University of BRISTOL

A101 Primary Care Attachment
Human Basis of Medicine (HBoM)

Centre for Academic Primary Care

A101 Student study guide, 2013/2014

Contents

Introduction

Welcome to your first attachment in general practice. This is an opportunity, amidst your very busy first and second year lectures to actually meet patients and front line health professionals. Your former colleagues valued this GP placement very highly and some were surprised at the extent of their learning. Some reasons for this include the low teacher to student ratio allowing interactive teaching, the enthusiasm of GPs to teach and the relaxed learning environment. As mature learners we hope that you, with your GP tutors, will shape these two days so that you gain as much as possible.

At their best, GP consultations are a place where the art of caring for patients is interwoven with the science of medicine. GPs deal with a great variety of clinical presentations and problems of all kinds, they tend to build relationships with patients over time, through multiple consultations and operate within a more level doctor-patient playing field. It is often the first point of contact for the public with the medical profession. You can read more about primary care from page 8.

Study guide

Please take your study guides to the GP surgery. There is more information on Blackboard so do familiarise yourself with this too. The guide is designed to give you key information about the attachment with a log at the end to record interesting cases. You can take this case log to your other Human Basis of Medicine (HBoM) tutorials as you will discuss cases you have seen in general practice in these sessions. There is also some information to stimulate your thinking, read when you have some spare time, and to provide a basis for discussions with your GP teacher.

Visiting the surgery

You should contact your GP prior to your arrival to check times, directions and whether you need to bring anything in particular. We do not expect you to have your own medical equipment at this stage. Please take your University of Bristol ID badge.

Blackboard

This is the University of Bristol's on-line learning resource. www.ole.bris.ac.uk

This course is: **MEDI10005_2013: Year 1 - HBOM - Introduction to Primary Care Element 2013.** Although much of the "*Course Information*" (find this under the menu on the left hand side of the screen) and archived past examples of work are not applicable to you (as we do not ask you to do assignments) you will find the tutorials of interest, and they may provide a basis for discussions with your GP tutor. Find "*GP tutorials*" under "*Learning materials*". A recorded copy of the introductory lecture given on 08/10/13 to the A100 students is also available on Blackboard; the first part given by Professor Salisbury details the importance of Primary Care and gives some basic information which it may be useful for you to study before you attachment.

Key dates

The two day attachment is Thursday 6th and Friday 7th March 2014. You should contact your GP teacher for arrival times (usually 9am) and should be able to leave by 5.30pm.

Travel expenses

You can claim reimbursement for travel expenses if you attend a placement in zone 2 or 3 (Bristol City bus networks). There is information in your year 1 handbook regarding eligibility and the claim process or see the web link below. You can use this link to download a form to complete and then return it (with bus tickets) to Kirsty Bright, MBChB Year 1 admin coordinator in the Curriculum Office, 1st Floor, Senate House.

http://www.bristol.ac.uk/medical-school/staffstudents/student/forms/claimform12-13.pdf

Please discuss with Kirsty if you have any queries regarding what can be claimed and do try to club together with your group to share costs. A useful website is www.travelbristol.org

Attendance

Student attendance should be 100% for all teaching. Any absence through sickness or another reason must be communicated to the GP by phone or email prior to the session you will be missing. You are also required to report any unplanned absence centrally to the University via: medadmin-absence@bristol.ac.uk (and ideally copy in phc-teaching@bristol.ac.uk). As a result of this an email will go to the office of the Academy in which you are studying and to the Primary Care teaching Office at phc-teaching@bristol.ac.uk.

Your GP will also inform us of absences at the end of the placement. University guidance and a student certification form for illness can be found here:
http://www.bris.ac.uk/esu/assessment/annex/201011/9studentillness.html

Student support

Students in Years 1&2 can access support through: The Faculty Student Advisor, Emma Teakle : 0117 9288444, http://www.bristol.ac.uk/medical-school/staffstudents/support/
Or the Pre-Clinical Dean (Dr Eugene Lloyd, Eugene.Lloyd@bristol.ac.uk).

The overall Director of Student Affairs is Revd Mr Nigel Rawlinson, Nigel.Rawlinson@bristol.ac.uk

In addition, you will all be allocated an Academic Mentor with particular focus on educational and professional/career aspects. You will need to arrange to meet with them in the second semester and thereafter twice a year, where you will review together your e-portfolio.

Galenicals Welfare - Lucy Huppler - preclinical@galenicals.org.uk

Details of University central student support services are available at: http://www.bris.ac.uk/studentservices/

Student Counselling. 1A Priory Road, Clifton, Bristol BS8 1TX. Tel: 0117 954 6655

Student Health

You are all encouraged to register with a local General Practice.

- Student Health. Tel: 0117 330 2720

Contact Information

The Centre for Academic Primary Care delivers and co-ordinates teaching GP placements for students in all 5 years of study. Much of the primary care teaching is delivered by a group of about 160 GPs in their practices in Bristol and the South West Region.

Centre for Academic Primary Care, School of Social and Community Medicine, Canynge Hall, 39 Whatley Road, Clifton, BS8 2PS
www.bris.ac.uk/primaryhealthcare

Element Lead	Dr Lucy Jenkins	Lucy.Jenkins@bristol.ac.uk
Element Admin	Alison Capey Jacqui Gregory	All enquiries to be directed to phc-teaching@bristol.ac.uk 0117 331 4546

Professional Behaviour

PAID – Personal, Professional and Inter-professional Development
(one of the vertical themes of the Medical course in Bristol)
Students should adhere to the professional code of practice at all times which can be found at: http://www.bristol.ac.uk/medical-school/staffstudents/rulesandpolicies

See also "Confidentiality" below.

This includes:

- Treating all patients with respect (including respecting confidentiality)
- Treating all staff and colleagues with respect (including not disrupting their teaching)
- Attending all teaching on time and adhering to the clinical dress code i.e. ladies – no cleavage or midriff, men – trousers, shirt +/- tie.
- Being honest and handing in all required paperwork/assessments to deadlines
- Taking care of your health and seeking help if your health may impact on patient care

The GMC has produced interactive case studies on professionalism in action and some of which are relevant to the GP placements. You can find them at: *www.gmc-uk.org/studentvalues*

Your GP should have asked all patients in advance for permission for you to observe consultations or to visit patients in their homes.

Medical Indemnity

Students on clinical placements should have their own professional indemnity (you can obtain free membership of the MDU/MPS). Your GP should brief you on Health and Safety Issues in the workplace.

Confidentiality

Respecting patient confidentiality is so important for you to be aware of during your GP attachment because from now on, you will be meeting patients and they may talk to you and trust you as a member of the medical profession.

Confidentiality is enshrined in law through the right to privacy, and is an important part of the doctor-patient relationship. This trust extends to those who work as part of the primary health care team, and would include nurses, physiotherapists and social workers. It also extends to receptionists and medical students. It is very important that you understand the privileged position you are placed in, both in the capacity as an observer in the surgery and visiting patients in their home.

Whenever you meet a patient during your medical training it is wise to check that the patient knows who you are and that you will keep all information confidential. If you keep notes these should be anonymous and kept in a secure place. Note that when patient's can still be recognized from discussion about them even if you don't use names so do not discuss patients outside of the course, or to each other (unless in a confidential learning capacity) and certainly not in public.

Although the preservation of confidentiality is important, it does have limits, for instance, to protect third parties from harm. This is best illustrated by the example of the Psychiatrist who is told by a patient that they will murder someone. Whilst the responsibilities of the Psychiatrist are clear, there are many grey areas that are still subject to debate. These sorts of issues will be dealt with in more detail in your Ethics & Law course.

The General Medical Council provides up to date guidance on the duty of confidentiality and the circumstances under which doctors can disclose information without consent. See their website: http://www.gmc-uk.org/guidance/current/library/confidentiality.asp#1

Aims and Learning objectives of the attachment

Aims – The aims of this placement are allied to the specific knowledge, skills and behaviours set out in Tomorrows Doctors, GMC 2009 as follows: The student will experience General Practice through observation of health care professionals and meeting and interviewing patients. The students will begin to: learn to communicate effectively with patients[1], understand how to behave according to ethical and legal principles[2,] establish the foundations of life-long learning [3], apply the theoretical knowledge of social and biomedical science to patients in primary care[4], and understand the framework within which medicine is practiced in the UK[5]. (see references at end of handbook for a description of the relevant Tomorrows Doctors outcomes.)

Objectives:

By the end of the attachment:

- You will have observed GPs consulting and considered skills that contribute to good verbal and non-verbal communication.
- You will have been introduced to professional behaviour through discussion with your GP tutor and demonstrated maintaining confidentiality and gaining consent to interview a patient.
- You will have had an opportunity to talk to one patient in more depth (long case), thereby practiced early consultation skills, and reflected on the patient's illness narrative and experience of health care though discussion with your GP.

NB. You should be able to direct your own learning with your GP, but you may like to ask to be introduced to basic clinical skills such as taking a temperature, blood pressure and pulse. Also through discussion with your GP you should aim to integrate the theoretical learning from the other elements of the Human Basis of Medicine (HBoM) with the cases you observe.

VERTICAL STUDIES
MB ChB PROGRAMME

Vertical Themes

As well as specialist topics, the Bristol MB ChB programme has six vertical themes that run through all the curriculum years. All themes are introduced during the Human Basis of Medicine Unit. The following logos are used in the handbook to signpost where the vertical themes are also relevant to the GP attachment. Further information about each theme is available on Blackboard.

3D

Disability, disadvantage and diversity (3D). These three components define the patient's environment, function and potential to live a fulfilling life. It similarly affects us as practitioners, and our own personal experience of these components will in turn determine our approach to this theme, and ultimately our practice.

CAPS

Consultation and Procedural Skills (CAPS). Doctor-patient communication is paramount in making and explaining a diagnosis, finding out how an illness impacts on a patient and discussion of treatment options. The GMC has now produced a list of core clinical skills that every student should have mastered before qualification to ensure they are well prepared for work as an F1 doctor.

ETHICS

The **Ethics and Law in Medicine (Ethics)** vertical theme seeks to help students develop awareness and understanding of ethical, legal and professional responsibilities required of them as students and doctors. Students learn to reflect critically on ethical and legal issues and to understand and respect the strengths and weaknesses of views different from their own while maintaining personal integrity.

EBM

Evidence Based Medicine (EBM) and Public Health. EBM is defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." Public health includes actions to promote healthy lifestyles, prevent disease, protect and improve general health and healthcare services for the local and global population.

PAID

Personal, Professional and Interprofessional Development (PAID). Producing a Doctor with personal skills, professional skills, world of work skills and the interprofessional skills required for the role is an essential part of medical undergraduate training. The most highly developed set of skills that the student must acquire are those that characterise professionalism; particularly the ability to function in a workplace, to work in a team and to work with fellow clinicians from other professions.

WPC

Medical Humanities and Whole Person Care (WPC). Medicine exists at a turbulent intersection between scientific and humanistic understandings of life. WPC exists to champion the human dimension. The WPC theme reminds us that, whatever the diagnosis, it always exists within the life of "whole" person. We draw illumination from the wealth of human endeavour that constitutes the "humanities". This includes literature, philosophy, history and the visual arts.

Introduction to primary care

This section reviews important and specific features of general practice and lists common conditions seen.

Common conditions

You may want to look up some of these common conditions (see Figure 1.) seen in general practice.

www.patient.co.uk is an excellent website. GPs often print information for patients from here.

Conditions you are most likely to see (ranked in order):

1. Upper respiratory tract infection
2. Tonsillitis
3. Hypertension (high blood pressure)
4. Gastroenteritis
5. Abdominal pain
6. Low back pain
7. Conjunctivitis
8. Anxiety and depression
9. Urinary tract infection
10. Osteoarthritis
11. Otitis media (ear infection)
12. Eczema
13. Hay fever
14. Asthma
15. Flu like illness
16. Sinusitis
17. Viral warts (veruccae)
18. Headache
19. Fatigue

Figure 1: Common conditions

Organisation of primary care

General practice can be seen as central to the NHS with an estimated 300 million consultations with GPs each year.[1] About 740,000 people (1.3% of the population) consult a GP each day. There are 40,000 GPs in the UK of which 53% are male and 47% female. Each general practice belongs to a Clinical Commissioning group (CCG). There are more that 200 CCGs who have a strategic role in implementing government health care policy and management of funding in primary care and commissioning services from secondary care and other providers. The government has made these changes as it is felt that GPs will be more responsive to the needs of patients as they have day-to-day contact with them. The aim is that this will make the NHS more efficient and improve the quality of care. The local council also has an increasing role. The primary health care system is organised into practices consisting of multidisciplinary teams usually co-ordinated and run by GPs.

Primary health care teams

The primary health care team (PHCT) includes a variety of professionals including: doctors, practice nurses, district nurses, health visitors, physiotherapists, podiatrists, counsellors and more. The patient/carer should also form part of that team. It is important that the team surrounding a patient communicate and work well together in order to provide seamless care e.g. a patient with angina seeing both a nurse and a doctor for their follow up. Each needs to know the care the other provides. The nurses will often work to protocols that have been agreed for monitoring chronic illness conditions such as Diabetes, Hypertension, Cardiovascular disease and Asthma etc. The doctor may review symptoms, medication etc.

Key features of general practice

Apart from working within multidisciplinary teams as explained above, general practice also means caring for individuals within their local community, co-ordinating patient care, offering continuity of care, dealing with a great variety of patient presentations during a single surgery and dealing with uncertainty. The GP is the person with whom the “buck stops”. Those patients who are turned away by specialist care, or who do not fit the criteria for care elsewhere, return to their GP.

[1] Haslam D, Baker R, Baker M, Colin-Thome D, De Lyon H, Graham-Jones S, Heath I, Marshall M, Roland M, Sibbald B, Sweeney K, Wilson T. The future of General Practice: A statement by the Royal College of General Practitioners. RCGP. 2004

Accessing the NHS

Apart from seeing one's local GP, other ways into the NHS include NHS direct (nurse led, telephone, 24 hour service) or NHS Walk-in-Centres (nurse led assessment and treatment for minor illnesses and injuries).

Observing the GP consult

Case Log: There is a case log at the end of this handbook for you to makes notes on some of the patients you see – both to ask questions of the GP and also to discuss in your other HBoM tutorials.

Whilst observing the GP consider if there are any consultations that strike you as challenging or particularly interesting. You can discuss these consultations further with the GP and in SHM tutorials. You can also consider the consultation skills the GP is using and whether these fit with the Cambridge-Calgary model – you can read more about these on page 12.

Things to think about whilst observing consultations

1. How long does the patient talk for before the GP speaks?
2. Find examples of closed and open questions as the GP consults with patients and reflect on the effect this has on the consultation.
3. How did the patient make you feel?
4. What body language did you observe?
5. Use of verbal/non-verbal communication
6. Consultation structure/flow based on Calgary-Cambridge model
7. Any cues/hidden agenda/elephant in room
8. Patient satisfaction

Themes for GP attachments

Sitting in with the GP touches on many aspects of medical care; some are important, specific features of general practice, and some are generally important topics whatever aspect of medicine you end up specialising in. If medical training is viewed like painting and decorating this attachment is part of the undercoat—a thin but essential overview of many topics that provides an excellent base for you to return to and add depth to during the rest of your training, and career.

The following are a list of the topics that this GP attachment is an excellent learning environment for:

- The doctor patient relationship—introducing consultation skills
- Scientific competence—introducing clinical skills
- Narrative based medicine—exploring the patient journey
- Access to care—the organisation of primary care, continuity of care and the medical record
- Lifelong learning— independent learning and reflection skills, self assessment
- Professional skills—self care, team work and peer assessment and support

Your learning in these areas is not just textbook learning and reading material. You should experience them through meeting and listening to patients, observing your GP "in action" and importantly through discussion with your peers and with your tutor. Your GP has unique experience in these areas that they can share with you. There is further teaching material on some of these topics on Blackboard to read.

Integration with other learning Human Basis of Medicine (HBoM)

The primary care attachment is one of five elements in the Human Basis of Medicine course, which runs during the first two terms of the first year of the medical curriculum. The other four elements might intersect with your clinical placement in some of the following ways:

Ethics and law

Resources:
i) What, if anything, about this situation might have put a strain on NHS resources, and how should it be dealt with fairly?
ii) Did you observe any instances of rationing of resources, how did the GP handle the situation?
iii) In a GP surgery how do you think the GP should deal with the conflict of interest in running to time and also giving each patient as much time as they need?

Confidentiality:
i) Have situations arisen where the GP had to be particularly careful to safeguard confidentiality?
ii) Did your GP ever consider breaching confidentiality? Why?
iii) What would you do if a patient asked you not to disclose something they wanted to tell you to the GP?

Autonomy:
i) Which patients have seemed to be more 'empowered' than others?
ii) Have you seen any cases of a patient passing a decision to the GP or to carers/family? Did this help the patient in any way (if so/ not, how)?
iii) Is it important for patients to make decisions about their treatment? What are the limits of this?
iv) How much responsibility do you think a patient has for her own health? (It may be interesting to repeat this question with different cases, depending on the causes of the health problems).

Society, Health and Medicine

1. How does the GP relationship with a patient affect their experience of being ill?
2. Why might a patient who is depressed delay consulting their GP for months or even years?
3. Why might a patient consult a homeopath?
4. How might you enable a person with Parkinson's to live a fulfilling and independent life?
5. How can doctors best support patients when dying?
6. Why do the children of poorer parents get more illnesses than the children of richer parents?
7. Why is living with AIDS more stigmatising than living with cancer?
8. Is the medical profession as important as it used to be?

Clinical Epidemiology

1. In a patient presenting with symptoms of mild depression, what is the evidence for the usefulness of CBT versus pharmaco-therapy?
2. A patient with osteoporosis says that they have heard that calcium may cause heart attacks. What sort of study did this come from? Are the conclusions sufficiently reliable to inform a change of treatment? What is the GP doing in practice?
3. If a woman requests HRT for menopausal symptoms. What could you tell her about the evidence regarding beneficial and harmful effects?

Whole Person Care

1. Did you feel “moved” by what happened in a consultation?
2. Did you ever sense an elephant in the room (a major issue that is palpably present though not directly voiced)?
3. Did a patient ever present with as simple problem but go on to reveal a deeper one (symptom iceberg)?
4. What are the important parts of the system that are connected to this person's presenting problems? (Likely responses to include intimate partners, family, work, religious convictions, drug culture)
5. How could we support this person in their struggle to become more resilient?
6. How important was the doctor's previous knowledge of the patient important in shaping how that consultation went?
7. Did you witness consultations that seemed stressful for the doctor? Why were they stressful? What did you see the doctor doing to manage those stresses?
8. Discuss any examples of the patient or doctor using complementary medicine
9. Did you notice examples of the doctor trying to change behaviour?
10. Did you witness the doctor doing something that seemed "intuitive" rather than strictly rational?

Reading List

You are expected to consult at least two textbooks or journal articles relevant to your primary care experience. See the full MBChB suggested reading list and those specific for your HBoM modules. In addition, the applied cases should be referenced as evidence of some of your reading. The following references may also be useful:

- Bub B. Communication skills that heal: a practical approach to a new professionalism in medicine. Oxford: Radcliffe Publishing Ltd 2006.
- Helman CG. Culture, Health and Illness, 4th edition, Oxford: Butterworth Heineman 2000.
- McWhinney IR. Textbook of Family Medicine, 2nd edition. Oxford: Oxford University Press 1997.
- Myerscough PR, Ford M. Talking with Patients. Oxford: Oxford University Press 1996.
- Sackett DL et al. Evidence-based medicine - How to practice and teach EBM, 2nd edition. Edinburgh: Churchill Livingstone 2000.
- Scambler G, editor. Sociology as applied to medicine. 4th edition, London: W.B. Saunders 1997.

Introducing consultation skills

Development of good consultation skills is an essential part of undergraduate medical education. For research relating to the importance of good communication: http://www.skillscascade.com/files/commresearch.htm

Objective for consultation skills in Year 1:

- Students should be proficient at listening to patients and respecting their views and beliefs
- Students should be able to reflect on consultations they observe or experience.

You will have been introduced to these objectives during the introductory session, and interviewing a patient on the home visit is a chance to practice these skills. You will also observe your GP consulting and consider how they use open questions and listening skills to draw out the patients’ story (see above: observing the GP consult for ideas of things to look out for).

The point of good communication is to be able to develop a shared understanding of the patient's problem and what management they hope for. The Cambridge-Calgary[2] consultation model will be used throughout the student curriculum, summarised below:

In addition, if you want to read/learn more about the consultation, see the Blackboard Learning Materials, Essential Clinical Communication. This is a seven-part tutorial series developed by the UK Council of Communication Skills Teaching in Undergraduate Medical Education.

Cambridge Calgary Consultation model

INITIATING THE SESSION –
Establish rapport - Identify reason(s) for consultation

GATHERING INFORMATION –
Explore problem – encourage patient to tell their story
- Elicit the patient's ideas, concerns and expectations

BUILDING THE RELATIONSHIP –
Develop rapport (non-verbal behaviour, show empathy)

EXPLANATION AND PLANNING –
Provide information - Achieve shared understanding
- Give explanations - Share decision making

CLOSING THE SESSION –
Summarise session and clarify plan of care
- Safety net

Patient-centred practice

In consulting with patients the doctor's agenda may include making a diagnosis, finding the right treatment and detecting any serious illness. It may also include getting through the consultation quickly because they are running behind or trying to make a patient change a behaviour that is harmful to their health. The concept of patient-centred practice means discerning the patient's agenda and addressing this, interwoven with a clinically competent practice. Addressing does not mean being able to meet all patient desires, but to take their hopes into consideration, explaining where these go beyond possibilities of what we can offer as their GP.

The patient's agenda may become obvious within the first minute of arrival e.g. wanting more treatment for their eczema. However it may also not be so clearly formulated in the patients mind (they just don't feel well and want some kind of help to feel better) or it may be hidden – they are afraid to mention their real concern (for example not mentioning their thoughts that their cough may be due to lung cancer or asking the doctor about their sore throat but really wanting to talk about their panic attacks).

What our patients tell us will depend on our questions, the space we give them to talk and the trust between us. Helpful questions that might uncover more of the patients' perspective can be remembered with the acronym ***ICE***:

IDEAS --what does the patient think is going on?
CONCERNS--what is the patient's main concern about their problem?
EXPECTATIONS--what was the patient hoping that you would do today?

[2] Kurtz SM, Silverman JD. *The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmes*. Med Educ 1996; 30(2):83-89.

Active listening

Why do we emphasis listening as a consultation skill? Dame Cicely Saunders, founder of the Hospice movement in this country, said, "When someone is in a climate of listening he'll say things he wouldn't have said before." [3]

Listening is a key "tool" you can use as a doctor to help draw out the history from the patient. The history is key in making an accurate diagnosis, and in many cases the clues are in what the patient tells you rather than high tech investigations (although they have their place.) In your training you will learn to "take a history", that is learn a systematic way of asking questions about why the patient has presented (come to see you, called you or come into hospital) to give you the clues as to what the diagnosis might be and where to go next e.g. reassure, order further investigations, treat or refer the patient. However often the patient tells you the answers to lots of the questions you'll have if you allow them to open up and show that you are really listening, interested and engaged. Above all remember developing our listening and dialogue skills is an ongoing process.

Listening is also therapeutic for the patient, the patient feels heard and understood. The personal impact of the doctor upon his patient was examined by the psychoanalyst Dr. Michael Balint (1957)[4] who pointed out that by far the most frequently used drug was the doctor himself, i.e. that it wasn't only the medicine that mattered, but the way the doctor gave it to his patient. Listening is giving yourself to the patient. The quality of the doctor-patient interaction is not just affected by how much you know as a doctor or what technical or consultation skills you develop but also your attitudes, maturity, kindness, emotional intelligence. It's not just what you do, but also who you are.

> *"I see no reason or need for my doctor to love me, nor would I expect him to suffer with me. I wouldn't demand a lot of my doctor's time, I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness…"*
>
> *(Anatole Broyard, literary critic and an editor of The New York Times Book Review, died of prostate cancer in October 1990)*

Listening can improve relationship between doctor and patient and can aid reaching a joint understanding of the person and their situation leading to more relevant information gathering and joint problem solving. For example a GP may find a patient frustrating as they attend with a lot of vague symptoms that the doctor can't get to the bottom of, and often don't turn up for booked appointments. When the doctor asks why, and really listens, the patient opens up about their alcohol problem. The patient and doctor now share the understanding of the problem, and can work together on it.

Questions to think about:

- How do you know if you are really being listened to?
- How does being listened to affect your ability to talk?
- How does it feel when you are really being listened to?
- What other things encourage you to talk? What blocks listening?

Observing others or yourself (self-reflection) listening:

HEADSPACE

- Making someone feel like they are the most important person in your world at that time. Often only you will truly know if this is your attitude to the person in front of you but it can be felt by the patient and picked up on by observers as being attentive.

VERBAL

- What is tone and volume of voice? Does this help or hinder listening?
- Look for clarifying questions "You said it hurts, can you tell me more about the pain?" but this can just be a word asked in a questioning tone to encourage more detail: "Painful?"

- Look for summarising what was said “So let me see if I’ve got this right? The pain came on gradually over the last 3 weeks but it started hurting before you did the gardening.” this demonstrates understanding and gives the patient the opportunity to correct you.
- Use of silence. Silence can be a very powerful tool to allow the patient time to say what they really want to say, but it can feel hard to hold at first, concentrate on non verbal listening skills such as nodding and waiting attentively rather than what you are going to say next.
- Look for encouraging phrases e.g. “umm”, “I see” that show listening

BODY LANGUAGE eye contact, no fiddling, nodding, smiling, open posture

THINGS THAT BLOCK LISTENING

- Your mood: being tired, stressed, or having your mind on something else
- Thinking of next question
- Looking at the computer or your notes
- Making judgments about the person or assumptions about the scenario

Open and closed questions

When we gather information from the patient we want to use a variety of questioning styles. Usually in the GP consultation open questions are used initially to find out why the patient is consulting or what is going on for them. Although GP’s use listening skills they need to be focused, and open questions help the patient know what aspect of their story the GP wants to hear about. Usually the GP focuses down on the extra information to be clear about what is going on or to form a differential diagnosis with closed questions. Closed questions can be particularly useful to rule things out. For example if you ask about patient if “there is anything else you’ve noticed?” they may still not think their weight loss is relevant or anything to worry about so “Have you noticed any weight loss recently?” clarifies for the doctor whether this is the case or not.

<u>Open questions</u>

- Helpful when exploring the problem e.g. “tell me about your sore throat”
- Allow the patient to direct the conversation and the history to flow in a non-threatening way, helpful at the start of the consultation.
- Too many open questions might lead to disorganised tangle of information and digression away from issue at hand.

<u>Closed questions</u>

- Usually result in a narrow yes/no or brief statement response
- Helpful to clarify responses and explore possible diagnoses
- Can rule out symptoms
- Too many closed questions might lead to missing what the patient wanted to say, also if used too early in the consultation rather than letting the patient tell their story

Meeting with a patient/home visit

During your two days, each of you should have an opportunity, alone or in pairs, to talk and listen to a patient at depth (for 30-60 minutes) either in surgery or as a home visit. You should then describe and reflect on what they have heard and learnt from the patient with your GP tutor. Do think about the consultation skills described above, active listening and open/closed questions during these encounters. The A100 student GP study guide is available on Blackboard and has further information and suggestions for questions etc for these encounters, and is available on Blackboard should you wish to read it.

Clinical skills (adapted from year 2 competence forms)

You should have an opportunity to learn and practice these and other skills during your placement. In year 2, you will be given a logbook, and during the following 4 years you will be observed and signed off for successfully carrying out these and other skills.

Taking a temperature

- Explain procedure and obtain consent
- Ask patient if they have any ear problem
- Wash hands
- Check thermometer is working
- Apply new cover for ear probe
- Hold pinna and pull backwards and upwards (for adult)
- Insert ear probe into auditory canal and press record button
- Share reading with patient
- Dispose of ear probe
- Document reading in notes
- Interpret reading and discuss with patient. Decide if further action/investigation is necessary

Measuring pulse rate and rhythm

- Explain procedure and obtain consent
- Wash hands
- Ensure that patient is comfortable and rested, with arm supported
- Ensure that site of radial pulse is exposed
- Position fingers (2 or 3) correctly over radial pulse
- Use pads of fingers to assess rate and rhythm of pulse over a period of at least 15 seconds (one minute if irregular). This time must be recorded accurately.
- Calculate rate, expressed as beats per minute
- Describe rhythm of pulse
- Explain findings and their significance to patient
- Record pulse correctly in notes
- Decide if further examination/action is necessary

Competence in measuring blood pressure

- Explain procedure and obtain consent.
- Ensure that patient has rested.
- Check sphygmomanometer and stethoscope are clean and in good working order.
- Select arm that is most comfortable for patient (if equally comfortable student should chose right arm).
- Ensure that patient's sleeve is rolled up high enough for cuff to be applied.
- Ensure that patient is comfortable with arm extended and supported, so the brachial pulse is at the same level as the heart.
- Choose correct size cuff. Length of bladder should be >2/3 of circumference of arm. Width (height) of bladder should be >1/2 circumference of arm.
- Wrap cuff around patient's arm so that the centre of the bladder is above the brachial artery and the lower border of the cuff is 2-3cm above the antecubital fossa.
- Position sphygmomanometer so that it is facing them (the student) with the gauge level with their eye.
- Palpate the brachial artery and make a rough assessment of its rate and rhythm. Keep thumb or fingers on the brachial pulse
- Inflate the cuff with the hand bulb until the brachial pulse can no longer be felt and make a mental note of this pressure
- Inflate the cuff by another 20-30mmHg
- Quickly place diaphragm of stethoscope over the brachial pulse and begin deflating the bladder, whilst listening with the stethoscope.
- Deflate the bladder at a speed which is proportionate to the patient's pulse, so that the blood pressure can be measured to 2mmHg. So if patient's pulse is 60bpm, deflate by 2mmHg every second.
- Note the pressure at which the 1st Korotkoff sounds appear (systolic)
- Note the pressure at which Korotkoff sounds completely disappear (diastolic)
- Release the valve in order to deflate the bladder completely
- Remove the bladder from the patient's arm
- If Korotkoff sounds did not disappear repeat the measurement but this time note the point of muffling (the 4th Korotkoff sound)
- Repeat the reading if first reading is abnormal
- Explain the result to the patient and record the result in the patient's notes

Prescribing

About half of the medicines prescribed for people with chronic conditions are not taken[5]. Only 43% of patients take their medicine correctly as prescribed to treat acute asthma and between 40% and 70% follow the doctor's orders for depression medication. The media recently has focused on the risks and high rate of errors in prescribing and the impact of this on patient care.

We are keen for you to observe prescribing and get a feel for issues surrounding this. As you have not yet studied Pharmacology or done any clinical Medicine, you are not expected to be familiar with any specific medications. However, you may be encouraged to look up your patient's medications in the BNF (prescribing formulary). Similarly, when you are observing consultations and chatting with patients, think about the stages of prescribing, risks and benefits of giving medications and what affects how well(if at all) the patient adheres to the medication.

You may also consider:

- The role of prescriptions in the doctor patient relationship
- What does the patient want?
- What does the doctor think the patient wants?

Assessment and Feedback on the course:

There is no formal assessment of this two day attachment as time is limited. You will be informally assessed by your GP on your professional behaviour and attitude. This is more formally assessed in your clinical years, but at this stage includes your dress code, attendance and punctuality, absences explained, respect for patients of all backgrounds, for colleagues and the other members of the health care team, maintaining patient confidentiality and the ability to express an opinion and to actively participate in discussion. There is feedback form that you will complete with the GP tutor which involves you both considering strengths and further learning needs and areas for development

You will also be asked for your feedback on the course. Your GP puts in a lot of work into organizing the placement; giving your views on what went well and where you think it could be improved is valuable and respects the effort your tutors put in, and helps us to improve the course for next year's students. Giving feedback is a skill and there are the same rules to adhere to: see below regarding this.

Principles of giving feedback

Feedback should be carefully thought through and based on the objectives provided. Good feedback should be:

- Constructive
- Specific
- Descriptive
- Objective, non judgmental
- Timely
- Given within supportive environment

Chatting with a patient/home visit record

Home visit reflective template - Background information	
Date	
Patients age/sex/ethnicity	
Brief summary of patients' story.	
Any other issues raised.	
Reflection	
One word to summarise this visit experience.	
What did I do well?	
One thing which challenged me.	
One thing which surprised me.	
What have I have learned?	
How did this visit make me feel?	
Any learning needs resulting?	

Case Log:

Age/sex	Problem	How GP dealt with	Learning points	Link with HBoM
36F	Failed contraception	Discussion options	Missed pills, action of contraceptive pill, efficacy	Ethics –what are her options, rights of the mother vs baby
30 M	Depression	Open q's, listening, explored patients desires and beliefs. Plan to cut back alcohol, reading material and review.	Risks of depression. Prevalence in general practice. How to assess suicidal risk. Affect of alcohol on mood.	Clinical Epi—evidence of drugs vs CBT SMH—stigma, WPC—encouraging resilence, see pt as whole in context
This is a space to note down any cases that are interesting or may spark debate – either within your GP attachment or as cases you can bring up in tutorials in the other elements of the Human Basis of Medicine Course (see previous page for examples).				
Age/sex	Problem	How GP dealt with	Learning points	Link with HBoM

Age/sex	Problem	How GP dealt with	Learning points	Link with HBoM

Other learning points:

"Tomorrow's Doctors": References relating to course aims

[1] "*Communicate effectively with patients and colleagues in a medical context*." Paragraph 15, Outcomes 3—The doctor as a professional. General medical Council *Tomorrow's Doctors* (2009). [on-line]. Available from: http//www.gmc-uk.org [Accessed 20/08/11]

[2)] "*The graduate will be able to behave according to ethical and legal principles*." Paragraph 20, Outcomes 3—The doctor as a professional. General medical Council *Tomorrow's Doctors* (2009). [on-line]. Available from: http//www.gmc-uk.org [Accessed 20/08/11]

[3]) "*Establish the foundations for lifelong learning and continuing professional development*" Paragraph 21(b), Outcomes 2—The doctor as a professional. General medical Council *Tomorrow's Doctors* (2009). [on-line]. Available from: http//www.gmc-uk.org [Accessed 20/08/11]

[4]) "*Apply social science principles, method and knowledge to medical practice*" Paragraph 10, Outcomes 2—The doctor as a scholar and scientist. General medical Council *Tomorrow's Doctors* (2009). [on-line]. Available from: http//www.gmc-uk.org [Accessed 20/08/11]

[5]) "*Understand the framework in which medicine is practised in the UK*" Paragraph 23(c), Outcomes 2—The doctor as a professional. General medical Council *Tomorrow's Doctors* (2009). [on-line]. Available from: http//www.gmc-uk.org [Accessed 20/08/11]

Feedback form

See below. This can be cut out and sent back to the University – or you can print or complete the electronic copy – thank you

FEEDBACK FORM 2 IN 1 GP PLACEMENT MARCH 2014

STUDENT NAME:

GP PRACTICE:

STUDENT FEEDBACK
3 THINGS I LEARNT:
3 AREAS I WOULD LIKE TO LEARN MORE ABOUT:
THINGS I ENJOYED ABOUT THE PLACEMENT:
ANYTHING THAT WOULD IMPROVE THE PLACEMENT:

GP TEACHER FEEDBACK

STUDENT STRENGTHS:

AREAS FOR DEVELOPMENT:

OTHER COMMENTS:

GP Teacher: Please give each student a copy of this form and also send a copy to PHC with your payment and feedback form