University of BRISTOL

Year 1 Primary Care Attachment, Human Basis of Medicine (HBoM)

Centre for Academic Primary Care

Study guide, 2013-14

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Introduction

Welcome to the Year 1 GP attachment. This is your very first chance in the curriculum to meet patients and health care professionals who are working at the coalface. Learning in General Practice has been highly valued by former students. Some reasons for this include the low teacher to student ratio allowing interactive teaching, the enthusiasm of GPs to teach and the relaxed learning environment.

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

Study guide

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

Blackboard

This course is: MEDI10005-HBOM-Introduction to Primary Care Element. Blackboard contains key course information that is not in, or only briefly summarised in this handbook - look under “Course Information” in the contents list. Important information may be communicated via Blackboard so keep an eye on it.

There are also lots of archived past examples of work to help you plan your assignments. See further information about these later in this guide.

Blackboard is also where you upload your assignments. It is essential that you do this so that your work can be reviewed. Please also give your GP a copy—either printed or by email (you can discuss with your GP their preferred method of submission). To upload your assignments you go to the “Assessment Upload” tab on the contents list of this course in Blackboard, and after you have filled in a form about consent about how your work can be used (e.g. to be used as archived material for future years) you will come to 2 tabs: Applied Case and Reflective Assignment. Choose the correct tab for the assignment you are uploading and click “Browse computer” to find the document you wish to submit, then “submit” at the bottom of the screen to upload it. Your marks and feedback will be on Blackboard once we have everyone’s feedback from the course.

There is also a feedback form on Blackboard that you need to complete at the end of your attachment.

Key dates

The course starts with an introductory session on **8th October 2013.** This consists of a lecture introducing you to the course, followed by small group sessions for consultation skills teaching and learning about communication. This is also where you will be told the detail of your placements.

Your eight-week placement will either be in the first or second semester.
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 (or Wednesday afternoons for some surgeries)

Travel expenses

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

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

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

Attendance

Student attendance should be 100% for all teaching. Any absence through sickness or another reason must be communicated to the GP by phone or email prior to the session you will be missing. You are also required to report any unplanned absence centrally to the University via: medadmin-absence@bristol.ac.uk (and ideally copy in phc-teaching@bristol.ac.uk). As a result of this an email will go to the office of the Academy in which you are studying and to the Primary Care teaching Office at phc-teaching@bristol.ac.uk. Your GP will also inform us of absences at the end of the placement. University guidance and a student certification form for illness can be found here: http://www.bris.ac.uk/esu/assessment/annex/201011/9studentillness.html

Student support

Students in Years 1&2 can access support through: The Faculty Student Advisor, 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).

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

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

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

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

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

Student Health

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

- Student Health. Tel: 0117 330 2720

Professional Behaviour

PAID – Personal, Professional and Inter-professional Development

(One of the vertical themes of the Medical course in Bristol)
Students should adhere to the professional code of practice at all times which can be found at: http://www.bristol.ac.uk/medical-school/staffstudents/rulesandpolicies

See also "Confidentiality" further on in this handbook.

This includes:

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

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

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

Medical Indemnity

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

Contact Information

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

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

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

Aims and Learning objectives of the attachment

Aims: the student will experience General Practice through observation of health care professionals and meeting and interviewing patients. The students will begin to: learn to communicate effectively with patients, 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.
(These aims relate to guidance in the GMC's Tomorrow's Doctors 2009)

Objectives: by the end of the GP attachment:

- You will have observed GPs consulting and consider skills that contribute to good verbal and non-verbal communication

- You will have been introduced to professional behaviour through discussion of expectations in the introductory session and discussion of ethical principles with your GP tutor. You should have demonstrated maintaining confidentiality during the attachment and gained consent to use patient narratives in your assignments.

- You will have conducted an interview with a patient during a home visit, thereby practiced early consultation skills, and reflected on the patient's illness narrative and experience of health care. This is assessed in the Reflective Assignment.

- You should have been introduced to basic clinical skills such as taking a temperature, blood pressure and pulse.

- You will have integrated 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.

- You will have learnt and developed skills in self and peer assessment and giving feedback

An overview of Year 1

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

The Human Basis of medicine (HBoM) which course consists of 5 elements:

- Society, health and medicine (1st semester)
- Primary care attachment (in the 1st or the 2nd semester)
- Clinical epidemiology (1st semester)
- Ethics (2nd semester)
- Whole person care (2nd semester)

This runs alongside the **Molecular and Cellular Basis of Medicine (MCBoM**) course which provides you with the science knowledge base necessary for later teaching. "Systems of the Body 1a" covers the anatomy, physiology and biochemistry of the Cardiovascular and Musculoskeletal Systems and you may see some relevant clinical cases to these systems while you observe your GP consult.

VERTICAL STUDIES
MB ChB PROGRAMME

Vertical Themes

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

3D

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

CAPS

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

ETHICS

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

EBM

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

PAID

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

WPC

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

Overview of GP placement

At the introductory session, you will be given details of your placement and one student will be the lead for the group. This student should contact your GP prior to your arrival to check times, directions and whether you need to bring anything in particular. We do not expect you to have your own medical equipment at this stage. Please take your University ID badge and this study guide.

Week 1: This session is a chance to get to know your GP and group and an introduction to general practice. As a group you will discuss the course, the plan for future weeks, and the assignments so please bring any queries you might have from the introductory session or reading the course material. You are likely to be shown around the practice and be introduced to other members of the healthcare team. You may also be walked, or sent off to walk around the area, to get a feel for the social context of the practice. The GP may bring in a few patients or teach you about some of our tools of examination e.g. the stethoscope, blood pressure cuff 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 feedback and questions as a group with the GP teacher. Your GP may arrange other activities like tutorials, debates or special visits and you should have an opportunity to practise clinical skills.

Week 7: 2 assignments are to be handed in (to give GPs time to assess).

1. Applied case: up to1500 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 at least 500 words of personal reflection and learning.

Week 8: review of assignments and feedback session.

- You will have some teaching from your GP on giving feedback
- You will present your reflective piece informally to the group, and there will be time for self and peer assessment.
- Your teacher will give you verbalfeedback on your assignments and on your time in general practice.
- There is also a feedback form to be completed on Blackboard (if you do not complete this during the session please do by the end of the week). All feedback is anonymous, and we use it to change and improve the course.
- In addition, your GP tutor will greatly appreciate feedback on their practice

Style of learning in clinical placements

Your learning in clinical practice will be experiential, collaborative and reflective i.e. you will have encounters with doctors and patients (experiential), have opportunities for dialogue with your GP tutor and colleagues (collaborative), and consider your experiences in more detail (reflection). This kind of learning is much more interactive than taking notes in a lecture theatre and the learning depends upon your own level of interest and curiosity. GP tutors enjoy enthusiastic and dynamic groups of students who ask questions, share their perspectives and learn together as a team.

Confidentiality

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

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

Whenever you meet a patient during your medical training it is wise to check that the patient knows who you are and that you will keep all information confidential. If you keep notes these should be anonymous and kept in a secure place. This also applies to your written assessments for your GP attachment. You can either change a patients name or write Mr. A, Miss R. Note that that often patients can still be recognized from discussion about them even if you don't use names so do not discuss patients outside of the course, or to each other (unless in a confidential learning capacity) and certainly not in public (e.g. on the bus back from your placement).

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

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

Observing the GP consult

Case Log: There is a case log at the end of this handbook for you to makes notes on and reflect on the patient encounters you see. Whilst observing the GP, you may consider if there are any consultations that strike you as challenging or particularly interesting. You can discuss these consultations further with the GP and in SH&M and consider using issues in writing your applied case.

Things to think about whilst observing consultations

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

Themes for the Year 1 GP attachment

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

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

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

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

Introduction to primary care

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

Common conditions

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

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

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

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

Figure 1: Common conditions

Organisation of primary care

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

Primary health care teams

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

Key features of general practice

Apart from working within multidisciplinary teams as explained above, general practice also means caring for individuals within their local community, co-ordinating patient care, offering continuity of care, dealing with a great variety of patient presentations during a single surgery and dealing with uncertainty. Some of these topics will be dealt with later.

The GP is the person with whom the “buck stops”. Those patients who are turned away by specialist care, or who do not fit the criteria for care elsewhere, return to their GP.

Accessing the NHS

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

Integration with other learning Human Basis of Medicine (HBoM)

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

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

Ethics and law

Resources:

i) What, if anything, about this situation might have put a strain on NHS resources, and how should it be dealt with fairly?

ii) Did you observe any instances of rationing of resources, how did the GP handle the situation?

iii) In a GP surgery how do you think the GP should deal with the conflict of interest in running to time and also giving each patient as much time as they need?

Confidentiality:

i) Have situations arisen where the GP had to be particularly careful to safeguard confidentiality?

ii) Did your GP ever consider breaching confidentiality? Why?

iii) What would you do if a patient asked you not to disclose something they wanted to tell you to the GP?

Autonomy:

i) Which patients have seemed to be more 'empowered' than others?

ii) Have you seen any cases of a patient passing a decision to the GP or to carers/family? Did this help the patient in any way (if so/ not, how)?

iii) Is it important for patients to make decisions about their treatment? What are the limits of this?

iv) How much responsibility do you think a patient has for her own health? (It may be interesting to repeat this question with different cases, depending on the causes of the health problems).

Society, Health and Medicine

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

Clinical Epidemiology

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

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

Reading List

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

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

Introducing consultation skills

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

Objective for consultation skills in Year 1:

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

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

The point of good communication is to be able to develop a shared understanding of the patient's problem and what management they hope for. The Cambridge-Calgary[2] consultation model will be used throughout the student curriculum, summarised below:
In addition, if you want to read/learn more about the consultation, see the Blackboard Learning Materials, Essential Clinical Communication. This is a seven-part tutorial series developed by the UK Council of Communication Skills Teaching in Undergraduate Medical Education.

Cambridge Calgary Consultation model

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

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

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

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

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

[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.

Patient-centred practice

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

Active listening

Why do we emphasis listening as a consultation skill?

Dame Cicely Saunders, founder of the Hospice movement in this country, said, "When someone is in a climate of listening he'll say things he wouldn't have said before." (Long A, 1990. *Listening.* London: Darton, Longman and Todd Ltd.)

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

Listening is also therapeutic for the patient, the patient feels heard and understood.

The personal impact of the doctor upon his patient was examined by the psychoanalyst Dr. Michael Balint (1957)[3] who pointed out that by far the most frequently used drug was the doctor himself, i.e. that it wasn't only the medicine that mattered, but the way the doctor gave it to his patient. Listening is giving yourself to the patient. The quality of the doctor-patient interaction is not just affected by how much you know as a doctor or what technical or consultation skills you develop but also your attitudes, maturity, kindness, emotional intelligence. It's not just what you do, but also who you are.

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

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

Questions to think about:

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

Observing others or yourself (self-reflection) listening:

HEADSPACE

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

VERBAL

- What is tone and volume of voice? Does this help or hinder listening?
- Look for clarifying questions "You said it hurts, can you tell me more about the pain?" but this can just be a word asked in a questioning tone to encourage more detail: "Painful?"
- Look for summarising what was said "So let me see if I've got this right? The pain came on gradually over the last 3 weeks but it started hurting before you did the gardening." this demonstrates understanding and gives the patient the opportunity to correct you.

[3] Balint M. *The doctor, his training and the illness.* New York: International University press, 1957

- Use of silence. Silence can be a very powerful tool to allow the patient time to say what they really want to say, but it can feel hard to hold at first, concentrate on non verbal listening skills such as nodding and waiting attentively rather than what you are going to say next.
- Look for encouraging phrases e.g. “umm”, “I see” that show listening

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

THINGS THAT BLOCK LISTENING

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

Open and closed questions

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

<u>Open questions</u>

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

<u>Closed questions</u>

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

Clinical skills (adapted from year 2 competence forms)

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

Taking a temperature

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

Measuring pulse rate and rhythm

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

Competence in measuring blood pressure

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

Prescribing

About half of the medicines prescribed for people with chronic conditions are not taken[4]. Only 43% of patients take their medicine correctly as prescribed to treat acute asthma and between 40% and 70% follow the doctor's orders for depression medication. The media recently has focused on the risks and high rate of errors in prescribing and the impact of this on patient care.

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

You may also consider:

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

Home visits

Home visiting has always been an important part of British General Practice. Although the number of home visits GPs routinely make are in decline, GPs still visit patients at home when they are too sick or unable to come to surgery. Home visiting for you as a student is made possible by patients kindly agreeing to spend time talking with you about their health and medical experiences for your learning. In visiting patients in their homes you have the opportunity not only to hear their story at length but also to see something of their lives in context. Your GP tutor will know the patient well and will brief you on the patient's background and what issues might come up. The patient will have been briefed as to why you are visiting, and should've received a copy of the letter on page 22. It is important you show respect for confidentiality and sensitivity towards the use of a patient's story so please also take a copy of the letter in this handbook out with you on visits. Please wear your ID badges and start by introducing who you are and why you have come to talk to them. **Your Reflective Assignment will not be considered for the prize if you do not include a sentence confirming that the patient has consented to the use of their story after reading the letter.**

The purpose of your home visit is to practice listening to and being with patients and hearing about the patient perspective on the NHS. The home visit is an opportunity to help you to think about your use of body language, tone of voice and questions, similarly to notice the patient's verbal and non-verbal communication.

A lot of students feel quite nervous about the home visit. They worry they might get emotional or not know what to say. Reading through this section and talking to your GP tutor might help, it is also worth bearing in mind that anxiety can be a normal emotion and some students reflect on this in their assignments. See the tutorial notes on the reflective assignment on Blackboard for examples of this. You can take notes (see log at the end of this handbook) or it might seem more appropriate to just listen. An alternative is that one student mainly asks questions and the other mainly writes.

A useful website where you can watch patients' accounts of their illness is: www.healthtalkonline.org

[4] Haynes RB, McKibbon A, Kanani R. *Systematic review of randomised trials of interventions to assist patients to follow prescriptions for medications*. Lancet 1996;348: 383-6

It may be useful to look at this before or after your home visit session. If before, you could note down some of the things you might try and find out from your patient. Afterwards, it could be helpful with your Reflective assignment to find different perspectives from other patients with the same condition

Talking with patients, difficult encounters

Possible opening (after introducing yourselves and explaining you are first year medics):

'Thank you for taking the time to talk to us this afternoon. Dr X has told us a little about you. Would you be able to tell us more about your health and the health care that you have received?'

You may want to start by listening attentively to their story. Many patients will be happy to talk at length about their health – it may even be in some way cathartic or therapeutic for them to share their experiences. Patients generally feel very comfortable talking to medical students. They may see you as open and as more sympathetic and less threatening than doctors. They may also be pleased to help in the education of future doctors. You may be surprised at patients' willingness to tell you about very personal aspects of their life and their illnesses. They may not have discussed such things in detail before – not even with family, friends or doctors.

It is possible that the patient may become emotional during your conversation. This is a normal response to relating an emotional experience. They may need time out and to be silent, they may weep. In such situations, it is valuable to you and the patient, to learn to be comfortable in the silence or the expression of emotions. After giving space, you may want to acknowledge their frustration, fear, and sorrow or grief e.g.

'It sounds like it has been a very lonely time for you' *'It must be very difficult going through this illness'*

Sample questions to use while a patient is telling their story to learn more about their experiences
• How were you given the diagnosis? Do you remember your reaction?'
• What was the impact of the illness on: your self-image? Your relationships with friends and family? Your roles at home? Your ability to work?
• What has helped you most to adjust to the illness?' (friends, family, faith?)
• What has been the most difficult part of adjusting to the illness?'
• What has your interaction with the health care services been like – including GP, nurses, physiotherapists etc and hospital appointments and investigations?'
• How do you feel about being in hospital/taking medication?'
• How do you find communicating with health professionals in the GP surgery or in the hospital – nervous, relaxed?' • What aspects of your doctors' care have been most/least helpful?'
• How would you describe a good doctor?'
• What advice would you give another person who had just been diagnosed with this illness?'

When you have finished the interview, thank the patient for their time and for helping you to learn about the impact of illness. Let them know that conversation with them has been helpful and that you will try to remember the issues they discussed as you care for patients in the future.

After the visit you will have the opportunity to tell your GP tutor about your experience with your patient, what you learnt and what surprised you. You may have some questions for your GP. Also think about whether you might base your GP assignment on your visit to this patient and how you might present their illness story (essay, poetry, painting etc).

Letter to give to patients

The letter to give to patients appears on the following page.

University of BRISTOL
SCHOOL OF SOCIAL AND COMMUNITY MEDICINE
Centre for Academic Primary Care
Primary Care Teaching Office
Canynge Hall, Whatley Rd, Bristol, BS8 2PS
T +44 (0)117 331 4546
F +44 (0)117 928 7325
phc-teaching@bristol.ac.uk
http://www.bristol.ac.uk/primaryhealthcare/

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.

Dr Lucy Jenkins - Teaching Fellow in Primary Care

Assessment

There are 2 assignments in the GP attachment to hand in for week 7, and the following pages give you some ideas and advice on writing them and the descriptors for assessment. There is not space in this handbook to give you lots of previous examples as these are archived in Blackboard (see folders Applied Case and for the Reflective assignment see under "Essay" and "Reflective/Creative Piece") There is also some tutorial notes on Blackboard that illustrates advice on the assignment with various examples from previous assignments.

General information for the assignments

Essential — Please:

- Word process your assignments
- Make sure each page contains your name and student number
- Clearly write the title of your work on the first page. This should include a date and description of the assignment e.g. "Applied Case for GP Attachment, Dec 2011: The Doctor-Patient Relationship" or "Reflective assignment for GP Attachment, Dec 2011. Reflection on sculpture: "Barbed wire heart"
- Make sure your Reflective assignment includes a sentence confirming that the patient has consented to the use of their story after reading the letter.
- **Include your word count**. This should be 1500 words for the Applied Case. 2000 words as suggested for a written Reflective Assignment. 500 words of written reflection are needed if your piece is a poem, artwork or other medium. This does not include footnotes, references or bibliography. If you work is significantly over or under the word count this will affect your result.
- **Anonymise the patient and ensure and mention patient consent**

Submitting work

- All assignments must be uploaded onto Blackboard (this is essential in order that you can receive your feedback). You can upload your work to Blackboard by selecting this course: MEDI10005: Year 1-HBOM-Introduction to Primary Care Element. On the contents tabs on your left you need to click on "Assignment Upload". Instructions will be there. **You will not see the submission point for your assignments until you have completed the consent form about possible future educational use of your work.**
- You must also submit a copy of your work to your GP for marking in case of difficulty accessing your work on Blackboard. You should check with your GP whether they would prefer you to print or email this.
- For artwork you should submit a digital photo to the GP of your creative work with your reflection. Some students have embedded the photo in a word document that contains the reflection

- Audio and video files bigger than 10 MB will be too big for loading onto Blackboard. These should be given to your GP on a CD or memory stick AND emailed to me (Lucy.Jenkins@bristol.ac.uk) via FLUFF (http://fluff.bris.ac.uk/fluff/)

You should also:

- Make sure your work is clearly laid out and easy to read. Consider line spacing, the size of your font, and try to use a standard font or it doesn't look very professional and is difficult for us to put your work on Blackboard as an example for future years.

- Check your references are correctly formatted, and up to date.

Assessment regulations

It is necessary to obtain a 'pass' in both assignments to pass the HBoM unit. Your GP teachers have clear descriptors for marking your work, see below, and their marking is moderated at the university. For full details regarding this process, please see the assessments section of the Medical school website at: http://www.bristol.ac.uk/medical-school/staffstudents/assessments/students/#year1.

Prize nomination

There will be a prize awarded for excellence to one student or split between more than one at the end of the year. GP tutors can nominate students who have completed two excellent pieces or work and performed well during the placement. See more details on the Medical school website.

Applied Case

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

Objective: 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.

The aim of this assignment is to make you think in more detail about some of the GP consultations you observe. It involves applying some of the theory that you have learned during your GP attachment or in other HBoM elements or in your own reading, to what you are seeing clinically. You will need to analyse and interpret what you observe using research to back up your analyses and conclusions (i.e. reference your work). This can feel like a difficult task, but learning to interpret clinical scenarios and draw on the literature in order to come to sensible conclusions are important skills for you as a future doctor. Getting a handle on what is happening in real life will always be more complex than any theory, but theories can help you begin to think about what is happening in practice. It is okay and even a sign of excellence to note where theories apply and also where they fall down in relation to your examples.

For this assignment chose a **challenging consultation** observed in the GP surgery (e.g. the issue of HRT in the example below) or choose a **challenging issue** (e.g. ethics and decision making, managing chronic illness – see blackboard for past work). Ideally this will tie in with some of your HBoM learning

Here are some ideas (HBoM integration in brackets):

- 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 when caring for 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? (WPC, SHM)
- Did you meet any patients using complementary or alternative therapies? What are the issues?
- Ethical dilemmas. Capacity and Consent — any consultations where these were challenged or possibly compromised? (Ethics)
- 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 behavior — What methods are there to do this? Cycle of change.
- Explaining risk to patients

Any of these scenarios may face you as a doctor.

Tips on writing the applied case:

1. Blackboard contains a number of previous examples. Read through other students' work with an evaluative eye, to see in what ways they are written well and how they could be improved.
2. Discuss cases you are thinking of using with your GP and colleagues. What are all the possible themes and issues about this patient, their situation or consultation? (The assessment scheme rewards deep or broad thinking about the issues). Choose a case or an issue that really captured your imagination.
3. Plan an outline (see points 6,7, & 8)
4. Write with the reader in mind; write for an intelligent but non professional reader– try to explain your thinking, use case examples clearly.
5. Give yourself enough time. It's helpful to write a draft and then go back to it a few days later and you will be more likely to see errors and you will have a fresh perspective, and might have new insights during that time.

6. You should have an introduction (about 300 words) to define the topic and briefly outline the structure of your piece. Why did you choose this topic?
7. Plan the middle of the piece. Your ideas should follow a logical progression. Think about what your main point is? How does the case illustrate the issues? Does the case contradict or build on the theory in any way?
8. Conclusion. Summarise the main points and make your viewpoint clear and say why. Include recommendations for practice or future research if appropriate.
9. When writing you can aid clarity by each paragraph starting with a sentence that outlines the point you are making and concludes the point at the end of the paragraph.
10. The complex part is weaving your practical observations together with relevant literature. This is where you can demonstrate your perceptiveness and understanding.
11. Your use of referenced ideas gives credibility to your writing e.g. you may think that patients don't often see the GP with the common cold, but do you have the experience and overview to make that statement? In order to strengthen your assertion you could review the literature to see if this is the case. You could read your assignment through with a critical eye that notices assumptions that you make and ask: "How do I know that is the case? If you have no evidence for it, you may want to remove the statement, find a reference, or clarify that this is your opinion rather than known as a result of research. This process should develop your critical thinking.
12. Remember to spell check, to check punctuation, referencing and paragraph structure.
13. Check your word count, you could be penalised if it falls a long way outside the required word count.
14. Consider the grade descriptors below when writing your essay as these will be used for feedback. Your GP Tutor will aim to give broad feedback including three specific things they liked about your work, three things that may be improved and to raise any other points of interest/for discussion.

Clear and accurate referencing is essential. The university uses plagiarism software which picks up any work which is not original.

The Vancouver System of referencing is recommended and here is a brief reminder (see Blackboard for more detail)

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.

Assessment descriptors for the applied case:

	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 use case to challenge theory. May contrast different or opposing theories.

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

Examples of applied cases with feedback

The doctor-patient relationship *by Marisa Caple*

We saw a 57-year old female, now in her sixth year of hormone replacement therapy (HRT), which she originally undertook because of severe hair loss at the onset of menopause. She had scheduled her appointment after recent media attention highlighted new risks putatively linked with HRT. She was visibly upset, and told us that she was becoming increasingly concerned over the possible dangers of the treatment she was receiving - particularly after speaking to several friends who suffer with breast cancer.

The GP asked her a series of very open questions, giving her a chance to elaborate on the circumstances that had brought her into the surgery. She told us that she had read in a number of newspaper articles that HRT may increase a woman's risk of breast cancer and heart disease, and that many scientists are beginning to doubt its safety. She recounted the main factors that led her to choose the therapy in the first place; the hair loss she experienced in her early 50's was embarrassing and socially debilitating for her. Having laid all of this information out on the table, she asked the GP what she should do. Should she stop the HRT and take the chance that her hair would fall out? Or should she continue, and accept the risks involved?

The GP chose not to assume a traditional paternalistic role in the doctor-patient relationship; he did not take the information she provided, mix it around in his expert brain, and provide her with a clear-cut answer.[1] This may in fact have been what she was looking for. But he imparted later that he is not comfortable being wholly responsible for such a decision as it is ultimately the patient who will have to live with the repercussions. At this point, the GP could have simply printed off a few leaflets and let the patient deliberate on her own. This sort of relationship would be characterized as informed, and would certainly have been easier from the doctor's point of view1. But it was very clear that she had come to the surgery because she didn't want to be left alone to decide. So, in cooperation, the two of them came up with a short list of the benefits she received with HRT, and the possible harm it could be doing.

They spent a good deal of time trying to achieve a shared understanding of exactly how important the prevention of hair loss was to the patient. They discussed alternative methods of baldness therapy, but agreed that none seemed very effective. In the process, the GP communicated his opinion about the recently-reported risks of hormone therapy - that while there is some evidence that it may indeed be doing harm, there is also support for the protective role it plays. For example, HRT has been shown to help prevent osteoporosis and reduce menopausal symptoms.[2] He listened intently to the patient's fears, and tried to put them in perspective given the medical evidence he had access to. By the end of the session, they had agreed that she would reduce the dosage of her hormones by half, and return in a few months for a re-appraisal of the situation. She was not ready to suddenly stop the HRT and risk losing her hair, but this concern could not entirely overrule the long-term effects she feared. It was mutually decided that if the lower dose could meet her needs, and reduce her anxiety in the meantime, then they would reconvene in 8 weeks and assess whether the medical evidence, or the patient's priorities had changed dramatically.

The recently-published "Million Woman Study" found that taking combination hormone therapy over a 10-year period doubled the risk of breast cancer, and consequently sent waves of anxiety through 1.5 million women in the UK who currently take HRT. In a BBC interview last month, Robin Parsons, manager of the Menopause Amarant Trust, noted: „many women are panic stricken after they read the headlines in the newspapers. They tend to stop their treatment suddenly, most times without consulting their doctors. It is a big problem."

In light of this problem, the British government has issued advice to doctors telling them to carefully weigh the individual risks and benefits when discussing HRT with women. Further, decisions should be continually

reviewed by both patient and physician. In any case, cautious interpretation of emerging evidence is advised before forming any conclusions.

1 Donovan, J. The social patterning of health and illness. Lecture at the University of Bristol. Bristol, 2003
2 Chilvers, C.E., Knibb, R.C., Armstrong, S.J., Woods, K.L., Logan, R.F. Post menopausal hormone replacement therapy and risk of acute myocardial infarction - a case control study of women in the East Midlands, U.K. European Heart Journal, 2003; 24:2197-2205.

Feedback to this applied case:
This applied case starts with a really clear summary of the case so that the reader ends up with a good understanding of the patient's dilemma.
"Should she stop the HRT and take the chance that her hair would fall out? Or should she continue, and accept the risks involved?"
The risks and benefits of HRT is a really topical question (especially so at the time of the student's writing – 2004) and is still a common presentation to GP's. Following this, there is a clear discussion around theory relating to consulting i.e. the paternalistic, informed or shared models and these models are very succinctly and clearly applied to the case under discussion.
This piece is fairly well referenced, with the references being relevant and correctly written up at the end of the piece. Ideally the "Million Women Study" and the BBC interview should also have been referenced. The final paragraph offers a good conclusion and acknowledges the complexity of clinical decision making. The work does not meet the word count.

Further examples based on specific parts of the Applied Case:

Title
Thinking about your title helps your work stand out. This student used a play on words to show the change in doctoring styles.
"Doctor — your patient will see you now: Informed Patients & Carers in Healthcare – Challenges to Medical Dominance" Lucas Brammer

Introduction
In your introduction you should outline the case, or the issues you are going to discuss. When you are planning try to think broadly about all the issues involved e.g. see this final sentence from an introduction about the important implications of an aging population with more co-morbidities and more consultations in the elderly compared to the general population.
"The challenges this already presents to doctors are diverse, not only in terms of the technical aspects of treatment but also the basic logistics of effective communication and care provision, through to important ethical and legal implications which can stem from those interactions" Peter Lillie

Weave the case with theory
This student engaged with the case she observed of a patient with medically unexplained symptoms and asked questions to further her understanding and looked at the evidence:
"*Ethically each and every patient has a right to treatment when they visit the GP and the doctor has a duty, if not obligation, to treat them. However if still after 6 months no diagnosis can be found, when is the cut off line for the doctor to label an illness as a medically unexplained symptoms and look to alternative support for the patient such as a pain clinic or cognitive behavioural therapy?* "*According to www.patient.co.uk up to 20% of Primary Care consultations involve a physical symptom with unlikely organic disease*."

Show evidence of wider reading

The following example shows a student using theory to look at the issue of stigma in various cases she saw, she showed she had read, comprehended and assimilated wider reading as well.

"Another issue that patients possessing concealable stigma must encounter is the psychological strain in the process of concealing their true identity. As Louganis (a world class athlete who suffered from HIV) once explained, trying to manage what is said and what is therefore kept from being said, in social interaction demands a great deal of mental control[1] she described her constant fear that someone may notice to the extent that she had stopped socialising in the same way as prior to her condition. The point here is that a secret can be a tremendous burden and can lead to an intense preoccupation with the secret. In the "preoccupation model of secrecy", Lane and Wegner (1995) propose that attempts at secrecy typically activate a set of processes which can in some people, lead to obsessive thinking about the secret.[2] Those with concealable stigmas therefore need to constantly grapple with the assortment of negative feelings that are evoked by hiding information about themselves, verses their own obsessive preoccupation with their stigma. This preoccupation can itself become a problem as it can permeate judgments and behaviours of patients (as demonstrated by Mrs.M").

Charlotte Coekin

[1] Wegner, D.M., & Erber, R, & Zanakos, S. (1993). Ironic processes in the mental control of mood and mood-related thought. Journal of Personality and Social Psychology, 65, 1093-1104.

[2] Wegner, D.M., & Lane, J.P. (1995). From secrecy to pyschopathology. In J.W. Pennebaker (Ed.), Emotion, disclosure, and health (pp. 25-46). Washington, DC: American Psychological Association.

Using cases you have seen or evidence to challenge theory

"According to Talcott Parsons, patients are passive individuals[1]. When an individual becomes ill, they are removed from the cultural norms and adopt the 'sick role' in which the responsibility falls on the clinician to allow them to function once more in their role within society. Throughout my Primary Care attachment however, I have come to disagree with this observation. I have experienced many 'informed patients'."

This student goes on to use evidence to back up his assumption that based on the patients he observed, patients are more informed than they were:

"The World Health Organisation now estimates that there are in excess of 100,000 health-orientated websites on the internet[2]. The NHS implemented NHS Direct, a telephone advisory service, costing £25 per call to the tax payer – the equivalent of a visit to your local GP[3]. With so many information sources available, it is obvious that patients are more informed than ever before, but what does this mean to the future doctor?" Lucas Brammer

[1]Stacey M. *The Sociology of Health and Illness*, Third Edition, London, Routledge Publishing; 1995.

[2]World Health Organisation. Report by the Secretariat. In: *Proposal for '.health' internet domain.* Geneva: WHO; 2003

[3]The Telegraph Online, Devlin K: *Every Call to NHS Direct Costs £25*. [Online]. Available from: http://www.telegraph.co.uk/health/3253245/Every-call-to-NHS-Direct-costs-25.html [Accessed: 27th February 2010]

Empathy and bringing life to your work

This student brought the theory to life by the use of carefully selected imagery and metaphors to illustrate the impact on the patient: *"The final - and in the case of Mrs.P - most profound issue relating to her concealable stigma, was her diminished confidence. Her husband forlornly described how his wife now spends hours getting ready every time they went out and how there would always be a pile of clothes on her bed that she had tried on and not been happy with."* Catrin Evans 2011

The Reflective Assignment

Developing into a skilled medical practitioner demands more than linear knowledge of diseases and diagnoses. People's illness experience does not just include physical diagnosis and treatment. They also have to face and deal with new symptoms, possible limitations to their lives, changes happening to them that lie beyond their control, fear of the unknown and what the future may hold. Any of these different strands may be brought into the consultation as patients try to make sense of what is happening to them. Your Reflective piece may help you consider some of these aspects associated with illness in more detail.

Why Reflect?

The GMC document "Tomorrow's Doctors" 2002 (available from http://www.gmc-uk.org stipulates that medical students should have time for personal reflection and personal growth. Reflective writing provides an opportunity to consider your own attitudes and perspectives that arise when meeting patients. See below for more guidance with regard to this.

Practicing reflective writing

Reflective writing requires practice and standing back from oneself. For example you could practice writing about the same event through different people's eyes. You can deepen your reflection with the help of dialogue with others so gaining other perspectives. By reflecting on what you have learnt from an incident, and how you would do something differently another time, this allows you to be continually learning and developing which is a vital skill for future doctors.

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 different ways reflecting—through art, writing, guided thinking or dialogue with others.

This assignment is very open. We want you use your intuition to distil out the essence of your encounter with the patient — what was really important for the patient or for yourself that arose from your dialogue? You can write an account of meeting the patient and weave your reflections through your piece, or you can write more creatively and put yourself "in the shoes" of the patient or carer followed by your reflection. Alternatively many students choose to express the patient story through poetry, artwork, photography, music, dance etc.

We want this to be an opportunity to develop your perception, intuition, interpretation and expression, thinking creatively and holistically and stretch your imagination as you try to convey a patient or a carer's experience and perspectives. So while you must do what feels right for you please do see this as an opportunity to try something new and consider pushing the boundaries of your comfort zone, technical ability is less important.

Tips on producing the Reflective Piece

1. Try to think about the way in which your chosen patient told their illness narratives (stories), what kind of language and words did they use, what metaphors and imagery is brought up, how are they making sense of the invasion of illness in their lives, how do their emotions penetrate the dialogue? How do you want to express that?
2. Consider if you may want to convey the whole illness narrative or focus on a small part of their story e.g. diagnosis, their perception of the disease, the impact of their illness
3. If you have chosen a written medium you can write an account of how the home visit was for you and tell the patients story that way or take the position of patient, carer or observer, or move between these. If you write from your perspective using patient quotes from your meeting can help convey the patient's voice and perspective and may demonstrate your attention and listening to the person.
4. Consider the grade descriptors as detailed below as these will be used for assessment and feedback.

Tips on writing the reflection:

1. If you choose poetry or medium that doesn't lend itself to weaving at least 500 words of reflection through it you will need to write a separate reflection piece of 500-1000 words.
2. There are 2 elements to think about in the reflection: **Self reflection**: How did you feel when you listened to the patient's story? What reactions did you have whilst communicating with the patient? Did any of your reactions surprise you? How will this meeting affect your future practice as a doctor? Did you learn from this encounter? And **Reflection on the patient's story**: What beliefs may the patient have about their illness, its aetiology and treatment? What questions or issues does their story raise? What are the learning points for you or other people? Do you think the patient told you the full story? Do you think the patient holds back from telling the GP or other doctors how they really feel? Read on for lots more about reflection.
3. You also need to be able to describe why you chose the medium you did. For this you might like to think about the voice you are using as the perspective you choose to take alters the message you convey. E.g. You might find yourself concentrating more on the patient voice (i.e. trying to get across their story in their words/images/metaphors e.g. with first person narrative/poetry or with a painting or photo of what the patient might see as they look out on the world) or you may focus on the student voice. This would be your take on the encounter, describing your experience with the patient (e.g. through a painting of how you see the patient), or your reactions and reflections to their story.
4. Excellent pieces often describe how they imagine their audience might interpret the work, and analyse what reactions they intended.

Assessment descriptors for the reflective case:

	POOR	SATISFACTORY	GOOD	EXCELLENT
Spelling and grammar* (for reflection if not written piece)	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 please feed back to them 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.

Examples of Reflection

An excellent description of reflection can be found in the Harry Potter novel "The Goblet of Fire". In the paragraph below Dumbledore the chief wizard and head teacher is talking to Harry about having excess thoughts!

Harry stared at the stone basin. The contents had returned to their original, silvery white state, swirling and rippling beneath his gaze. 'What is it?' Harry asked shakily. 'This? It is called a Pensieve,' said Dumbledore. 'I sometimes find, and I am sure you know the feeling, that I simply have too many thoughts and memories crammed into my mind.' 'Err,' said Harry who couldn't truthfully say that he had ever felt anything of the sort. 'At these times' said Dumbledore, indicating the stone basin, 'I use the Pensieve. One simply siphons the excess thoughts from one's mind, pours them into a basin, and examines them at one's leisure. It becomes easier to spot patterns and links, you understand, when they are in this form.' (J.K. Rowling)

Read and then compare the following 2 accounts of the same event. They show the difference between a descriptive and a reflective account:

Descriptive –

The patient was telling me about how difficult her life had been since she was diagnosed with diabetes and how she didn't much enjoy going to see the GP and nurse. She was worried about all the numbers that they measure, whether they would be OK (blood tests and blood pressures). She was concerned about the number of tablets she had to take and told me that she quite often forgot them. She was still smoking and more than she let on in clinic. It was one of her few comforts, even though she knew it was bad for her and worried about what it might be doing to her. She would rather stick her head in the sand, "ostrich style" she said.

Reflective – (sub-headings included just for clarity)

Describe your feelings / their feelings

As the patient was telling me about her worries and concerns regarding her diabetes and telling me about things that she hadn't mentioned to the doctor, I felt a bit uncomfortable. I wasn't sure how she would feel if I was to tell her doctor about the smoking and the not taking the tablets very well. I felt like she wanted me to be in on her secret with her. I felt privileged that she was talking to me honestly and I didn't want to abuse her trust but I didn't want to encourage her health damaging behaviour either. I didn't get into a discussion about smoking in any more detail.

Analyse

I think that patients are still sometimes afraid to say what they are really thinking to the doctor and instead say what they think the doctor wants to hear. When they talk to a student, because we are less confident and have more time, I think patients are sometimes more honest. She may also have felt more relaxed because I was in her home, so it was her territory. I think patients are probably more relaxed at home than in the GP surgery and I think they feel even less comfortable when they are in hospital.

Conclusion

I would like to try to remain aware when seeing patients, that they may not feel comfortable enough with me to be telling me things as they are, especially if they are ashamed or afraid of my reaction. No one likes to be told off.

<u>Some examples of student reflection</u>

Imagining self in situation

"I can't imagine what I would do if it had happened to me. It seems so unreal that I can't mentally relate myself to that situation"

New way of seeing

"meeting this lady and writing this poem made me think about addiction in a new way, as contributed to by society's presentation for smoking and drinking and eating very little…not just a result of personal choices."

Awareness of language

"The fact that she didn't call it an abortion made me think carefully about how to ask her about it… to use her own words and a more gentle and less scientifically based vocabulary."

Change in attitude

"Before I visited this patient, I admit that I had a stereotypical view of alcoholics as people who had chosen to be irresponsible drinkers. However, as I listened to the patient's story I learned that lots of stressful social factors had contributed to making her resort to drinking alcohol as a means of escaping from it all. I have learned that as a doctor you need to be aware of a patient's history and major life events as the way the patient copes with them can affect their health"

Self-awareness

Are there any other ways you might see the situation, how might you try to understand this patient and their life? How you might have coped given similar difficult living circumstances?

"I looked at him with pity and felt sorry for him, but I was unable to empathise with him….I couldn't stop blaming him inside my head for what had happened to him even though I knew I shouldn't judge him. I felt he was responsible for everything that had happened to him."

Use of metaphor

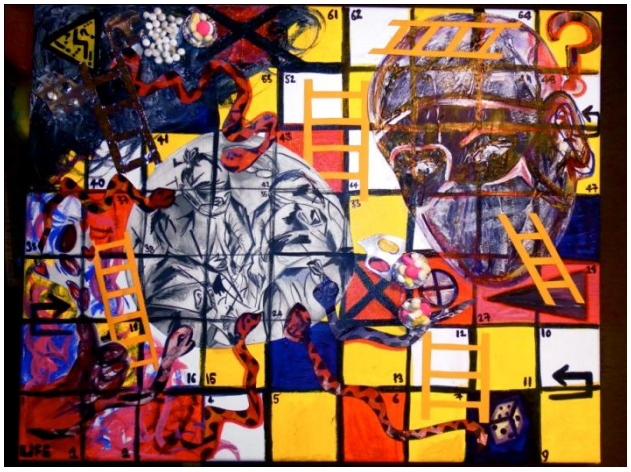
"Perhaps, referring back to the metaphor of the cocoon, survival depends on life cycles. Catching someone when they are on the verge of a natural internal renewal is indicative of the skill, patience and sheer luck required for the job."

Learning from the patient

"…the more I spoke to them, the more I realised that this is a story of hope and inspiration for others. His recovery is a miracle and it has changed them into more beautiful people who love life, for they have been so close to losing it."

<u>Ensuring the patient voice:</u>

When producing your creative piece you might find yourself concentrating more on the patient voice (i.e. trying to get across their story in their words/images/metaphors e.g. with first person narrative/poetry or with a painting or photo of what the patient might see as they look out on the world) e.g. Alex Coull 2011 used the metaphor of a game of snakes and ladders in the work below to express what it might feel like for a patient with renal failure in and out of hospital for dialysis and kidney transplants.



Or you may focus on the student voice. This would be your take on the encounter, describing your experience with the patient (e.g. through a painting of how you see the patient), or your reactions and reflections to their story (e.g. in your essay writing or your written reflections accompanying the creative piece). Some students present both patient and student voice.

Feedback and final session – week 8

The plan for week 8 is:

- Discuss: principles of feedback
- Students to review each other's reflective pieces
- Each student to describe and reflect on/self assess their reflective work
- Group discussion and feedback led by GP
- GP to give each student individual feedback on both pieces and time in General Practice using qualitative tool

Principles of giving feedback

Self assessment of work should be done first.

Feedback should be carefully thought through and based on the objectives and descriptors provided. Also it should be:

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

Hopefully you will all feel comfortable about sharing thoughts on your/others' work within the group. If you have any concerns regarding this, please speak with your GP Tutor. There are many recommendations on ways to give feedback. A popular one the "Feedback sandwich" – discuss positives first, and then any less positive/negative/constructive comments, try to finish with a positive/encouraging thing.

Peer learning - and sharing work

It is really valuable for you to be able to learn from each other's work as students. As a doctor you are going to have to work together, and your own understanding and learning can really be enhanced by hearing and seeing other student's ideas and perspectives. We hope at the end of your attachment you will have the chance to do this. You will know from getting feedback on your own work that you don't want to be criticised but also that just hearing that your effort is "good" does not give you confidence that the person looking at your work has really thought about it. Here is a framework to help you look critically at each other's work and help you learn from it too (adapted from Reis et al Begin the BEGAN (The Brown Educational Guide to the Analysis of Narrative)

1) Read carefully/engage with the creative piece and think about your "gut reactions." Perhaps the piece transports you into the experience described? Does the work move you? Has the student captured the patient/carer well?

2) Think about how your own judgment affects your views of your colleague's work: what clinical and/or personal experiences, views and biases does the work bring up for you? (N.B this may be personal to you and you don't have to share this, but it is useful to be aware of what may influence your views)
3) If you are looking at a piece of text, at this point reread and analyse it, highlighting salient quotes and key concepts, expressed emotions (e.g. verbs such as 'surprised', 'scared') and reflections your colleague has used.
4) If the work is creative either text or image or sound—what metaphors, images and symbolism have they used? How does this resonant with you as a reader/viewer
5) Are there any key themes that occur to you?
6) Does the medium they have chosen add to their message?
7) What did you learn? How might you apply this to future situations?

Feedback on the course:

You will also be asked for your feedback on the course. Your GP puts in a lot of work into organizing the placement; giving your views on what went well and where you think it could be improved is valuable and respects the effort your tutors put in. As discussed above, giving feedback is a skill and there are the same rules to adhere to: be constructive, specific, non-judgmental, offer observations not assumptions.

Your written feedback regarding this course and your GP teacher needs to be done via Blackboard: MEDI1005: Year 1-HBOM-Introduction to Primary Care element clicking on the "Feedback" tab on the contents menu. This should be completed within 1-2 days after finishing your GP attachment. Some GPs may have an available computer for you to complete your feedback during the session in week 8.

Your GP will likely also have their own feedback too for you to fill in and discuss during week 8.

<u>Points to think about when giving feedback on the course:</u>

- Were the aims and objectives for the course achieved?
- Why do people come to see the GP? Did you think the same at the beginning of the placement
- What have you got out of this experience?
- 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?

Case log (observed consultations)

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

Age/sex	Problem	Consultation skills used/needed	How GP dealt with	Learning points	Link with HBoM

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?	

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?	