Year 1 GP Tutor Guide

Clinical Contact in Human Health and Wellbeing block

The neurological system

Centre for Academic Primary Care

2018-19 MB21

Contents

How to use this guide:
This guide starts with the background to the students learning. **The busy GP teacher will find *all you need to know for the session in the session plan on pages 5 & 6*.** The subsequent pages (page 7 onwards) are copied from the information provided to the student about the particular things they should be thinking about and observing when they are on clinical placement this week. This is the background information to help the students make links between the patients they see and their learning on the case and the Effective Consulting course. This is there for your reference if you find it useful.

Dear GP tutor

Thank you for taking students for this session in Primary Care during their Case Based Learning. You should have been sent a link to the Tutor guide which gives you an overview of case-based learning in Year 1 of MB21 (or find this on the primary health care website) and an overview of the Effective Consulting course with links to general information you need to run the sessions.

This is a short guide to running a session in the neurological case (you will be sent a link to similar information in each case 2 weeks before the students are due)—and you can also find these on our website http://www.bristol.ac.uk/primaryhealthcare/teaching/teaching-in-practice-by-year/one/

This is the final session in Primary Care for these students, they have one more case (Endocrine) but will spend their Clinical Contact for this case in the hospital setting. We would like you to bring the year to a close by spending time with your group and a patient directly observing how your students interact with the patient, recapping what you have covered over their sessions with you, giving group feedback and spending time with each student giving individual feedback. Your students will have been working on their creative assignment and they may also bring this in to show you if it is based on a patient they have met during their time in Primary Care (information on the assignment is on page 17).

Dr Juliet Brown
Year 1 GP lead

Neurological—overview of the case

The case involves an older couple, George and Margaret. George makes an appointment to see his GP as he has been getting worried about his memory. When George attends his doctors' appointment the following week, his GP asks him some questions about his memory and general health and then does some simple memory tests. She notices a bruise on his arm (she asks about the cause, bearing domestic violence in mind) and he tells her how he tripped and fell in the park. She examines him, including checking his reflexes, and strokes the sole of his foot with a blunt orange stick to check his plantar reflex.

George had taken Emma, his granddaughter, to the park, to practise on her new bicycle. Initially learning to ride, she was fearful, but as she progressed she found the experience more rewarding. She felt much safer after learning to use the brake with her right hand. George chased after her on her bike but he tripped and landed awkwardly on the grass.

Lectures:

1. **Introduction to the case** - The essential structure and function of the central nervous system (including consciousness, language and other cognitive functions, attention, perception, executive function, vision and hearing, breathing and swallowing, movement, sensation, autonomic control and pain) Describe the structure and function of the spinal cord including movement, sensation and autonomic control.
2. **Brain formation and fluids -** anatomical and physiological principles underlying the blood supply to and drainage from the brain and spinal cord, blood brain barrier and cerebrospinal fluid.
3. **Structure and function of the somatosensory system** processes and pathways which lead to voluntary muscle movement starting in the motor cortex (including the corticobulbar and corticospinal pathways (upper motor neurone), the lower motor neurone, neuromuscular junction and muscle, the role of extrapyramidal systems
4. **How reflexes keep us safe**-- Describe the processes and pathways involved in the control of posture and reflex movement
5. **Functions of the basal ganglia and cerebellum** -- Compare and contrast the roles of the basal ganglia and cerebellum (extra pyramidal system) in the control of gait and fine motor skills of the upper limb
6. **Cognitive function** -- Describe the clinically relevant aspects of neural development and ageing processes. Outline the use of tests in the assessment of cognitive function, e.g. MOCA
7. **Fear, pleasure, anger, hunger and sex, getting to know your Limbic system**
8. **Psychology of risky behaviour in adolescence**

Practicals	*Helical themes:*
Tendon jerk reflex.	• Evidence based practice • 3D • Self-care and resilience • Whole person care

Neurology session plan

Neurological System Case

EC focus of the fortnight: Planning, closing and integrating

- ***Planning:*** *Describe how clinicians and patients collaborate in shared decision making for best care.*
- ***Closing:*** *Describe how to effectively bring consultations to a close*
- ***Integrating:*** *Describe how to learn from and reflect on each clinical encounter, both in terms of clinical knowledge and emotional processes.*

Global EC ILOs

- Describe the structure and components of a well-rounded medical history including assessment of cognitive function
- Describe the structure and components of a whole person approach to the clinical examination, including assessment of mental state

Clinical communication ILOs

- 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 integrating and learning from clinical encounters.
- Describe the importance of a whole person approach to the consultation and clinical care including the consultation as a therapeutic tool

Patient Perspective ILOs

- Consider how patients might integrate the clinical consultation

Neurological Session Plan Primary Care	
Check in. Review of last session Run through session objectives	**15 mins**
Tutor time: • Brainstorm the broad areas of the medical history • Consider the elements of cognitive function and mental state examination (see enclosed notes). • Prepare to meet the patient—briefing on any important information • Set tasks to achieve e.g. *observe students receiving a well-rounded history, consider what further information they might need e.g. from the clinical examination.* • Consider how to close and integrate a consultation.	**30 mins**
Practise the medical history with a patient Please bring a patient into the surgery to meet with the students **Tasks:** 1. Ask a student to start the interview with the group observing, you can either switch with another student ½ way through or you can ask the whole group to take turns in asking questions and talking with the patient. 2. Ask another student to take notes and "present back" the patient's story to the group. 3. Discuss with the group what they found out about the patient. What else would they like to know about? Why? What further information do they need e.g. what would they be looking for in the clinical examination? 4. Consider they were meeting this patient in a consultation or hospital clinic—how would they end the consultation? What would the patient have to do next? What would the doctor have to do next?	**1.25 hours** **45 mins with patient + allow 30 mins prep and debrief time.**
Discussion time and feedback time Spend time with your group reviewing your sessions together. What have they learnt? What did they like/what could be improved? Spend approximately 5 minutes with individual students giving them feedback on their progress and what to concentrate on in their clinical learning. Those students who had done a creative piece based on a patient they have met in GP may want to share it with you. The other members of the group will have this opportunity in their EC Lab (campus based session) The others should be given time to complete an online form (available to them on OneNote)	1 hour
Close and goodbye:	**5 mins**

Talking with patients

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. We would expect that the students will be starting to find out relevant details about the patient's condition, their background (medical and social), and the impact of the patient's physical or mental functioning on their lives. 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 summarize 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.

In this session, we would like you and your group to interview a patient.

- Try and be as hands off as possible to start with, and observe how the students get on.
- Step in if the student's get stuck or ask the other group members for advice
- Ask one student to take notes and summarize the key points from patient's story.
- Discuss what the patient has told you. What do the students think the important information is? Why? What would they like to know more about or what hasn't been covered?
- Discuss if they know what is going on or if they need information from another source e.g. another person or from a clinical examination or investigations.

Gathering information when talking to patients

When you and your students review the patients story, help them recap what areas they covered well and what areas they could find out more about. They have not yet learnt a traditional medical history template, but now is the time to introduce them to it, particularly in relation to presenting a story back to colleagues:

Nature of the current medical problem			Presenting problem
			Current health and current health problem
			History of presenting problem
			Background to the current problem
			Systems review
			More about the nature of the patient's overall health
			Past medical and surgical history
			Patient's previous health issues
			Drug and treatment history
			Current and past treatments and interventions Prescribed medication Allergies Over the counter meds Other interventions
		Relevant Background / lifestyle	Social history
			Social history: occupation, smoking, alcohol, accommodation, etc
			Other background information
			Risk factors – modifiable, and non-modifiable
	Patient perspective on the problem		*Assessment of wellbeing, lifestyle and relevant background* - *Connectedness (family, friends, community, self)* - *Physical and Mental wellbeing (sleep, healthy eating, exercise, emotional health)* - *Daily life (finance, work, environment, fun)*
			Ideas, concerns, expectations, impact, emotion (ICEIE)
			Ideas the patient has about their health and condition
			Things the patient is hoping to happen in the consultation today
			Concerns that patient has about the consultation, their health, their condition or anything else
			Impact that the patient feels this is having/ will have on their health, or more generally
			Emotions around the consultation (anger, fear, relief etc)

As you progress through your medical degree you will be introduced to the concept of a 'medical history': the formalized way in which we clinically record and present information both verbally and in writing. P11-20 and 32-39 of McCleod's Clinical Examination (13th Ed) provide an outline of content and format.

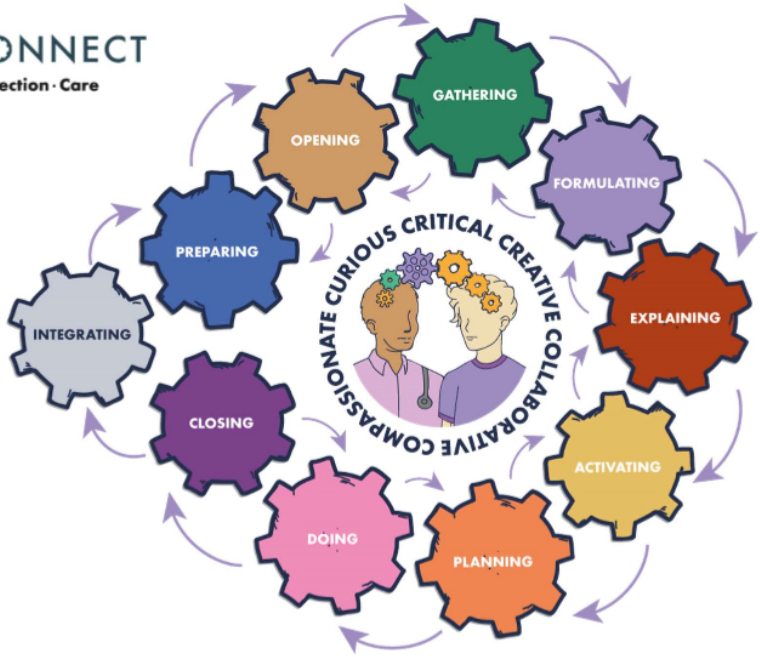
You are not expected, nor encouraged, to have clinical conversations with patients in this checklist fashion. The template here is provided to illustrate how GATHERING information through history overlays with a more traditional clerking structure. Remember, Gathering is broader than just 'history' it includes other sources of information, previous results, examination findings etc.

How to use this template: use this as an observation and reflection tool. Did you, your peers or your GP gather this information? How was it obtained? What worked well?

Recap of COGConnect:

The next page is an outline of the consultation model used to teach consultation skills in Bristol. Try using it to help the student reflect on their conversation. For instance, did the student open well? Did they bring their conversation to a satisfactory close? Was the student able to consider what was going on? Did the patient understand their condition, did they want an explanation?

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
Cognition · Connection · Care

Shared decision making in clinical practice

In their Effective Consulting session, the students are learning about shared decision making.

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**

What is Shared Decision Making?

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.

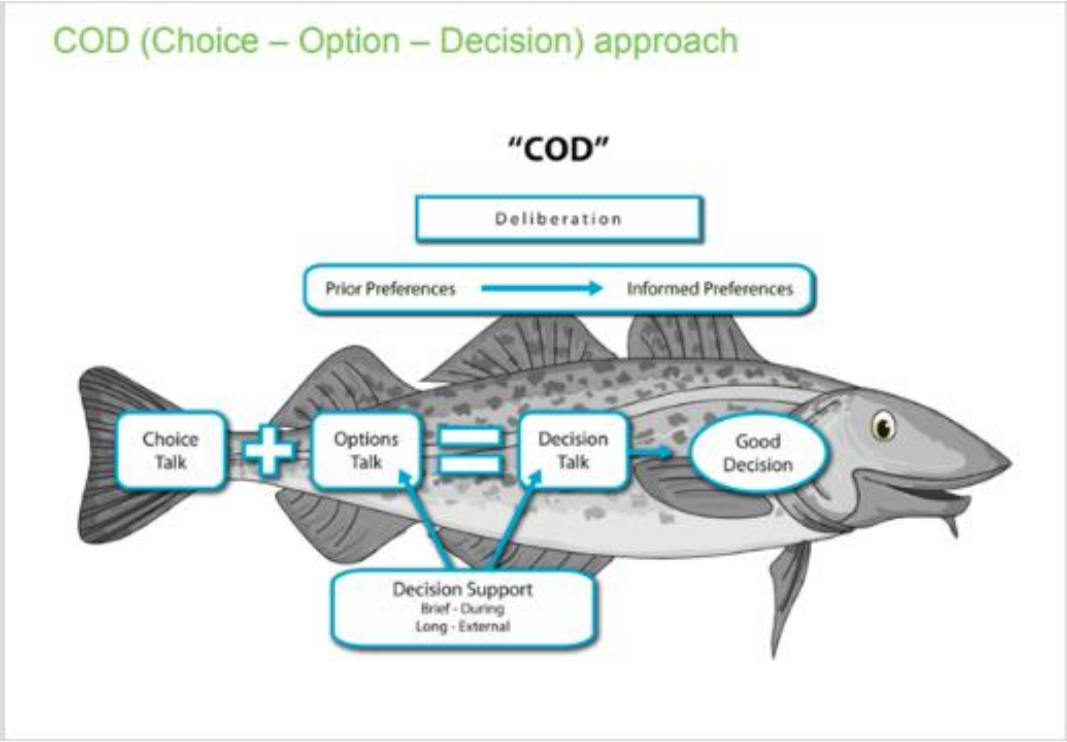
- Better communication and collaboration is correlated with better patient adherence. Training doctors to communicate better enhances patient adherence.
- Patients who are active participants in managing their health and healthcare have better outcomes that patients who are passive recipients of care
- 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:

Patients are being encouraged to be actively involved in shared decision making through 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, closing and integrating in clinical practice.

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?

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

When the consultation has finished, and the patient has left, the doctor hasn't finished yet. There are several things that still need to be done.

- Clinical record. The doctor needs to write up the notes into the records, they also have further tasks such as write a letter, chase a result, speak to a colleague for advice or make a note to follow the patient up.
- Informational needs. There may be an element of the consultation that the doctor needs more information on. This may be about the individual patient, or it may be educational needs about a case.
- Affective processing. Some cases are really emotionally tough, and some days are emotionally draining. Some consultations are really interesting, enlightening or life affirming. All of this needs processing and the doctor may need to take a moment to reflect or get ready for the next patient.

The patient may also have to do a significant amount of integrating to do. They may have to take a new diagnosis or information on board, tell a loved one, take new medication or make lifestyle changes.

An introduction to the mental state examination

You will come across the mental state examination at several points in your training. This is just an introduction to the concepts. The mental state examination is a structured way of assessing a patient's psychological functioning. It only provides a snapshot of their psychological function as it can change over time (sometimes quite rapidly). We may intuitively pick up on many of the aspects of the MSE as we talk to people or observe others in our daily lives. In the medical and psychiatric assessment, it is useful to have a recognised, reproducible way of recording this information

Task: Take each heading and discuss with a peer (or write down) some aspects of each domain that you might observe or assess in a person, and what this might indicate. You can gather clues about someone's self-care, hygiene levels and lifestyle by observing aspects of appearance, but assessing other aspects of the MSE such as cognition requires specific questions and tests (screening for cognitive impairment)

APPEARANCE
BEHAVIOUR
SPEECH
MOOD AND AFFECT
PERCEPTION
COGNITION
INSIGHT AND JUDGEMENT

Example answer for Appearance:

What are you looking for?
You might note someone's clothing—are they all in black or flamboyantly dressed? Is their clothing appropriate e.g. does it fit them, and is it what you would expect for the situation? What is their self-care like? Consider hygiene and grooming e.g. smell, cleanliness and tidiness of nails, hair, facial hair etc. You might notice scars from self-harming, or bruising from harm by others.

What might this tell you?
All aspects of the mental state examination are only clues and need to be take in context. Someone in their pyjama's in the supermarket may be a student demonstrating their relaxed lifestyle and attitude, or it may indicate a cognitive deficit as in dementia, with no

sense of time or place, or it may indicate lack of self-care or lack of awareness of social norms such as in psychosis.

Assessing cognitive function

You will cover in your case that it is common for patients to the complain about memory impairment. Sometimes the patient presents with concerns about their memory, but often it is a family member who is worried. Mild cognitive impairment has many causes and should be tested for. This enables forward planning but also to look for reversible causes, cognitive decline can put the patient and others at risk, for example leaving the gas on after cooking. Mild impairment can precede serious cognitive decline in dementia by many years. Causes include dementia, head injuries, Parkinson's, endocrine disorders e.g. hypothyroidism, metabolic e.g. hypoglycemia, nutritional deficiencies e.g. folate and vitamin B12, sedative medication, depression, and infections.

There are different parts to assessing cognitive function, a history including collateral history, mental state examination, physical examination of the patient, and formal cognitive testing with a standardized test.

The mini mental state examination is a commonly used test of cognitive function that scores out of 30. It tests orientation, short term memory, visuospatial and language skills and is thought to be sensitive (it picks up mild impairment) but not suitable for making a diagnosis. It needs to be purchased and can't be reproduced.

The test in the news is the Montreal Cognitive Assessment (Moca) which was administered to Donald Trump to assess his cognitive function. It is rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuospatial skills, conceptual thinking, calculations, and orientation. It scores out of 30 with 26 and above being normal.
http://www.mocatest.org/

The GPCOG test was designed to screen for cognitive impairment in primary care, it has 2 parts, first an assessment of the patient's cognitive function, then if their score is uncertain e.g. 5-8 there are further questions to ask someone who knows them (a collateral history or "informant"). You can read about it here:
https://patient.info/doctor/general-practitioner-assessment-of-cognition-gpcog-score

The "Six-item Cognitive Impairment test" (6CIT) can be used to screen for cognitive impairment is used in primary care. It is a little complicated to score (but computer versions available) but sensitive and still specific, and easy to translate to different languages and cultures (note this is not true of the AMT which needs questions adapting)

	SIX-ITEM COGNITIVE IMPAIRMENT TEST (6CIT)--Kingshill version 2000	Score if incorrect. (Score 0= correct)
1	What year is it?	4
2	What month is it?	3
3	Give a 5-part address for patient to remember e.g. John Smith, 42 West Street, Birmingham.	
4	What time is it? (To nearest hour)	3
5	Count backwards from 20	1 error= 2 points 2 + errors = 4 points
6	Say the months of the year in reverse	1 error= 2 points 2 + errors = 4 points
7	Repeat address phrase	Score on number of errors 1 = 2 points 2 = 4 points 3 =6 points 4 = 8 points All wrong= 10 points
SCORE	0-7 normal. 8 or more significant.	Total: 28

The Reflective Assignment and Feedback

The students are being asked to develop a creative piece of work based on a reflection they have made on a patient encounter this year (either met in primary or secondary care, or in their HCA attachment). As GP tutors, **you do not have to mark this this year.** But we hope that if the students have based their piece on a patient of yours, that they will share this with you. Please give them some feedback—some ideas are at the bottom of the page (they can't make changes at this stage, it's just to share with you). If you see an exceptional piece of work please let me know juliet.brown@bristol.ac.uk and I will pass your comments onto the Effective Consulting tutor. Likewise, if you have any serious concerns about a student work, please inform me.

One of the key things we want the students to experience is the chance to engage personally with medical themes through creative work. An artistic approach gets us to focus

on the individuality of the situation, and to deal with the emotional responses we often have to clinical situations.

In the COGConnect model of consultation, the final stage is Integrating. Whilst this includes some very practical things, like note writing and ensuring continuity of care, it also incorporates the ability to process our emotional responses to consultations. Some individual clinical encounters with patients will affect us deeply, for a variety of reasons, and it is this we want the students to explore in their assignments.

The assignment (information to students)

You should choose a particular patient or clinical encounter: either someone you meet during clinical contact in HHW CBL or FOM, or look back through notes you made on MyProgress during any of your clinical contact (HHW CBL and FOM), and use this as a basis for developing a creative piece of work. You can also use your clinical experience in your Healthcare assistantship as the basis for your work.

Guidelines for the creative assignment in EC

- Your creative piece should be based on a real, specific, encounter during clinical contact in Year 1.

- Once you have chosen the clinical encounter you should consider and chose a way to extend your understanding using creative methods.

- You can produce your creative work in any media, including but not limited to photography, art, dance, music, poetry, creative writing, digital storytelling, video, drama, blogging, vlogging etc.

- The work must be created specifically for this assignment, and must be based on a clinical encounter you have had as a Year 1 medical student

- Your creative work should be accompanied by a narrative of approximately 500 words. The narrative should include the following:

    - A description of the clinical encounter (and why you chose this encounter)
    - An explanation of the creative medium chosen (and why)
    - What you have learned about yourself and your patient from the clinical encounter
    - What you learned about yourself and your patient from the process of creating the piece
    - How you felt about the clinical experience and creative work based on this experience
    - Identify whether the work is based on HCA, Primary Care or Secondary Care
    - Any reference to individual patients should be anonymized

- Consent should be sought to use patient's story as the basis of your creative work. This should be documented in your narrative.

- If you include a photograph or image of a patient or other recognizable individual you MUST have signed consent to use this image for your creative work.

You are encouraged to look through the Out of Our Heads website to see examples of best practice, and there are some examples available here from Year 1 MB21 2017-18.

FAQs for the Creative Assignment

Why am I being asked to do a creative piece?

Even if you are not *naturally* creative, previous students have found that there is a lot to be learned about themselves and patients from engaging in creative ways to explore their clinical contact experiences.

The Arts offer an insight into the human predicament that can't be derived from raw experience alone. By using an artistic medium you deepen your appreciation of the paradoxes that you witness in clinical contact. Medical practice itself is creative. As clinicians we often face patients with uncertainty about what to do and somehow find a mutual way forward through creative thinking and practice. See Art in Medicine and the Art of Medicine, and the Creative Assignment - Context for more information

I can't draw, what can I do?!
You do not need to be fantastic at drawing or art to complete this assignment well. You can use any medium including but not restricted to photography, art, dance, music, poetry, creative writing, digital storytelling, video, drama, blog/vlog etc. What matters is that you explore, to the best of your ability, the human predicament faced in clinical encounters, through a creative medium with an accompanying narrative.

What can I base my creative piece and narrative on?
See guidelines above, but we recommend that you utilise the reflective accounts you have recorded in MyProgress about the patients you have met in clinical contact.

How does the creative piece link to what I've learnt in EC the rest of the year?
See here: Assignment mapping to ILOs to see how the creative piece and narrative link to what you learn in EC over the course of Year 1

How do I submit my creative piece, and to whom should I submit it?
- Your creative pieces and accompanying narrative should both be uploaded to your student EC OneNote which your EC Lab tutor can then view.
- If your work is based on a patient you met in primary care you should also email a copy to your GP
- If your work is based on a patient you met in secondary care you should email a copy to your hospital tutor

- If your work is based on a patient you met in HCA, you may like to consider sharing this work with the ward, and send a copy to Dr Robert Marshall

When should I submit my creative piece?
These should be uploaded alongside your narrative to OneNote, and emailed to the appropriate clinical contact person by the 4th EC tutorial of HHW CBL cycles (Date: Thursday 7th March 2019)

How is my creative piece assessed?
In the 6th tutorial of EC in HHW CBL Cycles (4th April 2019) you will each be given approx. 5 minutes to present your creative piece and narrative to your EC Lab tutor and EC tutorial group in a showcase during you EC tutorial. Your tutor and colleagues will be able to ask questions and you will be encouraged to provide peer feedback to each other. Your tutor will provide written feedback (via OneNote). Previous students have really valued this feedback from both peers and tutors. This assignment is tutorial work, and is formative, but your engagement in the process, submission on time, and participation in peer showcase is important professional behaviour.

What happens to my creative piece afterwards?
We ask each EC Lab tutor to put forward the best combined creative pieces and narrative (so this may not be the 'best' artwork/photography/writing etc, but may be the most insightful narrative and explanation) after the 6th tutorial. As a group you may also want to peer nominate the 'best' piece from your EC group. These pieces are then reviewed by the EC team and considered for submission to the Out of our Heads website, for certificates of commendation and for national awards. Please state clearly on your narrative if you would NOT want your work to be submitted. Otherwise all students work will be considered (you will be contacted if this is the case).

We hope the process will be fun, challenging, creative and enjoyable for you, and we are really looking forward to seeing your work.

Feedback

Those students who are waiting whilst you give individual feedback can be given access to a computer (or use their phones) to complete the student feedback form. This is available for them on OneNote but for information / access the link is here

Or copy and paste:
https://forms.office.com/Pages/ResponsePage.aspx?id=MH_ksn3NTkql2rGM8aQVGy4RKJKwFbBFozMxyEGh3ghUOUcyQlI2QksySDVJVllYRUpMMEJZWE41TC4u

Giving Feedback to students

Feedback is a high priority as it contributes greatly to student learning. Your feedback has the potential to help students develop academically, clinically, reflectively. The recent National Student Survey showed that students do not feel they receive enough feedback on their work, so we are encouraging this.

Spend approximately 5 minutes with individual students giving them feedback on their progress and what to concentrate on in their clinical learning. Those students who have done a creative piece based on a patient they have met in GP may want to share it with you during this 1:1 time.

Feedback should be:

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

Other considerations:

1. Affirm qualities—character traits that will serve them well as a doctor. There is evidence that this is motivating.

2. Areas for development—offer observations not assumptions. Students are often poor at identifying their weak areas and feedback from others can help them to improve.

3. End on a positive note (completing the feedback sandwich of "positive comment—area for improvement—positive comment")

General suggestions for feedback throughout the course

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