YEAR 1 CLINICAL CONTACT IN PRIMARY CARE SESSION
Thursday 29th February 2024 – am or pm – group B
Themes: Gastroenterology
Consultation skill: Explaining

Session plan		**Suggested timings: AM**	**PM**
Introduction	30 min	09.00-09.30	14.00-14.30
Patient contact	1 hour 20	09:30-10.50	14.30-15.50
10-minute break			
Debrief and discussion	50 min	11:00 – 11.50	16:00 – 16.50
Close	10 min	11:50 – 12.00	16:50 – 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 skill focus is **"explaining"**.
The appendix contains further information extracted from the students' digital notebook (OneNote) and resources to enable you to help the students make links between the patients they see and their university learning. There is also some guidance on exploring sensitive topics, and about the students' creative assignment.
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 focuses on Vikram, aged 55 who is physically inactive and has put on weight. A BMI calculator says he is obese. He is consuming 3,000 kcal per day and agrees to change his diet. Saira, aged 52, works as a nurse and sometimes doesn't eat on a shift. She can still fit her size 8 clothes that she wore pre-children. She avoids cow's milk as it gives her diarrhoea. She visits her GP at the end of a 12-hour shift with symptoms of a UTI and is found to have ketones + on urinalysis.
In **effective consulting labs,** the focus is on explaining and asking questions about sensitive topics. In pairs, the students will attempt collaborative discussion explaining information to their 'patient' using Check: Chunk: Check and Teach Back (you can read more about this in the appendix below).

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

- Describe an approach to asking sensitive questions (e.g. about bowel and bladder function)
- Describe some of the features involved in explaining ideas and developing shared understanding (chunking, checking, clarity and the use of aids) in the clinical encounter
- Practise explaining clinical information to patients, relating this to information gathered, clinical formulation, and the patient's ideas, concerns, and expectations.
- Describe the importance of eliciting and confirming the patient's understanding. Describe how the patients' ideas, concerns and expectations inform health professionals explanation of clinical problems

GP advance preparation
Read this guide: arrange a patient with a current or past GI 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 GI 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 the importance of and aspects of explaining
- Discuss how we can ask questions about sensitive issues (see appendix)
- Discuss a GI examination in GP: can it be done remotely? (see the appendix if needed)

Patient contact (1 hr 20) 09:30-10.50 or 14.30-15.50

- 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, the students should all introduce themselves to the patient by name and role.

Patient interview. Ideally, this will be a patient with a current or past GI problem such as IBD, coeliac disease, bowel cancer or previous acute abdomen e.g. pancreatitis. Students should take it in turns to lead the interview and be prepared to feedback to each other on consultation skills (see the GP Teacher guide for practical information about this and a patient letter). Specific student tasks:

- Continue to build on your skills of talking to patients.
- Consider the broad areas of the medical history when you are interviewing a patient or observing consultations this week. Try to gather a history in all three domains.
- Reflect on how you or the person you observed facilitated rapport with the patient: which verbal/non-verbal communication skills help the patient tell their story/demonstrated listening?
- How did you encourage the patient to talk? Were there any silences?
- Were there any difficult points in the interview and how did you deal with these?

Observing consultations. Ask the students to practice and observe **communication skills,** for feedback and discussion in the debrief. **Specific tasks:**

- Think about what information can be gathered from active, purposeful observation of patients
- Observe how the GP prepares for and opens the consultation (COGConnect template, available here)
- Reflect on gathering information, the content and process and what questions worked well
- Can you identify the patient's agenda? What do you think were their ideas, concerns, and expectations about what was going on? What about impact and emotions as well?
- Did the patient agree with their doctors' perspective, or do they have a different perspective?
- If appropriate, observe and note how you/your GP approached any sensitive topics e.g. weight or bowels

Regarding **explaining,** think about

  - What information did the patient want and need to know?
  - What is important to think about when you explain something to a patient? Does the patient have a good understanding of their condition?
  - Check/chunk/check or teach back *(see observation tool for this in the appendix)*
  - What resources help e.g. visual/decision-making aids or signposting online or to information leaflets?

○ When was it important that a "shared understanding" was reached e.g. did the doctor have to ask additional information to understand terminology that the patient used? Did the patient and doctor agree on a plan of action?
10-minute comfort/toilet/stretch/tea break as needed
Debrief and discussion (50 min) 11:00 – 11.50 or 16:00 – 16.50
Ask one student to summarise the patient's story from the **patient interview. Discuss and reflect** on the patient's narrative — you may wish to use the reflective tool based on the 5C's of COGConnect to aid this — available here. Reflect on the experiences of having a GI problem and how these impact on patients' lives. Students present the patients from **observed consultations** to the group: debrief, feedback and discussion around any issues that arise Discuss which communication skills and question types worked well with specific focus on gathering the history, and finding out the patients' ICE and **explaining** (refer to student consultation observation tasks above). Addressing **sensitive areas** of the history if not already covered — top tips from students and teachers (info in appendix)
Close (10 min) 11:50 – 12.00 or 16:50 – 17.00
• **Take home messages** – share something learned/something that surprised them/ a learning goal • Remind students about their reflective log/ePortfolio • Discuss what worked well/less well – anything to **stop/start/continue** for future sessions?

GP tasks after the session

- Make own **reflective notes** on the session if you wish (try to keep a record of which students interviewed patient/consulted).
- Prepare for and consider a patient to invite to the next session (with your other group Thurs 14th March 2024, CBL fortnight: Urinary/renal systems. Cons skill focus: activating)
- Complete online **attendance data**
- Any questions or feedback, email phc-teaching@bristol.ac.uk or lucy.jenkins@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. They could use the observation tool in the appendix
- **Show and tell** with common consulting room equipment. E.g. thermometer, auroscope, sphyg, urine dip, swab, sats probe. Hold one up and ask students to tell you what it is, how to use, what is normal etc.
- Discussing significant events that have occurred recently at the surgery

Role play as below: one student plays the patient; another is the medical student meeting the patient before their consultation. Please allocate the others specific areas to observe and give feedback on the role-play afterwards.

- 30-year-old with central abdo pain, off food and feeling hot/unwell. Tried Paracetamol and rested but not improving. Bowels normal and no problems passing urine. Normal periods, on the contraceptive pill. Possible appendicitis.
- Or 76-year-old, previously well other than high blood pressure for which he/she takes Amlodipine. Tired but otherwise well over the last few months, puts it down to doing less due to Covid. On direct questioning, has been a bit constipated and possibly lost some weight. Non-smoker, no alcohol. Possible colorectal cancer.

Use **https://speakingclinically.co.uk/.** Watch together a clip of a patient describing a condition and then reflect on this as a group. Log in at https://speakingclinically.co.uk/accounts/login/. Use email as phc-teaching@bristol.ac.uk. Password: primcareGP1GP2. The students have been signposted to specific relevant patients on this site and can access this with you through their OneNote if needed.

- https://speakingclinically.co.uk/videos/ulcerative-colitis-2/

A 19-year-old Mother of two who aspires to be a nurse or doctor. She has severe UC and has had many extra-intestinal manifestations such that she is considering a colectomy

- https://speakingclinically.co.uk/videos/crohns-disease-5/

A 41-year-old woman with Crohn's disease, with recurrent obstruction, now with a stoma. Symptoms impacting on all parts of her life.

For further patient experience videos, the students are also signposted to https://healthtalk.org/colorectal-cancer/symptoms-and-diagnosis-of-bowel-colorectal-cancer
There is some basic information about bowel cancer here followed by a selection of patient videos showing the different ways it can present.

And https://www.necuk.org.uk/post/my-journey-surviving-necrotising-enterocolitis
This is the account of a teenager who developed a condition called necrotising enterocolitis as a baby and required surgery. She was left with a very short gut meaning that she has ongoing problems and needs to go to the toilet many times a day.

APPENDICES

Exploring sensitive topics
Gathering info
Explaining – some pages are extracted from the students' digital notebook (OneNote)

- Understand the patient perspective and ideas, concerns, and expectations.
- Jargon
- What the patient wants to know and needs to know
- Chunking and checking – and observation tool
- Teach back
- Shared understanding
- Use of visual aids and leaflets
- Motivating patients to make lifestyle changes
- Observation tool for COGConnect

Remote examination of the gastrointestinal system and BMI
Creative assignment – for your info only

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:

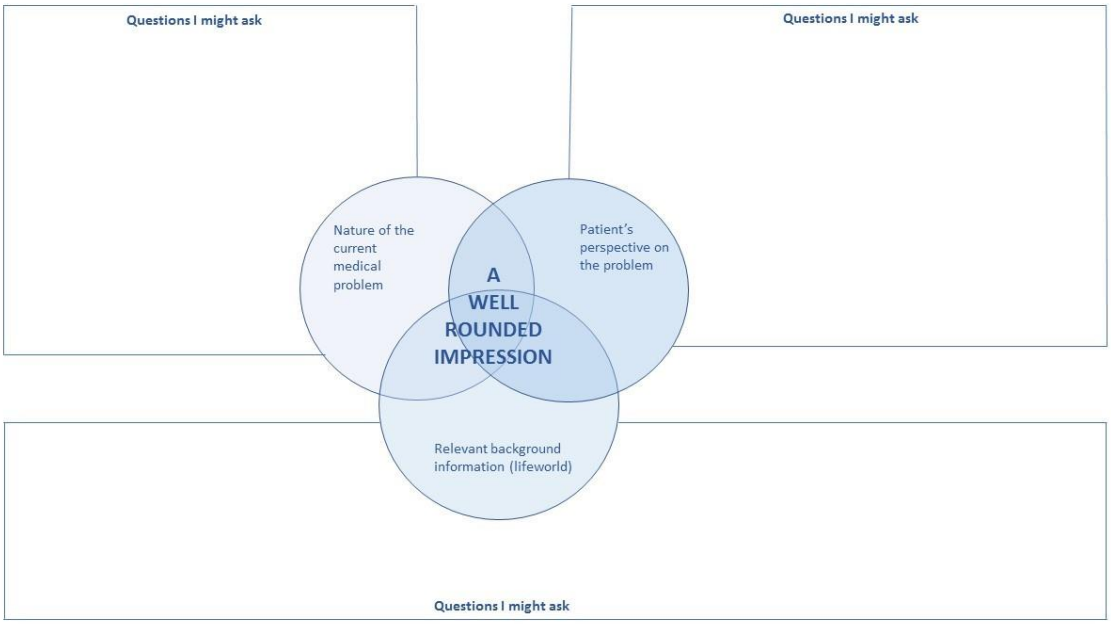
- Explain why you are asking—you may need to address confidentiality
- Ask permission
- Talk in factual terms (not judgmental terms)
- Ask about specifics not generalisations

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 be 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?"

Clinical Communication: taken from students' resources
Gathering Clinical Information

As we foreground a holistic approach to GATHERING information from/with patients during clinical encounters, you may want to encourage students to consider the information they gather in the 3 domains:

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



Explaining

Drawing on the information gathered and formulated, describe how to develop a shared understanding with the patient of their condition, its causes, and next steps.

There are various points in the consultation that will require you to explain things to patients. You may explain:

- Your thinking during the consultation, especially what you think is going on: "Well, I don't think it sounds like your symptoms indicate anything serious, but I think we are going to have to do some further tests to make sure."
- Why you want to do something, such as an examination or get a blood test.
- The risks of a procedure to gain consent from a patient.
- How to do something, such as get a urine specimen
- What is likely to happen if you don't do anything. An example is explaining the natural history of a condition. For instance, a viral sore throat typically resolves within a week.
- Different options for treatment including not treating. Patients should understand what the pros and cons of different treatment options are, and where there is uncertainty.

Understand the patient perspective and ideas, concerns, and expectations.
Explanation is not just telling the patient what is going on or what the options are and expecting them to sit and listen, it is a two-way process. The explanations you give for any of the above depends on what you have already discussed. It is based on your understanding of the patient's perspective.

Example: I once had a patient who was unhappy with my explanation of his stomach pains. I realised I hadn't found out what he thought was going on. It turned out that he had accidentally swallowed a whole almond a few days previously without chewing it. He had become worried that this had become lodged in his intestine and was causing the pain, he expected that he would need an endoscopy. I could never have guessed this, but once I knew his concerns I could tailor my explanation to how the gut worked and reassure him.

Find out what the patient wants to know and decide what they need to know. Later on, when students learn more detail about various conditions it's common to hear them launch into lengthy explanations about the patient's problem before finding out what the patient wants to know.

Why should you find out what the patient wants to know: Suppose you are meeting a friend in town? You think you are nearly at the café you are meeting at, but you can't quite remember if you need to turn left or right so you consult a map. A kindly passer-by stops and presumes you are a tourist and that you need to know where you should go next. They start telling you about Bristol's road lay out, history and all the major landmarks you should visit and in which order. You can barely get a word in and feel a bit overwhelmed by all the information they give you. They leave and you realise you still don't know where the café is because they didn't ask what you needed to know.

A simple "Would you like me to tell you about…" or "I would like you to do a urine specimen, it's important it's done properly to avoid contamination, so can I talk you through how to do it?" works well. It gives the patient the opportunity to say if they don't want/need the info. You never know, they might be a nurse on a urology ward and not need you to explain how to take a urine sample.

When you hear doctors give explanations to patients, listen to see if the doctor identifies the patient's starting point. An example would be: "From what you've told me and from examining you I suspect you have something called irritable bowel syndrome…if I say irritable bowel syndrome what does that mean to you?"

There are also numerous examples in medical practice of information that the patient needs to know but doesn't know that they need. They need to have been told the risks of a procedure before they can consent. They need to know what to look out for if their condition gets worse, what to do, and where and when to get help. You might hear doctors use signposting before they give information: "Having talked with you and examined you I think it is very unlikely that you have appendicitis, which is something you were concerned about. However, early on it can be hard to tell, and we need to discuss what to look out for…"

Remember to avoid jargon:

It's really important that you give explanations to patients in plain, straightforward language. Imagine you are talking to a family member who is not a doctor. Patient information leaflets such as those on www.patient.co.uk or patient support group websites for specific conditions are useful resources to look at to learn how to give simple explanations of sometimes quite complex problems. It can also be helpful to use the patient's own words.

Chunking and checking:

How we give patients information is important. Firstly, we need to check what information the patient wants and what their current understanding is.
We want to give information in a way that they will understand and recall. Particularly when we give a lot of information or complex explanations it helps to break it down into smaller "chunks".

“I am going to tell you 3 things about….The first is”

Also start with a simple “chunk” of information and check the patient has understood it before moving on. Checking is really asking the patient if they have any questions about what they are being told. One way to check if a patient has understood what you’ve talked about is to ask how they would explain it to their family or friends.

This is key to patient safety, key to patients understanding treatment options, and key to patients making changes to their behaviour and self-care. One of the ways in which you can do this is through a method called (variously) 'teach back' or 'closing the loop'.

CHECK Identify and elicit the current situation before you proceed with the actual explanation.
a) your knowledge of the situation and information to be shared. Do you know what the result is and what that means clinically?
b) the patient's understanding of the condition/situation - what does your patient already know?
b) the patient's perception of the situation (ICEIE). Maybe they thought they might have cancer and being something else (however serious) could be a huge relief. Or maybe it will be devastating - they're an ice-cream taster and have a new diagnosis of a dairy allergy. Maybe they phoned and had the result already read out to them by an administrator?
c) the patient's ability to understand. This is key and will affect how you explain.
d) the patient's desire for information. For instance in some settings, some patients may actually not want excessive detail.

CHUNK. Here is where you actually explain the test result to the patient.
a) deliver the information in appropriate-sized chunks of information that the patient can grasp
b) do mini checks of understanding
c) avoid technical language that most patients will not understand
d) speak at a rate, pitch and volume that aids and at least does not discourage understanding
e) try and weave into your explaining anything you picked up in the ICEIE.

CHECK. Here is where you check whether you have reached a shared understanding, based on your explanation.
a) encourage the patient to ask questions, e.g. " was there anything that I said that you didn't quite understand?" or "could I clarify anything for you?"
b) address any particular concerns divulged in ICEIE - e.g. "you told me you were worried about cancer - how are you doing with those worries now?" (notice use of open question).
c) you could use teach back techniques here

Teach back:

In a non-blaming way, asking patients to repeat in their own words what they need to know or do. This is NOT a test of the patient, but of how well you explained a concept. A chance to check for understanding and, if necessary, re-teach the information. For more information see: http://www.teachbacktraining.org/using-the-teach-back-toolkit

Shared understanding

When we talk about “shared understanding” with patients we are usually talking about shared decision making, helping patients understand their options and deciding together on the best way to proceed. All the way through an interview with a patient you want to check you are both “on the same page” i.e. you understand what the patient means, they understand what you mean, and that you encourage the patient to contribute or ask questions. The medical history is a meeting, not an

interrogation! Part of a shared understanding is eliciting the patient's perspective and relating your explanations back to their understanding of the situation. It is also being sensitive to the patient's verbal and non-verbal reactions as you talk and checking in with them:
"I can see you look a bit puzzled? Have I confused you?" "Hmmmm, I sense there is still something bothering you. Am I right?"

Use of visual aids and leaflets

Sometimes it helps to look at something together when giving explanations. A chart such as a Body Mass Index (BMI) chart clearly shows what is considered a healthy BMI and what isn't. It can be easier to show the patient where they are on the chart rather than verbal explanations alone. 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 Likewise, patient information leaflets such as healthy diet sheets can be gone through together to back up your explanations.

Motivating patients to make lifestyle changes

Another reason we might give explanations to patients is to motivate them to make changes in their life. If patients understand that their nutrition, habits, or lifestyle are causing some of their symptoms or puts them at future risk they may be more motivated to make changes.

Observation tool for explaining

Tutors, if you are feeling brave, the students could observe any explanations you give to patients! The students also have this in their OneNote online. You could later reflect for CPD purposes.

Skill	**Yes**	**Comment**
CHECK		
The person who is doing the explaining: understanding of what is to be explained (nature and impact).		
Patient's *current understanding* of what is going to be explained (ICE IE)		
Patient's likely *ability* to understand		
Patients *desire* to understand		
CHUNK		
Deliver in appropriately sized *chunks* of information (leave gaps), using the voice well (tone, volume, breath)		
Use *language* the patient is likely to understand - avoiding jargon		
Speak at an appropriate *pace* - neither too fast nor laboriously slow		
Weave in aspects of patient's prior perspectives (? metaphor)		
Uses appropriate visual and other aids to understandings		
CHECK		
Offer patient opportunity to *ask questions*		
Enquire over any *specific concerns* (raised in ICEIE)		
Ask patient to *rehearse* their understanding		

Remote examination of the gastrointestinal system

Ask the students to think about what they already know about how to do a standard GI examination. The purpose of this discussion is to get the students thinking about the different sorts of consultations that are being carried out and how not all medical consultations are held face to face nowadays.

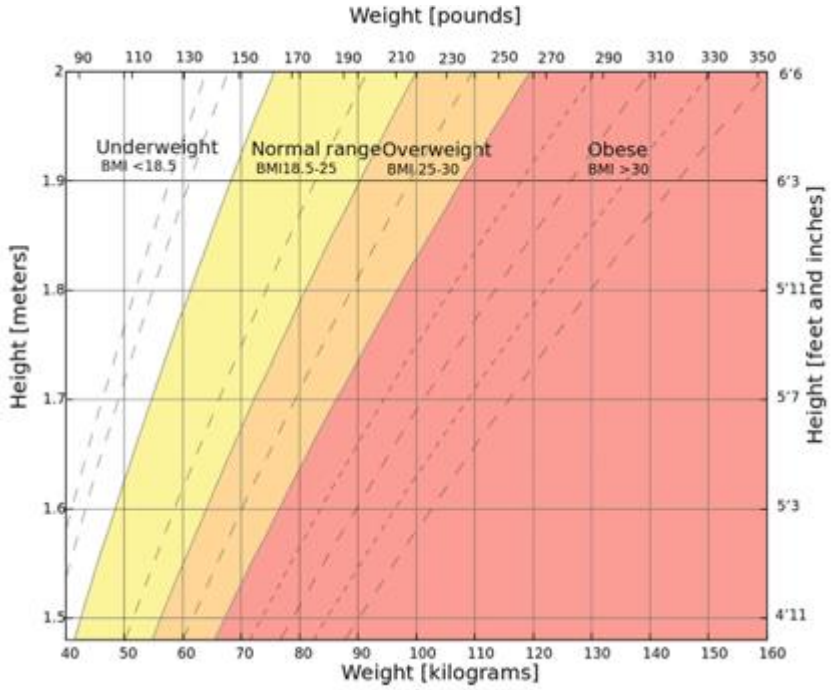
What can we examine over the phone?

- Patient can self-report weight and height. Can discuss possible issues with this and limitations of BMI as below
- 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, body habitus, if in pain.

Body mass index: a measure of whether someone is a healthy weight for their height. It needs plotting on a regular basis to give an objective measure of someone is gaining or losing weight. It is calculated by dividing body weight (in kilograms) by height squared (metres^2). You can find a BMI calculator here: https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/

It is a simple, inexpensive screening test but there are problems with it. It is a proxy measure of body fat, but it doesn't measure actual body fat or distribution of fat. It is less accurate if a patient has a high muscle mass e.g. athletes or has loaded with water (anorexic patients may drink excess amounts of water before weighing). In children BMI must be interpreted relative to age and sex.



Creative assignment – for GP tutor info only

You may wish to ask students about plans for their creative assignment. This is submitted to their EC Lab tutors (campus-based teaching groups) rather than to the GP, but students may choose to base their piece on a patient they have met either in primary care, secondary care or during their HCA shifts. If they complete a piece based on their GP placement, you may want to ask them to share it at a future session. This work is usually of high quality, lovely to see especially if based on a patient you know and facilitates interesting and useful reflection and discussions within the group. The remit for this is broadly the same as for previous years but there are some amendments to the criteria because of the impact of Covid. See the **guidance given to students** below: for info only.

One of the key things we want you to experience in Effective Consulting is the chance to engage personally, and individually, 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. This approach can help us learn about ourselves, and about our patients and colleagues, and can also be a form of self-care helping us to manage the personal and emotional challenges of medicine. In the COGConnect model of clinical encounters which you will learn in EC this year, 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 you to explore in your assignment for EC.*

Additionally, there are 5 Core values which we expect all Bristol Medical students to bring to each clinical encounter: compassion, curiosity, critical thinking, creativity, and collaboration.

Creativity will most usually mean developing creative and novel solutions, but we broaden this to its fullest meaning to include the arts in medicine. You may want to look at this article on compulsory creativity for more information. In Foundations of Medicine, you worked together as a group to develop creative work for the FOM Conference. Here, in EC, you have a unique opportunity to expand on this, and to explore your clinical contact with an individual creative piece which you will share with your EC colleagues.

Once you have chosen the clinical encounter you should consider and choose 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. *Your creative work should be accompanied by a narrative of approximately 500 words.*

Consent should be sought to use a patient's story as the basis of your creative work. This should be documented in your narrative or explained if impractical. All information should be anonymised.

Prizes and commendations are awarded for the best work in the EC Creative Assignment