 2 tasks (e.g. summarising, or providing a management plan) but not being told which of those tasks would be theirs – they felt it would keep students on their toes, and keep them engaged. It also meant they weren't passive observers and that the patient felt like the other students were part of the process rather than just being silent.

Authentic Examinations

While we are aiming for this as much as possible most people tried to get males to examine male chests and females to examine female chests. Given that there is a reasonable audience bras were always left on. We felt that in year 4 and 5 that full exposure would be more appropriate as those patients are 'live' encounters.

History or examination or both? Some patients are good historians without signs, some have signs but histories relating things in the distant past. It's ok to bring in patients just for one bit or the other.

Practical skills – the students don't normally know one end of an otoscope from the other. Giving 10 mins in between patients each session to play with the kit has gone down well.

Feedback with or without the patient present?

Consider whether it is more beneficial for the learning experience to have the patient present for the feedback after the patient has given his or her history and has been examined.

The patient staying may inhibit the students in their comments. Some comments will be 'about' the patient and in that way turning the patient into an 'object' rather than being the 'subject'. This may be uncomfortable for patients and learners.

Patients are also generally unschooled in giving feedback which may make it less specific and therefore less useful. Some felt that it is a good idea to ask for a general comment from the patient on the encounter with the students.

Students giving feedback

With year 3 we wanted to do similar things but in more detail. With both groups we felt that asking about who they were and what they wanted to get out of their time in GP was important. With the year three we expected the learning desires to be a bit more specific. To that end we would direct the watching students **to more specific areas of feedback** to match that need, such as commenting

on when summarising and signposting was used, the use of body language or the way that a system's relevant symptoms were asked about in one lot and not jumped back to.

Finding patients

Chose less complicated patients for Year 2 students

- Keep a list, ask all the time ad hoc patients as you see them. "We teach a lot of students in the practice …would you be interested in being someone we approach in the future as someone that could speak to the students about xxx….?"
- Use the practice; ask nurses and colleagues for suitable patient's—keep it fresh in everyone's minds
- If you keep a database allocate a staff member to keep it updated. Record what the patients have been involved in so that they don't get student fatigue
- Consider using a rare EMIS code (shark bite) though may get tricky with on line access for notes!
- Send thank you letters (can use a template) and consider getting the students to write Xmas cards to the patients they've seen (any time of year and post for them at the appropriate time)
- Use the morning triage list
- Use patients that need review or you'd like more information from—if stable

When a patient doesn't turn up

- Phone the day before to remind them/check they are still able to attend
- Consider home visits—ask the morning triage doctor for a suitable home visit or patient to take the students to
- Have a patient in mind that you'd like to review anyway and ask them
- Have back up patients who have agreed to be contacted at short notice
- Do alternative teaching. There is lots the students can practice on each other e.g. cranial nerves, fundoscopy etc. Look through a file of ECGs, look at the day's results (see below for pathology weeks in year 3) check the nurse's urinalysis, look through the days repeat prescribing, teaching according to the current unit e.g. look at the Bristol stool chart for GI.
- A quick shout / EMIS message around the practice / head in the treatment room door has usually found a patient with a spare 30mins willing to step in

Teaching examination (from Year 2 group with Year 3 input)

- Get the students to tell you what they have been learning
- Show them first (quick run through) then get them to have a go
- Be honest that you don't do it like this in a consultation but like driving you get to know the short cuts but have to learn it properly
- It is as important as the history as the students get little observed practice
- Watch the videos on Hippocrates yourself so you know what and how they are taught
- Students can get hung up on one aspect of not getting it right or having been taught slightly different ways. Reassure that repeated practice is the key, they will learn different things from different people and eventually form a technique that works….if something is wildly different from the majority of teachers or the videos - question that
- Get a student to watch the other and use a mark sheet to observe
- Get the student doing the examination to talk through what they are doing and why
- Get them to go back to the bits they struggled with and practice that in isolation.
- Encourage them to go away and re-watch the videos and read about the examination and practice at home.

Teaching depression and pathology (Year 3)

- Ask the 2 Whooley screening questions as part of the history in chronic disease patients
- Talk about the incidence of depression generally and in your practice
- Discuss MSE as part of examination, get them to think about what they are observing
- Show them NICE guidelines and step wise management
- Talk about the impact on the patient of undiagnosed depression and the effect of that on their disease and lifestyle—make connections.
- For pathology think about hypothyroid patients, diabetes, CKD, ?dialysis patients, LFTs and causes of abnormalities
- Look through the day's results and pick some abnormal ones and the process you go through to evaluate the result—is it normal for the patient? Is there already a diagnosis? Is the result stable or not? If not, what's changed? What do you need to do? Is it urgent or not. And perhaps most importantly of all….why was the test done anyway and was it necessary?

Handbooks & resources

Group agreed they were really useful, especially for planning session. Split between those who read it all and those who read the beginning and really just wanted top tips, changes and how to plan each session. Some read the students guidebook and were very encouraging of others to read it as said they found it really useful to know what the students were told.

Problems and concerns:

- Patients wanting to be paid for travel costs
- Students cancelling short notice or being difficult to pin down to sessions (a lot of time and effort)

Six essential steps

1. Prime the students
2. Prime the patient
3. Set the scene
4. Be transparent about the process
5. Tell students that you will interrupt, you will give feedback and you will bring the rest of the group in
6. Be explicit about the process of consultation skills and combining these with "factual" history taking, and use this in your feedback to students within the session.

Teaching clinical reasoning

Observable history taking behaviours associated with diagnostic competency

- Thoroughness of inquiry about the chief complaint
- Clarifying or verifying information
- Asking questions in close proximity within a line of reasoning
- Summarising

Stopping and starting

With the focus on clinical reasoning we were trying to get the 'student' to think how their histories could be improved in the context of working out what was wrong with the patient and using consultation skills to gain that information. **Stopping a student** who had had a stab and some presenting complaint with lots of closed questions and asking 'Do we know why the patient is here or what the problem is from their point of view' naturally elicited a 'no'. Asking 'how could we find that out?' drew out 'by asking open questions like why are you here today?' Getting the students to stop and summarise allowed them to think about what they knew and what else they needed to know.

We discussed how important it is to let students know that you might be interrupting them, and that this doesn't mean they've done a bad job, but that as an observer, you may notice something that they don't yet. We also discussed how it's imperative to let the patient know that you might interrupt as otherwise it can all seem a bit odd to them. Interestingly, our actor noticed that the GPs role playing students forgot to introduce themselves – we think our real students are better at this than us, but it was a timely reminder!

When students get stuck

We also felt that a more specific question to the group when students became stuck along the lines of 'What do we think the likely diagnosis is, what else could it be and what further information do we need from the history or examination to support our hypotheses' was useful.
Getting the patient's feedback we felt was important but the consensus was that when feeding back to the students the **patient should leave the room** to allow this to be as open and frank as possible.

Students often fail to get the details for a symptom. It was felt to be important to encourage them to explore in more depth 'go at it till you know what is wrong. Don't let it go'.

It is easy to forget that students are learning complex skills. They are listening to a story which may not be very well organised and they mostly lack the knowledge structures that help to sort important from less important information and to memorise information received. This can make it hard for them to respond to what the patient is saying and to non-verbal cues.

Students can get lost in the history. Ensure that they know that they can ask for time out and for help from the group.

If you notice they are struggling, pause the consultation and ask the other students to summarise, what they think the diagnosis is, what they would like to ask next to get closer to the diagnosis etc.

Make sure you tell the students that you will pause the scenario every now and then to highlight learning points, asking about diagnoses etc.

To scribe or not to scribe?

There are pros and cons to writing things down during history taking.

Positives

- Students often feel happier as they feel more secure that they won't forget things the patient said. This may make them feel more confident in their history

Negatives

- Takes time
- Less eye contact
- Gets in the way of the flow of the 'conversation'

It is a good idea to discuss this with the students and suggest that they aim for progression to not writing things down during the history. Highlight that in this learning group situation they can ask the observers to fill any gaps. Once students realise that they don't need to scribe to remember the salient points of the history this will be a huge boost to their confidence.

Listening to a heart

by Tom Cassidy

http://www.outofourheads.net/oooh/handler.php?id=632

Evaluation

Based on 14 completed questionnaires

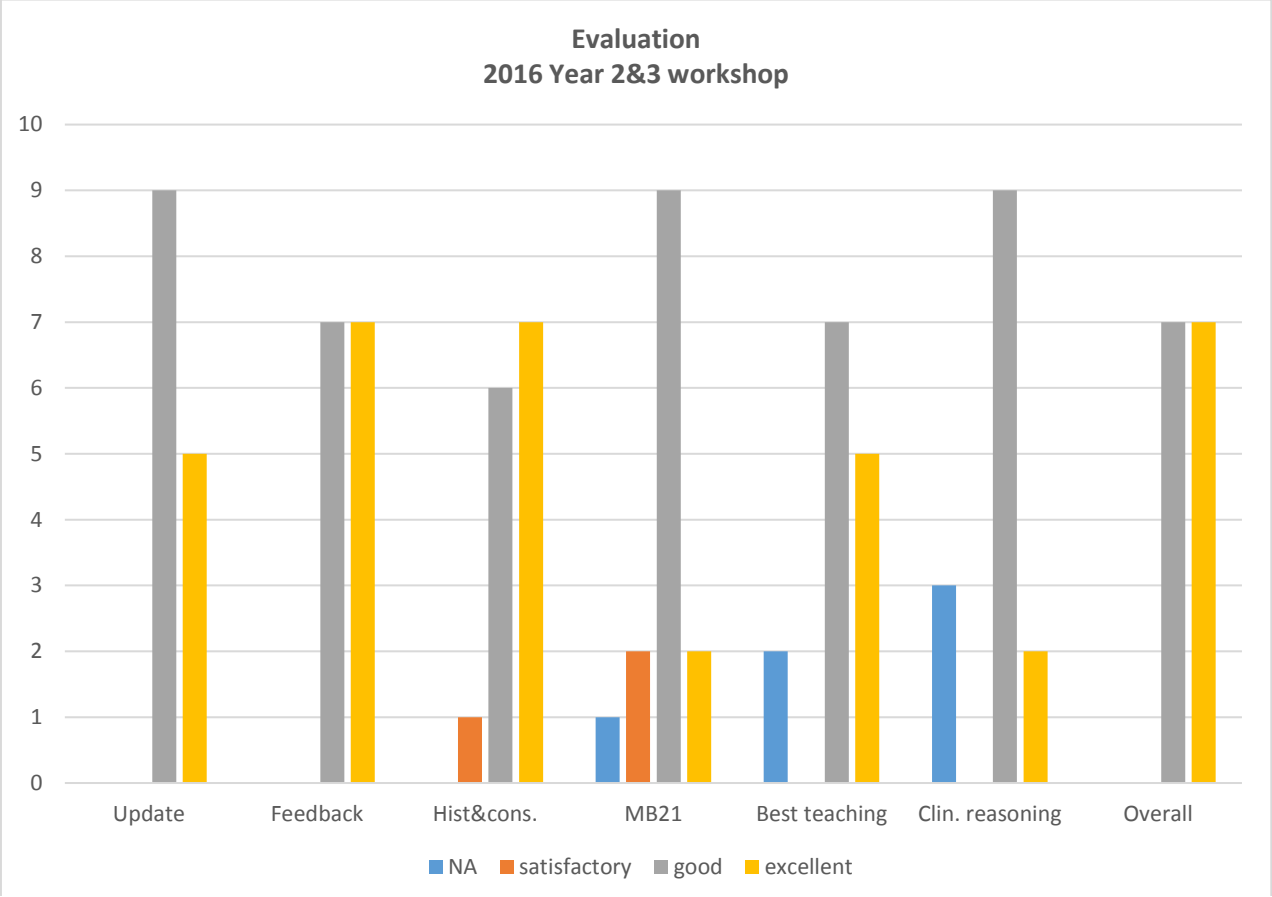
The rating

3 satisfactory 4 good 5 excellent

The questions

3. Welcome and update.
4. Feedback - More than a sandwich?
5. Teaching history and consultation skills.
6. MB21 Year 1&2 - what is happening?
7. Best teaching practice in Years 2 & 3
8. Clinical reasoning.
9. Please rate the workshop overall.

Really useful to hear from course leaders, benchmarking, and think wider than just the individual sessions I teach



Actor sessions were very good.