Year 1 Primary Care Attachment

Human Basis of Medicine (HBoM)
Academic Unit of Primary Health Care

GP Teacher Guide, 2013-14

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Contributors

Dr Louise Younie first wrote this handbook and is credited with much of the material, with thanks to all the contributions and suggestion from GP teachers, students at Bristol Medical School, course organisers on the Human Basis of Medicine Course in the Academic Unit of Primary Care since this handbook was first produced. This edition was rewritten and edited by Dr Jessica Buchan (August 2011) and has been reviewed and amended in August 2012 and 2013 by Dr Lucy Jenkins.
(Review due August 2014)

For course information not included in this book, please see:
*http://*www.bris.ac.uk/primaryhealthcare/teachingundergraduate/year
Within this site, the following is an excellent resource for GP tutors:
http://www.bris.ac.uk/primaryhealthcare/teachingtutors/

NEWS UPDATE

- Students placed in practices outside of zone 1 (City council bus limits) can claim back their travel expenses from the University.
- The small group introductory session (8th October) is again being facilitated by trained Communication skills actors. Student feedback on this was excellent in that they felt well prepared for early patient contact, in particular the home visit.
- The simplified assessment process (piloted last year) is to continue. Student work is to be assessed using the same descriptors, by a triad of self, peer and GP teacher assessment and each student will be given written and one-to-one qualitative feedback from GP Teachers (in response to student requests and GMC guidance).
- GP Teachers no longer have to upload feedback to Blackboard. Instead you can send the completed feedback to Dr Jenkins who will upload it.
- As of 2012, students are no longer graded on professional behavior in any GP placement. Instead, any concerns must be discussed and addressed via a student concern form – see page 6 for more information regarding this.
- The Academic Mentor Scheme is now up and running and if you wish to become a mentor, please contact chris.cooper@bristol.ac.uk for more information.
- GPs still have the opportunity to apply for Honorary Teacher Positions at the University, see http://www.bristol.ac.uk/primaryhealthcare/teachingtutors/
- For the second year in a row, students nominated GP teachers for prizes which were given out at the summer workshop and the graduation ceremony. This process will be repeated this year.
- GP Soc - The Undergraduate Society for Primary Care is flourishing with their own mini conference and an evening with Clare Gerada last year and more events planned for next year.

Key Information

The primary care course begins with the **Introductory Session October 8th 2013**. A lecture by Professor Chris Salisbury provides an overview of general practice and subsequently the nuts and bolts of this course and its assessment. Students are then divided up into small groups for a session led by our specifically trained consultation skills actors. The aim of this session is to introduce the students to communication skills e.g. generate the principles behind initiating a consultation, active listening skills and the importance of reflection. They also role play a home visit to increase their confidence when they start speaking with patients in practice. Students are given details of their general practice attachment during this afternoon (location, lead GP and key contact in practice, other group members, directions, dates etc).

GP Attachment Dates

1st semester (previously the Autumn term) –Half day session once weekly on either Tuesday mornings or afternoons from 15th October – 3rd December 2013 (or Wednesday afternoons for some surgeries)

2nd semester (previously the Spring term) – Half day session once weekly for 8 weeks on Thursday afternoons from 23rd January – 13th March 2014. (Please note- the student AGM is 6th February; please allow students to leave early on this day if they are planning to attend)

GP Teacher workshops

Each year in September (17th September 2013) there is a workshop for year 1 GP teachers. This is to keep GPs up to date with course changes and for sharing experiences, teaching tips and ideas. Reports from workshops in previous years will be available on the PHC website, as are details of the annual Teaching Inspirations workshop in the summer for teachers in all years. Details of this will be emailed through nearer the time, and included in the newsletter.

Payment for teaching

You will need to complete the attendance and payment form at the end of the placement to trigger payment. A copy of this will be emailed to you, and can also be found in appendix 9.

Teacher Guide

This guide gives an overview for running this course. It is designed for quick access to key information. There will more information on teaching and topics for discussion with students and assessments available on Blackboard (see below) and in the primary health care website: *www.bris.ac.uk/primaryhealthcare/teachingundergraduate/year*. We can email you a copy of the student guide if you wish.

Blackboard (online learning environment)

Blackboard is the University online learning resource: *www.ole.bris.ac.uk*. Students use this for many of their other medical training elements. There is lots of useful information and also you and your students can find examples of students' assignments from previous years (the Reflective Assignment was previously divided into essays and creative pieces so is filed under these headings).

***www.ole.bris.ac.uk*. Course = MEDI10005: Year1 – HBOM-Introduction to Primary Care element.**
You have been enrolled in the Year 1 GP placement course and need the usual GP login and password. This can be provided if you would like it. Please note, you need to use the Guest Login.

Student attendance

Student attendance should be 100% for all teaching. Students are advised that any absence through sickness or another reason must be communicated to the GP by phone or email prior to the session they will be missing. Students are also required to report any unplanned absence to the course administrator via phc-teaching@bristol.ac.uk and the university via a central link. **When we ask for feedback at the end of the attachment we will ask you to comment on absences so do keep a record of student names, session(s) missed and reason given for absence as this is fed into a central database**.

Student travel

Students may ask you about this. A recent change is that students can now claim reimbursement for travel expenses if they attend a placement in zone 2 or 3 (Bristol city bus networks). There will be information in their year 1 handbook regarding eligibility and the claim process.

Student support

Students may look to you for pastoral care and support. Students in Years 1&2 can access support through: The Faculty Student Advisor, Ros Forge: 0117 9288444, http://www.bristol.ac.uk/medical-school/staffstudents/support/ or the Pre-Clinical Dean (Dr Eugene Lloyd, Eugene.Lloyd@bristol.ac.uk). Details of University central student support services are available at: http://www.bris.ac.uk/studentservices/

Please see appendix 10 for a comprehensive guide, protocol and flow chart for dealing with concerns about a student. This can also be found at http://www.bristol.ac.uk/primaryhealthcare/teachingtutors/ - the precise link being 'Protocol for GP Tutors dealing with student concern', which can be found in the centre of the page

The student concern form (SCF) is in appendix 11 and at: http://www.bristol.ac.uk/medical-school/staffstudents/student/forms

The **academic mentorship scheme** has now been rolled out in all years. Every student has a mentor, they meet twice each year and review together the students e-portfolio. Their focus is more on educational and professional/career aspects than pastoral support. Year 1 students have their first meeting in the second semester. Please contact chris.cooper@bristol.ac.uk for further details if you are interested in becoming an academic mentor.

Staff Contact Information

Academic Unit of Primary Health Care, School of Social and Community Medicine, Canynge Hall, 39 Whatley Road, Clifton, BS8 2PS – http://www.bristol.ac.uk/primaryhealthcare/

Element Lead	Dr Lucy Jenkins	Lucy.Jenkins@bristol.ac.uk
Element Admin	Alison Capey (until Nov) Jacqui Gregory (after Nov)	All enquiries to be directed to phc-teaching@bristol.ac.uk 0117 3314546

The Primary Care Attachment in Year 1

Introduction

The students are in their first year of the medical course. There are approximately 250 students per year. The majority of students will not have had any clinical contact before. This is their only opportunity to meet patients in their first year; it is a wonderful introduction to clinical medicine and also puts the rest of their first year learning in context. They are also introduced to some of the "vertical themes" that run throughout their medical course. Feedback consistently shows they really enjoy this element.

"Seeing real patients so early on reminded me why I had come to medical school and was a welcome contrast to the science we were learning at the uni " – Year 1 student 2013

"My GP tutor was an inspiration and I learned a lot about the human side of Medicine. I particularly enjoyed the opportunity to meet patients in their own homes and hear about their lives and discussing this as a group afterwards"

Year 1 student 2012

"The students are a breath of fresh air, their enthusiasm and inquisitive minds mean that I always enjoy the teaching. It is an opportunity to reflect on being a GP and I often learn more about my patients too" GP Tutor feedback, 2013

Your commitment as a year one teacher:

- Commit to teaching the eight half day sessions per block (or arrange suitable cover)
- Be welcoming, and enthusiastic about teaching
- Create a supportive learning environment
- Organise home visits for pairs of students
- Organise "teaching surgeries" so the students can observe you consult
- Help students make links between the patients they see, the GP attachment themes, and themes from the other Human Basis of Medicine (HBoM) elements
- Assess two assignments: the Reflective Assignment and the Applied Case
- Identify students that cause concern and act on this
- Give comprehensive, clear and useful feedback to the students
- Submit final grades, and feedback for individual students to the course organiser
- Fill in GP feedback form (on line) at the end of the placement

Summary of the attachment (minimum must read)

If medical training is viewed like painting and decorating the GP attachment is part of the undercoat—a thin but broad and essential overview of many topics that provides an excellent base for the student to continually return to and add depth during the rest of their training, and careers. In this way students are introduced to a number of the outcomes and standards for undergraduate medical education set out by the GMC in *Tomorrow's Doctors 2009* [1].

Aim

The student will experience general practice through observation of health care professionals and meeting and interviewing patients. The student will begin to: learn to communicate effectively with patients, understand how to behave according to ethical and legal principles, establish the foundations of life-long learning, apply the theoretical knowledge of social and biomedical science to patients in primary care, and understand the framework within which medicine is practiced in the UK.

Objectives:

- The student will observe GPs consulting and consider skills that contribute to good verbal and non-verbal communication

- The student will develop professional behaviour through discussion of expectations in the introductory session and discussion of ethical principles with their GP tutor. The student will demonstrate maintaining confidentiality during their attachment and gaining consent to use patient narratives in their assignments.

- The student will conduct an interview with a patient during a home visit practicing early consultation skills, and reflect on the patient's illness narrative and experience of health care. This is assessed in the Reflective Assignment.

- The student will be competent at basic clinical skills including taking a temperature, blood pressure and pulse.

- Students will integrate theoretical learning from the other elements of the Human Basis of Medicine (HBoM) with clinical practice to better comprehend being a doctor in the NHS through discussion with the GP tutor, this is assessed in the Applied Case.

- Students will practice self assessment and experience peer assessment of their work and develop skills to give feedback on colleagues' work.

Phases of teaching: phase 1 = 1st and 2nd semester; consists of HBoM and MCBoM as below. Phase 2 starts in the second semester and encompasses year 2 as well with systems based teaching.

The primary care attachment forms one element of a course in the first year known as:

The Human Basis of medicine (HBoM)

This course consists of 5 elements:

- Society, Health and Medicine (1st semester)
- Primary Care Attachment
- Clinical Epidemiology (1st semester)
- Ethics and Law in Medicine (2nd semester)
- Whole Person Care (2nd semester)

Human Basis of Medicine (HBoM) integration

To help the students make links between what they are learning in the other elements of this course with the patients they see with you:

1) There is an outline of the different elements and some sample questions to use with the students in this handbook (see weeks 2-7)
2) You will be emailed an outline of the lectures the students are getting each week (with a link to lecture notes and more information available on Blackboard for those of you who would like more).

Molecular and Cellular Basis of Medicine (MCBoM)

In parallel with this course the first year the students also undertake the “Molecular and Cellular Basis of Medicine” course. This provides them with the science knowledge base necessary for later teaching and to bridge the gap between the courses they have followed at school and the more applied studies involved in the MB ChB. Elements include: The Body and its Organisation, Cellular Activity, Excitable Membranes Nerve and Muscle, Metabolic Homeostasis, Intervention in Homeostasis, Genetic Disease, Nutrition and Metabolic Disease, Infection and Immunity, Cancer and Cell Proliferative Disease. In phase 2 in the second semester, students learn the Anatomy, Physiology, and Biochemistry of these elements in relation to “Systems of the Body 1a” covering the Cardiovascular and Musculoskeletal Systems.

Vertical themes

VERTICAL STUDIES
MB ChB PROGRAMME

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.

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.

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.

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.

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.

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.

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.

Quick overview of GP placement

- **Week 1**: Time to get to know your students and an introduction for them to general practice – including hearing about your surgery and patients, meeting the staff, tour around the health centre. Also to discuss the course, the plan for future weeks, seeing patients on home visits and at the GP surgery, the assignments and hand in dates etc.

- **Week 2-7**: 1-2 students sit in with GP, the others visit patients in their homes in pairs.
    - After visits and surgery there should be opportunity for discussion, feedback and questions as a group with the GP teacher.

- **Week 7**: Two assignments are to be handed in (to give GPs time to assess)
    1. Applied Case: essay, 1500 words; apply theory to learning experiences with patients, for example consider Dr-Patient relationship illustrated with two patient cases.
    2. Reflective Assignment based on 1 home visit. This can be prose: a first or third person narrative of 2000 words which includes at least 500 words of reflection, or a piece of art, music, poem, dance or film with 500 words of personal reflection and learning.

- **Week 8**: Feedback session – self and peer review of work and time for you to give feedback on student assignments and their time in general practice. You could ask for verbal feedback from students. They also have an online written questionnaire to complete on line so please allow computer access to ensure this is done.

Organising the Student Placement

Preparation before the student arrives

Contact with your students prior to the attachment

Students are given your name and contact details at the introductory lecture. One student from your group is nominated to contact the surgery and confirm arrival time, resolve any queries about how to get there and anything they should bring with them. You may consider taking the lead student's phone number in case you need to contact them again. You may like to confirm details (including directions to the practice) in writing e.g. email.

Creating a timetable

It is useful to read through the suggested format for week one, weeks two to seven and week eight over the following pages and consider how you are going to best organise the time, prepare the patients, and prepare the surgery (especially reception).

Tasks prior to students arriving

Find and contact patients for the home visits. There is a letter you can send/give to these patients in appendix 3. We can email a copy of this if you like. Finding patients Essentially any patient who is happy to talk about their illness and their healthcare would be a good choice for the first years to visit. The visits can last up to one hour, so you may need to consider how much energy the patient has. Further considerations might include how reliable they are (in terms of being at home when the students arrive) and the possibility of people being too unwell to be seen. Having said that, students have visited carefully chosen patients who are terminally ill, or who are recovering drug addicts/alcoholics and these have often proved to be very fruitful encounters. Some suggestions from previous GP teachers: • New mums • Problem drinkers/drug users (may be unreliable so useful to have a backup plan) • Children with a disability e.g. Cerebral palsy • Someone with a story to tell who talks easily • Terminal patient • Fit elderly patient with multiple pathologies • Students like to see young people • Patient with: diabetes and complications, COPD, brittle asthma, stroke or heart disease, long term back pain (off work) rheumatoid arthritis, bipolar disorder etc
Decide on length and format of your surgeries for weeks 2-7 (typically 4- 6 patients with gaps for discussion). The students usually cannot arrive before 2pm and need to leave at 5pm. They need introductory time/ time to settle on home visits at the beginning of each session and a group debrief at the end of each session.
Which rooms will be available for the sessions? Consider if your consulting room is big enough for the whole group at discussion times or what space you will use. Especially in week 8 it is useful to be able to divide the group so that while you are giving individual students feedback the other students can have computer access to fill in their online feedback form.
Prepare surgery team: How are the reception staff going to brief patients booking for the teaching surgeries? Consider giving receptionists written information to read to the patient when they book and also print out a notice to have on the reception desk/room door (see appendix 1) or displayed near the automatic check in if you have one. Patients need reminding when they arrive that a student will be present in this surgery unless they request otherwise.
If possible the students really value a timetable that is drawn up in advance and which acts as a guide for the next 8 weeks – see appendix 4 for an example of this

Week 1: the students arrive: meeting and greeting

Tutor Tasks for session 1:

1) Get to know your students and help them feel comfortable, elicit and address concerns.
2) Introduce them to the practice and the area.
3) Some GP walk the students round the local area ending up in a café for the initial session; this enables the students to get an idea of the demographics of the GP's patient population.
4) Some GPs will bring a patient in to chat to the students as a group to get them used to chatting to patients before the home visit.
5) Discuss the plan for the coming sessions – try use a timetable as in appendix 4. Ask then about the type of cases they would like to see.
6) Outline expectations: student responsibilities, and professional behaviour. Also discuss medical indemnity.
7) Discuss group rules and feedback rules.
8) Discuss the assignments, deadlines for submission and signpost the final session.

Meeting your students – Relational

Inform practice staff – Let reception know that students are coming and give them a place to wait (housekeeping – bags etc, where to go, coffee).
Create a safe learning environment – Encourage questions. Remember students may not know each other well and may feel nervous at meeting health professionals and patients.
Find out a bit about your students – e.g. previous experiences with doctors (as patient or amongst their family or friends), what they did prior to University? Feel free to try any ice breaker activities at this stage
Ask students to reflect back on previous experiences with doctors – not the specifics, just remembering the associated emotions and perspectives – discuss as a group.
Tell them a bit about yourselves; students often comment on how much they enjoy getting to know a GP and hearing your perspectives. What is it like to be a GP?
Check their learning agenda –hopes and fears? How do they like to learn? Any particular learning needs?
Pastoral – anything you need to be aware of such as someone sick in their family (they might like to talk to you in private after the session). How are they finding the course so far/coping with the adjustment of University? Housekeeping: How was their journey to the surgery? What time do they need to leave to get back in time for meal times in their hall of residence?

Meeting your students – Informational

Show them round practice and introduce to staff – you could ask members of the primary health care team to introduce themselves and explain their role.
Information regarding your practice patients and area – e.g. rural, urban, deprived etc. *You could suggest they walk around the patch and notice housing types, closed down shops and numbers of people overweight, smoking, elderly, young, those with walking impairment etc.*
Introduction to surgery "processes" – health and safety in the surgery, records, repeat prescriptions, referrals, computer use .
Confidentiality and professional behaviour – it is essential to discuss these issues with your students including the importance of consent and anonymity of patients in assignments (see below) .
Talk about being with patients and making home visits – address questions or concerns e.g. what if a patient becomes emotional, what if the patient divulges information and asks the student not to inform the GP (see Home visits - student information further in this guide).
Course overview: Plan for next 7 weeks, including overview of the assignments (see more info further in this guide) and their hand in date (week 7). Ascertain if anyone has reasons to be late for hand in. Signpost the final session in week 8 as a time to draw together final questions/address topics that remain unclear so they may wish to keep a list.
Clinical skills – this is a good time to go over taking pulse, temperature and blood pressure with the students. See protocols page for this further in this guide.

Student responsibilities and professional behaviour

PAID

In *Tomorrow's Doctors* 2009 the GMC states that: The graduate will be able to behave according to ethical and legal principles. Understanding what this means is one of the aims of this course so please make your students aware that they 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

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 their own health and seeking help if their 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*

Medical Indemnity

The latest guidance from the UK Departments of Primary Care states that GPs who teach undergraduate medical students should:

- Inform their professional indemnity organisation (MDU/MPS) that they teach students.

- **Check that the student has his/her own professional indemnity (students are advised to do this at the start of the course and can obtain free membership of the MDU/MPS)**
- Take care to brief the students on Health and Safety Issues in the workplace

Confidentiality and consent

Students need to be aware that patients often talk to them and trust them as a member of the medical profession whatever stage they are at; from day 1 they are placed in a very privileged position both in the capacity as an observer in the surgery and visiting patients in their home. Confidentiality is enshrined in law through the right to privacy, and is an important part of the doctor-patient relationship. **Whenever they meet a patient during their medical training they should: Carry ID, check that the patient knows who they are, and that they will keep all information confidential within the medical team. Any notes that the student makes should be anonymous and kept in a secure place. This also applies to their written assessments where names should be changed or written as Mr A, Miss R etc. They should take the letter for home visits with them that is in their student study guide (also see appendix 3) and include a sentence in their assignments stating that the patient has given consent to their story being used. Please remind students not to talk about patients on the bus on the way home, or leave notes lying around.**

The General Medical Council provides up to date guidance on the duty of confidentiality with case studies. Try visiting its website:
http://www.gmc-uk.org/guidance/current/library/confidentiality.asp#1

Group rules

You and your students are going to spend the next 8 weeks together. It is important that they understand the basis of working together as a team. It could be worth going over some ground rules; you can form your own as a group but ideas include:

1) Confidentiality: What is discussed in the group stays in the group and is not discussed elsewhere (unless serious concerns are raised).
2) Respect: listen to each other, everyone's opinion counts.
3) Safety: participate, everyone has something to offer.
4) Time out: how to leave the group or call time out if necessary.
5) Peer learning: be willing to learn, follow feedback rules

Assignment

Students will be greatly helped with the Applied Case and the Reflective Assignment if they have opportunity to discuss what is required early on how you would like them to submit work to you and whether you are prepared to offer students feedback on a draft version before the hand in date (should enhance learning – to have specific feedback and the opportunity to act on it).

Weeks 2-7:

In these sessions some of the students will observe you consult with patients and discuss the issues raised by the consultation related to the GP attachment and HBoM themes with a view to exploring these further in their Applied Case. They should also have a chance to try out basic clinical skills. The other students will take it in turns to go (in pairs) on a home visit to interview a patient in detail

about their experience of illness and/or contact with the health care services. The student should be encouraged to reflect on this narrative in the Reflective Assignment.

Tasks before the students arrive:

Check the home visit patient/s are expecting the students today
Print out information for home visit— possibly summary record/map/clinical info
Check who is booked into teaching surgeries and for any obvious issues that may arise
Reception to remind patients on arrival that students are present—consider a note on reception desk

Outline for the sessions 2-7:

Housekeeping: When the students arrive check how their morning was and how they are today. Just like when we are doing surgeries, the students are likely to focus better when they have had a chance to acknowledge the "emotional baggage" that they bring to a session that can affect concentration.
Recap: Questions from last session and experiences, or from other elements. Try to find out what they are studying in other elements to increase integration of learning. Encourage their questions as this builds a safe learning environment. Give an overview of the session. Address concerns e.g. How are they getting on with their assignments? Do they need to be looking out for a suitable consultation to write up today? Address concerns about the home visit.
Home visit: Prepare students for home visit in pairs. Some GPs take the student and settle them in, some give directions. It's helpful to give your mobile number or surgery number in case of difficulties, and make sure you have theirs. Remind the students of timescale and to take notes for their assignment. They should take ID, and the home visit consent letter that is in the student guide and appendix 3 of this guide.
If you do take a pair of students to a home visit it is helpful for students staying behind to have a task e.g. practice clinical skills on each other e.g. BP/temp/pulse Or they could read some of the notes in their handbook or on-line prior to watching you consult They could research information based on the patients booked into the surgery You could arrange for them to sit in reception for 10 minutes and observe "the coal face" in action or in the waiting room to make observations of the type of patients there or the environment.

Record keeping and reflection

Consider keeping some notes on students so that you have something to feedback in the final session in week 8. Also, you may want to reflect after your teaching sessions for your own development and to contribute to your appraisal.

Teaching surgeries:

The middle bit of the afternoon will be taken up with you consulting with 6 patients observed by students, and students (in pairs) out on the home visit—see below. Please remind students to use their case logs for note taking – see in appendix 5. Read on for things students can observe in consultations.

Alternative to teaching surgeries:

You could arrange for a patient to come to the surgery for a student to meet prior to attending an appointment with you, the student could then attend the consultation with them, and follow this up with a brief interview with the patient once they've left the consulting room to find out how the consultation went from the patient's perspective. This would really help the student understand different perspectives.

The students learning could be tailored to consultations they've observed e.g. if you see a patient with diabetes together you could arrange for them to sit in with your practice nurse to observe one patient attending a diabetic clinic for variety and see if they observed any different patient or nurse perspectives.

Debrief at the end of the session:

Structured group discussion and reflection time when you have finished the surgery and the students are back from the home visit.

Example structure:

- Feedback from patient visit – whole summary, what surprised or challenged the student, what did they find interesting or what did they learn? Encourage them to complete the home visit reflective log- see in appendix 6.
- Feedback from GP surgery – Consider case log entries, any patients that surprised/challenged/interested the students? What would they like to share with your peers?
- Linking HBoM themes; framing and exploring any issues arising
- Any questions?

End each session by writing down one thing that challenged them and one thing they found interesting – this could be reviewed at the end of the course.

Weeks 3-5:

In the middle sessions you might want to check how the students would like to use their remaining time as their written feedback at the end of the attachment often says they wish they had "more home visits" or "more surgery sessions"

This is also a good time to check on progress for their assignments and helping with these if necessary.

Week 7

Students hand in assignments (See more about this below)

Week 8 – Feedback session and feedback tips

Focus on feedback

- GP Tutor to student on their work (individual)
- Self assessment and peer feedback (as a group)
- Feedback to GP on the placement (written and can be discussed)
- Students to feedback to university (online with Blackboard)

Outline for the session:

Outline for the session
Explain plan for session to students
GP to see each student alone for 5-10mins - discuss their GP experience and give feedback an assignments and student performance overall *During this time, remaining students to read/review each other's reflective work and complete university online feedback (via Blackboard) if time allows*
Once all students have had feedback from GP tutor, reconvene as a group: • Reinforce safe group environment • Explain reasons for peer feedback – as below • Discuss principles of good feedback within the group – see below. • Each student to briefly describe their reflective piece and attempt self assessment e.g. this bit I thought I did well, this part maybe I could've improved) • Other students to give feedback on the work • Tutor to encourage/question/explore further/stimulate discussion • Artwork to be returned to the student
Feedback to the students on their group performance
Practice feedback form - **optional –** see document in appendix 8 - this can be complete by students individually and given in or discussed as a group. It is also a useful reflective tool for the students
Address final questions—patients, topics, the course
Please encourage the students to formally complete their feedback on Blackboard – it is helpful if they can each have computer access for this before the end of the session.
Usually there will not be time for further home visits in week 8, and most GPs will not hold surgeries seeing patient so they can concentrate on giving feedback. Three is however some scope to be flexible. Other activities you may consider in week 8 include practical skills practice, review/update if appropriate of patients seen during the placement or students sending thank you letters to patients

Other GP tutor tasks during or immediately after final session:

Email your completed feedback on each student to lucy.jenkins@bristol.ac.uk
Fill in teacher questionnaire on blackboard (finance claim form is incorporated with this so triggers payment) this includes your feedback about your students to us, e.g. absences.

Example discussion points for final session

- Were the aims and objectives for the course achieved?
- Why do people come to see the GP (ask in 1st session, revisit in final session: any new reasons or surprises since doing the course?)
- What have the students got out of this experience?
- Any attitude change – towards doctors, patients, GPs, their studies?
- What was the best thing/worst thing on the course?
- How can we improve for next year, what really helped you to learn?
- What surprised you? Did the course meet expectations?
- Or you can discuss their answers to the GP feedback tool in the appendix

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 recent National Student Survey showed that students do not feel they receive enough feedback on their work, so we are encouraging this.

Feedback should be

- Constructive
- Specific
- Descriptive
- Objective, non judgmental
- Address behaviour not personality
- Normalise difficulties

Other considerations:

1) Affirm qualities—character traits that will serve them well as a doctor. There is evidence that this is motivating.
2) Areas for development—be constructive, specific, non judgmental, offer observations not assumptions. Students are often weak at knowing their weak areas; this is how feedback from others can help them improve.
3) End on positive note (completing the feedback sandwich of; positive comment-area for improvement—positive comment)

General suggestions for feedback throughout the course

Start off asking the student "How do you think you are doing?"
For a student who is reluctant to accept criticism "How do you think the patient felt about your...."
For girls with inappropriate dress code "How do you think your dress code may affect people of other cultures/in the older generation?"
Offer observations, don't make it personal; Good: "I noticed that you did not make eye contact with the patient…" Poor: "You are a poor at communicating"
Be specific not general Good: "I noticed that you do not greet your patients at the start of the consultation…." Poor: "You seem to have a problem establishing rapport with your patient…"
Focus on behaviour not personality Good: "I noticed that you chose the treatment option for your patient…." Poor: "You are very paternalistic with your patients…."

Peer learning from assignments

Some students produce very insightful work and students get added value from learning from each other and hearing different perspectives and observations.

One way of deepening student reflection is to look at voice—how sensitively has a student presented the patients voice and how self aware and considered is the student voice? Whose voice is strongest in a piece? There is a list of questions in the student handbook to aid students in reviewing their peers' work in the final session e.g.

- Do they consider how the patient might see them?
- Do they consider what framework they bring to their understanding of the patient e.g. a student may struggle to empathise with a drug addict do they explore why?
- Do they consider in their reflection how others might view their work?

Themes for the Year 1 GP attachment

Discussions with your students during the placement touch on many aspects of medical care; some are important, specific features of general practice, and some are important topics to introduce the students for the rest of their medical training. The following is a list of the topics that you might like to think about with your students:

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

As a GP you have unique experience in these areas that you can share with the students, but for information-the following covers some of the clinical skills the students are expected to learn, and there is further teaching material for the other topics available on the web.

1. Introducing consultation skills (teaching surgeries)

Learning to communicate effectively with patients is one of the aims of this course. Obviously we do not expect Year 1 students to be able to conduct a consultation but they should be introduced to the purpose of history taking. Consultation skills are built up throughout the clinical placements across the MB ChB, especially in the Primary Care elements in Years 2, 3 and 4. Consultation skills forms one of the vertical themes at Bristol and the student receives training in future years through role-play with actors. Consultation skills can be divided into verbal (e.g. open questions: "can you tell me more about your pain?") and non-verbal (e.g. nodding head or good eye contact). 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 consultation model [2] will be used throughout the student curriculum, summarised below:

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

Consultation skills: the curriculum wheel

Figure 1 is taken from the consultation skills handbook that students are given in year 2. It is included here as it puts the GP attachment in context and is a clear representation of the increasing complexity of tasks as learners move from the centre of the wheel to its edges.
The article in which this figure is published[3] reviews the elements that medical schools should be including in their curricula. The consultation curriculum at Bristol follows this progression with: Year 1 students learning respect for others, the theory and evidence; Year 2 students the clinical communication tasks (as summarised in the Calgary-Cambridge guide[2]); and Year 3 & 4 students learn about taking a sexual history, communication with deaf and visually impaired people, handling emotions such as anger and behaviour change. In Year 5 students learn about the outer rings of the wheel including telephone consultations, written communication (e.g. clinical computer medical records providing continuity of information) and use of interpreters.

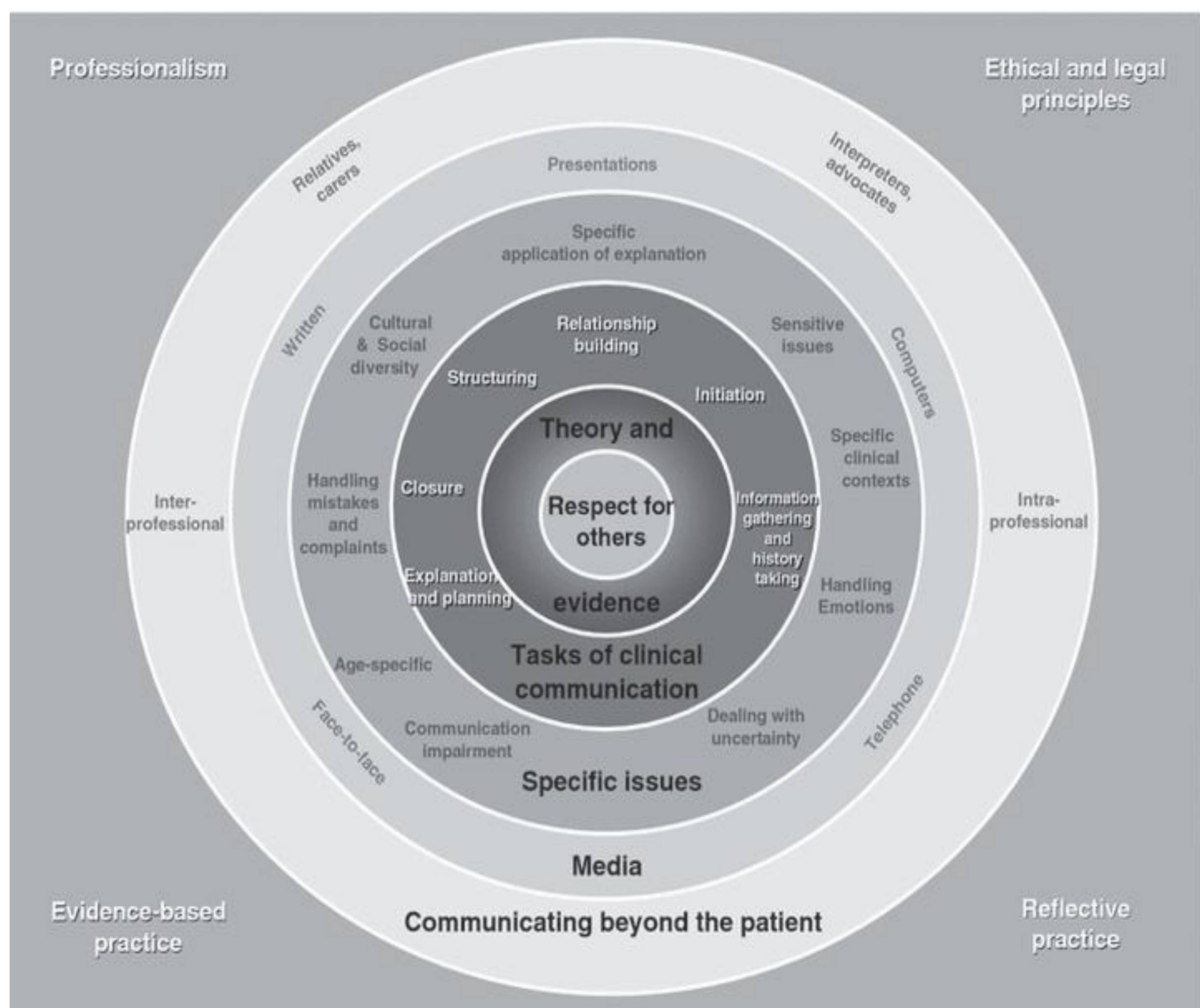


Figure 1

Learning from discussion with the GP tutor within the teaching surgeries

Through discussion with you, the GP tutor, students should gain an understanding that different patients and different clinical scenarios require varying levels of patient involvement in decisions about their care and treatment with an appreciation of informed consent and right to refuse or limit treatment. You should help the student begin to understand the importance of psychological, spiritual, religious, social and cultural factors on the patient's clinical presentation. For instance depression may present with more somatic features in the elderly or some cultural groups. Some of the patients you see together will illustrate that one of the roles of the GP is to support the patients in caring for themselves.

It is good for the students to have specific things to observe for and consider in consultations – to keep them alert and interested and encourage them to think about active listening and communication skills. Some suggestions are as below:

<u>Things for students to observe in consultations</u>

- how long patient speaks for initially
- How often Dr interrupts!
- Consultation structure/flow based on Calgary-Cambridge model
- Use of verbal/non-verbal communication
- Open/closed questions – they can write down examples
- Any cues/hidden agenda/elephant in room
- Patient satisfaction

<u>These can then be discussed after the consultation. Questions you could ask:</u>

- What was my relationship with that person like?
- What did you think about my/the patients attitude?
- Any idea why I felt uneasy about seeing that patient?
- Why do you think they came today?
- I wonder what they really wanted today?
- How do you think the consultation went?
- Do you think we reached a shared understanding?
- Did I change their understanding of their illness?
- How do you think a student being present alters the consultation?

Patient-centred practice - from student guide

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 today 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?

Patient-centred practice is more than just asking the right questions though. In the words of Roger Neighbour (Ex-President of the Royal College of General Practitioners):

'Patient-centeredness is not a performance: it is a frame of mind, a value system. Patient-centred consulting flows naturally from a mindset of respectful curiosity about individual patients – curiosity about what matters to them, what they are experiencing, what is going on in the consulting room[4].'

The Therapeutic Alliance:
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 have developed but also your attitudes, maturity, kindness, emotional intelligence. It's not just what you do, but also who you are. The personal impact of the doctor upon his patient was examined by the psychoanalyst Dr. Michael Balint (1957)[5] 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.

2. Teaching surgeries: prescribing

We are keen for students to observe prescribing and get a feel for issues surrounding this. As they have not yet studied Pharmacology or done any clinical Medicine, they are not expected to be familiar with any specific medications. However, please do encourage students to look up a patient's medications in the BNF. Similarly, when discussing cases, consider 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?

3.Teaching surgeries: clinical skills

Please can you/other health care practitioners in your practice) familiarise the students with these procedures: see below for the guidance students are given. The students have a copy of this in their study guide. In year 2, they will be given their CAPS logbook which also contains this.

Students love learning these core skills as for them it represents real "hands on" medicine. Their feedback is that is increases relevance of MCBoM learning and is good preparation for practicals in phase 2 teaching e.g.CVS

Ideas for teaching these skills are to introduce in week one, then allow the students to practice opportunistically in observed consultations/home visits. Some GP teachers focus on a different skill each week. Students can practice on each other - this is a good activity if they have some spare time (e.g. if the GP is taking other students to a visit). Week 8 is a good week to review and consolidate these skills. You may consider using the RCP National Early Warning Score (NEWS) chart for this. This tool (designed for standardising the assessment of acute-illness severity in the NHS) covers P/BP/temp/ox sats/GCS and BM which the student can practice and additional parameters which can be discussed. This can be downloaded from RCP website (address below). This helps increase the clinical relevance of learning these skill

http://www.rcplondon.ac.uk/sites/default/files/documents/news-observation-chart-a3-size-_0.pdf

Taking a temperature

- Explain procedure and obtain consent. Wash hands
- Ask patient if they have any ear problem
- 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 that that 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 that 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

4. Integration with Themes from Human Basis of Medicine (HBoM)

The GP attachment is one of 5 elements in the course "Human Basis of Medicine". Students receive tutorials in the other elements of HBoM and will have the opportunity to consider GP experiences within these groups. As a GP tutor you should aim to help the students make link between their learning across the unit that they will explore further in their Applied Case. To help you in this there is an outline of what they learn in the other elements and some examples of questions you might use in your discussions with the students. You will also be emailed an outline of HBoM lectures for each week. Also please could you encourage students to write in their 'Case Log' in their handbook for their HBoM tutorials.

Ethics and Law in Medicine

Lectures and tutorials on the nature and prevalence of ethics and law in medicine, morality, confidentiality and an overview of the relevant guidelines and law, justice and healthcare and the difficult decisions given limited resources. Could consider with students:

- Ways in which GPs ration resources (including GP time) did you see any examples?
- Confidentiality and when a GP might break this?
- How much responsibility do patients have for their own health and decisions about their treatment (try exploring this for different presentations and comparing
- For example, with respect to 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).

Clinical Epidemiology : The Clinical Epidemiology element consists of weekly tutorials that introduce students to different epidemiological study designs used to study disease and its control; provide the skills to interpret and critically appraise research findings hence enabling students to practice evidence-based medicine. Possible considerations:

1. In a patient presenting with symptoms of mild depression, what is the evidence for the usefulness of CBT vs 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:

This element consists of lectures and tutorials that cover thinking in systems in medicine, the art of medicine, emotional factors in health, mind-body medicine, and integrative medicine in practice

Consider with students:

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- intimate partners, family, work, religious beliefs, 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?

Society, Health and Medicine : The Society Health and Medicine course consists of lectures and tutorials. It looks at moral judgments about health and illness especially stigmatising conditions, the doctor patient relationship, help seeking behaviour and sources of information, the experience of living with chronic illness, the role and needs of carers, the impact of illness diagnosis and treatment on the social being as well as the physical body, doctors role in death and dying and health inequities.

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. Where else do you think they sought help or information from before coming to see me? 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. Discuss the stigma and difficulties a certain patient might face Why is living with AIDS more stigmatising than living with cancer?
8. Is the medical profession as important as it used to be?
9. Did you see indications of patients holding different beliefs or values from you?
10. Why might this patient not take their medication as prescribed?

The home visit

The purpose of the home visit is to practice listening to and being with patients. Their stories and experiences are likely to educate on the perspectives from the patient's side of the NHS. The home visit should also give students the opportunity to think about their use of body language, tone of voice and questions, similarly to notice the patient's verbal and non–verbal communication.
There is a role play of the home visit in the introductory session where students will have practised introducing themselves and asking questions. However, still some students are nervous about the home visit "what if the patient doesn't like me?" "What if I clam up – or cry?" It may help to run through these fears and offer some tips and reminders:

- Many patients welcome the opportunity to talk and tell their story; it may even be therapeutic or cathartic to share their experiences.
- Many patients are pleased to help in the future education of doctors
- Remind the students of their introductory session and use open questions and active listening skills
- It is okay to take notes if they are anonymous. The student should check briefly with the patient "I want to write a few things down to remind me of what we talk about today. I won't put your name on them—is that okay?" It also may feel more appropriate to just listen.
- One student could talk and the other write
- It is possible the patient becomes very emotional. This is a normal response to relating an emotional experience. They may just need some time and silence and it is valuable for the students to learn to be comfortable with emotion or silence.
- After a patient has been very emotional and space has been given it can be helpful to acknowledge their frustration, fear, sorrow or grief e.g. *"It must have been a very lonely time for you"*
- If the student is worried about freezing or getting stuck they might want to write down a few questions before the visit as a reminder e.g. *"How were you given the diagnosis, Do you remember your reaction*?" The student handbook has more useful questions in and a log at the back of their handbook to make notes about the home visit in. The group could all brainstorm some questions together if they did not do this in the introductory session.

There is a home visit log in the student study guide (and appendix 6 of this guide). We ask you to encourage students to write in this each week, it will increase reflection and make their assignments easier to produce. This can be something they can do if they arrive back from visits early and you are still consulting with the other students.

Assessment

As the GP tutor you will have two assignments to mark: the Applied Case and the Reflective Assignment. These are formative and enhance the student learning, they do not count towards a final mark for the year. However any student who is graded poor should be flagged up to the course organiser who will review the work and where required the student will be contacted and asked to redo the assignment for remarking. Failure to hand in an adequate assignment will prevent the student from progressing to the 2nd year.

General Information: assignments must be word-processed and handed in/emailed to their GP and uploaded to Blackboard) by week 7 of the attachment. You can access the work via Blackboard (log in details are on p5). Please at least open their work on Blackboard and check that the assignment is identical. This is to avoid problems with plagiarism. We also run a plagiarism check of all work.

We are no longer giving the students formal grades, but would still like the GP tutors to use the descriptors which are unchanged from before as a guide to their assessment of the student work. We are keen for each student to be given qualitative honest useful feedback on their pieces of work. This will be done on an individual basis and submitted to Blackboard. In addition, we have introduced self and peer assessment of the reflective piece in week 8 to encourage the students in developing skills to give and accept feedback. See below for further details regarding this. Please follow the mark schemes on the next few pages. The students have access to these schemes when they are working on the assignments and will have used them as a guide.

The mark schemes have been devised to reflect that normally “good” is the level we like to see in assignments and “excellent” should be reserved for seriously Excellent and Outstanding work. This has been altered due to previous feedback from GP tutors and students that the previous mark scheme was not discriminatory enough, which may have made it too easy to do well and did not duly reward the excellent candidates.

Essential – Students are asked to:

- Word process their assignments
- Make sure each page contains their name and student number
- Clearly write the title of their work on the first page. This should includes a date and description of the assignment e.g.
  “Applied Case for GP Attachment, Dec 2013: The Doctor-Patient Relationship”
- Make sure they include a sentence confirming that the patient has consented to the use of their story after reading the letter.
- Submit a digital photo to the GP of their creative work with their reflection.
- Audio and video files bigger than 10 MB will be too big for loading onto Blackboard. These should be given to the GP on a CD or memory stick AND emailed to the course lead (Lucy.Jenkins@bristol.ac.uk) via FLUFF (http://www.bristol.ac.uk/it-services/faqs/fluff.html).

Ideally – students are asked to:

- Include a word count (both for the applied case (aim for 1500 words) and reflective element of the reflective assignment (aim for 500 words). If they have written a narrative for the reflective assignment we ask for 2000 words that includes the 500 word reflection). This year for the applied case you are asked to feedback on assignments falling way outside the word count—see mark scheme for details.
- Correctly reference their applied case (see info below) and you should mark down for incorrect referencing according to the mark scheme.
- Think about layout and font to make their piece readable

Prize nominations

There will be a prize awarded for excellence to one student or split between more than one at the end of the year. Please nominate a student with your reasons for the nomination if you feel they have excelled on all parts of their GP attachment— graded excellent on both assignments, and you consider them an exceptional student in their attitude or contributions to the attachment. Please note the student **cannot be considered for the prize** if they do not include patient consent in their assignment or there is late hand-in without good reason

Applied Case

Aim: The Applied Case assignment meets the course aim of applying the theoretical knowledge of social science to patients in primary care.

Objectives:

- Observe clinical cases presenting to the GP and consider the issues surrounding them.
- Write a 1500 word descriptive case presentation from one or more consultations that the student has observed which applies referenced theory from any of the Human Basis of Medicine (HBoM) elements or own reading to the issues defined.

<u>Topics and advice given to students on writing the applied case</u>

For this assignment it is best to choose a complex or interesting issue or a challenging consultation e.g. a demanding or anxious or resistant patient. In this case the student is advised to start with a summary of a case scenario and think about the variety of issues faced in the consultation. If they should choose a challenging issue it should be linked to a patient they have encountered, e.g. an ethical dilemma or complex decision for the patient or doctor e.g. re investigation or treatment. In this case they should start with a summary of the issue drawing on the case/s they see that illustrate the issues you can help by telling them about other cases you have seen which illustrates a different perspective on the issue. If the student is stuck for a topic there is a list of suggestions in the student handbook and below:

- The doctor patient relationship. Perhaps you observed a break down in the doctor patient relationship you might link this to your learning in Society Health and Medicine
- Stigma. Did you see a patient with a stigmatizing condition? How can the doctor explore this? Can doctors help challenge or reduce stigma? How? (Society Health and Medicine)

- Examining evidence—you may observe a clinical scenario where the evidence is not clear cut what to do (Clinical Epidemiology) for example many trials have not included the very elderly patients so the research evidence may not exist to back up the GP's and patient's decision making.
- Medicine in the media—patients often bring in articles they have read telling them about new illnesses or treatments. How does the GP address this? (Clinical Epidemiology)
- Conveying risk—a patient may want treatment that has risks attached and you could examine the evidence e.g. Hormone Replacement Therapy HRT (Clinical Epidemiology) or a patient may request an investigation that the doctor feels is not in their best interest e.g. an x-ray (Ethics)
- Confidentiality—There may have been some kind of ethical confidentiality issue that you want to examine e.g. seeing a young girl wanting contraception (Ethics)
- Resource allocation—Did you see a patient who is on a very expensive treatment, or demanding a treatment that is difficult to get on the NHS (Ethics)
- Self care—how do doctors deal with their own emotions dealing with patients e.g. difficult patients or scenarios that raise something personal for the doctor? What are the theories about self care and avoiding stress and burnout in doctors?
- Did you meet any patients using complementary/alternative therapies? What are the issues?
- Ethical dilemmas. Capacity and Consent – any consultations where these were challenged or possibly compromised?
- Deprivation and health – Did you see any clear links between these? How can these be addressed on an individual and at higher levels?
- Difficult consultations – what skills did the GP use to manage this? Did the consultation fit the Cambridge-Calgary model
- Changing patient behaviour – What methods are there to do this? Cycle of change.
- Explaining risk to patients

GP tutor marking notes

See the descriptors as a guide below. Please use the specifics within this to feedback to the students, using the following:

- **Three things that impressed me about your applied case/reflective piece**
- **Three things that would improve your applied case/reflective piece:**
- **Discussion points**:

There is a template for this in appendix 7. These will be emailed to you towards the end of the placement with instructions. In the past, GP tutors have been asked to upload this to Blackboard but this has now changed**. Please email a completed sheet for each student to the unit lead at lucy.jenkins@bristol.ac.uk. The work will then be moderated and uploaded to Blackboard all together.**

Bear in mind that "good" is the level that we like to see and a good candidate will show that they can clearly present a case with a good consideration of context, showing understanding of issues and able to draw on relevant theory. The structure of the assignment will be logical and clear with an introduction, coherent progression of ideas, and a conclusion. There will be few or no mistakes in spelling or grammar and they will cite references and sources accurately. "Excellent" work can be hard to define precisely because it is original or presents the material in a new or interesting way but

the mark scheme is designed to help define excellent criteria. Please don't worry about marking a candidate as satisfactory, they will have achieved what is expected of them but will have areas that your feedback can help them improve on. However a poor candidate will **not** be able to demonstrate that they understand the issues involved in the case, the theoretical concepts or what is being asked of them. **If you feel a student's work does not meet the satisfactory criteria then please inform the unit lead so the work can be double marked.** Failing students will be reviewed and asked to repeat the assignment.

APPLIED CASE DESCRIPTORS

	POOR	SATISFACTORY	GOOD	EXCELLENT
Spelling, grammar and referencing*	Numerous mistakes and/or no references	Some errors, or attempt to cite sources but incorrect or inconsistent, less than 3 or more than 10 references.	Limited errors. Clear consistent presentation of references and citations. Between 3 and 10 appropriate references/sources.	As good but no errors and relevant, original references and sources correctly presented. Could be presented for publication.
Structure	No attempt to structure logically. Missing introduction. Difficult to follow progression of ideas. Missing conclusion.	Attempt to structure logically but could improve this or argument needs more clarity.	Clear structure. Good introduction and conclusion. Logical clear progression of ideas.	Introduction hooks reader and presents issues clearly. Logical clear progression of argument that weaves theory with case/s in a readable yet concise or innovative way. Viewpoint of conclusion clear.
Case presentation	Inaccurate or judgmental case presentation or lacks understanding of the context or alternative perspectives	Accurate portrayal of patient case/s and some understanding of context and issues. Could improve with wider reflection of case.	Clear portrayal of patient's case highlights wider context and issues. Demonstrates some understanding of alternative perspectives.	Shows deep or broad thinking about the patient's case and broad, insightful or original consideration of the issues.
Theory	A case presentation with no, or irrelevant, or very limited use of theory.	Uses limited theoretical concepts to illustrate case. Could improve relevance or application of theory	Shows that has understood theoretical concepts in reading/lectures by putting them in correct context. Relevant use of theory.	Shows wider reading than expected and grasp of concepts so that presents them in own voice/unique way. May highlight gaps in theory or challenge theory. May contrast different or opposing theories.

* The students are asked to write 1500 words for this assignment Therefore for feedback if word count is < 900 words or > 2500 not including references, footers or bibliography.

Guidance given to the students on how to reference—brief examples as below.

Referencing a book: Simon C, Everitt H, van Dorp F. Oxford Handbook of General Practice. 3rd Ed. Oxford: Oxford Medical Handbooks; 2009
Referencing a journal article: Spencer J. Learner centred approaches in medical education. *BMJ*. 1999 May 8; 318(7193): 1280–1283.
Referencing a web site: National Institute for Health and Clinical Excellence. Delirium: diagnosis, prevention and management. (Clinical guideline 103.) 2010 [Online] Available from: http://guidance.nice.org.uk/CG103 (Accessed 3rd August 2011)
A lecture: Buchan J. Introduction to the Year 1 GP attachment. *Lecture at the University of Bristol*, Bristol. 2011.

The Reflective Assignment

Reflection is a key skill for students to learn, not only so that they develop into “reflective practitioners” but because being able to reflect on what they observe, hear and do is a lifelong adult learning skill. Through reflecting on what they have learnt, or how they reacted in any given situation, the student may better integrate knowledge, improve decision-making skills and enhance their enjoyment of learning. Reflection helps develop communication skills and empathy if it is used to reflect on different perspectives, and this may be further aided by guided reflection and dialogue with others e.g. peer learning.

Aim: The Reflective Assignment meets the course aim of learning to communicate effectively with patients, and establish the foundations of life-long learning by develop skills of reflection and self awareness.

Objectives:

- Practice early consultation skills such as initiating a consultation, asking open questions and active listening skills by interviewing a patient in depth about their experiences of being a patient.
- To produce a piece of work that reflects the patient’s experience and allows the student to explore their attitude to the patient and the patient story.
- To experience ways of different ways reflecting—through art, writing, guided thinking or dialogue with others.

The student may find it helpful to discuss the way in which people tell their narratives (stories). What kind of language and words do they use? What metaphors and imagery is brought up? How are they making sense of the intrusion of illness into their lives or adapting to change? The student may choose simply to narrate their experience of meeting the patient and reflect throughout the piece on the patient’s narrative. Or they may choose more creative writing and “step into” the patient or carers shoes and tell the story from that person’s perspective. Instead they may choose to

express the story in other mediums such as painting, photography, sculpture and then explain in a reflection why they chose this medium and how it represents the patient's story and their personal reflections.

Again we request you use the descriptors below as a guide and give qualitative feedback, using the template provided.

<u>REFLECTIVE PIECE DESCRIPTORS</u>

	POOR	SATISFACTORY	GOOD	EXCELLENT
Spelling and grammar* (for reflection if not essay)	Numerous mistakes.	Some errors.	Limited errors.	No errors. Could be submitted for publication
Impact	Themes of the patient story were not addressed, or addressed superficially.	The work addresses the main or obvious points about the patient's story.	The work explores some interesting insights about the patient encounter showing understanding and empathy of the patient perspective.	Powerful. The work may have immediate impact or really moves/engages you. It stays with you and opens new doors and perspectives or strongly conveys the patient voice.
Reflection	The reflective element is descriptive with little or no reflection	There is some reflection e.g. reflection around meeting the patient or empathy with the patient but this could be expanded.	Demonstrates self awareness and describes own reactions to meeting the patient and the patient story. Shows some understanding of the patient or others perspectives. Likely to be able to explain reasons behind choice of medium.	Insightful reflection demonstrating conflicting views in self and understands the impact of the framework the student brings to their interpretation. Insightful understanding of patients and others perspectives. Deep or broad reasons for choice of medium that may include prediction of audience reaction to work.
Effort	Little original thought. Little effort. Poor choice of medium.	Appropriate choice of medium even if doesn't demonstrate why chosen, shows satisfactory effort	Has put in effort into producing work, shows careful consideration of choice of medium	Work produced to a very high standard, medium chosen contributes to engaging audience with its message.

* The students are asked to write 2000 words for this assignment including at least 500 of reflection which can be woven into the text. Therefore for feedback if word count is < 1000 words or > 3000 not including references, footers or bibliography. If a creative piece is submitted, they are asked to write 500 words of reflective – so feedback if <400.

References

[1] GMC, 2009. *Tomorrow's Doctors* (3rd Ed). London: the GMC.
[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.
[3] von FM, Silverman J, Cushing A, Quilligan S, Salisbury H, Wiskin C. UK consensus statement on the content of communication curricula in undergraduate medical education. Med Educ 2008.
[4] Neighbour R 2nd Ed. The Inner Consultation. Oxford: Radcliffe Publishing, 2004
[5] Balint M. The doctor, his training and the illness. New York: International University Press, 1957

Appendices

Appendix 1 - Sample Notice to Patients

Please Note:
Today a medical student is sitting in with the Doctor during surgery. You should have been informed of this at the time of booking into this surgery. If you would prefer that he/she is not present during your consultation, please inform the Receptionist. However, please remember that the rule of confidentiality applies also to Medical Students as well as Doctors and Nurses. Furthermore, accepting a Student being present will help in their training.
Thank you.

Appendix 2 - Sample thank you letter to patients

Dear

Thank you for allowing my medical students to interview you recently. They have reported back that it was a very valuable experience and I hope your time with the students felt well spent. It really was a great help.

Yours sincerely

Appendix 3 – Home visit letter

This can be sent/given to patients in advance or printed and given to students to take on visits.

From:
The Primary Health Care Teaching Office
School of Social and Community Medicine
Canynge Hall
39 Whatley Road
Bristol BS8 2PS
Tel: 0117 3314546
Fax: 0117 9287325
E-mail: phc-teaching@bristol.ac.uk
www.bris.ac.uk/primaryhealthcare

ACADEMIC UNIT OF PRIMARY HEALTH CARE
Head of Unit
Chris Salisbury, MD, MB.ChB, MSc, FRCGP
Professor of Primary Health Care

To patients who have agreed to help with first year medical student education

Thank you for agreeing to talk with first year medical students from the University of Bristol. We have asked your doctor to find some patients who are willing to spend time talking with new medical students for the following reasons:
1. For students to learn from your experiences of illness and your experiences with doctors and the hospitals.
2. For students to begin to learn how to talk with patients about their health. If you are chatty and open this will help the more shy students who may struggle to find questions to ask.

Please remember that these students are in their first few weeks of their course. *They will not be able to answer any questions that you might have about your health.*

How do students learn from their conversations with you?
Students are asked to write an essay or do a creative piece about one of their home visits. This is to help them think about what they have heard. Their work may be discussed with the GP and the group of students placed with them (up to 6 students). Students often write well about patient experiences. We would like to use some of these accounts in our teaching. That would mean allowing other students to see the work, using the work on our teaching website and in our course handbooks. Occasionally edited pieces of student art or written work and their reflections are collected into small books for wider distribution. We would keep your information confidential by changing key identifying factors such as names, ages and places.
Please inform the GP/student if you would not like them to consider your story and experiences for their assignment.

Lucy Jenkins.

Dr Lucy Jenkins
Teaching Fellow in Primary Care

Appendix 4 - Sample timetable

WEEK 1

Arrive 2pm - Get to know each other

Introduction to GP surgery, including demographics, tour, meet staff, badges, housekeeping etc

Any experience of GP as yet (family members/as patient/carer/work experience)??

Review professional behaviour in surgery

Plan for the next 8 weeks

Chat re assessments etc

Exchange mobile numbers/emails

- 2.45pm - Learn about Calgary-Cambridge Consultation model – if time allows – brief discussion

Practical skills - Intro to taking temperature, pulse and blood pressure

- 3.30 – 4.30 – meet first patient/walk round local area

Discussion in group re first patient met

- 4.40- wrap up, plan next week

WEEKS 2-6

2pm – meet at surgery, review plan for afternoon, introduction to patients for visits etc

2.30 – 4pm

2 students sit surgery with me. To observe consultations. 6 patients booked in

- each student will have specific criteria to observe eg. timing, Calgary-Cambridge details ***
- practice skills if patient allows (eg. BP, pulse, temperature)
- discussion of cases immediately afterwards if time allows
- students to document cases in log-book

1 pairs of students visiting patients in their home

- one hour to take history, one can talk/other take notes
- see reflection template to complete

4 - 5 – tea and discussion

- discuss patients seen and issues arising from this
- consider in context of course themes and assignments due

PLAN - Thursdays	Sit in surgery	Visit patient at home	
Week 2 – 26 Jan	H/X	G/F Mr DM (COPD)	
Week 3 – 2 Feb	G/F	H/X Mr BP (MS)	
Week 4 – 16 Feb	G/X	H/F Miss CF (leukaemia)	
Week 5 – 23 Feb	H/F	G/X-Mr + Mrs P(carer, dementia)	Discuss assignments Practical skills
Week 6 – 1 Mar		Mrs GR (alcoholism) TBC	

Week 7 – 8 March – Give in assignments – activities TBC

Week 8 – 15 March – feedback and reflection

- On placement and experiences
- One-to-one feedback from GP tutor
- Share/review peers' essays/creative pieces
- Practice newly learned skills
- Online feedback for University

Appendix 5 - Case Log

(in back of student guide)

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.

Age/sex	Problem	Consultation skills used/needed	How GP dealt with	Learning points	Link with HBoM
36F	Failed contraception	Closed questions for details	Discussion options	Missed pills, action of contraceptive pill, efficacy	Ethics –what are her options, rights of the mother vs. baby
30 M	Depression	Open questions, listening, explored patient's desires and beliefs. Empathy and non verbal listening	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 resilience, see pt as whole in context

Appendix 6 - 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?	
What sort of creative piece would I use to tell this patients' story?	
Forward planning	
Would I like to focus on this visit for my assignment?	
Anything I will do differently on the next home visit?	

Appendix 7 - Qualitative feedback tool for assessments

Student name:

Qualitative feedback tool for year 1 Primary Care assessments

Reflective piece - please write if possible fail/pass /prize nominated work:

Three things that impressed me about your **reflective piece**:

1.
2.
3.

Three things that would improve your **reflective piece**:

1.
2.
3.

Discussion points:

Applied assignments - please write if possible fail/pass or prize nominated work:

Three things that impressed me about your **applied assignment**:

1.
2.
3.

Three things that would improve your **applied assignment**:

1.
2.
3.

Discussion points:

GP Tutor name:
Date:

Appendix 8 - Sample Feedback tool to use in your practice

FEEDBACK date

XXXXX SURGERY YEAR 1 STUDENTS

PLEASE LIST

The main things you enjoyed

What you enjoyed least

What you learnt about being a doctor

Anything you learned about yourself?

Which patient affected you most?

How if at all has this changed your thoughts about General Practice/being a doctor?

How can we improve the student experience here?

Would you have preferred a smaller or bigger group?

Do you prefer sitting in with a GP or seeing patients or both?

Is seeing patients better in pairs or as a whole group?

Were the assignments manageable? Did you feel prepared for them?

Would you have preferred more formal education or discussion based on cases seen?

Any other comments??

Appendix 9 – Attendance and Payment form

ATTENDANCE & PAYMENT FORM

1st Year GP attachments Spring 2013-14

Please return this form at the end of the attachment to:

Primary Health Care Teaching Office
University of Bristol
Room 1.01, Canynge Hall
Whatley Road
BRISTOL
BS8 2PS

Student Name	Date of Absence	Reason given for absence	Concerns

- Please confirm you have marked assignments and submitted feedback: YES/NO
- Did you have any concerns about any of your students? YES/NO

If yes, please refer to our protocol (see our website: http://www.bristol.ac.uk/primaryhealthcare/teachingtutors/) which directs you to complete a Student Concern Form (below) and return it to the address on the form. Please also send a copy to the Primary Care Teaching Office. (NB We are aware that there will be a time lag between your potentially filling in a Student Concern Form and filling out this Attendance & Payment form.)

GP Teacher: ....

GP Practice: ....

I confirm that I taught the above medical students for .... sessions.

GP Teacher's signature: ……………………………………………………………………………Date: ....

Appendix 10 - Protocol and flow chart for dealing with concerns about students

What do we want to achieve?

1) **Help you identify the students that cause concern.**
   a) To enable students to receive the most appropriate support
   b) To prevent risk to patients/colleagues.
2) **Clarify the route for you to report a concern about a student.**
3) **Outline the action that you can expect from the primary care teaching team or GP academy leads.**
4) **Outline the role of the Academy Dean in concerns you may have about your students.**
5) **Keep the pathway for reporting concern as straightforward as possible involving the minimal number of people on a need to know basis.**

Frequently Asked Questions:

1. **When should I be concerned about a student?**

The following are common areas of concern (in bold) with a list of possible examples. This list is not exhaustive.

Professional behaviour/attitude e.g.

- Compulsory session missed without explanation or recurrent absence with explanation. (<80% attendance)
- Rude to peers, patients, teachers or staff.
- Inappropriate dress persists after request to make changes.
- Consistently late, disorganised or unprepared for the sessions.
- Not contributing to group discussions/group activities/bored/disinterested.
- Breach of confidentiality e.g. heard discussing patients/leaving computer switched on with records visible etc.

Pastoral e.g.

- NB/ Discussion about any of the above may reveal a pastoral care issue.
- Low mood/mental health issues interfering with ability to study/attend course.
- Physical health issue interfering with ability to study/attend course.
- Conflict of roles interfering with ability to study/attend course e.g. dependants, paid employment, outside interests, family issues.
- Uncertainty about course/career in medicine/geographical location.

Safety e.g.

- You consider that the student has acted above their level of knowledge/skills and not sought appropriate help.
- You consider that the student has put a patient or colleague at risk.

Clinical knowledge/skills, including communication e.g.

- In your opinion the student does not have the minimally acceptable clinical knowledge or skills for their stage of training.
- In your opinion the student does not have the minimally acceptable communication skills (including language) for their stage of training.

2. I am concerned about a student what should I do?

- Initially you may want to discuss amongst your primary care team, has anyone else taught or had contact with the student and shares your concerns?
- Keep good notes.
- Always try to discuss your concerns with the student concerned.
- If you are not easily able to resolve your concerns with the student try to inform the student that you will be seeking further advice.

3. Who should I contact if I am concerned about a student?

- We encourage you to phone or email the GP year lead in the Primary Care Teaching team (see contacts in your handbook or www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/year/) or the GP academy lead, in recognition that it can be helpful to discuss what constitutes "minimally acceptable" knowledge, clinical skills or an attitudinal concern.

4. What happens after this?

- The GP year lead (or GP academy lead) will be able to discuss your concerns, and advise. They are likely to ask you to put your concerns in writing (email) and from year 2 onwards they will forward this to the Academy Dean. This should not be seen as a punitive measure, but to enable a high level overview of individual students. The Academy Dean will make the decision to cascade information as appropriate on a need to know basis. You should decide between you who should complete the student concern form (see below).
- If the student is in year 1 the GP element lead may discuss the concerns with the Pre-Clinical Programme Director (Dr Eugene Lloyd) as the Academy Deans have little involvement with year 1.

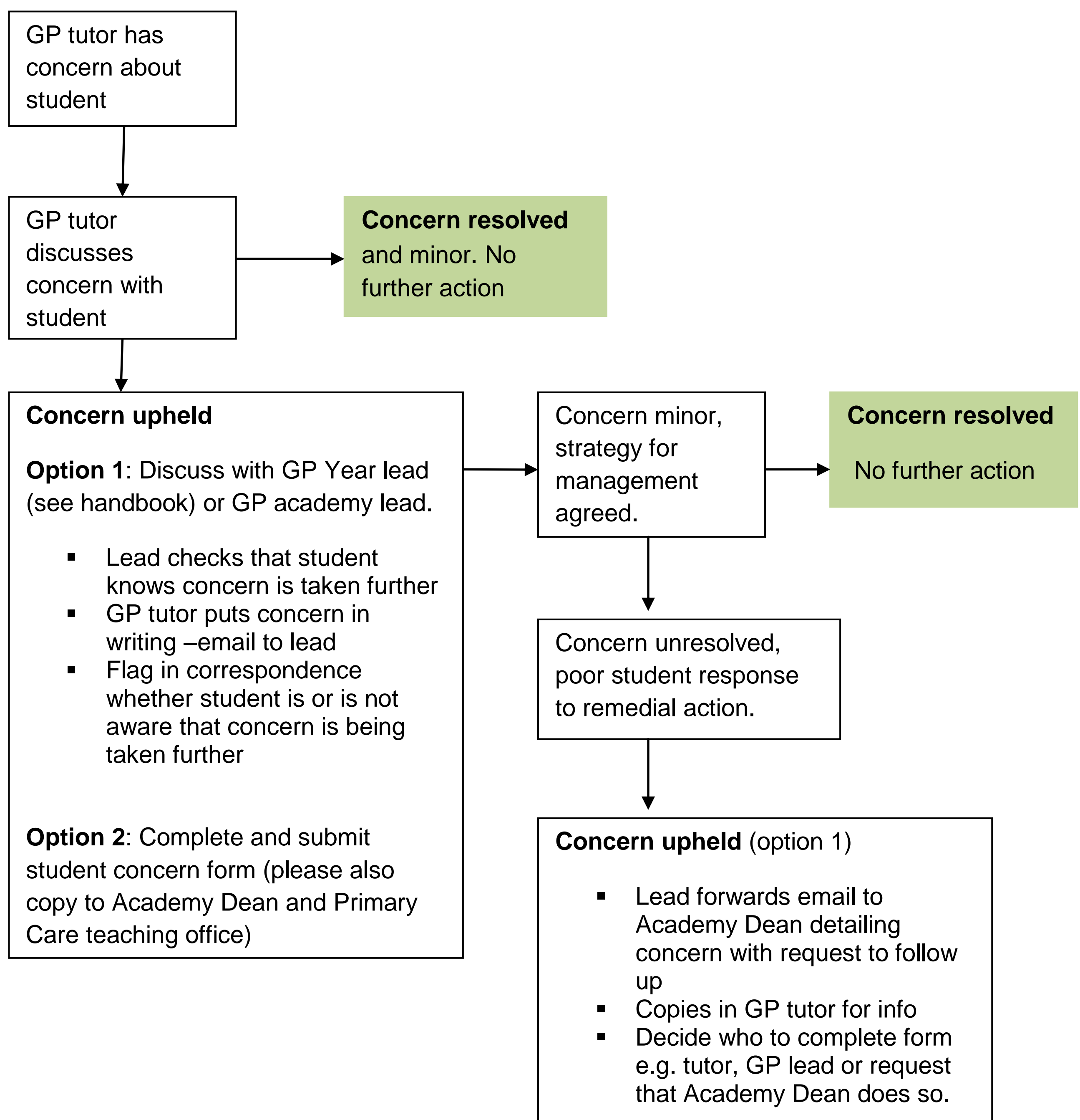
5. So what about "Student Concern Forms"?

See http://www.bris.ac.uk/medical-school/staffstudents/student/forms
The forms should also be in your tutor handbooks. The medical school encourages teachers to have a low threshold for filling these in, please submit to the address on the form, with a copy to the Primary Care Teaching Office and the Academy Dean (to keep them in the loop). However we recognise that every circumstance with a student is different and are happy to discuss the situation with you first.

Flowchart for communicating concern about students

Written	November 2012
Review date	September 2013
Responsible	Primary Health Care Teaching Office
	Email phc-teaching@bristol.ac.uk for more information or queries

Student concern form (SCF) at:
http://www.bristol.ac.uk/medical-school/staffstudents/student/forms



Appendix 11 - Student Concern Form

University of BRISTOL

Faculty of Medicine and Dentistry
Bristol Medical School
Student Professional Behaviour Concern Form

This form is for use by any University of Bristol or NHS staff members, University of Bristol students, patients or members of the public who feel that a particular medical student's standard of professional behaviour is a cause for concern.

It is hoped that most professional behaviour issues can be dealt with informally, by discussing the concern with the student, so that the student is given the opportunity to address the issues raised. Please consider this course of action, if appropriate, before you complete this form.

Your concern may relate to a number of areas:

- *Relationships with patients* – e.g. not respecting confidentiality, being impolite to patients, not informing patients they are a student, persistently not complying with the Clinical Dress Code
- *Working with others* – e.g. failing to follow instructions, being disrespectful towards other healthcare students, persistently disrupting teaching
- *Probity* – e.g. fraudulent behaviour, requesting money/gifts from patients
- *Learning* – e.g. persistent lateness or non attendance, not responding constructively to feedback
- *Health* – e.g. a drinking or drugs problem (this may be referred to the Disability & Health Panel)

Any concern you raise may be discussed with you prior to the student being contacted. Your concern will then be considered by the Fitness to Practise Case Investigator who will decide what appropriate action should be taken.

For further information on the procedures, please see the Rules, Policies & Procedures Handbook (available online at http://www.bristol.ac.uk/medical-school/staffstudents/rulesandpolicies

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Patient Safety

If you are very concerned about a student's behaviour and feel that patient safety is at risk you should immediately contact either the Director of Student Affairs or the Faculty Head of Academic Administration or, if they are not available, the Medicine & Dentistry Faculty Dean who will take action as appropriate.

If you wish to discuss your concern before you submit this form, please contact the Fitness to Practise Case Investigator, via the Faculty Head of Academic Administration on (0117 331 8317).

This form should be completed in full and returned in a sealed envelope marked 'Private & Confidential' to: Mrs Sylvia Elliott, Head of Academic Administration, Medicine and Dentistry Faculty Office, First Floor South, Senate House, Tyndall Avenue, Bristol, BS8 1TH

MB ChB Student Concern Form

Name of Student:

Year on Medical Programme (please circle if known): 1   2   3   4   5

Please describe the nature of your concern about the above student's professional behaviour (please use additional sheets of paper if required)

If possible, please specify the date/s & time/s on which the incident/s you refer to occurred:

Please Note:
All concerns must be made by a named individual. You should be aware that under the Data Protection Act it is very unlikely that if a written concern is received that the identity of the reporter can remain anonymous as students have a right to see information held about them by the University.

University staff or students who make malicious or deliberately misleading statements concerning a student may be referred to the relevant University disciplinary procedures. No action will be taken against a member of staff or student who raises a concern in good faith.

Name: ………………………………………… **Signature:**………………………………………..

Date: ………………………………………..…

Role (Please circle as appropriate) : NHS Staff / University Staff / Student / Other ………………………………….…

Contact Details (so you can be contacted to discuss the concern **– these will not be released to the student and will be kept confidential**)

Telephone:………………………………………… Email:……………………………………………………………..