

YEAR 1 CLINICAL CONTACT IN PRIMARY CARE SESSION

Thursday 2nd May 2024 – am or pm – group A

Theme: Neurology and cognitive assessment

Cons skills: planning, doing, integrating and closing

Session plan		Suggested timings: AM	PM
Introduction	20min	09.00-09.20	14.00-14.20
Patient contact	1 hour	09:20-10.20	14.20-15.20
10-minute break			
Debrief and discussion	30 min	10.30 – 11.00	15.30 – 16.00
Focus on cognitive assessment	30 min	11.00 – 11.30	16.00 – 16.30
Feedback and close	30 min	11.30 – 12.00	16:30 – 17.00

This will be your last session with this group (but you have one final session with your other group in 2 weeks' time). Please use this session guide in conjunction with the GP teacher guide [here](#) as needed.

The general format is the same as previous ones, though **the timings have changed** to allow for discussion about cognitive assessment and to share feedback. Half the group meet a patient (ideally with a neurological or cognitive problem) and half observe consultations with you, but the patient contact time is slightly less. This session may need a bit more preparation than previous ones, but the next session is the same so you will not need to do it again.

The consultation skills focus is on planning, doing, integrating, and closing the consultation, including the shared decision-making process that supports this. The students have practised this in their effective consulting session: this has included thinking about how patients' lifestyles contribute to their health, and how we, as doctors, motivate patients to make lifestyle changes and manage their health and wellbeing. It's helpful if you can share the resources you give to patients to help them to manage their own health e.g., websites, charities. You can read more about how the students are taught about planning and closing the consultation in the appendix.

The session includes an activity discussing **cognitive assessment** as this is an important early part of the curriculum and an area where GPs have lots of experience. This ties in with the endocrine case as cognitive impairment may be an unrecognised and early complication of a number of endocrine conditions and can be a presenting symptom e.g., in hypothyroidism. This discussion is based on a short consultation clip from GPs: Behind Closed Doors which the students will have viewed in advance and we ask that they watch again with you on the day. You can view this in advance if you wish or with the students before discussion on the day – see link and details on page 9 for instructions. The appendix contains info about different methods of cognitive assessment to support discussion.

The final part of the session is for **feedback**. Please can you give each student some individual feedback – tips in the appendix. During this time, please also ask the students to complete their feedback questionnaire. We will send this feedback out to you by the end of June which you can use for CPD purposes.

Timings are approximate and flexible. Most important is patient contact with subsequent discussion and reflection. Patient contact ideally involves a mix of students observing/participating in consultations and meeting patients, in their own homes where possible. Please use your own clinical experiences to feed into the discussion. It doesn't matter if you don't cover everything, relevant alternative discussions or activities are fine.

Any problems on the day, please email phc-teaching@bristol.ac.uk or call 0117 4282987.

Central University teaching context

The **CBL case** revisits Mr. Sayal (from the GI case) who is losing weight but at risk of Type 2 diabetes and metabolic syndrome. They also consider a medical student who panics before an exam as she has not brought any food and worries that she will go 'hypo'. She is not diabetic. Her uncle has hypertension, Type 2 diabetes, high cholesterol and is overweight. He is under chronic stress which he worries will have a negative effect on his physical and mental health. The students' learning is supported by lectures and practicals.

In their **effective consulting labs**, the students do small group work looking at activating people to make lifestyle changes, with focus on the cycle of change, practicing with actors, and they have a brief a brief introduction to motivational interviewing.

Learning objectives

By the end of the session, students will be able to:

- Describe the structure and components of a well-rounded medical history including assessment of cognitive function
- Describe the structure and components of a whole person approach to the clinical examination, including assessment of mental state
- Describe the importance of closing consultations effectively, and how to do this
- Describe the importance of planning - Describe how clinicians and patients collaborate in shared decision making for best patient care, including the importance of clear safety netting
- Describe the importance of integrating and learning from clinical encounters
- Describe the importance of a whole person approach to the consultation and clinical care including the consultation as a therapeutic tool
- Consider how patients might integrate the clinical consultation - Describe how to learn from and reflect on each clinical encounter, both in terms of clinical knowledge and emotional processes.
- Reflect on the importance of partnership and collaboration with patients in all parts of the consultation to provide whole person "patient shaped" care

GP advance preparation

- Read this guide: arrange a patient, ideally with an endocrine, neurological or cognitive problem, to meet with half the students (at home or in the surgery).
- Arrange a short surgery (3/4 patients) for the others to observe.
- Watch the 5 min GPs Behind Closed Doors clip if time (details on page 9)
You likely have already done this for the last session so do not need to repeat

Welcome, catch-up and introduction (20 min)	09.00-09.20 or 14.00-14.20
<p>Check in and pastoral review.</p> <ul style="list-style-type: none"> • Run through session plan and learning objectives/tasks • Brainstorm planning, doing, closing and integrating in the consultation 	
Patient contact (1 hr.)	09:20-10.20 or 14.20-15.20
<p>Patient interview Ideally, this will be a patient with a current or past endocrine, neurological condition, dementia or dementia carer. Students should take it in turns to lead the interview and be prepared to feedback to each other on consultation skills (see the GP Teacher guide for practical information about this and a patient letter).</p> <p>Observing consultations: as per previous sessions and some specifics based on planning and closing</p> <ul style="list-style-type: none"> ○ <i>Is there a patient-centred plan or shared decision making?</i> ○ <i>What does the GP do to end the consultation?</i> ○ <i>Was there a safety net?</i> ○ <i>Any integrating during or after the consultation?</i> 	
10-minute comfort/toilet/stretch/tea break as needed	
Debrief and discussion (30 min)	11:00 – 11.50 or 16:00 – 16.50
<p>Students present cases and discuss which communication skills and questions worked well in the patient encounters with specific focus on gathering info and ICEIE. Discuss planning and closing the consultations.</p> <p>During their first year the emphasis is on the students gaining confidence in talking with patients. They are not expected to receive and present a full or polished medical “clerking”, but they should now have an idea of the main domains of the medical history and how to structure a conversation with a patient. By the end of Year 1 students should also be able to present the key points to you, their tutor. It is an art to be able to summarise the relevant information without losing important detail, but at this stage they should understand that the way the patient tells their story differs in structure to the way they need to present the patient’s narrative and identify where the challenges lie. They should also be able to reflect on the information they gathered and what they would like to know more about.</p>	
Focus on Cognitive assessment (30 min)	11.00 – 11.30 or 16.00 – 16.30
<p>As a group, watch the clip from GPs: Behind Closed Doors. See details on p9</p> <ul style="list-style-type: none"> • Reflect on this consultation as a group (can use COGConnect template below) • Discuss the challenges of cognitive assessment. GP teachers to share tips and experiences diagnosing dementia, differentiating from other causes of cognitive decline, overlap with depression etc. 	
Feedback and close (30 min)	11.30 – 12.00 or 16.30 – 17.00
<p>Spend time with your group reviewing your sessions together. What have they learnt? What did they like/what could be improved?</p> <p>Please spend a few minutes separately with each individual students giving them individual feedback on their progress and what to concentrate on in their clinical and consultation skills learning. The others should be given time to complete an online form (link emailed to them and on OneNote). We can then share this feedback with you. Those students who had done a creative piece based on a patient they have met in GP may want to share it with you or the group.</p> <p>Finish with a final take home message about their first clinical contact on their journey to become doctors.</p> <p>Remind students about their reflective log/ePortfolio.</p>	

GP tasks after the session

- Prepare for and consider appropriate patient to invite to the next session (with your other group **Thurs 16th May 2024**, CBL fortnight: Endocrinology. Cons skill focus: planning, doing, integrating, and closing) as per this session
- Complete online **attendance data**
- Please complete our feedback questionnaire

Any questions or additional feedback, contact phc-teaching@bristol.ac.uk or lucy.jenkins@bristol.ac.uk

This is a full session so it is unlikely that you will need any additional activities! Just in case, see below, as in the GP Teacher Guide.

- Activity practising patient introductions – see [here](#)
- Discussing recent cases you've seen relevant to their learning
- Students could observe you telephone consulting or participate if the patient consents.
- **Show and tell** with consulting room equipment. E.g. thermometer, auroscope, sphyg, swab, sats probe. Hold up and students tell you what it is, how to use, what is normal etc.
- Discussing significant events that have occurred recently at the surgery

Also, the students can access **Speaking clinically**, which is a video archive of patients talking openly about their medical conditions. It is operated by the Medical Schools Council and all students can access it. These are not consultations but useful for self-directed learning about the patient perspective. You do not need to view this but if you wish to have access you can log in at <https://speakingclinically.co.uk/accounts/login/>. Use email as phc-teaching@bristol.ac.uk. Password: primcareGP1GP2

<https://speakingclinically.co.uk/videos/ketoacidosis/>

This young man describes his presentation with type 1 diabetes, generally well controlled except for an admission post alcohol excess with dehydration as part of ketoacidosis.

<https://speakingclinically.co.uk/videos/diabetic-complications/>

A 49-year-old former print finisher who has a 23-year history of poorly controlled type 1 leading to multiple and significant complications.

<https://speakingclinically.co.uk/videos/hypothyroidism-before-and-after/>

This 74-year-old retired receptionist describes classical symptoms of hypothyroidism – slowing down, deepening of the voice, hearing impairment, weight gain, constipation and loss of the outer third of her eyebrows. These had been longstanding, but she was diagnosed when she presented with a stroke. This is a follow up interview 18 months after starting treatment where the effects are striking.

APPENDICES

Effective consulting notes

Cognitive function

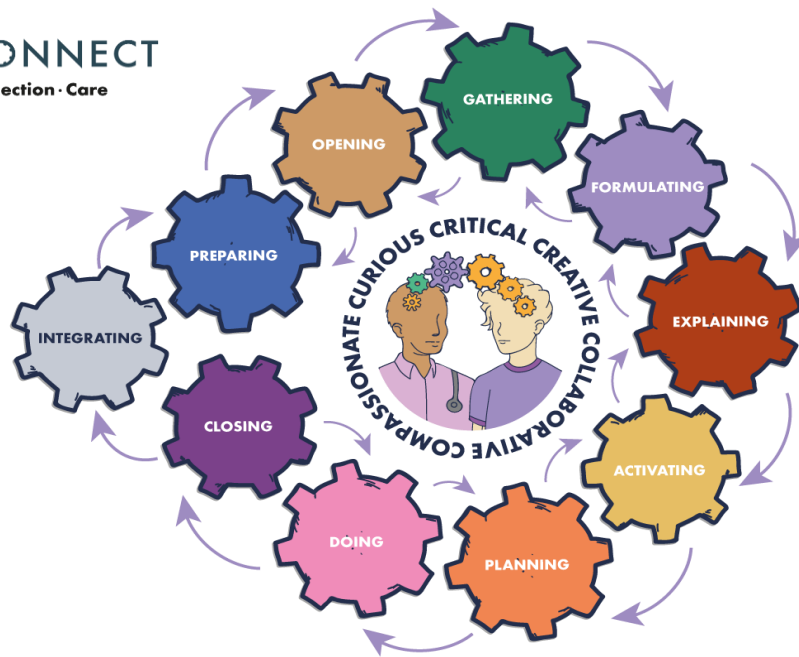
- Virtual Primary Care activity
- How to assess cognitive function
- Role play activity if needed

Tips for giving feedback

Effective consulting learning

Recap of COGConnect

The next page is an outline of the consultation model used to teach consultation skills in Bristol. Try using it to help the student reflect on their conversation. For instance, did the student open well? Did they bring their conversation to a satisfactory close? Was the student able to consider what was going on? Did the patient understand their condition, did they want an explanation?



PREPARING
Am I prepared?

- ⚙️ Preparing oneself
- ⚙️ Preparing the space
- ⚙️ Checking the medical record

OPENING
Are we off to a good start?

- ⚙️ Establishing the agenda
- ⚙️ Establishing relationships
- ⚙️ Initial observations

GATHERING
Have we covered all the relevant areas?

- ⚙️ Sources of understanding
- ⚙️ History
- ⚙️ Clinical examination

FORMULATING
What is going and what is next?

- ⚙️ Bias checking
- ⚙️ Considering the options
- ⚙️ Red flag signs and symptoms

EXPLAINING
Have we reached a shared understanding?

- ⚙️ Chunking
- ⚙️ Checking
- ⚙️ Visual Aids

ACTIVATING
Is the patient better placed to engage in self-care?

- ⚙️ Identifying problems and opportunities
- ⚙️ Rolling with resistance
- ⚙️ Building self-efficacy

PLANNING
Have we created a good plan forward?

- ⚙️ Encourages contribution
- ⚙️ Proposing options
- ⚙️ Attends to ICE (IE)

CLOSING
Have I brought things to a satisfactory end?

- ⚙️ Summary
- ⚙️ Patient questions
- ⚙️ Follow Up

DOING
Have I provided a safe and effective intervention?

- ⚙️ Formal and informal consent
- ⚙️ Due regard for safety
- ⚙️ Skilfully conducted procedure

INTEGRATING
Have I integrated the consultation effectively?

- ⚙️ Clinical record
- ⚙️ Informational needs
- ⚙️ Affective progressing

Shared decision making in clinical practice

In their previous Effective Consulting session last week, the students learnt about shared decision making. The following information is from this EC lab session.

In the recent Department of Health White Paper 'Equity and Excellence: Liberating the NHS', Shared Decision Making was highlighted as an essential feature of the NHS moving forwards. Following its publication, the slogan 'No decision about me, without me' hit the headlines.

Shared decision making relies on two sources of expertise:

- The health professional is an expert on the effectiveness, probable benefits, and potential harms of treatment options
- The patient is an expert on herself, her social circumstances, attitudes to illness and risk, values, and preferences

Shared Decision Making is a process in which clinicians and patients make an informed decision together using the best available evidence and based upon both clinical need and patient preferences and consideration of patient values and lifestyle.

Shared Decision Making has also been described as: an interactive process during which patients and practitioners collaborate in choosing healthcare.

Why is this important?

Decisions that are made on behalf of patients, without their input, do not promote an effective partnership between the clinician and the patient. Whilst not all patients want the same level of involvement in decisions about their treatment and care, it is important that clinicians explicitly discuss this with them.

Shared Decision Making encourages the patient to think about what is important to them. It identifies decisions, encourages an information exchange, encourages discussion about personal preferences and develops a shared responsibility for those decisions.

The current evidence base for shared decision making

- Approximately 50% of patients want to be more involved in their healthcare decisions
- On average, 50% of patients don't take medication prescribed (or take it incorrectly), and 70% don't adhere to dietary recommendations made by healthcare professionals.
- Better communication and collaboration are correlated with better patient adherence. Training doctors to communicate better enhances patient adherence.
- Patients who are active participants in managing their health and healthcare have better outcomes than patients who are passive recipients of care.
- Shared Decision Making may lead to a reduction in complaints and litigation

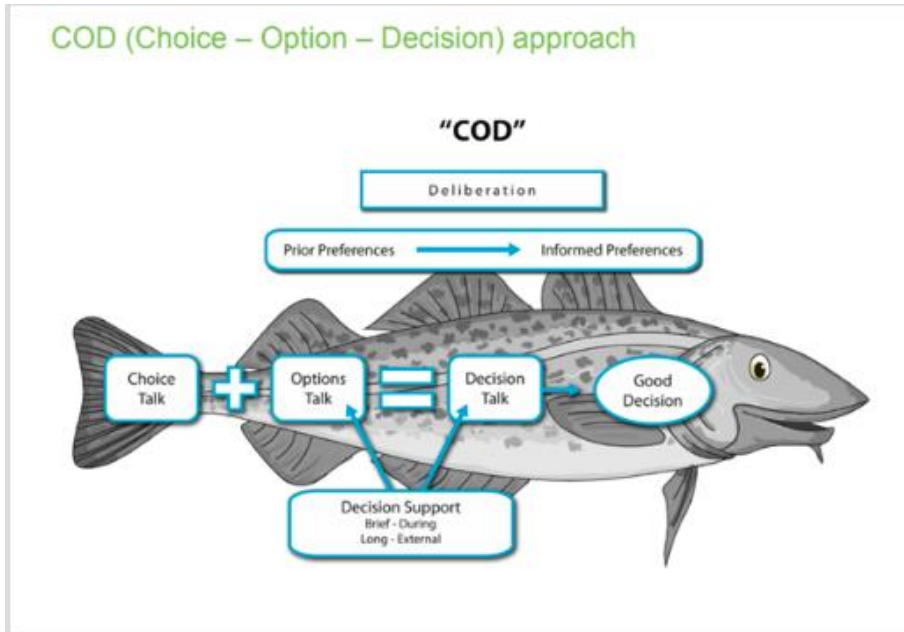
Some healthcare decisions are appropriate for shared decision making, and some are not, but the principles of sharing information and collaborative planning between patient and doctors are universal. Understanding the patient's ideas, worries, values and preferences can help negotiate the planning and decision-making aspects of any consultation.

If there is an opportunity for Shared Decision Making, there are a number of issues that need to be considered:

- Firstly, is there a decision to be made? If there is, is it preference-sensitive?
- Is there sufficient time for consideration/information gathering?

- Is the patient actively seeking a balanced relationship within the consultation?
- What are the different treatment options?
- Does the patient wish to be involved in choosing the treatment?

One way to implement Shared Decision Making is using the COD model:



Elwyn, G et al, *A Three Talk Model for shared decision making: multistage consultation process*, BMJ 2017;359:j4891

Patient perspective:

The "Ask 3 Questions" Campaign.

The above information is extracted and adapted from a variety of sources. We recommend using the open access e-learning resource Introduction to Shared Decision Making from which much of this material is derived. It is a well-designed e-learning module. You do not need to register. However,

please note that all medical students and other healthcare professionals are able to register for further online training modules at e-learning for health which is an invaluable resource.

Planning, closing, and integrating in clinical practice.

Planning

So, when doctors make a plan with their patients it should not be the doctor telling the patient what to do or what will happen next. Instead, the doctor should discuss the available options with the patient and provide enough information to collaborate with the patient to make the best decision for them. As part of this the doctor needs to work out how much information the patient needs and the patient's perspective—their ideas, concerns, and expectations. The doctor should try and enable the patient to be as involved as they can be and enable self-efficacy in their care.

Safety net

Part of making a plan is knowing when things are not going as expected and what to do about it. This is called "safety netting." Missed diagnoses are common, especially when doctors see patients at an early stage in their illness, so discussing uncertain diagnosis with patients is important. Also, certain conditions or medication carry a risk of complications or side effects so knowing what to do if they occur is important. Roger Neighbour¹ considered safety netting a core component of the consultation and said there were 3 questions to ask oneself:

1. If I'm right, what do I expect to happen?
2. How will I know if I'm wrong?
3. What would I do then?

¹Neighbour R. *The inner consultation*. 2nd edn. Oxford: Radcliffe Publishing; 2004.

Doing

Not all consultations have a 'doing' aspect, but many do. At one extreme this might include simply handing over a prescription, at the other perhaps a joint injection, a coil fitting, or implant insertion. We need to consider whether our intervention is appropriate, safe, and effective, and make sure the patient has consented in an informed way. Spend some time talking to students about the things you 'do' in consultations, and how you go about seeking consent.

Closing

Students often find bringing the consultation to a satisfactory end is tricky. They may have discovered on their home visits that the conversation with a patient came to an uncomfortable end as they "just couldn't think of anything else to say." But even experienced clinicians get the patient who brings up their most important problem just as they are leaving the room. Talk to your students about how you end consultations. You will have your own ways of doing this but use the following points to start you off:

- Identifying next steps; for you and the patient
- Summarising key points of your discussion. Consider a written summary or patient information leaflet
- Does the patient agree you've come to the end? Have they got anything they haven't asked, or you haven't covered, or they are still not sure about? (It can be good not to invite general questions right at the end—keep them specific to the consultation you've just had).

Integrating

When the consultation has finished, and the patient has left, the doctor hasn't finished yet. There are several things that still need to be done.

- Clinical record. The doctor needs to write up the notes into the records, they also have further tasks such as write a letter, chase a result, speak to a colleague for advice or make a note to follow the patient up.

- Informational needs. There may be an element of the consultation that the doctor needs more information on. This may be about the individual patient, or it may be educational needs about a case.
- Affective processing. Some cases are emotionally tough, and some days are emotionally draining. Some consultations are really interesting, enlightening or life affirming. All this needs processing and the doctor may need to take a moment to reflect or get ready for the next patient.

The patient may also have to do a significant amount of integrating to do. They may have to take a new diagnosis or information on board, tell a loved one, take new medication or make lifestyle changes.

Discussing assessing cognitive function

Virtual primary Care

The students have been asked to prepare in advance for this by viewing a 5-minute clip from the GPs: Behind Closed Door series. Please see below for their instructions. If you are able, you can also watch this brief clip in advance (instructions on how to navigate to this are here:

<https://www.bristol.ac.uk/media-library/sites/primaryhealthcare/documents/teaching/year-1-and-2/how-to-access-memory-problems-video-2024.pdf>

Please ask one student to present the case and then discuss the consultation with the group. The table below is a useful guide for this. Please share and reflect upon your experiences of assessing cognition in various instances in clinical practice. It may be useful to have in mind cases which have been particularly interesting or challenging.

Instructions given to students in advance

Please watch this 5-minute video in advance of the session and use the Consultation Observation Questions on the next page to make some notes about each phase of COGConnect that you observe in this consultation. *Prepare to 'present' this case to your group and to discuss with your GP tutor.* You may watch this again in your session and there should be time to discuss it.

Watch the video a second time and identify the components of the memory screening test. Have a read of the GP COG Assessment here <https://patient.info/doctor/general-practitioner-assessment-of-cognition-gpcog-score>: and see how it matches up.

COGConnect Phase	Questions to consider whilst watching the video	Space for your notes
Preparing	Pause the video and look at the way the room is set up for consulting. What do you notice?	
Opening	How does the Doctor open the consultation? What do you notice about the patient's response?	
Gathering	<i>This consultation is edited for TV and is therefore shorter than a normal consultation and some of the memory assessment is missing.</i> Despite that, what do you notice about the information gathered?	

	<p>What are the patient's ideas about his memory problems (what does he think might be causing them)?</p> <p>What are the patient's worries about this situation? What aspects of a patient's lifeworld might be important where memory is a problem?</p> <p>How do we 'examine' memory?</p> <p>What other information gathering can you identify?</p>	
Formulating	What does the doctor think is going on here?	
Explaining	Can you identify any explaining in this consultation? If so, does it take account of the patient's understanding?	
Activating	Do you notice any activating in this consultation? What aspects of lifestyle might be important for a patient with memory problems?	
Planning	Can you identify a clear management plan? What do you think the pitfalls might be?	
Closing	How does the doctor close this consultation?	
Integrating	<p>What does the doctor need to do now to appropriately integrate this consultation?</p> <p>How do patients integrate new information about their health, or new potential diagnoses?</p> <p>What might this patient do now?</p> <p>What might the emotional impact of this consultation be for the doctor?</p> <p>What might the emotional impact of this consultation be for the patient and his wife?</p>	
Generic Consulting skills	Note down the skills you observe being used in this consultation	

There is a lot of useful info here. <http://gpcog.com.au/index/frequently-asked-questions>. Read through the [FAQs](#) especially the bit about what to keep in mind when administering GPCOG.

Pre-reading given to students

You will cover in your case that it is common for patients to complain about memory impairment. Sometimes the patient presents with concerns about their memory, but often it is a family member who is worried. Mild cognitive impairment has many causes and should be tested for. This enables forward planning but also to look for reversible causes, as cognitive decline can put the patient and others at risk, for example leaving the gas on after cooking. Mild impairment can precede serious cognitive decline in dementia by many years. Causes include dementia, head injuries, Parkinson's, endocrine disorders e.g. hypothyroidism, metabolic e.g. hypoglycaemia, nutritional deficiencies e.g. folate and vitamin B12, sedative medication, depression, and infections.

There are different parts to assessing cognitive function, a history (including a collateral history), mental state examination, physical examination, and formal cognitive testing (a standardized test). The mini mental state examination is a commonly used test of cognitive function that scores out of 30. It tests orientation, short term memory, visuospatial and language skills and is thought to be sensitive (it picks up mild impairment) but is not suitable for making a diagnosis. It needs to be purchased and can't be reproduced.

The Montreal Cognitive Assessment (MoCA) is a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuospatial skills, conceptual thinking, calculations, and orientation. It scores out of 30 with 26 and above being normal. <http://www.mocatest.org/>

The GPCOG test was designed to screen for cognitive impairment in primary care. It has 2 parts: an assessment of the patient's cognitive function, then if their score is uncertain e.g. 5-8 there are further questions to ask someone who knows them (a collateral history or "informant"). <https://patient.info/doctor/general-practitioner-assessment-of-cognition-gpcog-score>

The "Six-item Cognitive Impairment test" (6CIT)¹ can be used to screen for cognitive impairment and is used in primary care. It is a little complicated to score (but computer versions available) but sensitive and still specific, and easy to translate to different languages and cultures.

SIX-ITEM COGNITIVE IMPAIRMENT TEST (6CIT) --Kingshill version 2000		Score if incorrect. (0= correct)
1	What year is it?	4
2	What month is it?	3
3	Give a 5-part address for patient to remember e.g. John Smith, 42 West Street, Birmingham.	
4	What time is it? (To nearest hour)	3
5	Count backwards from 20	1 error= 2 points 2 + errors = 4 points
6	Say the months of the year in reverse	1 error = 2 points 2 + errors = 4 points
7	Repeat address phrase	Score on number of errors 1 = 2 points 2 = 4 points 3 =6 points 4 = 8 points All wrong= 10 points
SCORE	0-7 normal. 8 or more significant.	Total: 28

The abbreviated mental test score (AMTS) was introduced by Hodkinson in 1972² to assess patients for the possibility of dementia. You may see it in hospital, but it hasn't been validated for screening

or use in primary care. It's simple and easy to score but over time the questions get adapted e.g. 2nd world war for dates and name the prime minister rather than monarch – so it is not very valid. In addition, questions often need adapting for patients depending on background and culture.

Put the following questions to the patient. Each question correctly answered scores one point, a score of 6 or less indicates dementia or delirium and indicates further testing.

	Abbreviated mental test score (AMTS)	Score if incorrect is 0 (Score 1 if correct)
1	What is your age?	0/1
2	What is the time? (to the nearest hour)	0/1
3	Give the patient an address, and ask him or her to repeat it e.g. 42 West Street (tell the patient you will ask them to remember it and ask them at the end of the test. No points for repeating—this is to check they've heard right)	
4	What is the year?	0/1
5	What is the name of this place? (the hospital or number of the residence where the patient is?)	0/1
6	Identification of 2 people. Can the patient recognize two of: family member, doctor, carer, etc.)	0/1
7	What is your date of birth? (day and month sufficient)	0/1
8	In what year did World War 1 begin?	0/1
9	Name of present monarch?	0/1
10	Count backwards from 20 down to 1.	0/1
11	Address recall	0/1
	Score: 6	10

1. Brooke P, Bullock R; Validation of a 6-item cognitive impairment test with a view to primary care usage. *Int J Geriatr Psychiatry*. 1999 Nov 14 (11): 936-40.
2. Hodkinson MH; Evaluation of a mental test score for assessment of mental impairment in the elderly, *Age and Ageing*, Volume 1, Issue 4, November 1972, Pages 233 – 238, <https://doi.org/10.1093/ageing/1.4.233>

Giving feedback

Group feedback

It may be useful, as a group, to reflect upon how this new way of learning and meeting patients has worked. You may be able to give general feedback to the group – e.g., contributions, enthusiasm, insight. Discuss what worked well/less well – use of MS teams, the patient interviews, how the debrief and discussion were carried out etc. Did they feel the group worked well? You may wish to ask specific questions and use this for your own CPD purposes. You do not need to submit this feedback to us, though we are interested to hear how things went and any tips or pitfalls. The university collects central year 1 feedback which includes questions about general practice, but PHC are not permitted to ask the students further specific feedback questions outside of their time in GP.

Suggested methods for collecting and collating this feedback.

- Ask everyone to say one thing that worked well and one thing that might be improved. Go round the group or use the chat function.
- If you would like to ask a specific set of questions, then Microsoft forms is an option – <https://forms.office.com/Pages/DesignPage.aspx>
- Survey monkey is good for this. https://help.surveymonkey.com/articles/en_US/kb/How-do-I-make-surveys-anonymous
- Padlet.com is an easy online notice board which can be anonymous—you just go to the site and set up a free account.

Giving individual feedback

Feedback is a high priority as it contributes greatly to student learning. Your feedback has the potential to help students develop academically, clinically, reflectively. The National Student Survey has highlighted that students do not feel they receive enough feedback on their work, so we are encouraging this. If you can, please spend a few minutes with individual students giving them feedback on their progress. This can be done using a breakout room if or alternatively you could send them a personal email. (You may have already given some feedback via their TAB – thank you for doing this as well).

Principles for giving feedback.

- 1) Ask the student what they think/how something went.
- 2) Affirm qualities—individual and thinking about group work, qualities that may help working in a team as a doctor and in future group learning. There is evidence that this is motivating.
- 3) Areas for development—offer observations not assumptions. Students are often poor at identifying their weak areas and feedback from others can help them to improve.
- 4) End on a positive note (completing the feedback sandwich of “positive comment—area for improvement—positive comment”)

Feedback should be:

- Constructive
- Specific. Good: “I noticed that you did not greet the patient at the start of the consultation....” Poor: “You seem to have a problem establishing rapport”
- Descriptive and based on observations. Good: “I noticed that you did not make eye contact with the patient...” Poor: “You are a poor at communicating”
- Objective, non-judgmental
- Address behaviour not personality. Good: “I noticed that you chose the treatment option for your patient....” Poor: “You are very paternalistic with your patients....”
- Normalise difficulties.