Year 1 Tutor Guide Clinical Contact

Case 1: The respiratory system

Centre for Academic Primary Care

2017-18 MB21

Contents

How to use this guide:

This guide starts with the background to the students learning. **The busy GP teacher will find *all you need to know for the session in the session plan on pages 5 & 6*; it outlines the learning objectives, the types of patients to find for students to visit at home, some tasks the students can be set when they are sitting in observing you consult and some discussion points you can raise with your students at the end of the session**. The subsequent pages (page 5 onwards) is copied from the background information provided to the students. It is interspersed with questions you can pose your students if you want to direct discussion in this way.

Dear GP tutor

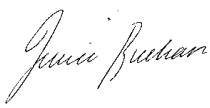
Thank you for taking students for their Clinical Contact during their Respiratory Case Based Learning (CBL). You should have been sent a link to the overall GP Tutor guide in CBL which gives you an overview of case-based learning in Year 1 of MB21 and an overview of the Effective Consulting course with links to general information you need to run the sessions.

This is a short guide to running a session in the Respiratory case (you will be sent a link to similar information in each case 2 weeks before the students are due)—and you can also find these on our website http://www.bristol.ac.uk/primaryhealthcare/teaching/teaching-in-practice-by-year/one/

We would like the students to be as hands on as possible when they are with you, especially in terms of talking with patients and "presenting" them back. At this stage, they are being introduced to the concept of the medical history—they should have a broad idea of the areas to cover, but they won't be expected to know the "right" questions to ask about a particular symptom. They should also be starting to present back a coherent narrative about a patient they have seen to you and the group. This week they will cover "formulating" in their Effective Consulting session—in other words thinking about the information they (or you) have gathered from a patient and what it might mean.

Please try and maximize the amount of time students spend talking directly with patients. Sessions in GP are quite flexible; you may have 1-2 students sitting in a reduced surgery with you and the rest out on home visits, or you could have all the students on a home visit in pairs with a tutorial/debrief at the end, or you could bring a patient or two into the surgery to meet you and the group. It is helpful if they can practice some clinical skills now such as feeling a pulse, counting respiratory rate or listening to chest sounds. If they don't get a chance to do this sitting in surgery, then they could practice a taking a pulse and pulse oximetry on each other.

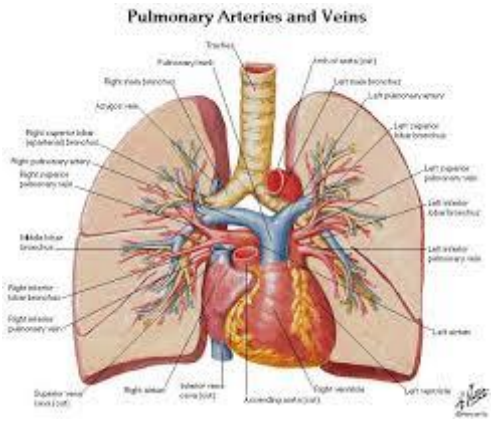
I hope it goes well and you enjoy having the students.



Dr Jessica Buchan, Year 1 GP lead

Respiratory—overview of the case

In the respiratory case, the students will consider a medical student who is getting breathless when running. She smokes and would like to stop. The case also considers an older woman who has smoked 5 cigarettes per day for 30 years and becomes suddenly breathless associated with anxiety. She is taken to the emergency department and after investigation a panic attack is diagnosed.



Lectures:

1. **Plenary Introduction** - Respiratory physiology –Define the terms 'tachypnoea', 'apnoea', 'hypoxia', 'hypercapnia', 'cyanosis' and 'vesicular breath sounds'. Structure and functions of the respiratory system including bronchus, bronchiole and alveolus, factors controlling its functions and factors that determine the resistance of the airways.
2. **Compliance and pulmonary circulation**
3. **Carriage of oxygen and carbon dioxide in the blood**
4. **Control of respiration**
5. **The respiratory system during exercise**
6. **Aerobic metabolism:** How active skeletal muscle produces energy using glucose under aerobic conditions. Glycolysis, gluconeogenesis and ketogenesis.
7. **Anaerobic metabolism:** How active skeletal muscle produces energy using glucose under anaerobic conditions.
8. **Respiratory embryology**
9. **PPD:** Library and academic writing skills
10. **The Respiratory System at Altitude**
11. **Introduction to Public Health:** Preventing disease and promoting health. Levels of prevention (primary, secondary and tertiary)
12. **PPD:** Well-being review of the students

Practicals:	*Helical Themes:*
Lung Function Tests practical **SIM practical—** To investigate the effects of hypoventilation and hyperventilation upon arterial blood gases To investigate the responses of the respiratory system to hypoxaemia and hypercapnia	• Learning and teaching • Patient safety and quality improvement • Global and public health • Self-care and resilience

Respiratory session plan

Objectives:

- Describe the structure and components of a medical history
- Describe the structure and components of the clinical examination
- Describe how the underlying anatomy and physiological processes of the cardio-respiratory system can be assessed clinically
- Describe the risk factors for cardio-respiratory disease and the role of the clinician in health improvement and illness prevention
- Describe the importance of developing an evidence based, patient-centred clinical formulation

Clinical communication ILOs

- Practise formulating a hypothesis drawing on the information gathered from a patient building on skills of active listening
- Practise presenting clinical information in a coherent structure

Patient perspective ILOs

- Describe the importance of eliciting the patient's understanding and agenda
- Describe how the patients' ideas, concerns and expectations inform health professionals formulation of clinical problems

Cardiovascular Session Plan Primary Care	
Check in. Review of last session e.g. reflective forms. Run through session objectives	**10 mins**
Tutor time: • Brainstorm the broad areas of the medical history • Consider the elements of the cardio-respiratory system that can be assessed clinically e.g. pulses, O2 sats, BP, heart sounds, chest sounds. • Prepare to meet the patient—briefing on any important information • Set tasks to achieve e.g. *the focus this week is on the information doctors need from their patients; history and examination. Included in this is the importance of finding out the patient's agenda and their ideas, concerns and expectations. They then need to consider "formulating" e.g. stop and think about what they've found out. What else they might need to know?*	**10 mins**
Meeting a patient or observing surgery Home visit in 2/3s, bringing patients in **or** observing clinic (if sitting in on GP consultations use the following as observation tasks)	**1.5-2 hours**

Tasks: 1. Consider the broad areas of the medical history when you are interviewing a patient this week (if sitting in on GP surgery observe the broad areas your GP finds out information in) **USE MEDICAL HISTORY TEMPLATE (see appendix)** 2. Reflect on the patients you have met. Can you identify the patient's agenda? What do you think were their ideas, concerns and expectations about what was going on? 3. Consider the anatomical and physiological processes of the cardio-respiratory system that can be assessed clinically e.g. pulse, respiratory rate, oxygen saturations, blood pressure, chest sounds. 4. Think about the patients you met today. Can you "tell a story" from the information you have so far? What else do you want to know about? *OPTIONAL TASK: If the students return early from the home visit you could ask them to practice taking each other's pulse or oxygen saturations. Or make a computer available so they can access their digital notebook	
Discussion time **Topics to discuss considering the patient/s you have encountered** 1. The broad areas of the medical history 2. The patient agenda and their ideas, worries, hopes… 3. Risk factors for cardio-respiratory disease. What can doctors do to influence risk factors for disease? 4. What information did your GP need to find out what was going on? Were all the clues in the history and examination or did they order further tests?	Approx. 45 mins
Feedback and Close:	**5 mins**

Gathering information (taken from the student guide—introduced in the cardiovascular case)

- Describe the structure and components of a medical history

If the link doesn't work or you are viewing this guide in printed format you can watch the video on gathering information here: https://www.youtube.com/watch?v=YT2Iv8_lD80&

As a medical student, you will learn how to gather information from your patients in a structured way known as the "medical history." It is an important skill to learn because to be a doctor you need to find out all the relevant information you need from a patient in an efficient way to make a diagnosis or solve a problem, so that you can plan what to do next.

The medical history is a structured assessment which includes:

- The patient's current health and health problems
- The patient's previous health problems
- Current and previous treatment
- Factors which might affect the patient's health and their response to treatment e.g. their perspective or risk factors/lifestyle
- The patient's family's health

The medical history is only a *part* of the medical assessment as useful information also comes from the clinical examination, and results from tests and investigations, and sometimes from other people (third parties). Making a diagnosis is not the only goal; to make an overall medical assessment (clerking) and form a plan you need to know the patient's perspective (what's important to them about their symptom and situation, how it impacts them, what they think is going on, what they are worried about and what they are hoping for or what their goals are.) This is sometimes shortened to Ideas, Concerns and Expectations (I.C.E)

Your goals as a medical student

- Understand, learn how, and then practise how to assess the medical history
- Understand, learn how, and then practise how to do a clinical examination
- Be able to gather enough information to define the problem to be solved
- Be able to gather enough information to form a sensible "differential diagnosis," in other words…form an idea of what might be going on
- Give a clear presentation of the medical history, examination, investigation and test results and your differential diagnosis to your colleagues

Learning to do this takes time, observation of more experienced peers and doctors and LOTS of practise. In Year 1 the focus is on health, not pathological symptoms. We do not expect you to learn to do a complete medical assessment just yet, that will be introduced in Year 2. But we do want you to think about the **broad areas** that a doctor can assess in a patient, and to be introduced to the concept and structure of the medical history.

The presenting complaint.

This really means the main symptom/s the patient is seeking medical advice about, it helps define the problem to be addressed. This may or may not be obvious. A patient may tell you a clear symptom "*I've got chest pain*" or you may have to do a little more investigation to identify any symptoms. For instance, in your CBL case, Harry may start with: "*I've come for advice; I want to run a marathon but I am worried about my health*." Harry's presenting complaint is his symptom e.g. light-headedness. There is often more than one presenting complaint, and these may or may not be linked. In emergency situations where the patient is not able to articulate the presenting complaint may be "collapse." In small children and babies, or in patients who are unable to articulate the problem, it may be expressed by a carer or witness "*they seem a bit breathless compared to usual*." Sometimes the presenting complaints not entirely clear until you've really listened to the patient and asked some clarifying questions.

Practising doctors often work with problem lists more than symptoms: In Harry's case although his "*presenting complaint*" is light-headedness, it's not his only *problem*—he has come for advice on exercising, he is also worried about his risk factors for hypertension. Also, patients have their "agenda" (the things they want to discuss) and the doctor has theirs. In Harry's case his doctor would also want to address anabolic steroids with him and find out his perspective on body image. The doctor would need to gather information about all these problems in the same way that information is gathered about a symptom.

What if there isn't a clear presenting complaint?

Medical students talking to patients who are describing past rather than current events often find it tricky to know what the presenting complaint is. You can tackle this in two ways; it really depends what your purpose is. If you want to learn how to structure a history, practise forming a diagnosis and present a history to your tutors you can focus on a past event as if you were seeing the patient at the time. Consider the presenting complaint of the patient *at the time* they first sought medical advice. For instance, if you meet a patient with a pacemaker ask them about the events that led up to their diagnosis and treatment, they may describe how they noticed their heart racing and felt dizzy before they passed out. In this case palpitations, light-headedness, and collapse would be the presenting complaints.

The other way to structure a patient's history is to start with a *problem list*, which is what doctors in clinic often do. The patient visiting a cardiologist (heart specialist) may have come for a review of their medication and not need a diagnosis making. So rather than start with a symptom or

symptoms, you start with key diagnoses and a problem list e.g. 1) Hypertension. 2) Depression. 3) Medication Review

History of the presenting complaint

This is where we find out more about the problem. You can use open questions "*Tell me more about that.*" or "*Talk me through exactly what happened."* For each symptom, there are many possible diagnoses, and in time you will learn the questions doctors need to find out the answers to help them decide what is going on.

- Before you ask more questions, clarify exactly what the patient means. What exactly are they experiencing?
- Remember to use open questions at first to let the patient explain in their own words. Later you can use more closed questions to clarify.
- To assess a symptom further you need to ask specific questions about it, to assess pain there is a useful mnemonic "SOCRATES" (see box 1) which can be adapted for other symptoms. Does the symptom come on suddenly or gradually? How severe is the symptom, or what does it stop you doing? When and how often does it happen and what is it associated with? It's important to know the context in which the symptoms happen. What happens, where and when? Is there a clear trigger? What relieves the symptom or makes it better? MacLeod's Clinical Examination chapter on history taking has a box of questions to further assess specific symptoms.
- Red Flag symptoms. You will also learn about specific symptoms for a presentation that may be serious or urgent that must not be missed.
- What does the patient think about their symptom or problem? They will often have read about it or spoken to friends or family. They may be worried about what's going on, even if they don't really think it's serious they may want to be sure. How is it affecting them? What are they hoping for? They might want an explanation, reassurance or advice, medication or further investigation.

Box 1: SOCRATES: Assessing pain

- **Site:** Where exactly is the pain?
- **Onset:** When did it start, was it gradual or sudden?
- **Character:** What is the pain like? It may be sharp, burning or a dull ache.
- **Radiation:** Can it be felt anywhere else, does it move?
- **Associated symptoms:** Is there anything else that happens with the pain, e.g. sweating, vomiting.
- **Timing (duration, course, pattern)** How long does it last? Does it follow any pattern, is it constant or does it come and go? If constant does it change in severity?
- **Exacerbating / relieving factors:** Does anything make it better or worse?
- **Severity:** How bad is it? You can use a scale of 1-10 where 10 is the worst pain imaginable.

Review of systems (or systematic enquiry)

When you are learning a medical assessment, this is often put at the end as a catch all "sweep" of all bodily systems in case you or the patient has forgotten anything. It's useful to practise these

questions when you are learning. As you get more experienced you will learn to target the systematic enquiry to the presenting complaint and then it is more useful early in the medical history. MacLeod's Clinical Examination chapter on history taking has a useful table on the Systematic Enquiry listing all the cardinal symptoms for all different systems e.g. cardiovascular.

Past medical history

Here you want to consider the patient's other health problems current or in the past. Have they had any operations or serious illnesses?

Drug history

For all medications (prescribed and non-prescribed) find out the name, the dose, the route by which they take it, how often they use it and for how long. Does the patient remember to take their medications or not? Patients may only mention prescribed medicines so ask about medication they've bought from a pharmacy, on-line, or herbal or homeopathic remedies. What have they taken in the past? Is there any medication they are known to be sensitive or allergic to?

Family history

You should ask general questions about the patient's family "Are there any illnesses that run in your family?" and then about relevant illnesses linked to the presenting complaint. It can also be useful to find out details about the family members. This will give you an indication of a patient's support network. It can be useful to draw a family tree including parents, siblings and children.

Social history/Lifestyle and resilience assessment

This really is last but not least, as here you want to really understand all about the patient's life, their lifestyle and their circumstances. This is the area of the medical history that often sheds light on the cause of the problem and holds the key to making a good management plan. There are many aspects you can find out about so consider what is relevant to the situation. In a patient who is at risk of blackouts or falls it's important to know if they live alone. A patient who has come with palpitations might be drinking excess alcohol or caffeine. There are a few areas to consider which are laid out in MacLeod's Clinical Examination "The social history" which includes diet, exercise, mood assessment, sleep, home life, occupation, finances, support and hobbies and interests. Alcohol, smoking and recreational drug us are often important, as are a relationship and sexual history if relevant. In your Effective Consulting lab sessions, you will have been introduced to the well-being wheel (appendix 2) to consider different aspects of the patient's life

GP TUTOR TASK: Gathering information. The medical history

Students sitting in with you might like to use the medical history template in the appendix (you can print it for them if they haven't brought a copy) and identify the different areas you find out information about when you are consulting with patients.

Students on the home visit might like to take a copy to use as a prompt.

When you discuss the patients with the student you could ask:

- What other information might you need?
- What other information might you want to ask and why?
- How might you phrase the questions you want to ask?

Risk Factors for respiratory disease

- Describe the risk factors for cardio-respiratory disease and the role of the clinician in health improvement and illness prevention

Several factors increase the risk of a person developing respiratory disease. These include:

- Smoking
- Genetic factors
- Occupational agents e.g. asbestos
- Allergens
- Pollutants
- Being overweight or physical inactivity

As you can see, some risk factors like smoking are *modifiable*, in other words the patient can do something to change the risk such as stop smoking or change their lifestyle to reduce weight. Other risk factors such as genetic factors are *non- modifiable*. Doctors identify risk factors to help predict the likelihood of someone developing disease and focus on the modifiable risk factors to try and prevent disease occurring (primary prevention).

Top tips for medical students in gathering information

Help! The patient isn't giving me the information in the right order.
Medical students often worry that they are not finding out information in the same order that they document it, or present back to their tutors. Don't worry. Consulting with patients is a very different thing to writing up a medical history or presenting structured information about a patient to your tutor. When you are talking to patients please don't get hung up at this stage about the order in which you ask questions or even asking "the right" questions. We just want you to have *conversations* with patients. We suggest you use the broad headings of the medical history as conversation prompts to remind you of areas to talk about. That's why in Effective Consulting we call this part of the consultation "Gathering Information." When you review and think about the information you've gathered and consider what might be going on (the stage we call "Formulating") or write up a patient's medical history or present it in a formal, structured way you will realise areas you missed or questions you wish you'd asked. The more you talk with patients in this way the more you will move towards a more structured conversation. If you realise you've forgotten to ask something while you are with the patient, you can always go back and ask it.

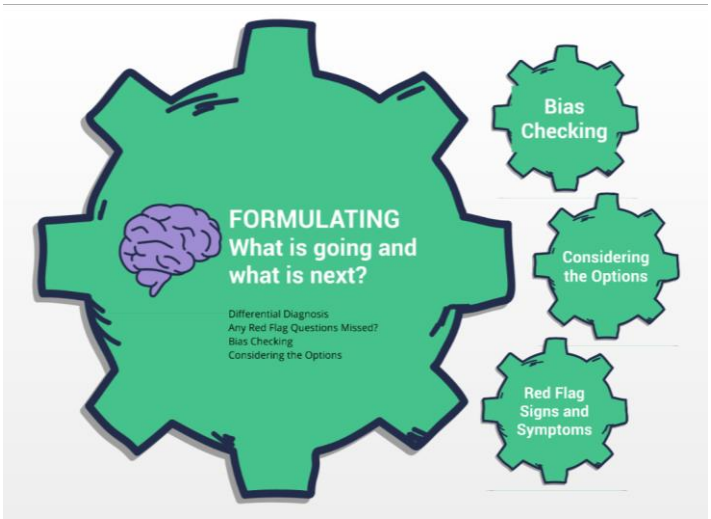
"Have you experienced any dyspnoea?"
"*Excuse me?*" As a medical student, you are learning a new language and you will do so remarkably fast. Medical terminology is known as "jargon" and it may be efficient, concise and precise when it comes to writing up a history but it shouldn't be a part of talking to patients. Be natural. Use the words you use every day, even better use the terminology and analogies that the patient uses. "*You said you're training for a marathon, have you noticed getting more out of breath than usual when you're running?*" Be careful with terms that can mean different things to different people for example asking about "drugs" when you mean medication. Also clarify any terminology the patient uses.

I can't ask that!
All sorts of questions may seem embarrassing to ask about when you start out. You may not be used to asking about people's feelings or their bowel habit. Remember to ask these questions in the same matter-of- fact manner as you ask the rest of the questions in the history. It can help to "signpost" a

sensitive question or ask permission or explain why you need to know first. "*Tummy pain can come from the gut so I want to ask you about your bowels."*
Write down phrases you hear doctors or colleagues use. Above all practise phrasing questions in a way that feels right for you and reflect on how they are working.

I can't remember all the questions (Warning: Do not simply rote learn lists of questions to ask). When you are learning to gather information, it can be useful to have a list of questions to practise, or to fall back on when you get stuck. However, if you routinely run down a list of questions with the patient you will exhaust yourself and them and end up with a lot of information that you don't know the meaning of. Try not to ask questions for the sake of it but think about what you need to ask and why. Every symptom has many different causes, think what those causes might be and what questions will help decide if a cause is more or less likely.

Formulating information Practise formulating a hypothesis drawing on the information gathered from a patient building on skills of active listening



When you are with your Clinical Contact tutors this week we want you to ask them their thoughts about patients you see together or present to your tutor. What does your tutor think is going on? Why? What does this mean for the patient?

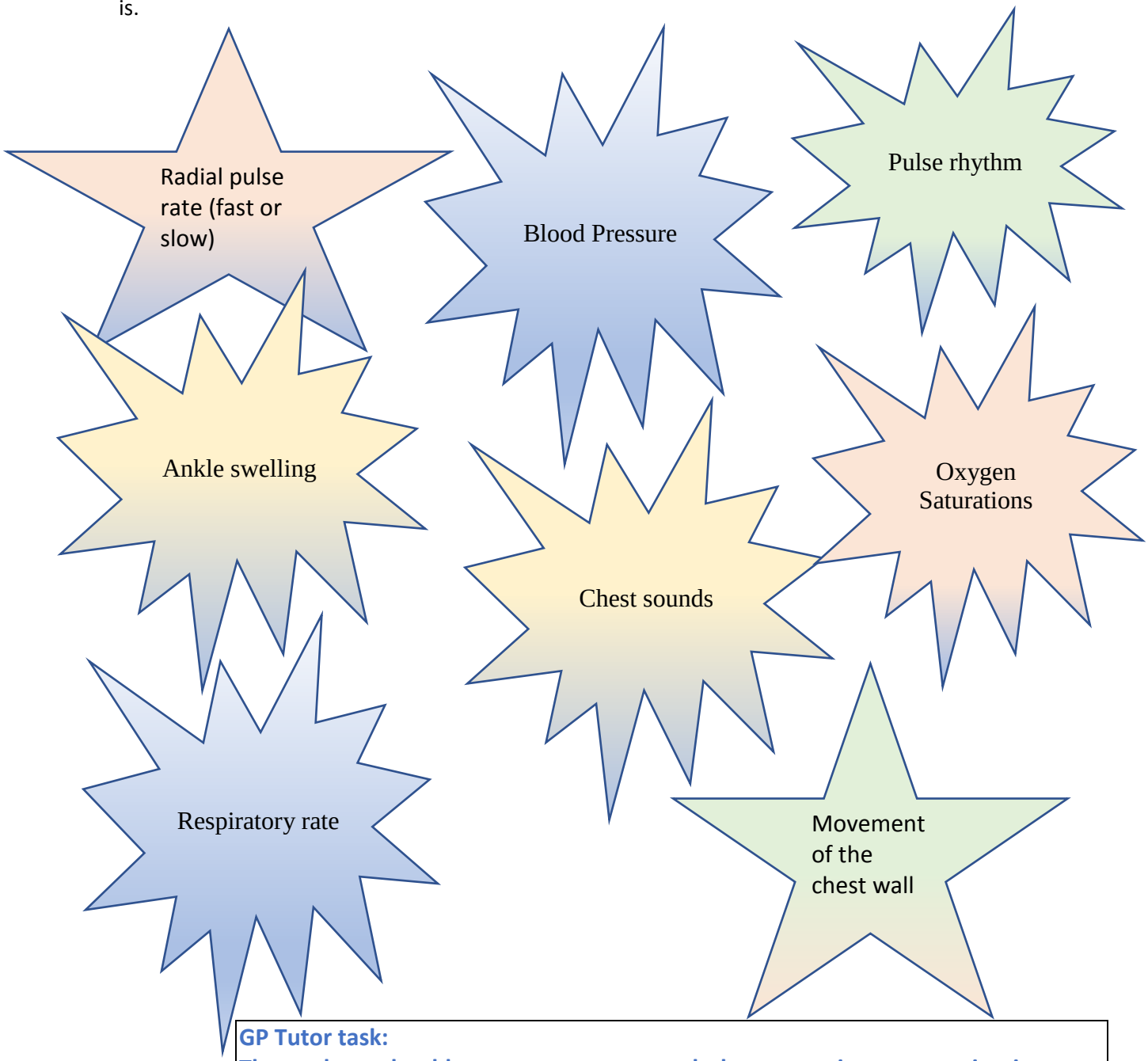
Once a doctor has gathered information from the history, examination and other sources such as test results the doctor needs to consider what to do next. The doctor should ask themselves if they understand what is going on and what it means for the patient? They may ask themselves questions like:

a) What do I think the main problem (or diagnosis) is?
b) What else could it be?
c) Is there anything that doesn't fit?
d) What must I not miss?
e) Is there more than one thing going on?
f) Do I need more information?

Experienced doctors may not seem to need to ask these questions. This is only because they can rely more on "Type 1" intuitive thinking and pattern recognition (or they are not verbalising their thinking!)—but they only got to this stage by seeing many patients and learning from their tutors. You won't be able to make good differential diagnoses yet because you don't yet know what all the options are. But you can begin to learn about how your tutors make the diagnoses and decisions by asking, encourage your tutors to "think out loud" about the patients you meet.
https://www.youtube.com/watch?v=YNFFyS1ykOwh shows a GP thinking about why a patient might have low mood or tiredness following his MI.

Assessing the respiratory system.

You will be introduced to pathology and symptoms such as breathlessness in Year 2. In Year 1 you are looking at how the normal cardiovascular and respiratory systems are structured (anatomy) and how they work (physiology). You will now be aware of that the processes of the heart, lungs, and cardiovascular system can be assessed clinically. What can we measure to assess the cardio-respiratory systems? Here are some ideas to get you started, for each item consider what "normal" is.



GP Tutor task:
The students should not expect you to teach them a respiratory examination, they will cover an introduction to the cardio-respiratory examination during their hospital placement, and they can watch videos (links at end) if they are keen! If you get a chance to show them how to feel the radial pulse, assess respiratory rate, oxygen saturations or listen to chest sounds. You can use the following notes.

The clinical examination.

(Do not examine patients without a tutor present. You may not cover examination on GP placement but this will be introduced on your hospital placements.)

- Describe the structure and components of the clinical examination

Once you have obtained verbal consent from the patient you should ask them whether they would like a chaperone present. Make sure the patient is comfortable; position them semi-supine at an angle of 45^0. Ask the patient to remove any clothing to expose the chest for examination but leave a loose cover over the chest if they are women or if it is cold as you are going to start with a general inspection followed by looking at the hands. Before you start, make sure you wash your hands.

You will notice within all the systems we follow the following order:

1. Observation around the patient, look for clues to help you work out what is going on – a patient may have brought a walking aid with them, portable oxygen or be carrying an inhaler.

2. General appearance Look at the patient from the end of the bed:
    a. Do they appear to be in pain or breathless?
    b. Do they look unwell? Consider their complexion.
    c. Do they have any obvious scars?

Feeling the radial pulse
Place the pads of your index and middle fingers over the radial pulse. This can be felt at the base of the thumb, just lateral to the flexor carpi radialis tendon.
Normal values:
Pulse: Most adults have a resting heart rate of 60-100 bpm (beats per minute) Athletes may have a lower rate.
Respiratory Rate: Normal respiration in an adult is 12-18 breaths per minute with expiration slightly longer than inspiration

3. Look at the hands and nails. You will learn a systematic approach to examining the hands and nails and all the things you need to look for in Year 2. For now, just consider what you can observe, your tutor will point out anything that may be significant.

4. Radial pulse. It is important to assess the rate and rhythm. For the rate, count for 15 seconds and multiply by 4. Is the rhythm regular or not? If irregular, you should feel the pulse for at least 30 seconds.

5. Respiratory rate. Count the respiratory rate by finding the number of breaths every 15 seconds and multiplying by 4.

6. Pulse Oximetry

Transcutaneous Monitoring of Oxygen Saturation is a non-invasive way of measuring oxygen saturation in arterial blood. It works through spectrophotometry. It compares the difference in absorption of red and infrared light by the blood and is usually placed on the fingertip, although other fingers or toes may be used, and ear probes are available. Two light-emitting diodes on one side of the probe are measured by a light detector on the other side. Oxyhaemaglobin absorbs more infrared light compared to deoxyhaemoglobin. Pulse oximetry measures the percentage of the arterial haemoglobin that is oxygenated, so you do need to know the total haemoglobin concentration. It only gives an approximation of arterial blood oxygen saturation, it is not substitute. It is also prone to error, so you still need to put the SpO2 in context and use your clinical judgement.

Use the right size probe; smaller probes are available for children.

Leave it on at least 30 seconds as each arterial pulsation brings the oxygenated blood, you can watch the SpO2 rise

What is normal? An SpO2 is < 94% indicates a problem. It may be normal for a patient with respiratory disease or be a falsely low reading but you need to find out why.

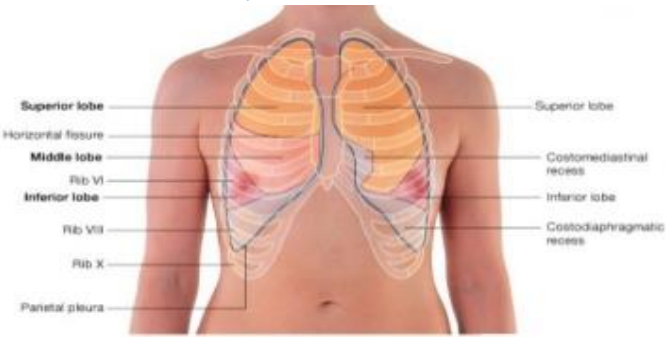
Reasons for error?

- Irregular heart beat
- Anaemia, haemoglobinopathies
- Poor perfusion e.g. Cold peripheries
- Nail varnish (especially red or dark varnish) or pigmented skin alters absorption of light
- Carbon monoxide poisoning can show normal or falsely high readings
- Dirt on the light emitting diode or light detector interferes with the function as can bright light shining on the probe
- Tremor/shaking makes it hard for probe to detect pulsations and can dislodge probe

7. Examination of the chest.

Remember…INSPECT, PALPATE, PERCUSS, ASCULTATE You will learn how to do these things in a systematic way in Year 2 (you can look in Macleod's Clinical Examination for detail). For now, we want you to be aware of what you can observe when you look at a patient and think about what you are observing. To start with, think about the anatomy you have learnt. What is the surface anatomy of the lungs?

Surface Anatomy—a reminder



The apices of the lung extend above the medial third of the clavicle as shown here. The blue line and shading shows the pleura.
The inferior margins of the lung are:
T6 mid-clavicular line
T8 mid-axillary line
T10 posteriorly.

Much of the surface area of the lung anteriorly is covered by the upper and middle lobes on the right, and upper lobe on the left. Posteriorly the lower lobe covers most of both sides.

https://www.youtube.com/watch?v=Dux1AnJCFAY

INSPECTION: Expose the patient's chest and sit them comfortably at a 45-degree angle.

Look at the patient's chest. What can you see? Look for:

- Symmetry
- Chest wall deformities
- Chest wall movement
- Scars

You can watch a respiratory examination at the following link, listening to the chest is from 3.54 minutes, there is also an e-tutorial on breath sounds where you can listen to the normal breath sounds. http://www.bristol.ac.uk/medical-school/hippocrates/medsurg/respiratory/

ASCULTATION

You may have the opportunity to listen to chest sounds. Start at the front of the chest and think about the surface anatomy as you listen. Place your stethoscope on the patient's chest asking them to take a deep breath in through their mouth each time your stethoscope is placed on their chest. Move from side to side before you move down. Don't forget to listen in the apices and at the axillae. You will need to listen in at least 4-5 places each side. All you are doing now is noting if you can hear the breath sounds. Your tutor will tell you if they are normal breath sounds or not, and if there are any additional sounds.

GP TUTOR TASK:
Debrief

- Discuss the patients seen today.
- Students who have been on the home visit should now start to be able to "present" the case back to you. Students who have observed a patient in clinic can present a patient you have seen together back to their colleagues.
- Students are unlikely to be able to present the case in the way you would present a medical history, instead ask them to try and "tell a story from beginning to end".
- Using the medical history template to identify some of the areas they covered and other areas that they might try and discuss with a patient next time.
- If the student has met any patients with respiratory disease can they identify any risk factors from the history?

Student Resources:

Your main text book for Clinical Contact is Macleod's Clinical Examination. This can be accessed through the reading lists and library link on blackboard here. Before Clinical Contact this week you will find it helpful to read the following sections:
Handwashing page 4
Chapter 2: History taking; pages 6-9; and Gathering information on pages 11-20.
Chapter 3: General Examination; pages 42-47.
Chapter 7: The Respiratory examination; Anatomy pages 139. Respiratory rate and pattern p143. The history p144-6. The physical examination p146-7 Hands p148-9. Thorax p150-1. Auscultation p153-5 Pulse oximetry 159.

For patient experience videos see health talk on line:
http://www.healthtalk.org/peoples-experiences/healthy-living/giving-smoking/effects-not-smoking
A collection of patients talking about the effect of giving up smoking. A useful patient resource!

http://www.healthtalk.org/peoples-experiences/heart-disease/heart-failure/symptoms-heart-failure-feeling-breathless-tired-and-lifeless Watch patients describe how breathlessness in heart failure feels, some felt they had a chest infection or were having a panic attack.

http://www.healthtalk.org/peoples-experiences/long-term-conditions/asthma/what-asthma-feels
Patients with asthma describe what asthma feels like.

Appendix 1: The medical history template

(students can use while sitting in, observing consultations or to reflect on after speaking with patients)

Medical History Template	
Presenting complaint or main problems	History of presenting complaint/problems
Past history	Medication
Family history	Social history (smoking, alcohol, drug use, diet, lifestyle, occupation, living situation, family, hobbies)
Any other symptoms or problems	What is the impact of the symptoms/problems on the patient?
What are the patient's ideas, and what are they concerned about?	What are the patient's goals/hopes?
Any other thoughts/comments? What do you think might be going on? What else do you need to know?	

Appendix 2: Wellbeing wheel from Effective Consulting

In their Effective Consulting labs students are introduced to the well-being wheel and have practiced using it on themselves and fictional cases. They might like to show it to you if you have not come across something like this before. They might like to try it out if talking with patients, where appropriate.