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University of BRISTOL

SCHOOL OF SOCIAL AND COMMUNITY MEDICINE
Canynge Hall, Whatley Road, Bristol, BS8 2PS

Year 4 GP Teachers' Workshop

Engineers' House, Clifton, Bristol
Tuesday 3rd November 2015

Contents

And please don't forget to explore our website. There are more resources for GP teachers and further teaching opportunities: http://www.bris.ac.uk/primaryhealthcare/teachingundergraduate/

Dear GP teacher,

Many thanks for coming to our Year 4 GP workshop on the 3rd November 2015. Whether you are an experienced GP teacher or just starting out taking Year 4 students in your surgery I hope you found it useful.

We covered an overview of teaching Year 4 students in primary care and changes in Year 4 teaching, especially in the way students are assessed. We had an update on teaching psychiatry, and on the new NICE cancer guidelines. We also met 2 members of the undergraduate GP society who are inspiring the next generation of GPs. We heard about some of the impending changes to the medical school curriculum. There is going to be lots of scope to be involved with the new curriculum; whether it is to give your opinion on proposed learning outcomes and the way teaching is structured, to continue to take students on placement in your surgery (the opportunities are likely to increase), or to apply to become a case-based learning tutor. Look out for information from the University over the coming year and let us know if you don't regularly receive the primary care newsletter which will continue to update you.

In the afternoon we split into small groups to discuss best practice teaching for Year 4 GP teachers and to discuss "case based learning"—one of the ways future students at Bristol will be taught. This was a chance for teachers to discuss teaching tips and good practice with each other. Another session was to experience designing a teaching case and develop this to draw on the wider primary care themes such as the GP consultation, reducing the risk of chronic disease, multi-morbidity, disability, breaking bad news and then draw on the new "helical themes" that are being introduced to the Bristol undergraduate medical curriculum. We know that GPs already teach from cases and wanted to introduce you to some of the new wider themes in the curriculum and see how to draw on a case to bring in a variety of learning outcomes.

A provisional date for your diaries is Tuesday 1st November for the next GP teacher workshop

Read on for more information…..

With all best wishes

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University working days Tuesday and Thursday
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Year 4 workshop programme 2015

Morning			
9.00	**Coffee and registration**		**Mel Butler**
9.15	Welcome and Intro to the day		Dr Jess Buchan
9.30	Teaching psychiatry in Year 4, and an overview of managing personality disorders		Dr Nicola Taylor
10.20	An update on Year 4 teaching		Dr Jess Buchan with Dr Barbara Laue
11.20	**Coffee**		
11.40	The GP society		Alice James and Alexa Lazarou
11.50	The new NICE cancer guidelines		Dr Alison Wint
12.40	**Lunch**		
Afternoon			
13.40	**Parallel small group sessions**		
13.40	Case based learning (Dr's Trevor Thompson and Simon Thornton) **Group 1 A&B**	Best practice teaching in Year 4 **Group 2 A** Dr Jessica Buchan **Group 2B** Dr's Sarah Jahfar & James Seddon	
14.40	Best practice teaching in Year 4 **Group 1 A** Dr Jessica Buchan **Group 1 B** Dr's Jahfar & Seddon	Case based learning **Group 2 A&B**	
15.40	**Tea**		
16.00	Plenary Q&A, Review of the day, Evaluation		Dr Jess Buchan
16.30	**Home**		

Workshop Objectives

- Update on teaching in Year 4
- Update on University News and the new curriculum
- Explore 'Best Practice' for Year 4 teaching with GP colleagues
- Update on Psychiatry teaching in Year 4
- Develop a teaching case and apply it to a case based learning session
- New NICE Cancer guidelines and the impact on teaching.

Speakers & Facilitators

- Dr Jess Buchan, GP and Teaching Fellow, GP Lead for Year 4 (maternity cover)
- Dr Barbara Laue, GP Lead for Years 2&3 and North Bristol Academy
- Dr Nicola Taylor, Psychiatrist & Clinical Lecturer
- Alice James Year 4 medical student and Chair, GPSoc. University of Bristol
- Alexa Lazarou, Year 3 medical student and GPSoc Clinical Rep years 3-5. University of Bristol
- Dr Alison Wint. Macmillan GP and Clinical Lead for Cancer S.Glos.CCG
- Dr Trevor Thompson GP & Reader in Healthcare Education and Head of Teaching for Primary Care
- Dr Sarah Jahfar GP and Teaching Fellow, GP lead for Year 1
- Dr Simon Thornton, Academic Clinical fellow in Primary Care
- Dr James Seddon, Academic Clinical fellow in Primary Care

Updates on teaching in Year 4

All the information you should require to have a Year 4 student in your surgery is in the GP handbook find this on-line by following the link:
http://www.bris.ac.uk/primaryhealthcare/teachingundergraduate/year/four/

Changes to assessment and how we can help our students prepare for it

The main change this year are the way the students are assessed. There is now going to be one 4th year assessment at the end of the year in June 2016. This will comprise of 2 written papers and an OSCE (objective structured clinical examination) covering Year 4. Year 4 is constructed of 4 units and an external student selected component. The four units in Year 4 are:

Community Orientated Medical Practice 1 (Child Health, Evidence-based Medicine & Public Health)
Community Orientated Medical Practice 2 (Primary Care, Medicine for Older People & Dermatology)
Reproductive Health and Care of the Newborn (RHCN)
Psychiatry, Peri-operative Medicine and Critical Care (PsPC)

Students will not have had an OSCE exam before. The academies have all been sent a practice scenario and marking sheet from each of the above specialities which are available on the medical school website to run practice sessions for the students. When the students are on placement in primary care with you the best practice is for them to consult with patients as much as possible and as well as take the history and examine, for you to ask them how they would explain their thinking to a patient and how they would form a management plan. It also helps if you can observe the student doing a *full* consultation and use the generic consultation observation form (see appendix) to structure your feedback.

This year the exam will be held on **21st June and 22nd June 2016** in Bristol and in Cheltenham, Bath and Taunton. Students will have two weeks of revision time prior to the exams (previously one week) so if you have a Year 4 student in the final block of the year we are hoping this will result in more focus on their clinical attachment.

From summative to formative assessment

There is now no longitudinal summative assessment through the year. Previously students were graded on projects or clerking portfolios. The assessments are still in place but only as a means to give students feedback on their progress. We also want to improve the mechanisms in place to pick up students who might be struggling or need additional clinical exposure due to absence. There is an exam board after every block to raise these issues and decide what individual students need to do before they can progress to their final year exam. This means that it is imperative that you let phc-teaching@bristol.ac.uk know (via the feedback and payment form) any concerns or absences by the last day of the student's placement with you.

We are also keen to recruit GP teachers as examiners and if you are interested in this or if you already examine we will be soon be holding examiner training sessions. The following dates are arranged. There will also be upcoming sessions in Taunton, Yeovil and Gloucester. Please get in touch with the local academy office to check dates and book your place.

Dates:
Weds **9th December 2015 10.30-12.30** Swindon email amanda.bell@gwh.nhs.uk to book
Tuesday **12th January 2016 9.30-11** Canynge Hall (for North and South Bristol) email phc-teaching@bristol.ac.uk to book
Thursday **28th January 2016 2-4pm** Bath. Email academy to book

Feedback: What are we doing well and where could we improve?

We discussed feedback from the students in 2014 and 2015 and again it is overwhelmingly positive. This is from the BOS survey link sent to all students at the end of the block to complete, the number of completed surveys was 83/113 = 73% response rate (proportion of students completing the survey is fairly consistent across the academies)

Please make a computer available and time for your student to do this in your final session.

Some of my favourite comments (among many) are:

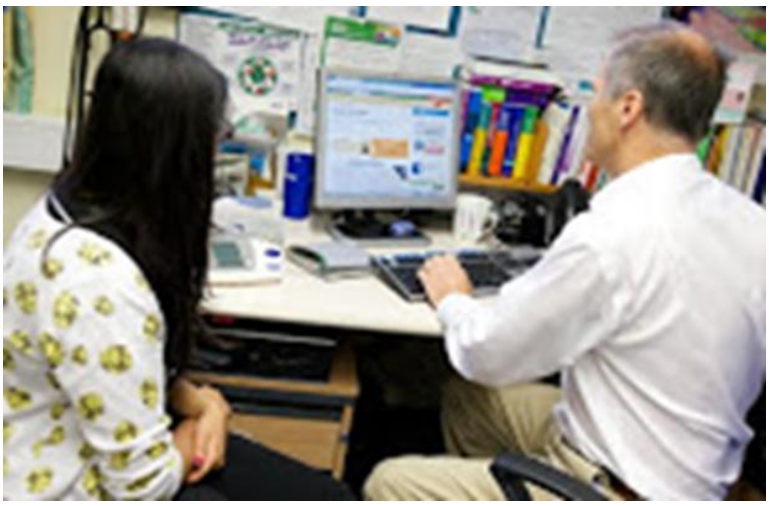
Although not wanting to pursue a career in GP, I found my GP rotation one of the most enjoyable placements in my entire time at Medical School….taught me more about how to be a Doctor as opposed to focusing just on passing the exam material…. even valued my clinical opinion as was asked for my thoughts on management and diagnosis.

All fantastic in different ways at teaching me and letting me practice clinical skills

I was made to feel very welcomed and included, given opportunities to ask questions and learn huge amounts

I wish the placement could have been longer

Very enthusiastic GPs who were very flexible to incorporate your needs as a student. Feedback readily given and lots of opportunity to ask



Credit: CAPC photolibrary. Photographer: Nick Smith.

Overall feedback showed that:

- The students overall are very fair and usually any negative feedback re consulting opportunities are balanced with positive feedback about the overall experience/GP teacher enthusiasm
- GP enthusiasm and practices being friendly and welcoming is consistently excellent
- The lowest scores are for opportunities to see patients on own and being observed doing own consultations (though this is generally good, and is improved from last year) Each student should have a minimum of 5 full consultations observed by you over the 4 weeks. Try the consultation observation form (see appendix) to guide you in giving feedback to your student.
- 75% of students cover at least ¾ of the core clinical topics; please use the learning needs analysis form (see appendix) and find other ways to cover the topics that the student doesn't see in a patient e.g. through tutorials/roleplay/ or inviting a patient in with a relevant condition that the student can interview.
- The other lower scoring area is learning about prescribing and there is scope to improve teaching on and exposure to learning about prescribing—getting the student to look up medication in the BNF as they observe or conduct consultations is a good discipline for them.
- Not all students are having the required minimum of 2 tutorials over the 4 weeks, please make sure
- There are improved scores this year for opportunities to learn from other health care professionals (e.g. community nurses). Students feedback that usually this is a good learning experience esp. for practical skills but at times this seems to be at the detriment of time spent with GPs.

University news and the current Primary Care teaching team (Nov. 2015)

Credit: CAPC photolibrary. Photographer: Nick Smith.

In terms of central organisation the headline news is the creation of the Faculty of Health Sciences which merged the Medicine & Dentistry schools, Veterinary school and Biomedical sciences. The Dean is Professor Jonathan Sandy, and the Associate Dean is Dr Sarah Purdy – a practising GP and primary care researcher.

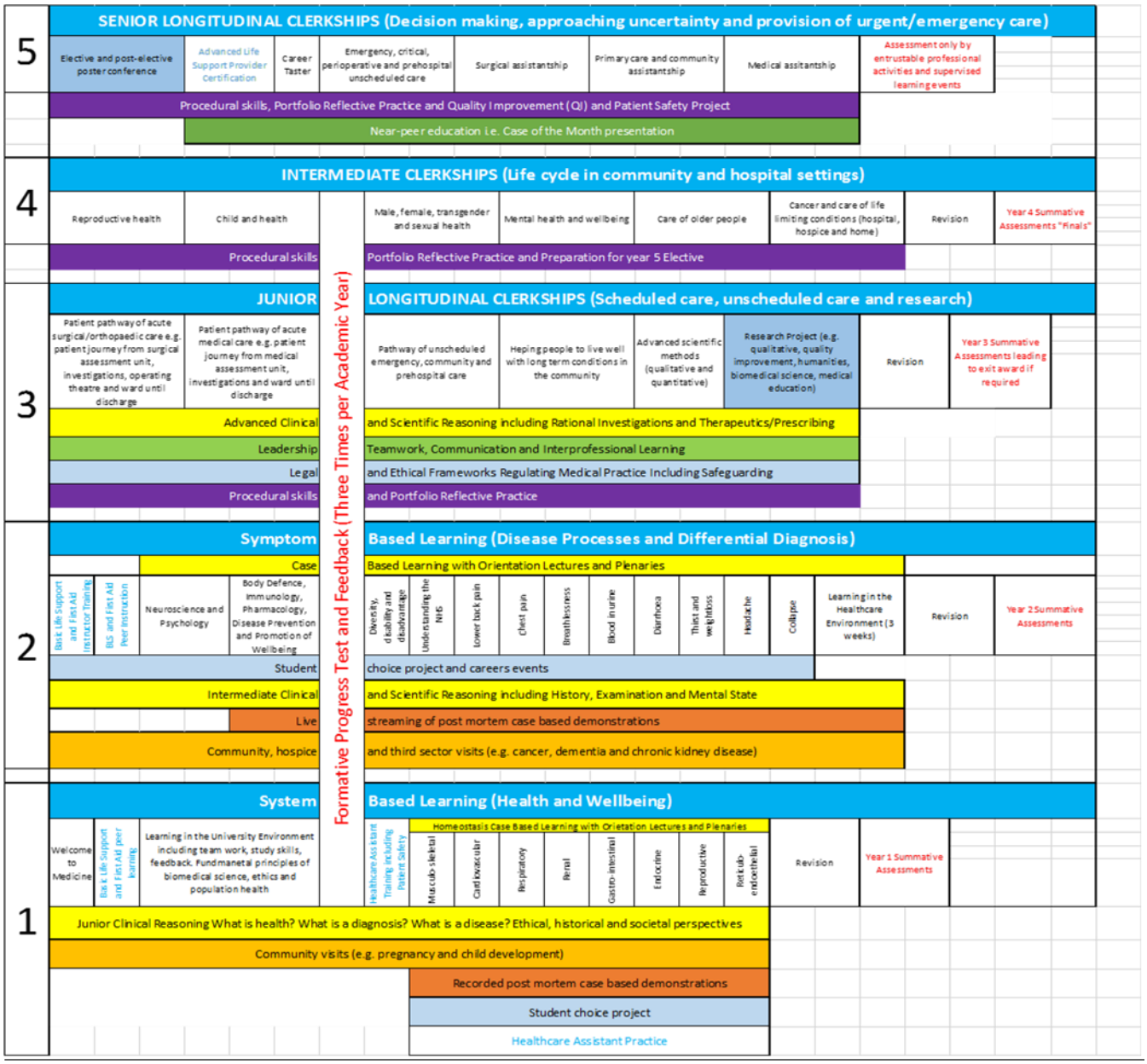
In the Primary Care Department there has been a fair amount of staff change this year. Congratulations to Dr Lucy Jenkins (Year 4 Primary Care Element Lead) and her husband on the birth of Benjamin this summer, her maternity leave is being covered by Dr Jessica Buchan who has returned from a year abroad in New Zealand.

We said goodbye to Dr Andrew Blythe, former Head of Primary Care Teaching and COMP2 lead; congratulations on his appointment to Director of Assessments and Feedback in the new Faculty of Health Sciences. We also wish Dr David Memel very best wishes in his retirement. Dr Trevor Thompson (whom many of you will know) is now Head of Primary Care Teaching, and another welcome to Veronica Boon, a former Academic Clinical Fellow in the department who has been appointed as a Teaching Fellow she leads on SSC's and disability teaching in Year 4. Dr Shalini Narayan, Consultant Dermatologist has taken on the COMP2 leadership.

Your other regular point of contact is your GP Academy Lead, their contact details are available in the Year 4 Teacher's Handbook.

The Bristol doctor: Developments so far in the undergraduate medical curriculum 2017

The current curriculum has a fairly traditional clear division between pre-clinical and clinical years, the first 2 years are mainly lecture based with little patient contact. A new curriculum will start in 2017 (with year's 1 &5) that emphasises early patient contact, case based learning, longitudinal clerkships, embedding in clinical teams as 'junior member' in year 5, revisiting of the sciences in the later years, formative progress testing, clinical reasoning and, as previously discussed, has *"helical themes"* running throughout the 5 years. The structure might look something like this:



We currently deliver the following teaching in primary care:

Y	No of students	No of sessions	Teaching task
1	3, 4 (6)	8	Visits to patients in pairs Observing surgeries WPC (whole person care), linked to HBoM (Human Basis of Medicine)
2	4 (5)	4	Clinical skills
3	4 (5)	8	Clinical skills (extended), diagnosing, investigations, management, prescribing
4	1	4 weeks =30 sessions	Core curriculum of common presentations
5	2	2 weeks =17 sessions	Complex patients, prescribing, $1^0/2^0$ care interface, acute care, consultation skills, chronic disease mx, multi-morbidities and medically unexplained physical symptoms
		67 sessions 5 years	

The basic framework for the new curriculum has been decided, and development groups for the different year groups have been formed from secondary and primary care academic clinicians and scientists. Their role is to work out the learning objectives for the year and integrate the helical themes. Detail such as the amount of teaching in community settings is yet to be finalised, but may well increase.

We are keen to hear the opinions of GP teacher's either through a Delphi process where you are asked for your comments on deciding learning objectives for each year (look out for emails) or you are welcome to email in your thoughts and suggestions.

The following link is an introduction to the new Faculty of Health Sciences.
https://www.youtube.com/watch?v=JmvRK34tA94&feature=iv&src_vid=gP-s7QV71Vg&annotation_id=annotation_2315545437

▪ Best practice teaching in Year 4

We ran 4 parallel small group sessions which looked at top tips for teaching in Year 4 by discussing what a student should get out of the placement, some of the challenges of teaching Year 4 students in your surgery and what has worked well for your colleagues. We also looked at how to pitch teaching at the right level for Year 4 and how to meet the teaching needs of student who are struggling either with knowledge or confidence, and the student who is performing well and needs additional challenge.

Things we thought most valuable about the GP attachment:

- 1:1 time with a GP tutor
    - Allows development of skills or confidence in a truly student oriented manner
    - Opportunity to identify pastoral / personal issues that might be affecting progress.
    - Enthusiasm for GP / Primary Care
- Experience longitudinal and holistic care
- Variety of knowledge and presentations
- Taking a focused history
- Thinking broadly and biopsychosocial diagnosis

- Moving from diagnosis to explanation and planning
- Developing confidence in management

Top tips for teaching Year 4

Learning needs analysis

- Welcome email with 'What do you want to get out the placement?'
- Attach core topics learning needs analysis to complete before first session (see appendix)
- Reviewing progress by revisiting core topics learning needs analysis half way through the block

Covering the core topics

- GP to role play presentations that the student hasn't been exposed to e.g. handling a domestic violence consultation
- ST2/3 to run a tutorial
- E-learning modules BMJ

The wider picture

- ST2/3 talk about GP training
- Time with the practice manager; tutorial on business / organisation of healthcare
- INR clinics with nurse / phlebotomy; good preparation for foundation doctor

Experiential learning

- Observe the student consulting, especially in acute surgeries (should do at least 5 full observed consultations in a 4 week block) and use consultation observation form for feedback (see attached appendix to this report).

Prescribing top tips

- Spot quizzes on prescribing – what class is that, name a side effect, name a contraindication, how should it be monitored?
- Get students to use BNF regularly –to look up the medication you prescribe or are frequently found in the repeat prescriptions.
- Getting the student to prescribe the drug on the screen / write out the handwritten visit script and so get them to take ownership of the decision

Feedback

- Weekly check in about what's working and what's not
- Use form in the handbook; this doesn't need submitting but is a useful resource to keep in case you are asked to be a referee in the future
- Badging: label your feedback to them as such, otherwise they may not realise where they are getting feedback

Administration

- Federate with local teaching practices—can you share a teaching session or community visit with another practice that also has a Year 4 student, or act as a back-up in an emergency if you were ever unable to teach a session, or simply share tips and experiences.
- Keep good records and get consent to take student's photo and keep on file. Your student may ask you for a future reference and your notes will help you remember them. (see appendix Student record form)
- Ask patients who are good teaching cases or good at talking to students if they would be interested in being contacted in future for teaching. Keep a central practice list or read code them for easy searching.

Managing challenges

- *Students who are 'too busy' – e.g. at exam times*.
    - Make it clear that revision is in their own time, this is the only four weeks of GP specialty teaching they have.
    - Identify and address their learning needs
    - Lots of consultation practice with observation and feedback (see appendix)
    - Speak to the PHC office if there is a concern; there is an 'attendance concern form' as an appendix to the handbook.

- *Colleagues feeling hard done* by at picking up the slack while you're giving tutorials / having advice slots booked out
    - Actively ask if colleagues would like to be involved in teaching and then spread the responsibilities around; students like variety.

- *Students going through emotionally difficult times* – speak to them; document the conversation, have a low threshold for submitting a 'student concern form'; more guidance is available on page 28 of the handbook.

Pitching at the right level

Confident and able students need a challenge.

- Get them doing things they can't learn from books e.g. consulting—especially consultation skills-heavy problems like mental health/ forming management plans / using community resources / prescribing/ medically unexplained symptoms.
- We found it helpful to think of turning the student from "journalist" to "detective". From asking and recording the information to really asking themselves what is going on and why.
- Move from diagnosis to appraising evidence and comparing treatment options.
- Let them make mistakes in this safe environment and learn from them.
- Actively ask what they want to get from the placement as they will probably know.

The confident but less able student can be challenging.

- Again, get them doing things and observe them.
- Videoing consultation and review.
- If concerns about attitude / team work get them to do a 360^0 feedback early in the placement.
- Keep the learning environment 'safe' – this is a great opportunity to identify and address knowledge gaps before their final year.
- Enthuse—talk about what you like about your job.
- Are they underchallenged? Let them choose their level of challenge for the session—are they up for some difficult questions from you?

The less confident but able/knowledgeable student benefits greatly from this placement as they are not competing for attention with other students.

- 'Exposure therapy' – it's usually consulting that's the problem – get them to consult and consult and consult with lots of positive feedback and little challenges for the next time to aim for.
- Introduce checklist type diagnostic tools such as the PHQ-9 so that they can learn how to phrase a question and to act as a reminder of what to cover.

The less confident and less able student is a rarity.

- Ask about pastoral issues that might be affecting them and proceed as above. If it is just an intrinsic problem to the student, consider a 'student concern form'.
- Go back to their level of competence and build up – do what you can, even if that's going back to basic examination and consultation skills.

- Being a safe doctor is paramount.
- In so doing, remain positive and don't demoralise them.
- Get them to observe the GP consulting and talk through what you are doing.
- Role play situations with the student and yourself as the patient
- 'The Body' app (of simple anatomy) has been a useful tool.

We also discussed how the style of the teacher should change depending on the needs of the learner. We looked at a cartoon from Gerald Grow's article (Teaching learners to be self-directed. Adult Education Quarterly, 41 (3) 125-149 available on-line from http://www.famu.edu/sjmga.ggrow) Which reminds us as teachers that not all students are ready for the more self-directed learning styles of discussion and collaboration and we may need to meet them at an earlier stage of imparting knowledge, demonstrating, instructing and motivating and slowly moving them towards a more self-directed style.

Small group session: Case based learning

Developing a primary care teaching case to use in case based learning

During this session we explored how we might design a primary care patient case. We started with an initial patient presentation with background demographics. We then thought about prompts we might ask the student to help met the learning outcomes. These included questions that ensured the student had addressed the patient's ideas, concerns and expectations (ICE), as well as more detailed questions about the presenting symptom such as the duration of onset, associated features and what investigations they might consider doing.

The case was then expanded with a prompt drawing on one of the wider themes of the Year 4 primary care curriculum such as 'prescribing skills' or 'disability'. In one example, the 22 year old basketball player presenting with chest tightness became a wheelchair basketball player prompting discussion about clinical examination in a wheelchair user.

A final level of complexity was added by the addition of one of the helical themes such as 'evidence based medicine' or 'global health'. For example, the case of a 78 year old lady admitted to a nursing home post CVA with recurrent aspiration pneumonia was complicated by the addition of a son who lives in California constantly demanding that she has a PEG insertion. The helical themes are aspects of learning to be a doctor that should weave throughout a student's other system based or specialty specific teaching. They are topics such as consultation skills, ethics and law in medicine, smart prescribing, the arts and humanities in medicine, patient safety and quality improvement, and self-care and resilience grouped in 4 distinct areas: Doctor as; scholar and scientist, practitioner and educator, professional and agent of change, and person and citizen which map to the GMC's outcomes for graduates.

At the end of the session we shared how we had found the case writing experience, and discussed how this was just one model of how it can be done. We also discussed how most of us already use case based teaching for year four students, and we felt the expansion of this style of teaching to the more junior years was a good thing. A number of GPs expressed an interest in getting involved in the case writing process for the new curriculum.

Teaching mental health

Consultant Liaison Psychiatrist Nicola Taylor who helps organise the teaching in the undergraduate curriculum told us about the new psychiatry course.

From this year Bristol medical students will have their main psychiatry block in Year 4 rather than Year 3. This means that students coming out to primary care at the beginning of Year 4 will not yet have done a placement in psychiatry, a change from previous years. However they do have some mental health teaching and lectures in the other years.

Nicola explained that the change has allowed them to redesign the course. It will run over 6 weeks in a number of different sites across 3 NHS trusts and follows an apprenticeship model with weekly workshops, small tutorials and individual educational supervision to help guide them through their attachment.

Students complete a formative clerking portfolio, logbook and student project (internal student selected component) and receive feedback on their progress. The assessment is part of the Year 4 end of year OSCE and written paper.

The introductory lectures are:

1. History taking, Mental State Examination and Classification
2. Mood disorders
3. Anxiety disorders
4. Personality disorders
5. Substance misuse, including alcohol dependency
6. Self-harm and suicide
7. Eating disorders
8. Medically unexplained symptoms
9. Dementias and delirium

For more information check out:
http://www.bristol.ac.uk/medical-school/hippocrates/psychiatry/

Personality disorders

As a Consultant Liaison Psychiatrist Nicola shared her experience in working with patients with personality disorder (focusing on impulsive and borderline types) and gave us a really helpful insight into some of the challenges and effective management strategies. It is helpful to talk to students about managing patients with complex needs, they are with you in an apprentice style learning environment and to see the "coal face" of medicine where situations and conversations can be multi-faceted and challenging.

Nicola was honest about how these patients could make health care professionals feel. She reminded us of the value of being kind, life is difficult for someone who is unable to control their impulses and emotions, and who are often unable to form stable personal relationships, many live with chronic feelings of emptiness. A helpful way of thinking about this was that as adults we learn to get what we want in a socially acceptable manner, those with personality disorders often haven't learned these skills. The means they resort to are extreme and blatant –often labeled "manipulative."

What carers (including doctors) might say/think about patients with personality disorder	What they might mean
"They are so manipulative"	"I feel manipulated and I don't like it"
"Why don't they just do it?"	"I don't feel like I can stop them doing it."
"What do they want from us?"	"I don't think I can stop this."
"Attention seeker."	"I don't have the time to give this person the attention they feel they need. And I don't know what that might be."
"It's a cry for help. They won't do it."	But they do. People with emotionally unstable personality disorder have a higher rate of completed suicide
If people really want to kill themselves, then there is nothing you can do to stop them.	Untrue. There is a period when we can intervene to make a difference.

Diagnosis

- Have an index of suspicion, treat symptomatically, and refer.

Ways to tell someone you think they have a personality disorder

- I think that you're having a difficult time, and you've had problems for a long time….
- In my experience, people who have had difficult childhoods can have a range of ways of thinking about themselves or other people, and that makes life difficult for them.
- It might be that their emotions are all over the place, and feel out of control.
- It might be that they do things impulsively that hurt them in the long term
- Sometimes they are so frightened of people leaving them that they cling on or push them away before they can be hurt
- Sometimes when they are really distressed they hurt themselves
- Sometimes they even hear what sounds like voices in their head
- Does that make any sense?
- I'm afraid there's not an easy answer to this, but there is help available.
- One of the best treatments is a talking therapy called DBT/MBT. We have evidence to say that it can help reduce your distress, and help you live the life you want to live.
- It is available here. I'd like to refer you on to mental health to help confirm the diagnosis and get you linked in to the therapy.

What helps therapeutically:

- Managing endings and transitions
- Harm Reduction: Ice, bands, pens as alternatives to self-harm such as cutting
- Psychotherapy:
- Mentalisation based therapy*, Dialectical behavioural therapy**
- Medication
- Short term sedation, NICE say 1 week
- Little evidence that standard psychiatric in-patient care is helpful

Also think about:

- Care planning
- Crisis planning
- Consistency
- Kindness
- Instilling hope
- Not letting them feel trapped

*Mentalization based therapy (MBT) is a specific type of psychodynamically-oriented psychotherapy designed to help people with borderline personality disorder (BPD). Its focus is helping people to differentiate and separate out their own thoughts and feelings from those around them.

**Dialectical behavioural therapy
DBT teaching four sets of behavioral skills. The term "dialectical" means a synthesis or integration of opposites.

1. Mindfulness: the practice of being fully aware and present in this one moment
2. Distress Tolerance: how to tolerate pain in difficult situations, not change it
3. Interpersonal Effectiveness: how to ask for what you want and say no while maintaining self-respect and relationships with others
4. Emotion Regulation: how to change emotions that you want to change

There is increasing evidence that DBT skills training alone is a promising intervention for a wide variety of both clinical and nonclinical populations and across settings.

Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms) but is considered in the treatment of comorbid conditions.

The GP undergraduate society (GPSoc)

It was brilliant to have Alice and Alexa at the workshop, both to tell us about the aims of the GP Society and to hear the student perspective in the sessions. They explained how GPSoc is inspiring the next generation of GPs by showcasing General Practice as a wide ranging, versatile and stimulating career to medical students. They provide information about GP training and run regular events to inspire students—past speakers include Clare Gerada when she was president of the RCGP and Ellie Canon, media GP. They have made links with the primary care department, the Deanery, other medical school primary care societies and local GPs but would love to hear from you if you can help—perhaps talking to students about your career journey. Contact Alice, GPSoc Chair on info_bristolgpsoc@me.com

Update on the NICE cancer guidelines

Dr Alison Wint, Macmillan GP and South Glos. Cancer Lead outlined the main changes that will affect practice following the publication of the new NICE cancer guidelines published in June 2015. https://www.nice.org.uk/guidance/ng12 (accessed November 2015)

Common cancer is a core topic for the primary care undergraduate curriculum. This was a chance to update on the changes so that we can update our students but also to open a dialogue with our students about how to keep up to date. The earlier version of the NICE guidelines were prescriptive, the current ones are more open to interpretation—the pros and cons of different guidelines is an interesting topic to discuss with your students.

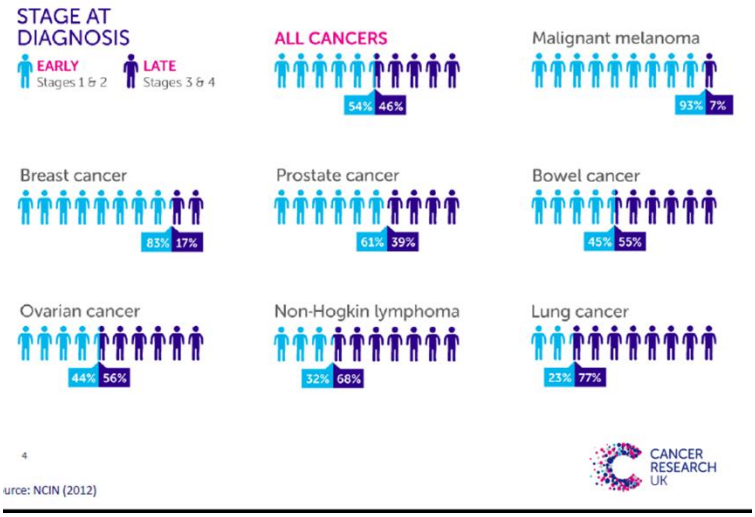
Alison put the guidelines in context and said that the story of cancer is changing: New screening tests are being introduced all the time, the public awareness of risk factors is rising, and more cancers are being diagnosed (300,000/yr). There are 200 different types of cancer and now a lifetime individual risk of cancer approaching 50%. Many cancers are becoming a long term condition rather than a death sentence as treatments become more effective and survival rates improve, and as reported recently end of life care in the UK is exemplary.

Early diagnosis is key to survival. Cancer is still a major cause of death and the South West Cancer Network has reported that cancer now has a higher mortality rate locally (12,527) than circulatory disease (12, 416).

Breast, lung, prostate and colorectal cancers have the highest incidence, with breast cancer having two peaks—in middle life, then increasing in incidence with age.

An analysis of the population based cancer registry published in the Lancet in 2011 showed how the 1 year survival rate of lung, colorectal and ovarian cancer in the UK lagged behind other countries with a comparable health care system such as Australia, Canada and Sweden. 1 year survival in Breast cancer in the UK also lagged behind but is catching up.

Early diagnosis makes a significant difference to survival and results in less invasive treatment.



The challenge for primary care is that patients present with vague ill-defined symptoms and GPs are increasingly dealing with an ageing population where frailty can mimic cancer and older patients more likely to have co-morbidities.

The average GP diagnoses 8 cancers/year but a GP considers a cancer diagnosis several times/day.

Alison explained that the overarching principle of the 2015 guidance is that it is based on symptoms presenting to Primary Care whereas the 2005 TWW guidance was based on Secondary care data. They consider the identification/recognition and selection of patients for further investigation in primary care or for referral in people of all ages and emphasis that these are recommendations and not requirements and are not intended to override clinical judgement. We discussed that parts of the new guidelines seem vague in comparison to previous guidelines but this reflects that GP should not be a gate-keeper using symptoms to filter who is seen in secondary care, but rather the presence of symptoms should trigger investigation. We need to lower the threshold for investigation and more investigation should be done in primary care to identify patients with cancer and reduce the referrals of people who don't. We should actively monitor symptomatic patients who are do not meet the referral criteria: "Low risk, but not no risk" and ensure we have a protocol for results to be reviewed and acted on and be aware of false-negative results. This is going to increase our workload and responsibility.

Primary care investigations include:
PSA
Ca125
Ca+
FBC for leucopenia, thrombocytosis and anaemia
Ferritin for iron deficiency
FOB – GI symptoms without rectal bleeding

Note that:
Thrombocytosis has a 40% risk of cancer and should prompt further investigation—lung, endometrial or oesophagus/stomach.
New diagnosis diabetes with weight loss >60yrs – consider pancreatic cancer
Leucocytosis with non-visible haematuria >60yrs consider bladder Cancer

Urgent direct access from Primary Care for investigation within 2 weeks is recommended in several cancer sites such as CXR, Endoscopy, Non-obstetric USS and MRI of the brain

The guidance is easy to navigate and laid out based on:

1. Cancer site
2. Patient support
3. Symptoms

We looked specifically at the change to the guidelines for colorectal cancer as one of the core topics for the Year 4 primary care course.

Site:

We should be referring people using the 2 week suspected cancer referral pathway for colorectal cancer if they are

- 40 or over with unexplained weight loss and abdominal pain
- 50 or over with unexplained rectal bleeding
- 60 or over with iron deficiency anaemia or changes in bowel habit (note the loss of the previous timescale or levels of anaemia)
- Or tests show occult blood in their faeces
    - FOB should be done if 50 and over with abdominal pain or weight loss, under 60 with changes in bowel habit or iron deficiency anaemia or in the over 60's with any anaemia even in the absence of iron deficiency.

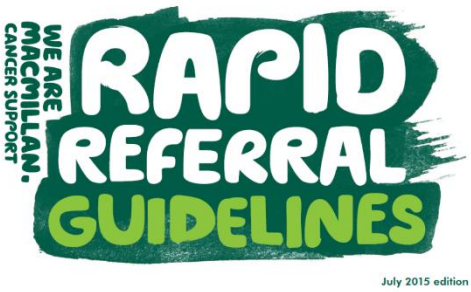
Symptoms:

- Consider referring patients with a rectal or abdominal mass under the 2 week suspected cancer referral pathway for colorectal cancer
- Offer a digital rectal examination to those with unexplained symptoms related to the lower gastrointestinal tract.

Support:

- Shared decision making and informed patients is a key principle
- Information at the time of referral: on process, investigations, risks & likelihood of cancer.
- Reassurance and information for patients with low risk symptoms.

Alison introduced two really helpful decision support tools that we can introduce our students to. The Macmillan rapid referral guidelines found on:



http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/PCCL/Rapidreferralguidelines.pdf (accessed November 2015)

And a referral and investigation pathway diagram Stahl-Timmins W. Assessing and Referring Adult cancers. BMJ, 2015. http://www.bmj.com/content/bmj/suppl/2015/07/17/bmj.h3044.DC1/adult_cancer_NICE_graphic_v3.1.pdf (accessed November 2015)

Appendix 1

Year 4 student consultation observation form (Updated 24/11/15)

The purpose of this form is for the GP teacher to record your observations of a year4 student conducting a consultation with a patient in full, or to focus on parts of the consultation and help structure feedback. During a 4 week placement each student should have the opportunity to have **5** complete consultations observed by their GP teacher. This form is based on the Calgary-Cambridge model of the consultation.

Brief description of presentation:

Date:

Competence task	**Yes/No/Not relevant**	**Comments**
Initiating the session:		
Student introduces themselves and gains initial rapport		
Identifies reason for the consultation		
Gathering information:		
Student obtains biomedical perspective of presenting problem and relevant medical history including red flags.		Any medical information missed?
Student elicits patients perspective: ideas concerns and expectations		
Student elicits background information e.g. work, social background.		
Physical examination:		
Student examines patient (where relevant) and explains findings		Was the examination focused and relevant?
Explanation and planning:		
Student offers explanation to patient and provides correct amount and type of information and aids understanding and recall.		Any examples of chunking, checking or clarifying?
Student achieves shared understanding of problems taking into account the patient's illness framework		
Student formulates appropriate management plan with patient.		
Closing and housekeeping:		
Student closes the consultation at appropriate point		
Arranges appropriate follow up		
Safety nets		
Building relationship: also please comment on the following		
• Non verbal behaviour • Rapport • Involves patient		
Providing structure: also please comment on the following		
• Overall fluency of the consultation . • Student provides structure to consultation • Gives patient opportunity to ask questions • Responds appropriately • Summarises		

▪ Appendix 2 Core Problems in Primary Care 2015/16 – Learning Needs Analysis

Problem	Presentations	Learning objectives	Confidence (1 not at all, 5 fully confident)
Asthma, angina (chest tightness)	**My chest feels tight**	*Describe how to diagnose asthma & angina, when to refer & how to manage these conditions including commonly used medications.*	**1 2 3 4 5**
Breathlessness e.g. Chronic obstructive pulmonary disease (COPD), anaemia, heart failure & smoking	**I get out of breath easily**	*Describe how to diagnose & manage COPD and heart failure including the main treatment options. Describe how to investigate anaemia. Demonstrate ability to help someone stop smoking and have an understanding of the main medications used including nicotine replacement.*	**1 2 3 4 5**
Common cancers: lung, bowel, prostate & breast	**I'm losing weight; I'm still coughing; I have to go to the toilet all the time; I've found a lump in my breast**	*Describe how these 4 common cancers might present and know how to reach a definite diagnosis. Describe how to manage a patient who is terminally ill as the result of any of these cancers.*	**1 2 3 4 5**
Contraception	**I'd like to go on the pill**	*Be familiar with at least one combined oral contraceptive pill. Demonstrate how to assess a patient before starting her on the pill and how to follow her up. Discuss methods of post-coital (emergency) contraception. Discuss other contraception options.*	**1 2 3 4 5**
Depression	**I feel useless**	*Be alert to possibility of depression and use skilful questioning to confirm diagnosis. Be aware of treatment options and be familiar with at least one antidepressant drug.*	**1 2 3 4 5**
Domestic violence	**I have tummy ache I can't sleep**	*Identify patients who may be at risk of intimate partner violence and have strategies to help them*	**1 2 3 4 5**

Problem	Presentations	Learning objectives	Confidence (1 not at all, 5 fully confident)
Dysuria e.g. Urinary tract infection, chlamydia & common STIs	**It stings when I go to the toilet**	*Demonstrate how to manage simple UTIs including commonly prescribed antibiotics. Be alert to possibility of prostatic hypertrophy/ cancer in men. Be alert to possibility of STDs causing dysuria. Feel confident in taking a sexual history.*	**1 2 3 4 5**
Gastroenteritis	**I've got diarrhoea**	*Describe the management of diarrhoea in adults*	**1 2 3 4 5**
Gastro-oesophageal reflux & alcohol dependence	**I've got heartburn**	*Describe investigation & management of heartburn understand the role of medication in the aetiology of heartburn, and in managing heartburn.*	**1 2 3 4 5**
Headaches e.g. Migraine & tension headache	**I've had a headache for the last 2 days**	*Demonstrate how to assess and manage a patient with a headache. Discuss treatment & prophylaxis for migraine.*	**1 2 3 4 5**
Hypertension and cardiovascular risk	**The nurse said my blood pressure was high**	*Demonstrate how to diagnose and manage hypertension including choosing treatment options. Demonstrate how to estimate the risk of someone developing cardiovascular disease over the next 10 years. Be familiar with the indications for prescribing statins including the risks, benefits and monitoring required. Describe the role of a GP in managing patients following a myocardial infarction. Discuss the use of sildenafil in a patient presenting with erectile dysfunction.*	**1 2 3 4 5**
Non-specific low back pain	**My back hurts**	*Be familiar with common causes of back pain, and red flag symptoms & discuss when investigation is warranted. Demonstrate management of back pain*	**1 2 3 4 5**

Problem	Presentations	Learning objectives	Confidence (1 not at all, 5 fully confident)
Otitis media & externa	**My ear hurts**	*List differential diagnosis of earache & management options for otitis media & externa including medications used.*	**1 2 3 4 5**
Respiratory tract infections: Viral sore throat, glandular fever, tonsillitis, upper respiratory tract infection and influenza	**I've got a sore throat**	*Discuss management options for each of these conditions including commonly prescribed antibiotics. Communicate the potential benefits & disadvantages of antibiotics to the patient. Be able to counsel a patient on the use of simple over the counter analgesics e.g. paracetamol and nonsteroidal anti-inflammatories. Understand the flu vaccination and when it should be issued.*	**1 2 3 4 5**
Substance misuse	**My wife says I am drinking too much alcohol.** **Can you prescribe me some methadone?**	*Make an initial assessment of someone with an alcohol or drug problem. Demonstrate ability to recognize alcohol dependence & offer help with stopping drinking.* *Be aware of the associated medical and social problems. Gain understanding of services for addicts within primary care.*	**1 2 3 4 5**
Tiredness: Diabetes, anaemia, hypothyroidism, insomnia, depression, early pregnancy, chronic fatigue syndrome	**I feel tired all the time**	*List differential diagnosis of tiredness.* *Describe presentation, investigation & management of each of these conditions.*	**1 2 3 4 5**

- **Appendix 3 Year 4 GP attachment student record form**

(For GP teacher use only)

This form is for your own use to keep a record of the students that you have taught in practice. You can fill this form in with the student at the end of the placement to help you structure your feedback, and also keep it as a record in case the student requests a reference from you in future. You do not need to send this form back to the teaching office unless there are concerns in which case please see http://www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/year/four/ and follow the link for the student concern form or absence concern form which has further information.

The students benefit from feedback on their:

1) Clinical skills and factual knowledge. Compare the student's self-reflection of learning needs with your objective observations.
2) Appropriate behaviour towards both patients, and staff.
3) Appropriate attitudes to patients, staff, society and their own learning.

STUDENT'S NAME ……..……..…

Dates of Attachment……...

Name of Surgery……..

CATEGORY	Record comments with examples where possible
Appearance: Personal appearance and compliance with dress code	
Attendance & Punctuality: At formal teaching and clinical sessions Reasons for absences/lateness explained	
Professional behaviour: Respect for patient confidentiality Respect for patient comfort and safety Integrity and honesty Recognition of own limitations and appropriately seeks help	

Clinical skills and factual knowledge: Factual knowledge of core clinical problems and how this has developed during placement Observed clinical skills using CAPS logbook. Any areas to work on?	
Communication skills Respectful and appropriate communication with patients and sensitive to culture and background Demonstrates an understanding of the importance of working effectively with others	
Attitude to learning Enthusiasm for participation in clinical work Demonstrates an ability to prioritise tasks and information Ability to self-reflect and be self-directed in their learning Acceptance of constructive criticism Ability to express an opinion/participate in discussion	
Other comments e.g. feedback from other staff	
Any special circumstances during the attachment that you or your student would like to record:	