University of BRISTOL

Medical School

The art of General Practice by Anna Brown
http://www.outofourheads.net

GP Teacher Guide 2013-14

Introduction to Clinical Skills
For Year 2 Students

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Please refer to p5 for local contacts.

Welcome

Thank you for teaching Year 2 students in 2013-14 and welcome to the Year 2 GP Teacher guide.

The student feedback for last year's GP attachments was excellent. I hope you enjoyed reading it. Thank you for your enthusiasm for teaching and for doing a great job.

The ICS Course is the first time that students lay hands on patients. It is a very exciting time for the students but may also bring new anxieties. We know that you understand this and try and help your students build up confidence. Please continue with your pastoral care and making your students feel welcome.

The essential information you need for teaching second year students is in this guide. Please make sure that you are familiar with

- The 'Core Curriculum'
- The 'rules' for good feedback giving (p. 27)
- The Cambridge Calgary consultation skills guide (CCG, p. 34) which provides the structure for the consultation skills teaching sessions students have in years 2-5.

Changes for 2013-14

As you already know the ICS weeks have been shortened with the loss of some clinical sessions during the year. This has been compensated for with a four week clinical block at the end of Year 2 called LITHE (learning in the hospital environment). Overall this means that students will have 2 more clinical weeks than in previous years. I am pleased to say that students will still have one GP session per body system in ICS. We appreciate that it is much more difficult for you to take two groups in the same week and are very grateful to all of you for making this work. At the time of writing no GP sessions are planned for LITHE.

Professional behaviour assessment

This year the University is asking teachers to use the 'student concern form' if they have concerns about the professional behaviour, academic ability, engagement with learning or health and well being of their students. Please read more on page 8.

Professional indemnity for students

Students are advised to join a medical defence organisation. The MPS and MDU offer students free membership. It is important that students are covered when they are on clinical placements. Please check that your students have indemnity.

Prescribing

Prescribing is an important and frequent task for most doctors. To make sure that students can prescribe safely when they qualify a national prescribing exam has been developed. It will be mandatory for Year 5 students in this academic year for the first time.

Students will already have learned a bit about drugs in their physiology tutorials. You can build on this in relation to the patients and problems/diseases they will be seeing with you.

The CAPS logbook

Students are given a thick booklet listing 32 clinical skills and procedures and consultation skills they are expected to be competent in by the end of year 5. Each competency needs to be observed by a teacher and signed off.

You will be teaching your students some of these skills in relation to specific conditions, for example peak flow measurements in conjunction with Asthma and will need to sign their CAPs logbook. This should not be the main focus of the GP sessions. Please do not spend a lot of time on it. The most important task for the GP sessions is to observe the students taking histories and examining and giving feedback.

‘Tomorrows’ Doctor’ (TD)

The Bristol medical curriculum is based on the ‘framework’ set by the GMC for all UK medical schools. This ‘framework’ is described in ‘Tomorrow’s Doctor’ (TD) which you can access at http://www.gmc-uk.org/TomorrowsDoctors_2009.pdf_39260971.pdf. It is organised into three ‘Outcomes’ - ‘O1-The doctor as scholar and scientist’, ‘O2-The doctor as a practitioner’ and ‘O3-The doctor as a professional’ and further divided into paragraphs. I have referenced most of the learning objectives to the relevant outcomes and paragraphs in TD, i.e. TD Outcome 2 13a) refers to ‘take and record a medical history etc.’ This shows which aspects of the curriculum are covered in the Year 2 GP attachments.

References to Vertical Themes (VT)

The teaching in Primary Care will touch on the VTs in many ways. I have identified obvious connections to the VT by placing the relevant symbols in the text.

PAID - Personal and inter-professional development, Ethics and law in medicine, EBM - Evidence based medicine, WPC - Whole person care and medical humanities, CAPS - Consultation and procedural skills, 3D - Disability, Disadvantage and Diversity

Teaching office info

We currently have four regular part time administrators in post. Mel Butler manages the Teaching Office and also oversees Years 4-5. Jacqui Gregory manages Years 1 and 2. Stephanie Burke manages SSCs (student selected components) and provides support for all the years. Julia Carver looks after workshops and Year 3.

To make sure that your emails are answered promptly our admin team are using a shared email inbox. Please send all communications to phc-teaching@bristol.ac.uk.

I hope that you and your students will have an enjoyable year learning together.

With best wishes

Barbara

Barbara Laue GP lead for Year 2

The session is an amazing opportunity to get really personal feedback and advice on your history taking/examinations skills. Learn more in these 3 hours than the rest of the week

Good to explore ideas of differential diagnosis and to concentrate on open questions. Great examination tips – very encouraging teacher

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Teaching dates for 2013-14

	Week starting
Cardiovascular system	30.9.13
Respiratory system	28.10.13
Abdominal systems (gastro & renal)	16.12.13
Nervous system & whole patient	3.3.14

The Teaching Administrator at each hospital will be responsible for allocating the students to practices and they will be writing to you separately with names, dates and times.

Contact details

Within the University of Bristol, the overall administrator for GP placements in Year 2 is Jacqui Gregory Tel: 0117 331 4546 phc-teaching@bristol.ac.uk
The academic GP lead for Year 2 is Dr. Barbara Laue barbara.laue@bristol.ac.uk

GP ACADEMY LEADS	ACADEMY ADMINISTRATORS
Bath **Academy Dean: Clare Taylor Clare.Taylor@ruh-bath.swest.nhs.uk**	
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North Bristol **Academy Dean: Justin Morgan Justin.Morgan@nbt.nhs.uk**	
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Lindsay O'Kelly lindsay.okelly@nhs.net	Roshan Printer roshan.printer@gwh.nhs.uk Tel: 01793 60 5913

If you have **concerns about any of your students** please contact your Academy GP lead and/or barbara.laue@bristol.ac.uk. You may need to complete a student concern form, see page 8.

Student support

For support outside their units students can contact the Faculty Student Advisor Emma Teakle, Tel. 0117 928 8444, med-support@bristol.ac.uk or the Director of Student Affairs, the Reverend Mr. Nigel Rawlinson, Tel: 0117 928 9057, Nigel.Rawlinson@bristol.ac.uk

Aims and objectives for the GP attachment

Aim

To help students develop clinical skills and knowledge through practising history taking, communication skills and physical examination

Objectives **TD Outcome 3** 20a)-f) 21a)-e) 23a), f), i)

By the end of the GP attachment students should have:

- Taken, recorded and presented relevant histories from patients with symptoms relating to cardiovascular, respiratory, gastrointestinal, renal and neurological systems using a range of communication skills
- Examined patients, recognised what is normal and elicited, demonstrated and interpreted common physical signs in these systems
- Gained a holistic understanding of the causation and effects of diseases through listening to patients and group discussions
- Received formative feedback on their developing clinical skills from their GP teacher and the other students in the group
- Actively contributed to group learning through giving constructive feedback to their peers
- Reflected on their clinical skills and professional development

Core curriculum relating to the systems from page 10 onwards

Please also see the ICS Unit handbook for more detailed information on the core curriculum and standards

Essential teaching information

Teaching in Year 2 – What you need to do as a GP teacher

- To be well organised (patients, room, cover etc)
- To be welcoming
- To show your enthusiasm for teaching and patient care
- To invite two or more patients per session with conditions relevant to the system for that week
- To teach history taking, communication and examination skills
- To help students 'put it all together' and make sense of the history and examination
- To observe students directly consulting with patients and examining patients
- To inform the GP Academy lead or GP Year lead if you have concerns about any of your students
- To complete a student concern form if indicated (see information below)
- To give students feedback within the group during the sessions and individual feedback at the end of the last session
- To complete the attendance and payment form after the last session

Introduction to the GP sessions

Students now have four half weeks of ICS teaching spread over Year 2. Each half week focuses on one body system. At the end of Year 2 they will have a four week clinical block. The programme for this is currently being developed.

In each week students have an introductory lecture which is followed by more information in the academies and hands on practice with actors as patients. Students will then either go onto the wards to see patients or go to their GP practices. Then groups swap over. This means that different

groups of students will have had different amounts of experience before they come to you. For example you could have a group who has practiced on actors but not laid hands on a real patient or you could have students who have already seen patients on the wards (similar to previous years). This is different to last year when all groups of students had already seen patients on the wards prior to going to their GP. This means that it is even more important to carry out a 'learning needs analysis' at the start of each session to make sure you understand what students have already done and to pitch your session at the right level. Please see **'Learning needs analysis'** for practical tips.

As a GP tutor you will get to know your students in the course of the sessions. This puts you in a good position to comment on their progress. Please provide formative feedback throughout the sessions and individually at the end of the last session.

Students also benefit from the in depth knowledge you have of your patients. Please help the students to gain a whole person perspective. They need to learn how to integrate physical, social and psychological factors in their understanding of the causation and effects of disease and illness.

Students naturally focus in on signs and symptoms and enjoy 'truffling out' diagnoses. This sometimes leaves less time for hearing about the patient experience. Please make sure that patients have the time to tell 'their story' and that the students get in depth insight what it is like for patients to live with a particular medical condition.

Structure of the GP teaching sessions

Session	What you need to do in each session
1 2 3 4	Welcome students
	Brief introduction to your surgery (reception, toilets etc)
	Brief outline of GP attachment
	Brief outline how and when you will be giving feedback to the students
2 3 4	Setting learning objectives for the session
	1st patient 2nd patient
	Review learning objectives, sum up session, plan for next session
3	Reminding students to complete self assessment form in preparation for individual feedback at the end of session 4
4	Brief individual feedback for each student
	Feedback for you: Please hand each student an evaluation form and invite them to feedback on your teaching. This is the only way for us to provide you with individual feedback. Please don't forget.
	Complete the attendance and payment form and return to the Teaching Office

Assessment

Formative
ICS is an introductory course to clinical skills and mostly the assessment is formative to show the students how they are progressing. Students are usually taught by different hospital doctors in different weeks of the course. As a GP teacher you will have the advantage of seeing the same students for all their sessions. Therefore **the feedback you give them during the sessions and individually at the end of the last session is particularly important**.

Assessing professionalism
You will also be assessing 'professionalism'. This consists of: Attendance and punctuality, appearance, attitude and behaviour, and clinical skills development. If you have any concerns about any of your students please discuss this with the academy GP lead or the Year 2 GP lead. You may need to complete a student concern form. The form and more information is at the back of this guide.
Please do not save your concerns till the end of the attachment, contact us at the time of the event.

At the back of this guide are

- A protocol for raising concerns about students
- A flowchart for raising concerns
- Student concern form

Year 2 form to return to the Teaching Office

ICS Attendance and payment form

We need you to complete this form as evidence for the teaching that has taken place. Please complete it after the last session so we can pay you promptly

You need to complete one ICS Attendance and payment form for each group

Please post this form to the Teaching Office. This is essential for triggering payment

Forms for you and the students to keep

ICS Teacher's record form

This will allow you to keep a record of each student's performance over the four sessions. As the sessions are spread out over the academic year we consider it essential that you record your impressions of each student at the end of each session. This will enable you to provide specific feedback at the end of the students' attachment and help you to complete Form A for each student.

Please keep your completed forms for future reference. Students increasingly ask their GP teachers for references. Also, time flies and before you know it your 2nd year students will have metamorphosed into 4th year students, F2 doctors or GP Registrars. You and the students/young doctors may find it helpful and interesting to look back.

Please use these forms as the basis for your final feedback session with the students.

ICS Student self-assessment form

At the end of the final session with your students (Nervous System and Whole Patient) please spend 5 minutes or so with each student individually and discuss how they have progressed in the course. Please give positive feedback where appropriate and highlight areas for further development.

Students should use the **Student self-assessment form** to keep a record of their own progress, strengths and weaknesses. It would be most useful for students to complete this prior to their individual feedback with their GP in the final session. Please give those forms to the students at the end of session 3.

This is a good model for learning the skills of self-assessment and reflection expected by the GMC and will continue to be important to students later in the course and when they qualify. Other benefits are that teachers can gain insight into the students' degree of self-awareness, and this will guide the identification of additional learning goals. Students should write down their teacher's comments on the form during the appraisal discussion. This form is for the students to keep. They could use them for their e-portfolio.

Please do not return these two forms to the Teaching Office

ICS Student teaching evaluation form **Student feedback for you**

Please hand out this form to your students at the end of the final session. They could complete this while you are giving feedback to individual students. The students should place their forms in an envelope addressed to the Primary Care Teaching Office. We will collate the results and provide you with anonymised individual feedback from your students and the overall feedback result. Please try and remember to hand out this form as we will not be able to provide you with individual feedback on your teaching without this. We will remind you nearer the time.

Core curriculum and standards for Year 2

This provides a framework for students' learning in Year 2, covering the systems: cardiovascular, respiratory, gastrointestinal, renal/urology, neurological and 'the whole patient'. Other systems are covered in later years of the course. Listed under each system heading are the required outcomes for knowledge of common symptoms, clinical examination and knowledge of diagnostic tests/medication for each system.

Year 2 is an introduction to clinical skills. In Year 3 students will consolidate and extend their clinical skills and also focus on investigations and making a management plan.

Year 2 Core curriculum

TD Outcome 1 8a),b),g)
TD Outcome2 13a)-c), g) 14a),b),e) 15a),b),c) 17a),f),h) 19a),c),d)

Cardiovascular system

Common symptoms of cardiovascular disease

Chest pain	Explore basic characteristics including site, radiation, precipitating, relieving and associated factors Identify specific history and assoc features of angina and myocardial infarction pain, and distinguish from other causes of chest pain Assess severity (nil, ordinary exertion, severe exertion, rest)
Breathlessness	See Respiratory Curriculum Identify specific history of Shortness of Breath on Exertion, Orthopnoea and Paroxysmal Nocturnal Dyspnoea Identify assoc symptoms of cardiac failure
Palpitations	Identify history of frequency and rhythm of heart beat and associated symptoms
Dizziness/blackouts	Identify history of sudden faintness, with or without ensuing loss of consciousness, which may be cardiovascular in origin
Leg pain	Identify specific history and assoc features of intermittent claudication, acute ischaemia of leg and deep vein thrombosis

Examination of the cardio-vascular system

General examination	Recognise clear pallor, central and peripheral cyanosis Identify the constellation of signs of cardiac failure
Pulse	Ability to measure radial pulse, rate and rhythm Compare radial and apex pulses Examine radial, brachial, femoral, popliteal, posterior tibial and dorsalis pedis pulses and classify correctly as normal, weak or absent. Identify clear deep vein thrombosis in calf and thigh
Blood pressure	Demonstrate correct method of measuring blood pressure, including applying cuff, inflating and deflating at right rate, and identifying Korotkov sounds Identify clearly raised level of blood pressure
JVP	Demonstrate correct method of measuring JVP Identify clearly elevated JVP
Murmurs	Detect clear cardiac murmur and classify as systolic or diastolic
Lungs	See Respiratory Curriculum Recognise clear basal crackles
Oedema	Identify ankle and sacral oedema

Diagnostic tests/medication of cardiovascular system

Chest X-ray	Ability to measure cardiothoracic ratio, and recognise cardiomegaly Recognise clear pulmonary oedema
ECG	Recognise features of a normal ECG, rate and rhythm Identify cardiac arrhythmia's: AF, ectopic beats Identify clear myocardial infarction
Use of GTN	Describe use as diagnostic test, technique, side effects

Respiratory system

Common symptoms of respiratory disease

Breathlessness	Explore precipitants, relieving factors, speed of onset and progression of breathlessness, and associated symptoms. Associate type of breathlessness and assoc symptoms with common causes: asthma, COPD, pneumonia, pulmonary embolism, lung cancer Assess severity (nil, ordinary exertion, severe exertion, rest)
Chest pain	See cardiovascular curriculum Identify specific features of pleuritic chest pain
Cough	Explore nature of cough (dry, productive) precipitants, relieving factors, speed of onset and progression, and associated symptoms
Sputum/Haemoptysis	Explore nature of sputum (mucoid, purulent, haemoptysis) and associated symptoms
Wheeze/Stridor	Identify clear description of wheeze and stridor and associate with common causes

Examination of respiratory system

General examination	Identify noisy breathing, clubbing, cyanosis, cervical lymphadenopathy, signs of smoking, recent weight loss
Shape of chest wall	Identify barrel, pigeon and funnel chests and clear thoracic scoliosis
Respiratory movements	Assess respiratory frequency and depth. Identify clear tachypnoea, intercostal recession and hyperventilation
Percussion	Identify dullness and resonance over different lung areas Identify clear pleural effusion and pneumothorax
Breath sounds	Identify normal breath sounds. Identify clear cases of localised and generalised wheezes (rhonchi) and pitch (high medium, low), crackles (crepitations) and pleural rub, and associate with common causes. Identify localised or generalised reduced breath sounds
Voice sounds	Identify normal, and clearly increased and decreased voice sounds

Diagnostic tests/medication of respiratory system

Chest X-ray	Recognise clear cases of pneumonia, pneumothorax, pleural effusion, lung mass and fractured ribs Appreciate absence of radiological signs in some serious conditions – asthma, pulmonary embolus
Peak Flow meter	Demonstrate correct technique for measurement of Peak Flow
Use of bronchodilator	Demonstrate correct technique for use of bronchodilator MDI and adult spacer device

Gastrointestinal system

Common symptoms of gastrointestinal disease

Abdominal pain	Explore basic characteristics including site, radiation, precipitating , relieving and associated factors. Identify specific history and assoc. features of heartburn, 'ulcer-pain', intestinal colic, and intestinal obstruction.
Weight loss	Explore amount, duration, dieting and associated anorexia.
Vomiting	Explore amount, frequency, description of vomit, presence of blood, assoc. factors
Diarrhoea	Assess frequency, description of stool, presence of blood, associated factors. Obtain contact and travel history.
Constipation	Assess duration, severity (stool or flatus or both), description of stool, straining, associated symptoms.
Rectal bleeding	Explore amount, frequency, appearance of blood, associated factors, description of stool including melaena
Jaundice	Identify duration, colour of stool and urine, associated pain, change weight. Explore contacts or travel, alcohol or drug use/abuse
Dysphagia	Assess duration, severity (food or fluid or both), associated features such as weight loss or pain.

Examination of the gastrointestinal system

General inspection	State of nutrition, cachexia
Hands	Look for clubbing, palmar erythema, Dupytren's contracture, flap with jaundice
Face/mouth	Look for anaemia, jaundice, oral ulcers, appearance of tongue, spider naevi
Lymph nodes	Identify enlarged supraclavicular and groin LNs.
Abdominal inspection	Define different regions of the abdomen. Look for distension, scars, masses,
Abdominal palpation	Careful light and deep palpation, correct approach to palpate liver, spleen, kidneys and the ability to differentiate between these. Recognise both localised and generalised tenderness and guarding.
Abdominal percussion	Percuss appropriately the liver and spleen and understand how to detect ascites by shifting dullness.
Abdominal auscultation	Recognise normal and clearly abnormal bowel sounds
Hernias	Identify direct and indirect inguinal hernia, including reducibility.

Diagnostic tests / medications of gastrointestinal system

Plain abdominal X-ray and CXR	Recognise free gas aand bowel obstruction

Renal/Urology system

Common symptoms of renal/urology disease

Abdominal pain	Identify the specific history, radiation and associated features of renal/ureteric colic Identify burning pain of dysuria, and association with increased urinary frequency in bladder/urethral inflammation
Urinary frequency	Identify clearly abnormal urinary frequency and distinguish from polyuria. Identify oliguria/anuria
Urinary stream	Identify the constellation of symptoms associated with bladder outflow obstruction
Urinary incontinence	Distinguish urge and stress incontinence
Haematuria	Identify blood in the urine. Recognise that it may be the only manifestation of serious urinary tract disease

Examination of renal/urology system

Abdominal palpation	Correct technique of bilateral examination for renal enlargement Identify clearly enlarged bladder by palpation and percussion
Scrotum	Identify normal and clearly abnormal testicles by palpation. Identify scrotal swelling, and distinguish testicular and epididymal swelling and hydrocoele, varicocoele and spermatocoele. Distinguish from inguinal hernia. Demonstrate transillumination of hydrocoele. (See lumps and bumps curriculum)
Oedema	Identify constellation of symptoms and signs associated with nephrotic syndrome, and distinguish from cardiac failure

Diagnostic tests of renal/urology system

Urine testing	Identify haematuria, proteinuria, glycosuria and ketonuria on urine stick testing

Nervous system

Common symptoms of neurological disease

Headache	Take history and identify specific and associated features of migraine, tension headache and subarachnoid haemorrhage
Weakness/Immobility	Identify history of generalised, localised and hemiplegic weakness. Identify slow progressive history and typical features of Parkinson's Disease. Identify acute onset of stroke and TIA
Unconsciousness	Know major causes and identifying features of unconsciousness. Identify clear history of generalised epileptic seizure

Examination of the nervous system

General examination	Identify constellation of signs of major hemiplegic stroke and Parkinson's Disease. Distinguish constellation of signs of upper and lower motor neurone lesion.
Tone	Examine upper and lower limbs, and identify clearly increased and decreased muscle tone, and pattern (generalised, localised, hemiplegic, bilateral). Distinguish spasticity and rigidity
Power	Examine limbs and identify clearly decreased power and pattern Identify clear facial palsy, and distinguish upper from lower motor neurone lesion
Muscle wasting	Identify clear muscle wasting and pattern
Reflexes	Examine the biceps, triceps, supinator, knee and ankle and plantar reflexes. Identify clearly increased and decreased/absent tendon reflexes.
Tremor	Recognise the tremor of Parkinson's Disease and distinguish from hyperthyroidism/anxiety
Gait	Examine patient's gait, and identify clear neurological abnormality due to major hemiplegic stroke and Parkinson's Disease
Speech	Recognise clear speech abnormality. Identify expressive and receptive dysphasia, dysarthria and dysphonia
Sensation	Examine limbs and trunk for fine touch and pain sensation. Identify clearly reduced sensation and pattern.

The whole patient

TD Outcome 1 9a)-d) 10a)-d)

Social and personal history	Take a comprehensive history including: ▪ Employment and housing ▪ Personal relationships ▪ Lifestyle ▪ Alcohol, smoking and drugs Identify social factors in causation and effects of physical illness
Family history	Take a family history of age and health, or cause of death of close relatives. Understand the significance of a family history regarding inherited and environmental factors and patient anxiety. Identify family history of a clear dominant or recessive inherited disorder
Psychological history	Identify major symptoms and signs of generalised anxiety disorder and panic attack, and differentiate from physical illness Recognise patient who is clearly anxious Identify major symptoms and signs of depression. and differentiate from physical illness Recognise patient who is clearly depressed Identify suicidal ideas and plans Identify psychological factors in causation and effects of physical illness
Integration of body systems	Take history and examine patient with common diseases affecting different body systems e.g. diabetes Explore history including related symptoms, examine and apply clinical problem-solving in patient with problems that can have various causes in different body systems • tired all the time • weight loss • fever Apply clinical reasoning where problems affecting one body system have effects on other body systems e.g. gastrointestinal bleeding causing anaemia causing breathlessness and worsening angina

Please integrate whole person care perspectives and discussions throughout your sessions.

- Evaluating patients' stories in the context of their lives
- It can be useful to compare two patients who are coping with their disability in different ways.
- Using art and literature to gain deeper understanding of the lived patient experience
- Highlight the high prevalence of depression in patients with a chronic disease

Teaching resources for weekly themes

- Please read in conjunction with the core curriculum and standards
- For all system examinations please highlight the value of the traditional order of inspection, palpation, percussion and auscultation.
- Students generally struggle with explaining conditions and diseases in non jargon patient centred language. Please give them lots of opportunities to practice this.
    - Exercise in pairs – explaining a diagnosis to each other
    - Ask the patient whether they have any questions about their condition
- CAPS logbook
    - Identify skills that are relevant to the system of the week and plan to sign off some of the students.

Week 1: Cardiovascular System

Suitable patients

- Good history of angina
- Signs of cardiac failure
- Valvular heart disease
- Symptoms and signs of intermittent claudication

Skills

- Taking a pulse
- Measuring BP
- Listening to heart sounds
- Brief look at an ECG
    - Recognising sinus rhythm
    - Recognising obvious ischaemia

Assessment of severity of breathlessness using the NYHA classification

- I Nil
- II Ordinary exertion
- III Severe exertion
- IV Rest

How to measure blood pressure

For information on validated BP measuring devices, how to take BP with different devices, the right cuff sizes and a tutorial see http://www.bhsoc.org//index.php?cID=162 accessed 1.8.13

Please make students aware that the process for diagnosing Hypertension has changed and that we now use HBPM or ABPM.

Questions to ask your students

How do we diagnose HT?

- This has become a bit more complicated.
- Guidelines at http://guidance.nice.org.uk/QS28 pdf accessed 18.9.13

What do we mean by “White coat hypertension”?

- Prevalence of around 10%.

Why is it important for us to pick up high blood pressure?

- Risk factor, primary and secondary prevention
- How can we help patients take medication for a condition when it isn’t making them feel bad?

Should we measure BP in both arms?

- Definitely yes, when taking a BP for the first time in a patient. Research has shown that an interarm difference of ≥10mmHg predicts increased all cause mortality and cardiovascular events (BMJ2012;344:e1327) Measuring BP in both arms should be part of a cardiovascular assessment (Lancet 2012;379;872)
- For follow up measurements and monitoring of patients on anti hypertensive treatment measure BP in the arm with the higher reading.

Week 2: Respiratory System

Importance of smoking, talk about smoking cessation
Assessing impact of COPD

- Assessing severity and impact on life using simple questions – CAT test http://www.catestonline.org/images/UserGuides/CATHCPUser%20guideEn.pdf
- Take the CAT test at http://www.catestonline.org/ different language options
- Assessing shortness of breath using the MRC scale

Medical Research Council dyspnoea scale

At http://www.nice.org.uk/usingguidance/commissioningguides/pulmonaryrehabilitationserviceforpatientswithcopd/mrc_dyspnoea_scale.jsp accessed 29.8.12

Grade	Degree of breathlessness related to activities
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying or walking up a slight hill
3	Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4	Stops for breath after walking about 100m or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing or undressing

Adapted from Fletcher CM, Elmes PC, Fairbairn MB et al. (1959) The significance of respiratory symptoms and the diagnosis of chronic bronchitis in a working population. British Medical Journal

Skills

- Peak flow meter
- MDI
- Spacers

Suitable patients

- Young person with asthma
- Person disabled from COPD or fibrosing alveolitis
- Lung cancer
- Home visit to patient with severe COPD

Week 3: Abdominal - Gastrointestinal system

Symptoms are not always indicative of serious disease e.g. irritable bowel syndrome.
Highlight red flags
Suitable patients

- Good history of peptic ulcer
- Chest pain due to reflux oesophagitis
- Alcohol related GI problems
- Person with inflammatory bowel disease (hidden disability)
- Colostomy

Renal system

Provide simple classification – voiding v storage problems
Skills

- urinalysis

Suitable patients

- Renal colic
- Polycystic kidneys
- Urinary incontinence
- Voiding or storage problems
- Recurrent urinary tract infection

Week 4: Nervous System and the Whole Patient

Teach patterns

- Upper and lower motor neurone lesions
- Neuralgia and neuropathy – 'glove and stocking' v dermatomal loss of sensation

Suitable patients

- Stroke
- Parkinson's disease
- MS
- Bell's palsy
- Slipped disc - sciatica

Teaching prescribing

From 2013-14 onwards final year students will have to pass the **national prescribing skills assessment**. This should ensure systematic testing of prescribing knowledge and focus learning and teaching to make sure that newly qualified doctors are safe prescribers.

Here is a sample question from the exam

Prescription Review Item | **ID** REV001 | This question item is worth **4 marks** | You may use the BNF at any time

Case presentation
A 57-year-old man with chronic obstructive pulmonary disease has been admitted to hospital with a lower respiratory tract infection. He began taking antibiotics the day before admission. He also has mildly impaired renal function and his blood pressure is 106/76 mmHg. He has complained for several weeks that he has a sore mouth. His current regular medicines are listed (right).

Question A
Identify the ONE prescription that is *most likely* to be a cause of his sore mouth.
(*mark it with a tick in column A*).

Question B
Identify the THREE prescriptions that are *most likely* to be contributing to his low blood pressure.
(*mark them with a tick in column B*)

CURRENT PRESCRIPTIONS

Drug name	Dose	Freq.	Route	A	B
theophylline	350 mg	12-hrly	ORAL	☐	☐
beclometasone	200 micrograms	12-hrly	INH	✓	☐
clarithromycin	500 mg	12-hrly	ORAL	☐	☐
ibuprofen	200 mg	8-hrly	ORAL	☐	☐
paracetamol	1 g	6-hrly	ORAL	☐	☐
amoxicillin	500 mg	8-hrly	ORAL	☐	☐
furosemide	40 mg	daily	ORAL	☐	✓
ramipril	5 mg	daily	ORAL	☐	✓
isosorbide mononitrate	60 mg	daily	ORAL	☐	✓

Answer box

Question A Marks per correct tick 1

Beclometasone is an inhaled corticosteroid. Patients who use oral corticosteroids sometimes experience a sore mouth and throat because of the development of oral candidiasis as a result of local suppression of the cellular immune response

Question B Marks per tick correct 1

Furosemide is a loop diuretic which can reduce blood pressure secondary to volume depletion. Ramipril is an ACE inhibitor which reduces the production of angiotensin II and is an antihypertensive drug. Isosorbide mononitrate dilates both arteries and veins and is known to reduce vascular resistance.

BPS BRITISH PHARMACOLOGICAL SOCIETY — Prescribing Skills Assessment – *Prescription Review Question Item Authoring Tool* — Medical Schools Council

Suggestions for teaching prescribing in Year 2

At the summer teaching workshop in June 2012 we discussed in small groups how we could best teach prescribing in years 1-5 in General Practice. Students learn about some medications and pharmacological pathways in their science teaching in years 1 and 2. We can build on that in year 2. Here are some practical suggestions.

General teaching principles for teaching prescribing

- Keep it relaxed
- Interactive – concrete examples
- Assess students particular learning needs
- Teaching should make things simple – stick to simple drugs
- Need to give them structures and frameworks, hooks to hang knowledge on
  i.e. highlight classifiable endings (-olos, -prils)
- Share golden rules
  - Always ask about pregnancy if a woman is of childbearing age
- Build confidence - ask questions to show them what they already know, get them to guess

Teach the bigger picture

- Importance of prescribing
- Cost
- Ethics
  - Rationing
  - Generic prescribing /cheaper substitutes
- Access to medication
  - Can patients collect prescriptions themselves, do they need help?
  - Can patients remember how to take medication?
  - Dossette box etc
- Mechanics – how does something written on a script turn into a treatment?
- Concordance
  - How do we know whether patients are taking their medication?
  - Important to encourage patients to be honest with GP

Prescribing

- Role in condition
- Role in doctor patient relationship
- What does the patient want?
- What does the doctor think the patient wants?
- As time mx tool?

In relation to a patient

- Hands on, for example with inhaler and insulin preparations – how do they work, what does the patient have to do
- Look at drug list
  - What classes of drugs do you recognise?
  - How do the drugs relate to the history?
  - 1 drug – name 2 side effects
- Asking questions
  - What do you already know about this drug?
  - How does this drug work?
  - How is this drug used?
  - What does a drug need to do to help in this problem, i.e. heart failure?)
- Give students homework, reviewing common drugs or class of drugs – actions / interactions / side effects

Your thoughts and ideas how to teach prescribing in year 2 would be very welcome. Please email them to barbara.laue@bristol.ac.uk

Learning needs analysis

Asking questions

- Find out what they have been taught so far and what they know
    - Start by asking *open questions*: re-capping prior experience, discussing any burning issues, asking them directly about learning needs
- Asking very open questions, particularly at the start of the very first session in Year 2 may not work, i.e. 'What are you hoping to get out of this session?'
  Try asking more focused but still open questions
    - 'What are the key things that you have learned about CV exam. so far?'
    - 'What is the most important thing for you to learn about CV exam./history today?'
    - 'What skill do you want to focus on today?'
- Fill in gaps
- Ask challenging questions
    - How do you know this symptom relates to a heart problem and not something else?

Process and organisation

- Preparation
    - Spend 20-30 minutes before the patient comes in
    - Assess what the students know before the patient comes in
- Brainstorming
    - What symptoms might go with this system?
    - What are you going to ask the patient?
    - What else might this symptom be a sign off?
    - What are you going to do with the information that comes back from the patient?
- Resources
    - Encourage them to buy Mcleod at the start of Year 2 so they can read things up
    - ICS student handbook (on the primary care website – year 2)

Teaching tips

Importance of adequate introduction and explanation

It is important to invest the time at the beginning of a teaching session to outline learning objectives, ground-rules and what to expect. For example, explaining to students that they may take 'time-out' if they get stuck – when they can ask for help from the group or teacher before trying again. Also gaining genuine consent from patients and properly explaining the role of the student is likely to reduce patient anxiety. Please remember that you will be a role model for being a GP and also for being a teacher.

Provide focus

- Focus on specific areas within a bigger topic

Setting learning objectives

It is important to discuss and agree at the start of each session what you want the students can expect to have learned by the end of the session. Also involve your students in planning for the next session.

Patients for teaching

There are no strict rules about the number of patients to bring in - though usually two or three per session works best. Different patients can be used to emphasise different aspects of the system. For example, one to teach physical signs, one with a typical history and another to teach about the functional effects of a disease.

Priming the patient
Patients for the Year 2 sessions generally have ongoing problems and rarely have a clear-cut 'presenting complaint' for students to elicit in the way they have been learning in other settings. It is important to prime the patient at which point in their history they should start telling their story or to tell it as if they were telling it for the first time. They should not give the diagnosis away at the start. This would then allow the students to explore symptoms in depth, i.e. shortness of breath and provide an opportunity for testing hypotheses and differential diagnoses.

Demonstrations – role modelling
Prior to coming to the surgery students will already have had theoretical and practical teaching how to take a history and examine the relevant system. In most academies they will have received a lecture on the relevant common symptoms and signs, as well as a demonstration of history taking and examination of the system. They will also have practiced examination skills with actors. Teaching in the academies varies a bit. Please check how much experience they already have so you can gauge your teaching.

Students may initially be a little nervous about talking to patients. You may want to start off with the history or examination yourself and then handover. Check what the students would like you to do. If they have already had several opportunities to observe they would probably prefer to get started straight away. The emphasis should be on students actively taking histories, examining, discussing and feeding back to each other.

Demonstrate some skills

Observation of students
This is one of the most important aspects of the course. Students are rarely directly observed either interviewing patients or performing examinations. The opportunity to receive individual feedback when they are working with real patients is highly valued by students. Please give regular constructive feedback to your students.

Symptom-orientated learning
In Year 2 students are initially taught how to take a full and systematic history. As we know, in 'real life' GPs (and other doctors) largely use a 'pattern recognition' or 'hypothetico-deductive' model focusing in on what they think is the likely cause of the problem at an early stage. It is useful for students to understand this in Year 2 and practice it once they can competently take a systematic history. A good way to teach the focused approach is to take a common symptom e.g. breathlessness and explore how a doctor decides whether this is likely to be due to cardiovascular disease, respiratory disease or anxiety.

Students should also learn the importance of the ***timing of symptoms*** in aiding diagnosis, e.g. sudden onset of symptoms in a stroke, compared to slow insidious onset of symptoms with Parkinson's disease, compared to intermittent symptoms in epilepsy.

Students should realise that it is the ***combination of symptoms*** that is often important, e.g. the likely diagnosis of pleuritic chest pain in a young woman on the pill is different from pleuritic chest pain in a middle aged man with a temperature and purulent sputum.

Linking to students' anatomy knowledge
Draw an abdomen on a flipchart and ask the students to think of the organs in the abdomen and add '-itis' to the name. This is a fun way to make them think about abdominal problems and draws on what they already know.

Impact of disease on patients
Students should be encouraged to ask patients what it is like to live with particular symptoms and/or conditions.

Consultation skills: The importance of the history
Students should appreciate that most diagnoses are made from the patient's history, with physical examination secondary, and investigations least important. This is particularly true in General Practice. It is helpful for the students to start by seeing patients with relatively simple and clear cut histories and then progress to more complicated histories.

Marrying up the '20 questions approach' to a 'Holistic Model'
It was noted that students in years 2 and 3 may find the 'process' aspects of the medical interview more difficult to demonstrate than 1st or 4th year students. 1st year students have little clinical content knowledge which means that they prioritise the process. By the 4th year the clinical knowledge is better embedded. In year 2 and 3 students have the difficulty of limited clinical knowledge and may find keeping the balance between meeting both the doctor's and patient's agendas more of a challenge. Please also see diagrams in section on consultation skills.

Student preparation
It is a good idea to ask the students to do some preparation before each session. For example familiarisation with the questions to ask in relation to a specific symptom (e.g. SOB). Also students could practice or run through the physical examination of systems – so they are ready to put this into practice with patients. It is important to maximise hands on time with patients

Learning by experience – 'having another go'
Students generally want to 'have another go' - incorporating points of feedback. This way a teaching session is more likely to finish on a positive note with a more confident student. The time this takes needs to be built into the session.

Managing the group

- Establish group rules
    - *Group rules* were discussed: Reassurance that nothing said in the group should leave the group, either regarding patients or students
- Create 'safe' environment
    - GPs commented that they want to stress the fact that this is a *safe learning environment* in which no question is too stupid to ask. One encouraged the students to see the session as a "playground" for fun and discovery.
- Present history to all after taking it (incl. the patient)
- Group needs v individual needs
    - One way is to set tasks for students to look up prior to the next session, by email. These can be individualised and emphasis altered depending on need for each student
- Peer teaching and learning
    - We encourage students to learn from each other (although they are very reluctant to offer each other constructive criticism at this stage). Some GPs ask students to be prepared to offer 3 positive comments. Others give role of bad cop to one student, good cop to another and the role of summing up to a third
- Encourage a more holistic perspective
    - Students tend to be very exam focused. Our job is to steer them away from this, to a degree, to teach them about impact of illness on life (and other things in the Johari window which they don't know that they don't know)

Role modelling (hidden curriculum)

Role model being a professional

- Show them that you are continuously learning (PUNs and DENs, appraisal portfolio etc)
- Talk about being a professional
- What you do if you don't know
- How common uncertainty is and how you manage it
- Helps students to visualise themselves in your role
- Emphasis that learning is an ongoing process
    - You don't have to know everything
    - Be honest with your patients, ok to look things up in front of the patients
- Share the resources you routinely use – BNF, EMIS mentor, websites etc
    - Show them that you have McLeod (or similar) on the shelves
- When asked a question, turn it round and ask 'where can we find that out?' This works for everything

Models for organising the teaching sessions

The quality of teaching time is more important than the quantity. We suggest a 3-hour teaching session, including ½ hour coffee break in the middle. There are various ways the sessions could be structured. Based on having 4 students, here are some examples how to organise teaching about the respiratory system. If you have built a teaching session that works well, please email us and we can disseminate it via the teaching newsletter.

Model 1

2.00-2.15pm	**Introduction** Discussion of prepared work, prior knowledge and experience Setting learning objectives for the afternoon
2.15-3.15pm	**Patient 1** ***Elderly patient with COPD*** 20mins – student 1 interviews the patient while the other 3 observe, followed by a brief feedback session with patient present. 20mins – student 2 examines the patient while the others observe, the patient is then allowed to leave and feedback given. 20mins – feedback to both students from the group and teacher with suggestions for improvement
3.00-3.15pm	Coffee break
3.15-4.15pm	**Patient 2** ***Young asthmatic patient with frequent admissions*** 20mins – student 3 interviews 20mins – student 4 examines 20mins - feedback
4.15-4.45pm	Revisiting learning objectives, 'putting it all together', identifying individual learning needs, Q&A
4.45-5pm	Planning for the next session

Model 2
You could also split the tasks into smaller chunks. For example student 1 could take the presenting complaint and past medical history and student 2 social, family and drug history. Students could be swapped in at the halfway point in the examination. The split method means however that students have less of an opportunity to demonstrate a full set of skills or build rapport with the patient. Could be suitable with the first patient in the first session to get everybody engaged in the task.

Model 3
Some students and teachers prefer it if one student completes a whole interview and examination themselves, for a more authentic experience. This means that the other students are relatively inactive for a long period and may get bored. You need to consider how you will keep them engaged. Here are some suggestions

- Other students to provide a running commentary on another's student's examination
- Other students to feedback "What was done well?" "What would they do differently?" "How could that student improve his or her examination of the abdomen?"
- Advise students that you will ask one of them to provide a succinct summary of the history and findings but don't tell them who that will be in advance

This model generally works less well. If you only have 2 patients it would mean that 2 students don't take a history or examine. If you brought in 4 patients, one for each student, you would either run out of time or you would be unable to observe all of them.

Visiting patients in their homes
During the rest of the hospital ICS course students do not have the opportunity to see patients in their homes. Home visits can demonstrate how patients with serious chronic diseases and significant impairment can be supported to live an independent life in their own home. Student feedback has shown that students enjoy home visits and consider them a good learning experience.

Teaching Practical Skills - 4 Stage Technique

Dr Isabelle Hancock
Clinical Teaching Fellow
North Bristol Trust 2012

Evidence shows that the 4 stage approach is an effective teaching method based on how we acquire motor skills using the psychomotor domain, with the emphasis on repetition as well as learning through seeing and doing (Simpson: 1966 as Cited in Curzon 2004).

Four-Stage technique for skills teaching Bullock et al (2010)

Stage 1 Demonstration of the skill, performed at real speed with or without speech. Performed in real time. Provides strong visual imagery which shapes new learning.

Stage 2 Repeat demonstration with dialogues, providing the rationale for actions. (Opportunity for questions and clarification)

Stage 3 Repeat demonstration guided by one of the learners – demonstrating comprehension (Opportunity to correct error or misapprehension, answer further questions and reflection)

Stage 4 Repeat demonstration by the learner, and practice of the skill by all learners (practice, practice, practice)

At the beginning of all lessons one is advised to give students clear, realistic learning outcomes and gain entry criteria. One can motivate candidates by explaining the skills importance and put it into the context with the rest of the course. For example, when is blood pressure measurement required? Why is it a useful skill to have? How does it benefit the patient?

The key to the skills session's success is the instructor's ability to help candidates identify how they can apply information, skill and attitudes to every day clinical practice. Grantcahrov and Renznick (2008) even advocate a 5 stage technique with an additional initial step being a description of how it fits with practice. This familiarity with the context significantly enhances the learning of the new skill and greatly increases retention. Also, making adult learners aware of the session plan empowers them, and the tutor can communicate what participation is expected of the students during the session.

This well structured and systematic approach allows repeat practice in a safe environment. The main focus of using this methodology is to effectively transfer skill from the expert (instructor) to the novice (candidate) as the first step towards gaining skill mastery. Learning, practice and correcting performance are key factors in this process. Curzon (2004: p259) had stated: "skill lesson is apt to be a slow process" and there are very few short cuts! Although the process is time consuming and it requires small groups with high tutor to student ratio, evidence has shown it to be the most effective way of teaching a practical skill.

For virtually all newly learnt skills a single practice may be insufficient, therefore all candidates must be encourage to continue to practice to gain further confidence and competence until mastery is achieved. Research also demonstrates retention of knowledge and psychomotor skill decline sharply over 4-6 months if not practiced, Bullock et al (2000). Therefore one might consider setting a number of skills to be observed/achieved during the placement (through use of a log book) and plan to revisit skills throughout the years. To conclude, a debrief is advocated, highlighting the key points learnt and checking that the learning objectives have been achieved.

Other useful Tips for teaching a practical skill

- Teach progressively from simple to the complex
- Teach skills in the order in which they will be used
- Break the procedure into steps, achieving each step prior to performing the whole procedure.
- Teach one Technique at a time
- Continual Reinforcement
- Acquire knowledge that is specific to procedure
- Follow learning with practice
- Integrate cognitive and psychomotor learning
- Encourage confident employment of the skill

References

Bullock, I, Davis, M, Lockey, A, Mackway-Jones, K (2010). *Pocket Guide to Teaching Medical Instructors.* Second Edition. Oxford: Blackwell Publishing.

Curzon, LB (2004). *Teaching in Further Education*. Sixth edition. London: Continuum

Grantcharov, TP, Reznick, RK. (2008). Teaching Rounds – Teaching Procedural Skills. *BMJ.* 336 1129-1131.

Simpson, EJ. (1966). *The classification of educational objectives, psychomotor domain.* Urbane, Illinois: Illinois University.

Spencer, J and Jordan, K. (1999). Learner Centred Approaches in medical education. *BMJ, 318,* 1280-1

Dr. Kate Mitchell
Clinical Teaching Fellow
Bath Academy 2010

Teaching CV history and examination – 'diagnosticians' rather than 'information gatherers'

Kate's teaching of history taking is based on the hypothetico-deductive model. This can be done with the whole group taking turns to ask questions or with a single student leading the history taking. She stops the student after one or two history questions, asks the group for their differential diagnosis at that point and writes them on a flip chart. The students ask more questions and Kate continues to stop them at appropriate points. This teaches the students to focus on the problem and leads them down a diagnostic path rather than just amassing a lot of information with their questioning.

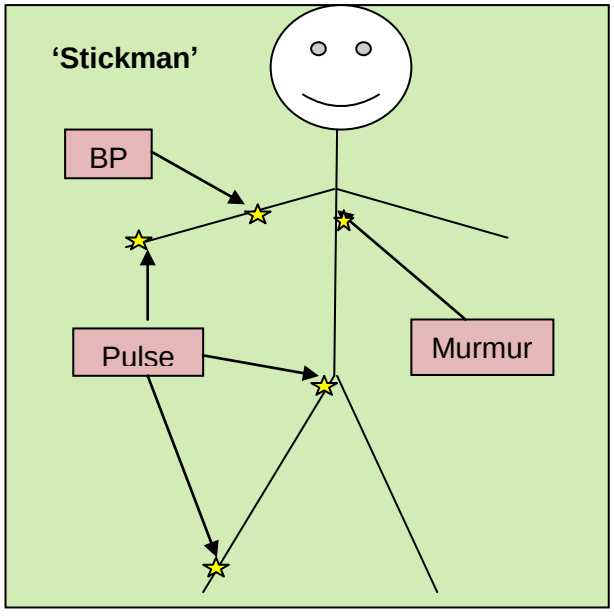
It is important to outline this method for the patient and students beforehand so they understand the rationale behind this process. The patients need clear instructions at what point to begin their story, i.e. when symptoms started, not to divulge too much information in one go and not to give the diagnosis away.

Here is an example for 'I get a pain in my chest'

Kate	**Students**
What is your diagnosis at this point?	Students brainstorm possible diagnoses
Kate draws a mind map	
How will you differentiate between these diagnoses?	Students ask questions about type of pain, radiation, etc
What does this type of pain sound like? What can we rule out at this point?	Rule out tumours and pneumonia
What other questions could you ask to differentiate?	Ask about risk factors
What have you learned from that?	Angina is less likely
What is more likely/less likely at this point?	Aortic stenosis more likely
Would you like to ask some questions about that (AS)?	Students ask about collapse
What does that tell us about the diagnosis?	

Anticipating clinical findings

Kate teaches examination skills by making students visualise the different parts of the examination with the help of a 'stickman'. She draws a stickman on a flipchart and asks the students what they would examine and what they would expect to find. She marks this on the stickman.
This helps the students to anticipate what signs they could expect to find with a given history



Keeping up the interest of the group while one student is examining

- Student to give running commentary on what other student is doing
- Summarising
- Sharing examination

Giving and receiving feedback

Giving feedback to students

Students, just as teachers, are keen to know how they are doing. It is important to give feedback in a constructive way that allows the student to accept and consider it. The following two pages summarise evidence based guidance for good feedback giving. It is essential that you are familiar with these rules and follow them.

Feedback is essential to help students get the most from their GP attachment. It is important to clarify with each group of students at the beginning of the first session how and when feedback will be given.

- Regular and frequent feedback to individual students and the whole group during each session.
- We would like you to give brief individual feedback to each student at the end of the final session. To help you and your students to make this as relevant and effective as possible we have asked the students to complete a self-assessment form and to bring this to the final session. Please remind them at the end of session 3 to bring this form. A sample of this form is in the Appendix.
- Please encourage the students to write down your feedback on their form, or you may want to write this yourself.

Students learn much from their peers and it is therefore important to encourage the students to give each other feedback. This also helps to create a more relaxed atmosphere (see examples of teaching clinical skills in the Appendix).

Giving feedback can be learned as a skill and it would be helpful if you could discuss 'effective feedback giving' with your students, including the students feeding back on your teaching. This section about feedback giving is also in the GP section of their ICS handbook.

Feedback rules

The following is a brief summary of evidence based guidance and it may be useful to highlight them for the students

Giving feedback

- Well timed
- Be descriptive
- Be specific
- Direct feedback at behaviour that can be changed
- Check understanding
- Check group understanding

Receiving feedback

- Listen carefully
- Accept the feedback as genuine
- Consider the feedback
- Tell giver of the feedback how they can help
- Thank the person giving you feedback

Good practice when giving feedback

- Be non-judgemental
- Offer your observations (not assumptions or personal comments)
- Offer ideas rather than advice
- "Sandwich" negative feedback
- End feedback session on a positive note
- Be aware of your body language; is it leaking a message that is different to the verbal one?

Examples

- Based on direct observation
  - Poor: "Dr. X said you spend time taking a careful history yesterday…."
  - Good: "I noticed that you allowed the patient a lot of time to…."
- Phrased in as non-evaluative language as possible
  - Poor: "Your history taking was poor…"
  - Good: "I noticed that you did not ask the patient about side effects…"
    "I noticed that you did not make eye contact with the patient…"
    "I noticed that you interrupted the patient several times…"
- Specific not generalised
  - Poor: "You seem to have a problem establishing rapport with your patient…"
  - Good: "I noticed that you do not greet your patients at the start of the consultation…."
    "I noticed that you looked at your notes and not the patient for most of the interview
- Focussed on behaviour not personality
  - Poor: "You are very paternalistic with your patients…."
  - Good: "I noticed that you chose the treatment option for your patient…."

Asking students for feedback on the organisation and delivery of your teaching

Students are generally unschooled in giving feedback and may be reticent to do so and as GP teachers we may be anxious about possible criticism and antagonism. A relaxed atmosphere facilitates feedback.

Creating a supportive atmosphere

- Asking for feedback in itself can help to foster a relaxed atmosphere
- Questions such as "how are your studies going?" show interest and foster a sense of shared endeavour.

Leading by example – start with self-evaluation ("I demonstrated the whole examination, what did you think about that…")

- It can introduce non-judgemental language
- It can focus on behaviour rather than personality
- It shows openness to feedback
- It provides a starting point

Sticking to specifics

- Begin the discussion with particular elements of the teaching in mind "I am not sure that I made it really clear how to use the ophthalmoscope?"
- Ask about the effect of a particular teaching technique "With this patient two of you took the history. What did you think about doing it that way?"

Evaluate the feedback

- Evaluate feedback before you act on it
- Important points can be clarified by restating them
- Comments from one learner can be put into perspective by asking others

Complete the loop

- Potentially useful suggestions can be incorporated into the teaching and re-evaluated

Request feedback early

- Early requests convey to the students that their contributions are expected and welcome

How to ensure that you get feedback from your students

- Students to complete the teaching evaluation form at the end of their final session in your practice, put them in an envelope and seal it (confidentiality)
- You need to give your students a SAE for posting the forms
- Teaching Office will return collated and individual results to you twice a year

What do students do with the feedback they receive?

Research shows that learners expect FB but also ignore it. If they receive a good mark 'smile and file'. If they receive a bad mark 'bin and forget'.

Encourage your students to work with the feedback they receive

- Ask learners to build on your FB, how did they incorporate your FB from last time into this learning event

- Ask learners to respond selectively to your FB by starting a reflection with one of the following sentences or similar
    - The part of the feedback that puzzles me the most...
    - The comment that rang the truest for me was...
    - I don't get what you mean when you say…
    - I would welcome some advice on...

- Create opportunities to help student make informed judgements about their own learning – self assessment. Self assessment all the time

- Recognise that learning by doing is how it happens

- Think questions – any important concept is just the answer to a question

Students' prior experience of General Practice

Year 1 Primary Care attachment
Students will have attended 8 afternoon sessions in General Practice in their first year. They should have gained an appreciation of the scope and nature of primary health care through

- Visiting patients at home in pairs to develop interviewing and listening skills to elicit patients' perspectives on their health, illness and the health care that they have received.
- Observing the GP consult with a variety of patients and begin to understand the skills that contribute to good verbal and non-verbal communication.
- Applying and evaluating theoretical information from social anthropology lectures and the first year handbook
- Through writing a reflective account or a creative piece (poem, painting etc) relating to their experiences with patients

Consultation Skills Teaching

Communication skills teaching is one of the six vertical themes in the Bristol medical curriculum. The others are Ethics and law in medicine, EBM, 3D –disability, disadvantage, diversity, PAID – personal and Interprofessional development and WPC- medical humanities and whole person care. At present Primary Care organises the communication skills teaching and Trevor Thompson is the overall lead for the vertical themes.

Teaching history taking and consultation skills

Students start to talk with patients in their Year 1 GP attachments and in Year 2 they have formal consultation skills training with actors. The Cambridge- Calgary Consultation skills guide (CCG) forms the basis of this teaching. In Year 3 and 4 they only have one formal consultation skills session in each year. It is therefore important that clinical teachers, including GP teachers, provide constructive feedback on these skills. A copy of the CCG is in the Appendix.

Students are given a communication skills handbook in Year 2 and encouraged to write down the feedback they receive after their role plays, to reflect on it and to develop a learning plan for communication/consultation skills from that. From this academic year the CAPS logbook will also have pages for consultation skills to be signed off.

Both, you and the students may find it helpful to use the consultation skills handbook and CAPS logbook to discuss which areas of their consultation skills they feel confident in and which need further work. This would help to join up their learning experiences and to help them make use of the resources they have been given.

Year 1
The introductory lecture to Primary Care at the start of Year 1 is followed by a small group session. In this session practical exercises help students understand why and how we listen, how this can go wrong and how we can learn from this through reflection.

Year 2
In year 2, each student will take part in two small group teaching sessions facilitated by a GP tutor with actors role playing patients. The focus will be on establishing rapport, information gathering and understanding the patient's concerns.

In each session 3-5 scenarios are played out with the students taking the role of the doctor. Some scenarios are set in General Practice, some in hospital. They focus mainly on the process of the consultation. Students receive constructive feedback from the GP Tutor, the actor and peers. Students complete log sheets of their consultations with reference to the Calgary-Cambridge Consultation Skills Guide. They should also record the feedback they receive alongside their own reflections on their strengths, weaknesses and strategies for improvement.

Students will have a third consultation skills session as part of the new LITHE block.

Please ask the students to bring their communication skills log and CAPS logbook to the GP ICS sessions.

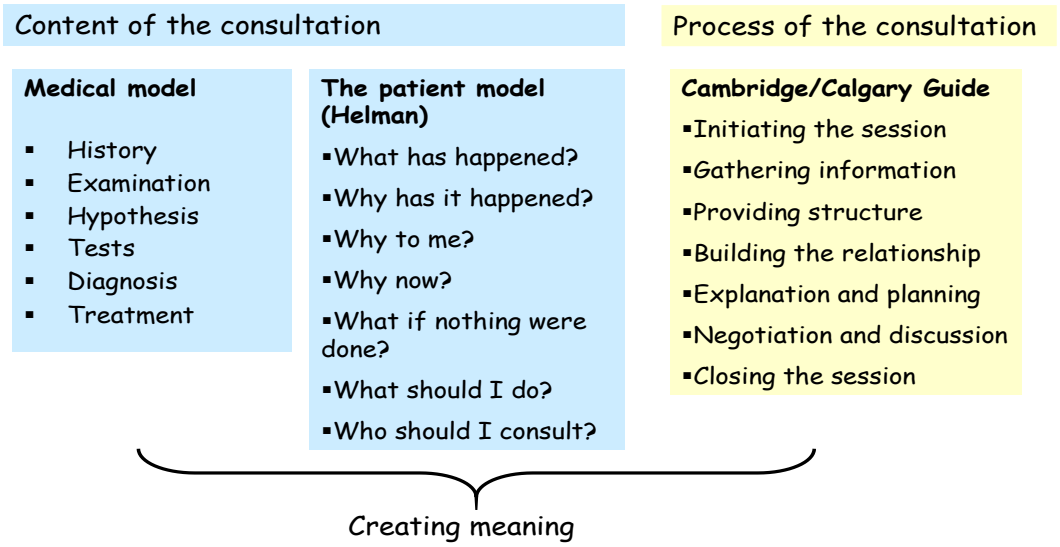
This provides an opportunity for sharing the learning needs the students have identified and for integrating the University based communication skills sessions with learning from real patients.

History taking or consulting?

Students tend to get confused between the apparently conflicting models of medical history taking (presenting complaint, ongoing problems, PH etc) and the Cambridge-Calgary consultation skills guide (CCG). Your students will find it very helpful to discuss the relationship between the two. Here are some diagrams to highlight the relationships between the two, the content and process of consultations.

- The medical history template relates to the content you are trying to unearth
- The CCG is a model of the process of gathering this information effectively by establishing

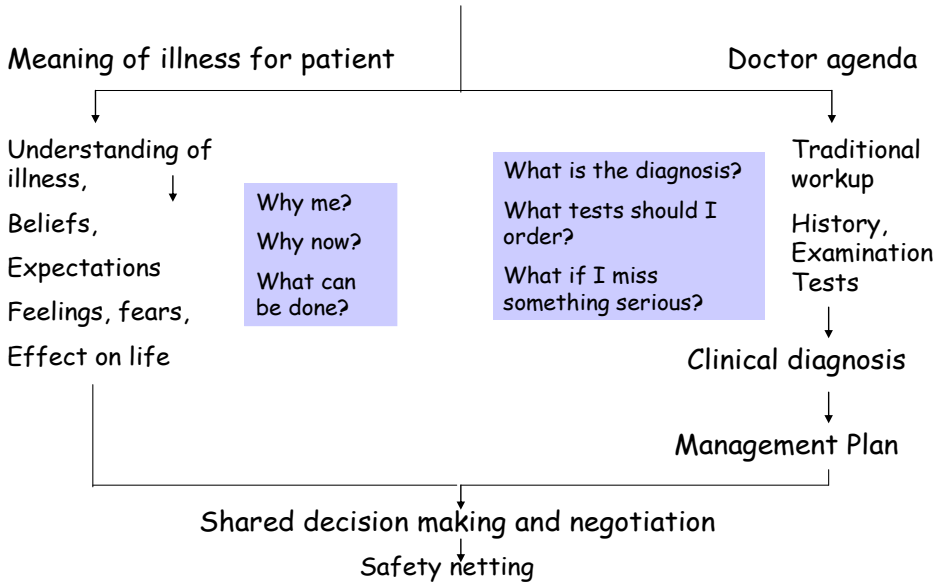
Content and process of the consultation



Ref.: Kurtz, S, Silverman, J and Benson, J (2003) Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge Guides, *Academic Medicine,* Vol. 78, No. 8

Students may find it helpful to consider the different agendas being addressed in a consultation. The following diagram highlights the different agendas

Bringing together the patient and doctor agenda



Year 2 students are taught how to take a systematic and comprehensive history and carry out an equally systematic and comprehensive examination. This familiarises students with all aspects of history and examination and will hopefully be "burned into their hard disc" for future reference.

The disadvantage of this approach is that it does not encourage students to think about what they are doing and the meaning that is being created. This can sometimes lead to inappropriate questions. Here is an example:

Student: "Are there any diseases running in the family, for example heart attacks?"
Patient: "My mother has had a problem with her memory for some time and last week we were told that she definitely has Alzheimer's".
Student: "Do you smoke?"

The student was following a list rather than responding to the information or "cue" from the patient. A diagnosis of Alzheimer's disease has many implications and it would have been more helpful to the patient if the student had expressed empathy:

Student: "That must have been a shock for you. Would you like to talk about it?"

It is easy to see that asking one medical question after another, without taking account of the patient's responses, can hinder our interaction with patients.

From "checklisting" to "problem solving" and whole person care (WPC)

Some helpful questions for students to become more focussed in their history taking from Elwyn Davies, GP Teacher and Trainer, Cheddar Medical Centre

When you have run through your checklist of relevant symptoms and are wondering what to do with the information ask yourself some simple questions

- Can you summarise what you have been told so far?
- Does it tell a story from beginning to end?
- Is the story unique to the individual and their situation?
- Can you tell what the probable diagnosis is (main problem)?
- And what it isn't (differential diagnosis)?
- What is the worst thing it could be (What you must not miss)?
- Do you know what the patient thinks is wrong and worries about?

- the key to a happy consultation

Specific consultation skills students may like to practice

- Attentive listening
- Picking up cues
- Open and closed questions
- Patient friendly (non-jargon) language
- Empathy
- Clarification
- Summarising

Pendleton feedback rules

Some of you will remember these rules from your GPR year. These rules can apply to group or individual feedback.

1. Clarify any points of information/fact
2. Ask the learner what s/he did well – ensure that they identify the strengths of the performance and do not stray into weaknesses.
3. Discuss what went well, adding your own observations (if there is a group observing the performance, ask the group what went well; again, keep them to the strengths.
4. Ask the learner to say what went less well and what they would do differently next time.
5. Discuss what went less well, adding your own observations and recommendations (if there is a group observing the performance, ask the group to add their observations and recommendations.

Strengths of these rules

- Allows initial learner observations to be built upon by the observer(s).
- Ensures strengths are given parity with weaknesses.
- Deals with specifics.
- Feels safe and therefore a good tool for new groups and if students are new to performing clinical skills in front of peers and teachers

Some weaknesses of these rules

- People may find it hard to separate strengths and weaknesses in the formulaic manner prescribed. Insisting upon this formula can interrupt thought processes and perhaps cause the loss of important points. Though it sets out to protect the learner, it is artificial.
- Feedback on areas of need is held back until part way through the session, although learners' may be anxious and wanting to explore these as a priority. This may reduce the effectiveness of feedback on strengths.
- Holding four separate conversations covering the same performance can be time consuming and inefficient. It can prevent more in-depth consideration of priorities.

What do you think?

Here is another model for structuring feedback after a consultation

'Agenda-led, outcome-based analysis'

- **Start with learner's agenda** – ask how it went and if they had any problems and whether the group might help (student should be encouraged to look at positives too)
- **Look at desired outcome** for learner and patient
- **Help the learner to self-assess, problem solve** – how the outcome might be achieved
- **Involve the whole group** in problem solving
- **Non-judgement feedback** using examples – make descriptive comments of what was done and not generalisations
- **Generate and offer** alternatives
- **'Rehearsing'** – repeat parts of consultation to enable learner to try out suggestions
- **Material for the group** – see the observation as providing "raw material" to be explored by the group. Group members can learn as much as the learner who is being observed
- **Opportunistically introduce concepts**, principles, research evidence and wider discussion
- **Structure and summarise** learning so that a constructive end-point is reached

You may like to try this model when students are a bit more confident.
Ask your students for feedback which process they prefer.

The Calgary-Cambridge Consultation Skills Guide

This is used as a framework for teaching students about consultation skills in Year 2. It may seem a very long list at first glance. Please do not be daunted by it and take a closer look. You will find that it all makes a lot of sense. This guide provides a detailed language to reflect on and discuss consultation skills and to feedback on the students' performance.

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TASK ONE: INITIATING THE CONSULTATION

Establishing Initial Rapport

1. GREETS patient and obtains patient's name
2. INTRODUCES self, role and nature of interview; obtains consent if necessary
3. DEMONSTRATES RESPECT and interest, attends to patient's physical comfort

Identifying the Reason(s) for the Consultation

4. IDENTIFIES PROBLEMS LIST or issues patient wishes to discuss (e.g., "What would you like to discuss?; "What questions did you hope to get answered today?")
5. LISTENS attentively to the patient's opening statement without interrupting or directing patient's response
6. CONFIRMS LIST AND SCREENS for further problems (e.g., "so that's headaches and tiredness; anything else?"
7. NEGOTIATES AGENDA taking both patient's & doctor's perspectives into account

TASK TWO: GATHERING INFORMATION

Exploration of Patient's Problem

8. ENCOURAGES PATIENT TO TELL STORY of problem(s) from when first started to the present in own words (clarifies reason for presenting now)
9. USES OPEN-ENDED AND CLOSED QUESTIONS, appropriately moving from open-ended to closed
10. LISTENS ATTENTIVELY, allows patient to complete statements without interruption, leaves space for patient to think before answering, go on after pausing
11. FACILITATES PATIENTS RESPONSES VERBALLY & NON-VERBALLY (e.g., uses encouragement, silence, repetition, paraphrasing)
12. PICKS UP VERBAL AND NON-VERBAL CLUES (i.e., body language, speech, facial expression, affect); CHECKS OUT & ACKNOWLEDGES as appropriate
13. CLARIFIES PATIENT'S STATEMENTS that are unclear or need amplification (e.g.. "Could you explain what you mean by light headed")
14. USES concise, EASILY UNDERSTOOD QUESTIONS AND COMMENTS, avoids or adequately explains jargon
15. ESTABLISHES DATES AND SEQUENCE of events

Additional Skills for Understanding the Patient's Perspective

16. Actively DETERMINES AND APPROPRIATELY EXPLORES:
    - PATIENT'S IDEAS (i.e., beliefs re cause)
    - PATIENT'S CONCERNS (i.e.; worries) regarding each problem
    - PATIENT'S EXPECTATIONS (i.e.; goals, help patient expects re each problem)
    - EFFECTS ON PATIENT: how each problem affects the patient's life
17. ENCOURAGES PATIENT TO EXPRESS FEELINGS

TASK THREE: PROVIDING STRUCTURE TO THE CONSULTATION

Making Organization Overt

18. SUMMARIZES AT END OF A SPECIFIC LINE OF INQUIRY (e.g., HPI) to confirm understanding & ensure no important data was missed; invites patient to correct

19. PROGRESSES from one section to another USING SIGNPOSTING, TRANSITIONAL STATEMENTS; includes rationale for next section

Attending to Flow

20. STRUCTURES interview in LOGICAL SEQUENCE

21. ATTENDS TO TIMING and keeping interview on task

TASK FOUR: BUILDING THE RELATIONSHIP - Facilitating Patient's Involvement

Using Appropriate Non-Verbal Behaviour

22. DEMONSTRATES APPROPRIATE NON-VERBAL BEHAVIOUR
    - eye contact, facial expressions
    - posture, position, gestures & other movement
    - vocal cues, e.g., rate, volume, tone, pitch

23. If READS, WRITES NOTES or uses computer, does IN A MANNER THAT DOES NOT INTERFERE WITH DIALOGUE OR RAPPORT

24. DEMONSTRATES appropriate CONFIDENCE

Developing Rapport

25. ACCEPTS LEGITIMACY OF PATIENT'S VIEWS and feelings; is not judgmental

26. USES EMPATHY to communicate understanding and appreciation of patient's feelings or situation; overtly ACKNOWLEDGES PATIENT'S VIEWS & feelings

27. PROVIDES SUPPORT: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership

28. DEALS SENSITIVELY with embarrassing or disturbing topics and physical pain, including when associated with physical examination

Involving The Patient

29. SHARES THINKING with patient to encourage patient's involvement (e.g., "What I am thinking now is…..")

30. EXPLAINS RATIONAL for questions or parts of physical examination that could appear to be non-sequiturs

31. When doing PHYSICAL EXAMINATION, explains process, asks permission

TASK FIVE: CLOSING THE CONSULTATION (Preliminary Explanation & Planning)

32. GIVES EXPLANATION AT APPROPRIATE TIMES (avoids giving advice, information, opinions prematurely)
33. GIVES INFORMATION IN CLEAR, WELL-ORGANIZED FASHION without overloading patient, avoids or explains jargon
34. CONTRACTS WITH PATIENT RE: NEXT STEPS for patient and physician
35. CHECKS PATIENT'S UNDERSTANDING AND ACCEPTANCE of explanation and plans; ensures that concerns have been addressed
36. SUMMARIZES SESSION briefly
37. ENCOURAGES PATIENT TO DISCUSS ANY ADDITIONAL POINTS and provides opportunity to do so (e.g.. "Are there any questions you'd like to ask or anything at all you'd like to discuss further?")

Forward Planning

37. CONTRACTS WITH PATIENT re steps for patient and physician
38. SAFETY NETS, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

Ensuring Appropriate Point of Closure

39. SUMMARIZES SESSION briefly and clarifies plan of care
40. FINAL CHECK that patient agrees and is comfortable with plan and asks if any correction, questions or other items to discuss

TASK SIX: EXPLANATION AND PLANNING

Providing the Correct Amount and Type of Information

1. INITIATES: summarizes to date, determines expectations, sets agenda
2. ASSESSES PATIENT'S STARTING POINT: ask for patient's prior knowledge early, discovers extent of patient's wish for information
3. CHUNKS AND CHECKS: gives information in chunks, checks for understanding, uses patient's response as a guide on how to proceed
4. ASKS patient WHAT OTHER INFORMATION WOULD BE HELPFUL: e.g.. aetiology, prognosis
5. GIVES EXPLANATION AT APPROPRIATE TIMES: avoids giving advice, information or reassurance prematurely

Aiding Accurate Recall and Understanding

6. ORGANIZES EXPLANATION: divides into discrete sections, develops logical sequence
7. USES EXPLICIT CATEGORIZATION OR SIGNPOSTING: (e.g.. "There are three important things that I would like to discuss. 1st…Now we shall move on to…")
8. USES REPETITION AND SUMMARIZING: to reinforce information
9. LANGUAGE: uses concise, easily understood statements, avoids or explains jargon
10. USES VISUAL METHODS OF CONVEYING INFORMATION: diagrams, models, written information and instructions
11. CHECKS PATIENT'S UNDERSTANDING OF INFORMATION GIVEN (or plans made): e.g.. by asking patient to restate in own words; clarifies as necessary

Incorporating the Patient's Perspective - Achieving Shared Understanding

12. RELATES EXPLANATIONS TO PATIENT'S ILLNESS FRAMEWORK: to previously elicited beliefs, concerns, and expectations
13. PROVIDES OPPORTUNITIES/ENCOURAGES PATIENT TO CONTRIBUTE: to ask questions, seek clarification or express doubts, responds appropriately
14. PICKS UP VERBAL AND NONVERBAL CUES: e.g.. patient's need to contribute information or ask questions, information overload, distress
15. ELICITS PATIENT'S BELIEFS, REACTIONS AND FEELING: re information given, decisions, terms used, acknowledges and addresses where necessary

Planning: Shared Decision Making

16. SHARES OWN THOUGHTS: ideas, thought processes and dilemmas
17. INVOLVES PATIENT by making suggestions rather than directives
18. ENCOURAGES PATIENT TO CONTRIBUTE their IDEAS, suggestions, preferences, beliefs
19. NEGOTIATES a MUTUALLY ACCEPTABLE PLAN
20. OFFERS CHOICES: encourages patient to make choices/decisions to level they wish
21. CHECKS WITH PATIENT: if accepts plans, if concerns have been addressed

TASK SIX (continued): OPTIONS IN EXPLANATION & PLANNING

IF Discussion Opinion And Significance of Problem

22. OFFERS OPINION of what is going on and names if possible
23. REVEALS RATIONALE for opinion
24. EXPLAINS causation, seriousness, expected outcome, short & long term consequences
25. CHECKS PATIENT'S UNDERSTANDING of what has been said
26. ELICITS PATIENT'S BELIEFS, REACTIONS AND CONCERNS e.g.. if opinion matches patient's thoughts, acceptability, feelings

IF Negotiating Mutual Plan Of Action

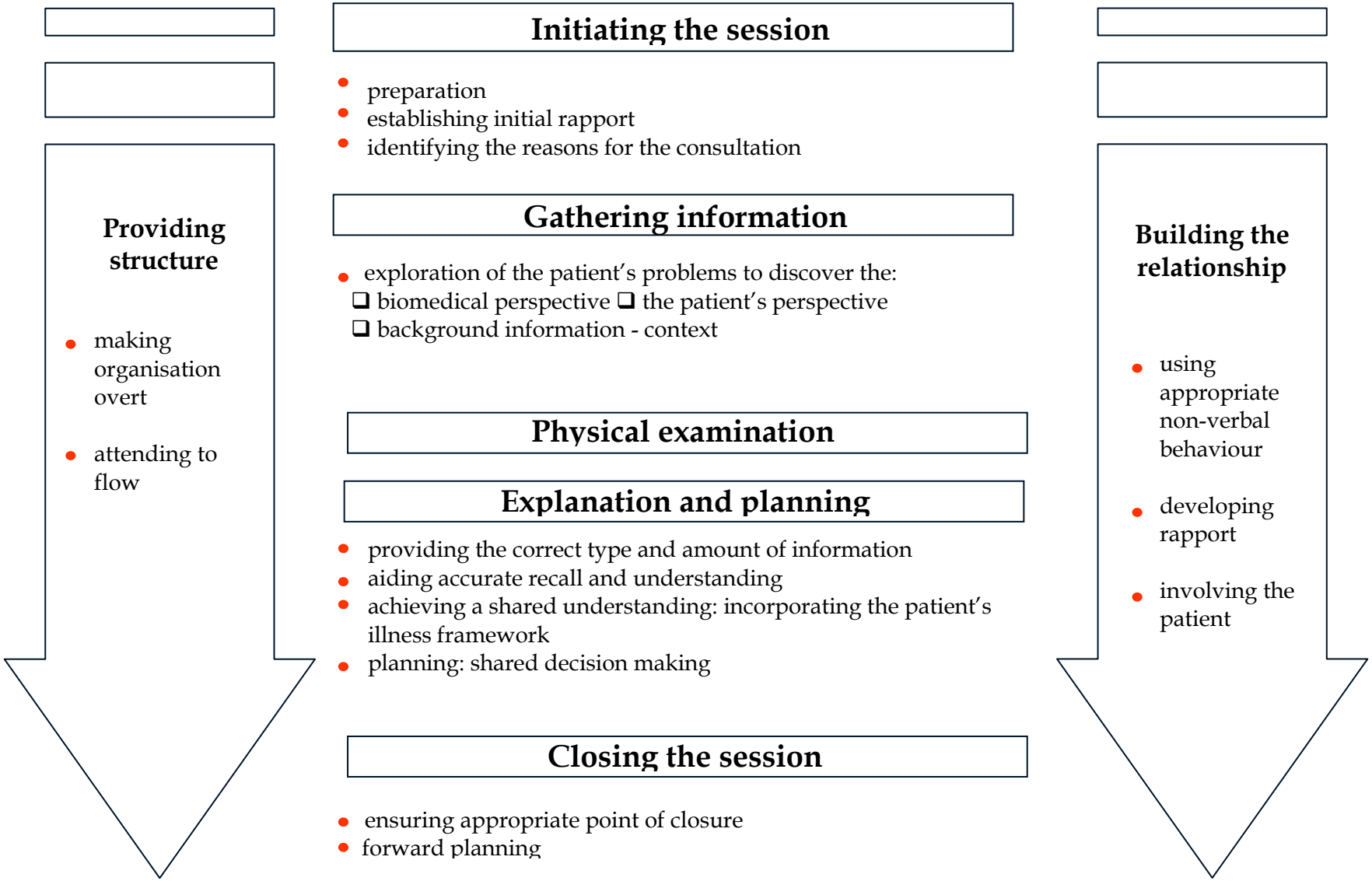
27. DISCUSSES OPTIONS e.g.. no action, investigation, medication or surgery, non-drug treatments (physiotherapy, walking aids, fluids, counselling), preventative measures
28. PROVIDES INFORMATION on action or treatment offered
    a) name
    b) steps involved, how it works
    c) benefits and advantages
    d) possible side effects
29. ELICITS PATIENT'S UNDERSTANDING REACTIONS AND CONCERNS about plans and treatments, including acceptability
30. OBTAINS PATIENT'S VIEW of NEED for action, BENEFITS, BARRIERS, MOTIVATION; accepts and advocates alternative viewpoint as needed
31. TAKES PATIENT'S LIFESTYLE, BELIEFS, cultural BACKGROUND and ABILITIES INTO CONSIDERATION
32. ENCOURAGES PATIENT to be involved in implementing plans, TO TAKE RESPONSIBILITY and be self reliant
33. ASKS ABOUT PATIENT SUPPORT SYSTEMS, discusses other

IF Discussing Investigations and Procedures

34. PROVIDES CLEAR INFORMATION ON PROCEDURES including what patient might experience and how patient will be informed of results
35. RELATES PROCEDURE TO TREATMENT PLAN: value and purpose
36. ENCOURAGES QUESTIONS AND EXPRESSION OF THOUGHTS re potential anxieties or negative outcome

Communications skills within the clinical consultation.

Kurtz et al.[1]



Textbooks Websites References

Textbooks

Munro, JF and Ford, MJ (latest edition), **Introduction to clinical examination**, London: Churchill Livingstone This is a short textbook useful for quick revision

Cox, NLT and Roper, TA (Eds.) (2005) **Clinical skills**, Oxford Core Texts, Oxford University Press.
This is a more recent book on clinical skills with detailed descriptions of examination techniques, almost 500 pages. It also gives a score to each examination how easy or difficult this is, which is helpful for students

Websites

UoB Primary Care website hyperlink not working http://www.bristol.ac.uk/primaryhealthcare/

UoB Medical School teaching- Medici Website http://www.bris.ac.uk/medical-school/

Background material specially prepared for students on this course is available in the UoB virtual learning environment **BLACKBOARD**: http://www.ole.bris.ac.uk
Here you will find the main lectures and tutorials. GP teachers can be enrolled as guests. Email dominic.alder@bristol.ac.uk if you wish to be enrolled.

www.patient.co.uk
This site has helpful leaflets on medical conditions and problems for patients. It can be useful to read these leaflets as a simple overview of a condition before you read more in depth material.
There is also a section titled 'Professional references' which is intended for doctors. Here you find the 'Patient Plus' and 'Other references'.

Patient Plus has expert level information on a huge range of conditions and 'Other References' has links to all the relevant guidelines and to excellent image libraries, including anatomy and dermatology.

References

1. Kurtz S, Silverman J, and Draper J (1998) **Teaching and Learning Communication Skills in Medicine.** Oxford, UK: Radcliffe Medical Press

2. Silverman J, Kurtz S, and Draper J (1998) **Skills for Communicating with Patients.** Oxford, UK: Radcliffe Medical Press

Whole person medicine (WPM) and poetry

Whole person medicine is a vertical and revisited in different years. In Year 1 students have lectures to highlight research into body and mind connections followed by small group work exploring the concept of WPM in depth. The teaching for this theme encourages students to keep their focus on the person not the disease, not to forget the real suffering behind diagnoses and medical evidence.

The emphasis on science in medicine can squeeze out attention to emotions that accompany learning in medicine. Using ideas and processes from the medical humanities are intended to keep learners in touch with their emotional world and connect to that of their patients. For example, reading accounts of illness in the literature such as Bauby's description of "locked in syndrome" after a stroke can extend the learning beyond medical facts.

Using "non-linear" processes such as reading, writing poetry, making music or drawing can enhance personal and professional development. You could for example ask students to draw how they feel about examining patients for the first time and then ask them to talk through it, either in pairs or in the group.

Please take a look at "Poetry and medical student teaching" written by Dr. Marion Steiner, a GP teacher at the Willow Tree Surgery, North Bristol. Could you use some of these poems in your teaching?

Poetry and Medical Student Teaching by Dr. Marion Steiner

Some of our GP Teachers use poetry and other art forms to enhance the learning experience of their students. Here is a brief article from Dr. Marion Steiner, Willow Tree Surgery in North Bristol. You can contact Marion on marion.steiner@gp-L81067.nhs.uk

Introduction

Using poetry to help medical students become good doctors may not be an obvious thing to do, and may not suit all teachers or all students. However, the art of medicine is a subtle one, and the teaching of that art is not easy - poetry can be a stimulating and enjoyable tool to enrich the experience of students, teachers and patients.

Sir William Osler's advice to doctors was "Nothing will sustain you more potently than the power to recognize in your humdrum routine…the true poetry of life"

Dylan Thomas said "Poetry is what makes me laugh or cry or yawn, what makes my toenails twinkle, what makes me want to do this or that or nothing"

Students are encouraged to develop their creative sides in Year 1 on the Whole Person Care course and are encouraged to complete a creative piece in their GP attachments. It is possible to find space for poetry in teaching students throughout their clinical course, something that seems to be particularly good at stimulating 'right-brain' learning.

Patients as Poets

There have been several initiatives encouraging patients to write poetry to improve well-being, especially in the field of mental health. One of these was a poet-in-residency project run by the Poetry Society, in which the Bedminster Family Practice in Bristol participated.

Lapidus is a national organisation which seeks to promote healing and personal growth through writing and reading http://www.lapidus.org.uk/

Poems for Students
As an adjunct to more conventional methods, I give students copies of poems during teaching sessions (I can't offer any evidence that this makes them better doctors, but feedback is good).

Some of these have a physical theme e.g. when teaching CVS to 2nd years, some deal with communication skills, others with emotions relating to diagnoses. A selection is included here, and may be reproduced for teaching purposes only. Copyright is covered by a central NHS licence.

Poems for doctors
We all need to look after ourselves, and poetry can help refresh the parts of a doctor that the BNF cannot reach. Sharing poetry with patients, students and colleagues is one of many ways of keeping General Practice interesting.

The Stethoscope

Dannie Abse

Through it,
over young women's tense abdomens,
I have heard the sound of creation
and, in a dead man's chest, the silence
before creation began.

Should I
pray therefore? Hold this instrument in awe
and aloft a procession of banners?
Hang this thing in the interior
of a cold, mushroom-dark church?

Should I
kneel before it, chant an apophthegm
from a small text? Mimic priest or rabbi,
the swaying noises of religious men?
Never! Yet I could praise it.

I should
by doing so celebrate my own ears,
by praising them praise speech at midnight
when men become philosophers;
laughter of the sane and insane;

night cries
of injured creatures, wide-eyed or blind;
moonlight sonatas on a needle;
lovers with doves in their throats; the wind
travelling from where it began.

Names

Wendy Cope

She was Eliza for a few weeks
When she was a baby-
Eliza Lily. Soon it changed to Lil.

Later she was Miss Steward in the baker's shop
And then 'my love', 'my darling', Mother.

Widowed at thirty, she went back to work
As Mrs Hand. Her daughter grew up,
Married and gave birth.

Now she was Nana. 'Everybody
Calls me Nana,' she would say to visitors.
And so they did- friends, tradesmen, the doctor.

In the geriatric ward
They used the patients' Christian names.
'Lil' we said, 'or Nana,'
But it wasn't on her file
And for those last bewildered weeks
She was Eliza once again.

ATTENDANCE & PAYMENT FORM

2nd Year GP Attachments 2013-14

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

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

Student names:

Please give details if any absences or concerns:

Year 2 teaching	Name of student	Date of absence	Reason for absence	Concern
Session 1a: w/c 30.9.13 (1st part of week)				
Session 1b: w/c 30.9.13 (2nd part of week)				
Session 2a: w/c 28.10.13 (1st part of week)				
Session 2b: w/c 28.10.13 (2nd part of week)				
Session 3a: w/c 16.12.13 (1st part of week)				
Session 3b: w/c 16.12.13 (2nd part of week)				
Session 4a: w/c 3.3.14 (1st part of week)				
Session 4b: w/c 3.3.14 (2nd part of week)				

Did you have any concerns about any of your students? Yes/No

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

GP Teacher: .....

GP Practice: .....

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

GP teacher's signature:..... **Date**: .....

University of BRISTOL

Student Evaluation of the Year 2 GP teaching sessions in 2013-14

Please complete this form at the end of your last session with your GP teacher.

Academy

GP's Name and Practice (please print clearly or use stamp)

	Yes	No	Comment
Our GP teacher made us feel welcome			
Our GP was an enthusiastic teacher			
Our sessions were well organised (started on time, well planned, well structured)			
We saw 2 or more patients in each session			
The GP teacher observed me taking a history and examining a patient			
The GP teacher commented on our skills during the sessions			
The GP teacher gave me individual feedback at the end of the last session			
I found the feedback from my GP teacher helpful			

What was good about the sessions in this practice?

How could this GP Teacher improve the sessions?

What do you think about learning clinical skills in a General Practice setting?

Thank you for taking the time to complete this form.

Please place your form and those from the other students in the envelope provided by your GP teacher and seal the envelope. Please ask your GP teacher to post it to the Primary Care Teaching Office.

Dealing with Concerns about Students
(A protocol for GP teachers)

What do we want to achieve?

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

Frequently Asked Questions:

1. When should I be concerned about a student?

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

Professional behaviour/attitude e.g.

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

Pastoral e.g.

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

Safety e.g.

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

Clinical knowledge/skills, including communication e.g.

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

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

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

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

- We encourage you to phone or email the GP year lead in the Primary Care Teaching team (see contacts in your handbook or www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/year/) or the GP academy lead, in recognition that it can be helpful to discuss what constitutes "minimally acceptable" knowledge, clinical skills or an attitudinal concern.
- **If you consider your concern about a student a matter of urgency risking patient safety please follow the guidance on the student concern form to immediately contact either the Director of Student Affairs or the Faculty Education Manager or, if they are not available, the Medicine & Dentistry Faculty Dean who will take action as appropriate.**

4. What happens after this?

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

5. So what about "Student Concern Forms"?

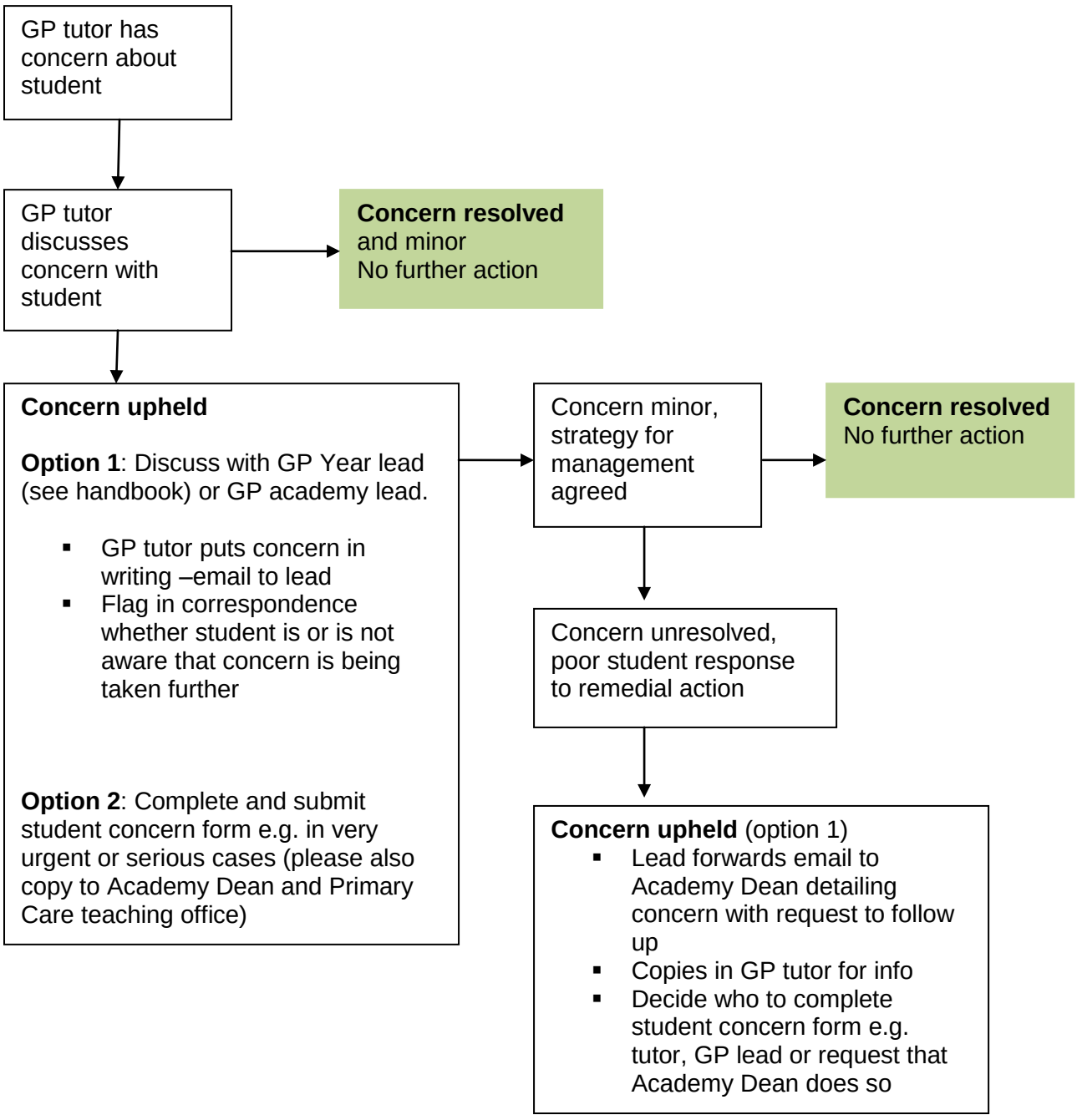
See http://www.bris.ac.uk/medical-school/staffstudents/student/forms

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

Flowchart for communicating concern about students

Written November 2012. Last revision: September 2013
Review date August 2014
Responsible Primary Health Care Teaching Office
Email phc-teaching@bristol.ac.uk for more information or queries

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



Faculty of Medicine and Dentistry

Student Concern Form

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

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

Your concern may relate to a number of areas:

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

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

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

Patient Safety

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

If you wish to discuss your concern before you submit this form, please contact the Fitness to Practise Case Investigator, via the Faculty Education Manager on (0117 3318317).

This form should be completed in full and returned marked 'Private & Confidential' by e-mail to: t.l.chapman@bristol.ac.uk or sylvia.elliott@bristol.ac.uk.
Or sent by hard copy to Mrs Sylvia Elliott, Faculty Education Manager, C/O Tracey Chapman, Level 1 Senate House, Tyndall Avenue

Student Concern Form

Name of Student:

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

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

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

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

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

Name: …… **Signature:**……..

Date: ……

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

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

Telephone:…… Email:…….

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GP Teacher Reflections on Year 2 ICS teaching sessions 2013-14

Here are some suggestions for reflection

- What went well?
- What will I change for next time?
- How well am I keeping those students engaged who are not actively taking the history or examining?

Group A

Session Dates	Reflections
1	
2	
3	
4	

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GP Teacher Reflections on Year 2 ICS teaching sessions 2013-14

Here are some suggestions for reflection

- What went well?
- What will I change for next time?
- How am I doing in keeping those students engaged who are not taking the history or examining?

Group B

Session Dates	Reflections
1	
2	
3	
4	

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Year 2 ICS GP Teacher Record Form 2013-14

Student's Name:

	Session 1/Date	Session 2/Date	Session 3/Date	Session 4/Date
Attendance and punctuality				
Appearance, attitude and behaviour				
History taking & communication skills				
Clinical examination skills				
Medical knowledge				
Additional comments				

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Year 2 ICS GP Teacher Record Form 2013-14

Student's Name:

	Session 1/Date	**Session 2/Date**	**Session 3/Date**	**Session 4/Date**
Attendance and punctuality				
Appearance, attitude and behaviour				
History taking & communication skills				
Clinical examination skills				
Medical knowledge				
Additional comments				

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Year 2 ICS GP Teacher Record Form 2013-14

Student's Name:

	Session 1/Date	Session 2/Date	Session 3/Date	Session 4/Date
Attendance and punctuality				
Appearance, attitude and behaviour				
History taking & communication skills				
Clinical examination skills				
Medical knowledge				
Additional comments				

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Year 2 ICS GP Teacher Record Form 2013-14

Student's Name:

	Session 1/Date	Session 2/Date	Session 3/Date	Session 4/Date
Attendance and punctuality				
Appearance, attitude and behaviour				
History taking & communication skills				
Clinical examination skills				
Medical knowledge				
Additional comments				

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Year 2 ICS GP Attachment – Student Self Assessment Form

Student's Name:

Date	Student's comments	Teacher's comments
History taking and communication skills		
Clinical examination skills		
Knowledge		
'Putting it all together'		
Any other comments: e.g. feedback to teacher about sessions		