YEAR 1 CLINICAL CONTACT IN PRIMARY CARE SESSION
Thursday 1st May 2025 – am or pm – group B (red stream)
Renal/Urinary system
Consultation skill: Planning, Doing, Closing and Integrating

Session plan		**Suggested timings: AM**	**PM**
Introduction	30 min	09.00-09.30	14.00-14.30
Patient contact	1 hr 10 mins	09:30-10.40	14.30-15.40
10-minute break			
Debrief and discussion	40 min	10:50 – 11.30	15:50 – 16.30
Feed back and Close	30 min	11:30 – 12.00	16:30 – 17.00

The busy GP teacher will find all you need to know for the session in the first few pages. The format is the same as previous sessions. Please use this plan in conjunction with the GP teacher guide which can be found here.

The main consultation focus is **"planning, doing closing and integrating"** including the shared decision-making process that supports this. You can read more about how the students are taught about planning and closing the consultation in the appendix.

Exploring sensitive topics and remote examination of the urinary/GI system are included again so that this cohort can consider and discuss these important topics. There are notes on all this in the appendix including info the students are given about shared decision making.

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

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

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

Central University teaching context
Case-based learning - The urinary case explores fluid balance, dehydration and overhydration. Two students training for a marathon debate whether it is better to drink regularly or when thirsty. The second case is a post-operative patient on IV fluids, and how doctors work out how much fluid is needed.

In effective consulting labs: the students had the opportunity to consult with a simulated patient, to practice gathering information relevant to urinary symptoms/ diabetes and then looked at how to plan and close the consultation.

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

- Describe the structure and components of a well-rounded medical history
- Describe an approach to asking sensitive questions (eg about bowel and bladder function)
- Describe the importance of closing consultations effectively, and how to do this
- Describe the importance of planning and shared decision making for best patient care, including the importance of clear safety netting
- Describe the importance of a whole person approach to the consultation and clinical care including the consultation as a therapeutic tool

- Reflect on the importance of partnership and collaboration with patients in all parts of the consultation to provide whole person "patient shaped" care

GP advance preparation

Read this guide: arrange a patient with a past or current urological or renal condition to meet with half the students (ideally in their home).

Arrange a short surgery (3/4 patients) for the others to observe. These consultations do not have to be about a urological problem.

Welcome, catch-up and introduction (30 min) 09.00-09.30 or 14.00-14.30

- Welcome and **catch up**
- **Pastoral** check in, anything for you to be aware of? Offer support and one-to-one discussion if needed
- Run through the **learning objectives, session plan and timings** for this session

You may wish to:

- Brainstorm planning, doing and closing in the consultation
- Discuss how we can ask questions about sensitive issues and shared decision making (see appendix)
- Discuss if the urinary/GI system can be examined remotely. Can remote urine testing help?
- Optional activity: the students could try dipping urine/ observing this

Patient contact (1 hr 10) 09:30-10.40 or 14.30-15.40

- Half the students interview a patient – ideally a home visit (but can be at the surgery if needed)
- The remaining 2 or 3 students observe you consulting with 3 or 4 patients
- You may wish to brief the students on the patients in advance. Whether they are interviewing a patient or observing consultations, all students should all introduce themselves to the patient by name and role.

Students should take it in turns to lead the interview and be prepared to feed back to each other on consultation skills (see the GP Teacher guide for practical information about this and a patient letter).

Observing consultations. as per previous sessions and some specifics based on planning, doing, closing and integrating

- *Is there a patient-centred plan or shared decision making?*
- *What is done to end the consultation?*
- *Was there summarising and safety netting?*
- *How might the consulter feel?*

Student tasks:

- Were there any topics that felt difficult or sensitive to raise with the patient?
- Observe and note how you or your GP approached any sensitive topics e.g. weight or bladder
- Observe how your GP and patients collaborate in shared decision making for best patient care making a patient centred plan

10-minute comfort/toilet/stretch/tea break as needed

Debrief and discussion (40 min) 10:50 – 11.30 or 15:50 – 16.30

Students present cases and discuss which communication skills and questions worked well in the patient encounters with specific focus on planning, doing closing and integrating.

During their first year the emphasis is on the students gaining confidence in talking with patients. They are not expected to receive and present a full or polished medical "clerking", but they should now have an idea of the main domains of the medical history and how to structure a conversation with a patient. By the end of Year 1 students should also be able to present the key points to you, their tutor. It is an art to be able to summarise the

relevant information without losing important detail, but at this stage they should understand that the way the patient tells their story differs in structure to the way they need to present the patient's narrative and identify where the challenges lie. They should also be able to reflect on the information they gathered and what they would like to know more about.
Addressing **sensitive areas** of the history (info in appendix)
Optional activity: the students could try dipping urine/ observing this

Feedback and close (30 mins) 11.30-12.00 or 16.30 - 1700

Spend time with your **group reviewing your sessions** together. What have they learnt? What did they like/what could be improved?

Please spend a few minutes separately with each individual students giving them **individual feedback** on their progress and what to concentrate on in their clinical and consultation skills learning. The others should be given time to complete an online form (link emailed to them and on OneNote). We can then share this feedback with you. Those students who had done a **creative piece** based on a patient they have met in GP may want to share it with you or the group.

Finish with a **final take home message** about their first clinical contact on their journey to become doctors.

Remind students about their reflective log/ePortfolio.

GP tasks after the session

Prepare for and consider appropriate patient (with endocrine, neurological or cognitive problem) to invite to the next session (with your other group **Thurs 15th May 2024**, CBL fortnight: Endocrinology. Cons skill focus: integrating, and cognitive assessment)

- Complete online **attendance data**
- Please complete our feedback questionnaire

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

Debrief and discussion

The students should be starting to present back a coherent narrative about a patient they have seen to you and the group. This is likely to be more of 'the story so far' rather than a structured case presentation, but please support them in developing this.

Optional additional activities if needed (as in the GP Teacher Guide)

The session plans are reasonably full but sometimes patients cancel or there may be other circumstances when additional teaching resources are needed.

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

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

This young man describes his presentation with type 1 diabetes, generally well controlled except for an admission post alcohol excess with dehydration as part of ketoacidosis.
https://speakingclinically.co.uk/videos/overactive-bladder-syndrome/
A man who is fearful that drinking will worsen his irritable bladder and discusses his investigations
https://speakingclinically.co.uk/videos/primary-bladder-neck-obstruction/
A man with urinary tract symptoms now needing self-catheterisation, resulting in frequent UTIs.

APPENDICES

Exploring sensitive topics
Remote examination of the urinary system and patients doing home urine tests
COGConnect reminder
Shared decision making
Planning doing closing and integrating
Group feedback

Clinical Communication: Exploring sensitive topics

Doctors have the privilege and responsibility of gathering information about all aspects of a patient's health and life, and as medical students you are often conferred that privilege. To start with it can be nerve-racking asking patients about areas of life that are often 'taboo' like bowel and urinary habits. Making sure you have got off to a good start (prepared well), developed a good rapport with your patient and explained to them why you are asking (opened well) can facilitate gathering this sort of information. The gastrointestinal and urinary system covers several topics that students and patients may perceive to be sensitive areas:

- Weight
- Bowel habit
- Urinary symptoms
- Alcohol intake
- Chance of pregnancy (and sexual history) – you will cover this later in the course.

Medical student anxiety may stem from not being used to asking about these topics, not knowing how to word questions, or not knowing how patients will react. Patient anxiety may stem from embarrassment, worries about being judged, worries about confidentiality or being uncertain of the relevance of the questions they are being asked.

Techniques that decrease anxiety include:

- Explain why you are asking — you may need to address confidentiality
- Ask permission
- Talk in factual terms (not judgmental terms)
- Ask about specifics, not generalisations

Preparing the patient and setting the context	"I need to ask you about your lifestyle to better understand your situation" "I need to ask you about your bowels to understand how your gut is working"
Asking permission	"Is it okay if I ask you some questions about your lifestyle to get an understanding of your overall health?"
Ask factual, specific questions.	"How often do you open your bowels?" (rather than 'do you open your bowels frequently?' (which contains a judgement)) "Has your weight changed recently?"
Avoid generalisations and judgmental questions e.g. "Do you eat a healthy diet?"	Instead: "Talk me through what you eat in a typical day?"
Normalise	"Sometimes people notice blood in the stool or after they've opened their bowels, is that something you've ever noticed?" Discussing stool consistency with patients can be helped by using the Bristol stool chart see here: https://www.bladderandbowel.org/wp-content/uploads/2017/05/BBC002_Bristol-Stool-Chart-Jan-2016.pdf
Assume the behaviour is already happening (normalizing)	"How often do you have a drink containing alcohol?" (be careful as these might leading questions…)
Closed questions and a "menu" of responses	When asking sensitive questions, closed questions can help relieve anxiety about how to answer as can giving a menu of responses. "Do you open your bowels: every day, several times a day, or do you go for a day or more without opening your bowels?"

Remote examination of the urinary (and gastrointestinal) systems

Ask the students to think about what they already know about how a standard abdominal examination should be conducted. The purpose of this discussion is to get the students thinking about the different sorts of consultations that are being carried out in GP surgeries (including during the pandemic) and how decisions are made about whether patients need to be seen face to face.

What can we examine over the phone?

- Patient can self-report weight and height and BMI can be calculated
- Can ask patient if looking/others noticed pallor/jaundice etc.
- Thinking outside the box for proxy measures e.g. reduced frequency of urination or darker urine as markers of possible dehydration
- Self-measured temperature, pulse and blood pressure.
- As a screening tool, a family member or carer can be instructed on abdominal palpation solely to elicit any signs of tenderness. What are the advantages and disadvantages of this?

On a video consultation you may be able to assess colour, general health, and body habitus, if in pain. Can ask to see mouth (?dry) or demonstrate skin turgor to assess hydration status.
The GP surgery may be able to supply urinalysis equipment, and some patients will have strips to test their urine for specific things e.g. ketostix for diabetics.

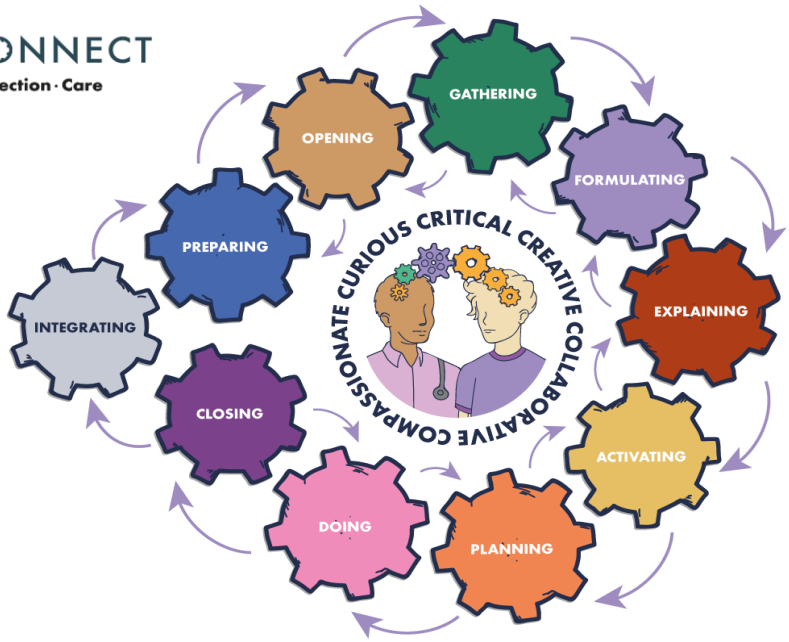
Clinical Skills: Urinalysis

Dipping a urine sample with a multistix test detects several substances in the urine including glucose, proteins, red cells, ketones and by products of bacteria such as nitrites. It is used to help investigate for urinary tract infection, and test for and monitor diabetes, kidney disease, high blood pressure, liver disease and other conditions such as metabolic disorders. It is also used for monitoring in pregnancy.

An explanation to patients about what a urine dipstick test is can be found here: https://patient.info/treatment-medication/urine-dipstick-test and how to collect a mid-stream specimen of urine here: https://patient.info/mens-health/urine-infection-in-men/midstream-specimen-of-urine-msu

Clinical Communication: taken from students' resources

COGCONNECT
Cognition · Connection · Care



PREPARING
Am I prepared?

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

OPENING
Are we off to a good start?

- Establishing the agenda
- Establishing relationships
- Initial observations

GATHERING
Have we covered all the relevant areas?

- Sources of understanding
- History
- Clinical examination

FORMULATING
What is going and what is next?

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

EXPLAINING
Have we reached a shared understanding?

- Chunking
- Checking
- Visual Aids

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

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

PLANNING
Have we created a good plan forward?

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

CLOSING
Have I brought things to a satisfactory end?

- Summary
- Patient questions
- Follow Up

DOING
Have I provided a safe and effective intervention?

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

INTEGRATING
Have I integrated the consultation effectively?

- Clinical record
- Informational needs
- Affective progressing

COGCONNECT
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Gathering clinical (hi)stories

A comprehensive history is essential to help activating patients with self-care and lifestyle change. Students are encouraged to obtain a well-rounded impression and to consider the information they gather in the 3 domains:

- Nature of the medical problem
- Patient perspective on the problem
- Relevant background and lifeworld

Shared decision making in clinical practice

In their previous Effective Consulting session last week, the students learnt about shared decision making. The following information is from this EC lab session.
In the recent Department of Health White Paper 'Equity and Excellence: Liberating the NHS', Shared Decision Making was highlighted as an essential feature of the NHS moving forwards. Following its publication, the slogan 'No decision about me, without me' hit the headlines.

Shared decision making relies on two sources of expertise:

- The health professional is an expert on the effectiveness, probable benefits, and potential harms of treatment options

- The patient is an expert on herself, her social circumstances, attitudes to illness and risk, values, and preferences

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

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

Why is this important?

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

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

The current evidence base for shared decision making

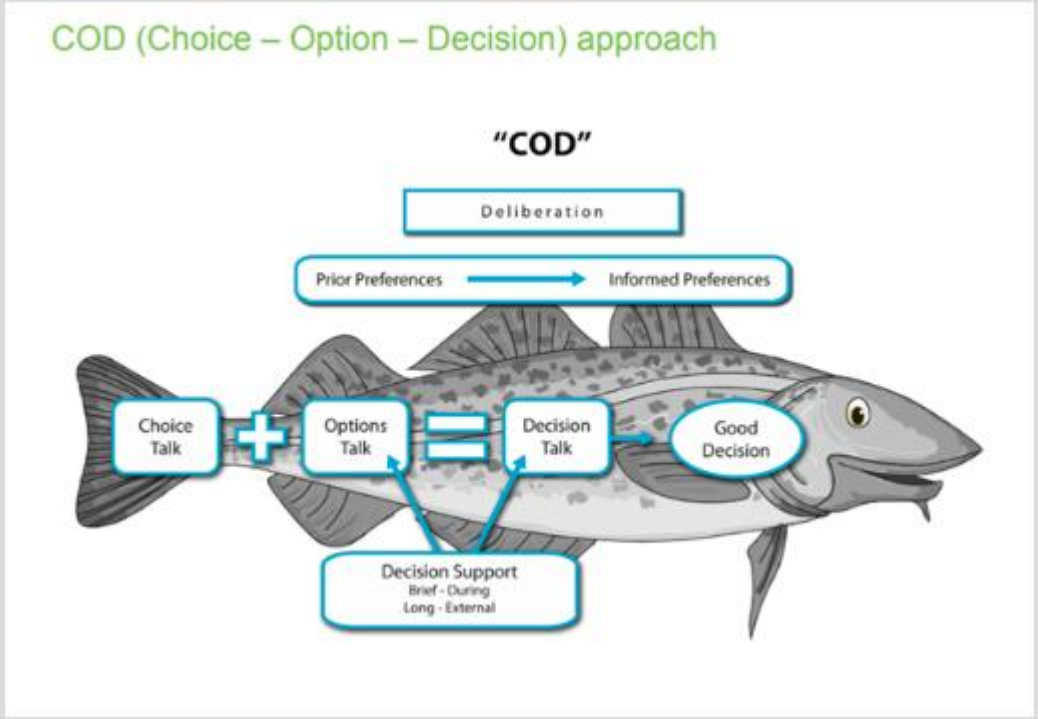
- Approximately 50% of patients want to be more involved in their healthcare decisions
- On average, 50% of patients don't take medication prescribed (or take it incorrectly), and 70% don't adhere to dietary recommendations made by healthcare professionals.
- Better communication and collaboration are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

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

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

- Firstly, is there a decision to be made? If there is, is it preference-sensitive?
- Is there sufficient time for consideration/information gathering?
- Is the patient actively seeking a balanced relationship within the consultation?
- What are the different treatment options?
- Does the patient wish to be involved in choosing the treatment?

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



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

Patient perspective:

The "Ask 3 Questions" Campaign.

The above information is extracted and adapted from a variety of sources. We recommend using the open access e-learning resource Introduction to Shared Decision Making from which much of this material is derived. It is a well-designed e-learning module. You do not need to register. However, please note that all medical students and other healthcare professionals are able to register for further online training modules at e-learning for health which is an invaluable resource.

Planning

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

Safety net

Part of making a plan is knowing when things are not going as expected and what to do about it. This is called "safety netting." Missed diagnoses are common, especially when doctors see patients at an early stage in their illness, so discussing uncertain diagnosis with patients is important. Also, certain conditions or medication carry a risk of complications or side effects so knowing what to do if they occur is important. Roger Neighbour[1] considered safety netting a core component of the consultation and said there were 3 questions to ask oneself:

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

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

Doing

Not all consultations have a 'doing' aspect, but many do. At one extreme this might include simply handing over a prescription, at the other perhaps a joint injection, a coil fitting, or implant insertion. We need to consider whether our intervention is appropriate, safe, and effective, and make sure the

patient has consented in an informed way. Spend some time talking to students about the things you 'do' in consultations, and how you go about seeking consent.

Closing

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

- Identifying next steps; for you and the patient
- Summarising key points of your discussion. Consider a written summary or patient information leaflet

Does the patient agree you've come to the end? Have they got anything they haven't asked, or you haven't covered, or they are still not sure about? (It can be good not to invite general questions right at the end—keep them specific to the consultation you've just had).

Integrating

Sits somewhat outside the consultation and covers the things that happen in the space within and between clinical interactions.

There are various aspects of Integrating, some of which are very practical, for example

- Updating the clinical record
- Presenting clinical information
- Handing over to a colleague
- Asking for help
- Arranging a referral

Some aspects are more reflective and will include:

Identifying learning needs

Was there something they didn't know during the consultation that they need to look up? A medication they weren't sure about? A condition they hadn't heard of?

Did they identify a bias in themselves during formulating? Does this need challenging? Identifying ones own bias (and bias in colleagues) are essential skills for effective consulting: patient safety is at risk if bias remains unchecked.

Dealing with the emotional and psychological impact of consulting

Discussing these with students, how this can be managed and where help can be sought will be one of the most important things we can share with students. Here is a paragraph from the students EC learning on this subject.

Consulting is tiring! As a medical student you are taking on new information almost every time you meet someone. As a clinician each person's story is unique, even if you have heard similar before. You need to maintain your curiosity and interest at all times, and also identify when this is becoming

challenging. The big consultations are easy to identify - if you have just broken bad news to a patient or relative, you might want to take some time, even just a few minutes to debrief with a colleague. Even just an acknowledgement that 'that was hard' .... the smaller, incremental drains on our emotional reserves can be harder to notice. But each patient deserves your full attention, so you need to find a way to reset between each patient and after a long day. It might be something as simple as taking a few deep breaths, or it might be getting up from your desk, but you need to find your own way to manage this aspect of medicine. Two excellent accounts for tips on looking after yourself are

https://www.instagram.com/themindmedic/

If you are struggling, please seek support there are lots of resources available

BMA - Your wellbeing

Giving feedback

Group feedback

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

Suggested methods for collecting and collating this feedback.

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

Giving individual feedback

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

Principles for giving feedback.

1) Ask the student what they think/how something went.
2) Affirm qualities—individual and thinking about group work, qualities that may help

working in a team as a doctor and in future group learning. There is evidence that this is motivating.

3) Areas for development—offer observations, not assumptions. Students are often poor at identifying their weak areas and feedback from others can help them to improve.
4) End on a positive note (completing the feedback sandwich of "positive comment—area for improvement—positive comment")

Feedback should be:

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