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University of BRISTOL

Report

2013 Workshop

For Year 2&3 GP Teachers

Overview and update for Years 2&3	Barbara Laue
Learning needs analysis Planning a teaching session Teaching 'history taking' Transitions	} Small groups
	Barny Hole/Natasha & Amy
Portfolios and reflection	Natasha Ward
Teaching otoscopy	Fiona Lyall/Natasha Ward
Teaching prescribing skills	Amy Thompson
Epley Monoeuvre	Otto Marsingh
Facilitators	Sarah Jahfar and Tim Davis

'The interactive aspect worked well in both small groups and lectures. Everyone was very friendly and enthusiastic'

'I found it particularly useful to understand the level the students are expected to work at. This will certainly encourage me to push them more when necessary'

Organiser Barbara Laue

Dear colleagues,

Many thanks for coming to our 2013 Year 2&3 GP teacher workshop.

The feedback showed that most of you enjoyed the day and picked up useful teaching tips. We are grateful to the Clinical Teaching Fellows from North Bristol, Barny Hole, Natasha Ward, Amy Thomson and Fiona Lyall who prepared and presented the afternoon sessions. A special thanks also to our Dutch guest from Amsterdam, Otto Marsingh, for offering an impromptu teaching session on how to carry out the Epley manoeuvre for BPPV. Have you had a chance to offer it to a patient yet?

Here is a brief synopsis of the topics we covered in this workshop.

Changes in Year 2 for 2013-14

One of the biggest changes for next year is the University wide move from trimesters to semesters which will result in shortening of the clinical weeks in Year 2 to 2 ½ days per student. Students will still have 1 GP session per body system but **all the GP sessions will have to be taught in the same week**. At present the GP teaching sessions are delivered on consecutive Thursdays in each clinical week, i.e. half the year is taught in one week and the other half in the following week.

Overall students will gain more time for clinical learning. The shortened science teaching has created space for a new clinical block at the end of Year 2. This consists of four weeks being based in the academy that the students will start in at the beginning of Year 3. It has been called LITHE (Learning in the Hospital Environment). Unfortunately no GP teaching is currently planned for this block.

Dr. Nikki Cohen, a neuropathologist by trade and the deputy programme director, has also been appointed as lead for ICS (Introduction to clinical skills). She is overseeing the change to the new timetable and has provided the outline structure for the LITHE weeks.

Nikki was keen to meet you all and to explain the changes to you. Unfortunately she was called to give evidence in court and was unable to attend. Please take a look at her slides which we sent out with this report.

More information has now gone out to Year 2 practices.

The need for a 'LNA'

Second year students will almost certainly have had less hands on experience when they come to you and their experience may also be more variable than it currently is. This means that it is particularly important to start each session with a 'learning needs analysis' (LNA). We chose LNA as one of the topics for the small group sessions to give you a chance to share your expertise and top tips.

Planning a teaching session

The LNA is a good starting point for planning the whole session and defining learning outcomes with the students. Your discussions highlighted good practice and varied strategies for this.

Teaching 'history taking'

In this session we explored how we teach this complex skill. The challenges are how to teach

- 'Hearing the history and making sense'
- Moving from interrogation style questions to a shared dialogue
- Using empathy to build rapport
- Picking up cues and responding to them
- Being thorough in exploring presenting symptoms (not jumping to conclusions)

Transitions and learning theory

We are all aware that students undergo significant personal changes between starting Year 1 and leaving the medical school to take up their first post. Natasha and Amy presented a talk prepared by Barny Hole. This provided an overview of the structure of the 5 year curriculum. It showed that students need to negotiate an abrupt change from lectures in Years 1 and 2 to learning on the wards at the start of Year 3.

Teaching prescribing

Amy Thompson provided us with the background to the new national prescribing exam. Although pharmacology has always had a place in the curriculum, teaching prescribing was not clearly identified. Studies carried out by the GMC showed that F1 doctors were not well prepared for writing prescriptions safely. This has led to the introduction of a national prescribing skills assessment (PSA). There will be another pilot exam this year and from 2014 onwards taking and passing the PSA will be mandatory.

Otoscopy

This talk had been prepared by Fiona Lyall who is training to be an ENT specialist. Natasha presented her slides and we learned how little ENT teaching students get, just one week in Bristol. GP sessions are an ideal place for learning this important everyday skill.

Looking ahead

We hope that the workshop enthused you to continue or to start teaching second or third year students and that you will find this report a useful teaching resource for your sessions. Don't forget to add this workshop to your CPD log. A reflective template is included with the report in case you would like to use it.

This year's **Summer Education Day is on 18th June**. Topics are 'Your practice as a learning environment' and 'teaching consultation skills'. The programme will be sent out shortly.

Best wishes from all of us in the Teaching Office

Barbara

Learning needs analysis (LNA)

Key tips

- We all undertake *ongoing* learning needs analyses
- Establish group rules
    - *Group rules* were discussed: Reassurance that nothing said in the group should leave the group, either regarding patients or students
- Create 'safe' environment
    - GPs commented that they want to stress the fact that this is a *safe learning environment* in which no question is too stupid to ask. One encouraged the students to see the session as a "playground" for fun and discovery.
- Find out what they know
    - Most GP colleagues start by asking the students *open questions*: re-capping prior experience, discussing any burning issues, asking them directly about learning needs
- Asking very open questions, particularly at the start of the very first session in Year 2 may not work, i.e. 'What are you hoping to get out of this session?'
  Try asking more focused but still open questions
    - 'What are the key things that you have learned about CV exam. so far?'
    - 'What is the most important thing for you to learn about CV exam./history today?'
    - 'What skill do you want to focus on today?'
- Fill in gaps
- Preparation
    - Spend 20-30 minutes before the patient comes in
    - Assess what the students know before the patient comes in
    - Brainstorming
        - What symptoms might go with this system?
        - What are you going to ask the patient?
        - What else might this symptom be a sign off?
        - What are you going to do with the information that comes back from the patient?
- Ask challenging questions
    - How do you know this symptom relates to a heart problem and not something else?
- Encourage a more holistic perspective
    - It was noted that students tend to be very exam focused. The group felt that our job is to steer them away from this, to a degree, to teach them about impact of illness on life (and other things in the Johari window which they don't know that they don't know)
- Focus on specific areas within a bigger topic
- Demonstrate some skills beforehand
- Present history to all after taking it (incl. the patient)
- Evaluate
- Student self assessment

- Some GPS do use the sheet (self-reported learning needs/confidence levels) provided in the handbook for the students to complete at the first and last sessions. Many of us do not use it and find it "just too busy, it puts the students off". One GP who does use it finds it a useful and systematic tool
- Group needs v individual needs
  - One way is to set tasks for students to look up prior to the next session, by email. These can be individualised and emphasis altered depending on need for each student
- Peer teaching and learning
  - We encourage students to learn from each other (although they are very reluctant to offer each other constructive criticism at this stage). Some GPs ask students to be prepared to offer 3 positive comments. Others give role of bad cop to one student, good cop to another and the role of summing up to a third
- Resources
  - Encourage them to buy McLeod at the start of Year 2 so they can read things up
  - GPs use the excellent handbooks provided by the University to know what the students need to know
- Reflection and record keeping
  - We all use the tables provided to record our thoughts and comments about the sessions. This allows us to reflect on observed individual and group needs and can inform the next session. It also serves as a aide memoire for the final session and feedback

Role modelling (hidden curriculum)

Role model being a professional

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

Planning a teaching session

Content/curriculum

- Many of us use students' emails to schedule the date and ask which topic they would like to cover, which block they are currently in, etc
- We take a look at the curriculum and think about which skills the students need to practice (and which they can teach us!).

Finding patients

- A few GPs had a database of willing patients.
- Create a list of suitable patients for teaching
  - Assign specific code
  - Create list on intranet
  - Ask colleagues to contribute to lists
- Send message round for patients with acute signs on the day of the session
  - 'Practice note' (EMIS) to duty doctor

Plan for backup in case a patient doesn't turn up

- Examine each other
- Use prompt cards for problems that they can act out such as neurological problems
- Practice ophthalmoscopy

  Instructions how to create a 'practice eye' using a marble, piece of card and some small print available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1857447/
- Practice otoscopy
- Practice inhaler and spacer techniques, peak flow measurements
- Housebound patients, nursing home patients
- Clinical skills session, such as urine dipstick testing, BP measurement, prepared tutorial

Organisation

- Make sure you have the contact mobile number for group leader
- Plan a 15-20 min gap at the end of each session to recap and plan next session
- Some GPs give homework every time (look up BNF on a subject, research meds etc)

Introductions

- Catch up – find out what has been done before and since the last session
- Outline structure of the day including tasks for observers such as
- "look for one thing that was good/bad/could be improved"
- share a feedback structure for them to follow e.g. Pendleton's

Managing the group - Teaching 4-5 students

- Some GPs give each student a full go at history or exam, asking the others to summarise after
- Others divide up the history into sections. During psychiatry, one student can do MMSE, another history, another PHQ-9 etc
- We try to allow each student to palpate any physical signs present.

Visiting patients at home

- Good for Neuro/WPC session in Year 2, easy to show personal/social aspect
  - Students can better appreciate how difficult it may be for a person to get to the toilet etc
- May be the only time a student who is planning to become a hospital doctor will see a patient managing significant illness in the home, i.e. home oxygen
- May be more time consuming, could be harder to fit in two patients
- May decide to just have one patient for that session if they are very complex
- Would show students how challenging it can be to examine patients at home

- Patient may feel more comfortable
- Need to keep it focused to manage time
- Perhaps focus in on a particular aspect of the examination

Examination

- Do the whole thing, an approach that works for everything
- Start at the hand and work up from there
- One GP starts the session (before the patient comes in) with the students demonstrating perfect exam technique (e.g. shoulder exam in MDEMO)

Debriefing

- Using a feedback structure at end of session and asking them some specific questions
- What did the students learn?
- What do they want to do next time?
- Setting homework for the students to review particularly for examination techniques
  - McLeod examination on YouTube videos
    - http://www.youtube.com/playlist?list=PL9C21348F9C7BAEDA
  - Arthritis research council videos for musculoskeletal examinations
    - http://www.arthritisresearchuk.org/health-professionals-and-students/video-resources.aspx

Year 3

- Difficult to fit everything in
- Ask students at the start of each session or by email before the session what skills they want to focus on in that session, i.e. otoscopy
  - Will be useful for students to see normal ear drums
- MDEMO - Bring in a patient with OA and one with RA to compare and contrast
- Give students print out from EMIS mentor at the end of the session
- Give students opportunity to practice using otoscope and ophthalmoscope, don't worry too much about signs, very valuable for them to practice

Year 2 neurology

- Comment: In the year 2 neurology session the students knew less than the GP expected
- Don't have to do the whole thing; Focus on a smaller area i.e. a limb
- Show specific signs, such as hyperreflexia

Year 2 v Year 3

- In year 2 it is great if they can hear a murmur
- In year 3, push them, 'What does that murmur mean'?

Presenting

- Ask students to present the history
- Will help them to focus on why they are asking the question
- Will help them to realise that there is a person behind the answers
- Involve group, ask other students to summarise

Challenge of 'cold' problems

- The fact that the patient's presenting complaint is contrived (non-acute) can be challenging
- One GP occasionally invites in patients with acute minor illness to engage students in reality (e.g. an antibiotic prescription)

Teaching 'history taking'

<u>Students' learning curve with 'history taking'</u>

Consulting with patients and finding out what they want help with is a challenging task. We explored how we teach our students this complex skill. Our personal observations during teaching sessions and as OSCE examiners show that students struggle to take a complete history of a given symptom, to satisfactorily exclude red flags and to respond appropriately to what the patient is saying.

We had a lively discussion what the cause of these problems may be. The root of it may lie in the way the curriculum is organised and the way these skills are being taught. The curriculum is organised by systems. This doesn't sit well with the real world in which patients routinely present with an array of symptoms that requires careful exploration rather than offering a quick route to a single definitive diagnosis.

The focus tends to be on information gathering and 'truffeling out' a diagnosis rather than 'hearing the patient's story and looking for the meaning in it'. Clinical experiences may be too far removed from the real clinical world to properly engage students.

The clerking portfolio may further emphasise this dilemma. Students are largely unobserved and not questioned sufficiently about their patients. It seems to become more of a tick box exercise.

There is an 'art' to history taking as well as skill. Established practitioners have a lot of experience to draw on to help them focus in on what is important. 'We can't expect the students to run before they can walk. They need to learn the basics'.

Students are learning 'new languages'. The medical way of transforming lay histories into medical problem formulations and diagnoses and each individual patient's use of language. Students need to experience how different patients will use words in different ways creating different meanings.

<u>Challenges</u>

- Timekeeping with history
- Signposting '20 minutes'
- Warn, may interrupt
- Open to group
- Steer the patient

<u>How are we teaching it?</u>

- **There needs to be a structure for feedback**
    - For example 'Pendleton'
- Students need to experience a number of patients
    - Use Cambridge-Calgary guide
- Prepare the topic in advance
- Active listening
    - Listening to the patient's answers
- Patient tells their story
    - Opening gambit
- Use of open and closed questions
- Picking up 'cues'
- Use of silence

- Avoiding a list of closed questions – need to know the basics
- 'Stock phrases'
    - Many of us teach stock phrases to help the students to get a more garrulous patient back to the doctor agenda
- Need to explore 'red flags'
    - Use closed questions
    - 'Signposting'
    - 'Framing'
- Establish reason for attendance – ICE
- Write down 'key words' – ask 'Why did you take that direction?
- Some GPs use the Cambridge-Calgary as a guide and tend to teach a fairly traditional history taking skill

Challenges for students

- Our experience is that students good at information gathering, but less good at moving things on from this
- It was noted that students often ask open questions, but then close them down immediately by adding a closed question to qualify the open question

What works well

- We all agreed we start with a LNA
- Framework –when to stop each part
- Summarising
- Reassuring students that it is ok to make mistakes
- Make notes for feedback at the time
- Keep FB 90% positive

4 open questions in a row exercise

One GP suggests that the students ask "4 open questions in a row" and commented that the patient almost always gives the entire history as a result. She also prints out the section in the GP handbook "bringing together doctor and patient agenda" and shows this to the students early on. We all agreed that this was a very good idea and that it is crucial that students understand both the doctor and the patient agenda. One GP commented that time in GP is an opportunity for students to redress the balance of the heavily weighted doctor agenda in hospitals, back towards the patient agenda in GP. This led to discussions that we need to introduce the patient agenda early on, so that the students do not perceive an artificial distinction between "history taking in hospital" and "consultation skills in GP".

Teaching 'history building'

Many of us find that teaching history building gives us an opportunity to really hear some of our patients' stories, can allow us the time to explore unusual symptoms or illness behaviour. One Dr discovered an undiagnosed psychosis in a 3rd year session!

Problem based history taking

We discussed "problem based history taking" such as describing a symptom and then asking the students what they need to know and hence what to ask. This was felt to be higher up Bloom's taxonomy and there seemed to be a general consensus that we should teach the traditional model of history taking first. (They need the basic scaffolding from which to build further history taking skills).

Stop-start method for ‘hearing the story’ and teaching clinical reasoning

- The general conclusion was that this is a useful additional teaching tool
- It may help observers more than the history taker
- You would probably not want to do this for every consultation. Possibly most useful early on to highlight the clinical reasoning behind questions and to learn how to fashion what they are hearing into a cohesive story rather than just completing a tick list.
- Students also need to learn how to take a complete history and they generally like to ‘do the whole thing’. We need to bear in mind that this tends to give the other students a more passive role for a longer period and actively engage the observing students.
- We wondered whether it could be a tool to teach information gathering in a way that would help students to bypass the ‘interrogation stage’ of their history taking skill development by bringing to consciousness more openly and frequently what goes on in our mind when consulting.

Positives

- Alternative method to videoing learners
- We can write notes on what students have said, but they may have forgotten by the end of the consultation when we traditionally feed comments and questions back.
- It is an opportunity for teachers to help students to pick up on missed cues, to analyse the implications of where the conversation is going, to ask the whole group to consider what to ask, why and when...
- The technique allows *exploration of students' medical processing* as well as *pointing out cues that may have been missed.* A suggested question was "Can anyone think of any questions they would like to ask the patient at this point"? Others were "Why did you ask what medicines they took for the pain? What did you want to find out? What did you think the patient may have been thinking?"
- Others can summarise and bring the history taker back to where they were.

Negatives

- It could be perceived as negative by the student ("he interrupted because I was not doing well...")
- Can be hard for the patient to get back to their own agenda and may be an odd experience for the patient. Many felt it would lend itself better to actors as patients (or, at the very least, very experienced patients).
- Some of us were worried that these students are young and sensitive, with fragile self-esteem and were worried how much this could throw them.

How to make it work

It was commented that this would seem to be an. There is a great need to fully brief the students and patient first.

It was suggested we would not use on the first session, that we should start with the most confident student. Another suggestion was that it could be done as a role play the first time (no patient), thus less threatening. We have to bear in mind that they are similar to "learner drivers", with so much new information to consolidate, that this could be a challenge.

We could combine interruptions with Pendleton technique, to make it less threatening.

<u>Questions</u>

- We discussed whether we could involve the other students in the group in the stop-start technique, i.e. allowing them to interrupt. There was a strong consensus that we should not, as they may interrupt too often and the session would degenerate.
- GPs wondered whether best to interrupt after a question or an answer. We decided either could work.

Key tips

<u>Set the scene</u>

- Explain the stop-start process to students and the patient
- Reassure students that it is a safe environment and that they can make mistakes – nobody does a perfect consultation
- During interruptions the group will be asked for suggestions on what to do next
- Set ground rules
  - What happens in the group, stays in the group
  - Student in the hot seat can ask group and tutor for help
  - Group will be asked for observations and suggestions
  - Everybody should be prepared to give a concise summary of the history so far
  - Learning exercise, no assessment, can try out questions
- Timekeeping - set a timeframe of 20 minutes for history

<u>Key tips for students</u>

- What is the primary reason for the patient attending? **ICE**
- Try to listen well and take in 'key words', be alert to other 'cues'
- Start of consultation most important part
- Use mini summaries to keep yourself and patient on track, to help your thinking process
- Exclude red flags

<u>Provide feedback (following the 'good feedback rules')</u>

- Highlight what student is doing well
- Observation how challenging it is
  - I could see you thinking of the next question, were you listening?
- Timing of questions
  - 'Did you take anything?' was too early
  - Before going onto risk factors, do you have enough information about the history?
  - The smoking question was too early and seemed out of context. Could suggest asking smoking question as part of lifestyle history. Good idea to frame or 'signpost' question re lifestyle 'I would now like to ask a few questions about your lifestyle, is that ok?' and then bunch them together – smoking, drinking, exercise etc
- Suggestions for exploring symptoms more fully
  - Let patient tell their story. May encouraging noises to help them tell it. Keep closed questions for later
  - Talk about how to use body language to facilitate patient talk
  - 'Consider asking more about the pain. What questions might you ask about the pain?'
  - 'Try more open questions to let the patient tell his story'
  - Try reflecting back 'Indigestion?'
  - Clarify 'breathlessness
  - SOCRATES

- **S**ite - Where is the pain? Or the maximal site of the pain.
- **O**nset - When did the pain start, and was it sudden or gradual? Include also whether it is progressive or regressive.
- **C**haracter - What is the pain like? An ache? Stabbing?
- **R**adiation - Does the pain radiate anywhere? (See also Radiation.)
- **A**ssociations - Any other signs or symptoms associated with the pain?
- **T**ime course - Does the pain follow any pattern?
- **E**xacerbating/Relieving factors - Does anything change the

- Direction
    - 'Hold onto your question, go back to what the patient just said.'

Looking for key words

- What triggered that line of questioning?

'Steering' the consultation

- Learning the art of "steering the patient" to keep them on task for the consultation
- Use of summarising sentences to check student and patients understanding

Questions to stimulate critical thinking and clinical reasoning

- What is going through your mind?
- What do you think about what the patient has just told you?
- Ask yourself 'What might indigestion mean to the patient?'

Involve the group

- 'What would be a good open question at this point?'
- If you could ask just one question now, what would it be?

Teach about empathy

- Provide feedback about empathy
- Effect of expressing empathy on the patient and the consultation
- How to express empathy
- Show them how to pick up cues and how to respond to them. In this scenario for example' …, I thought I was going to die'. A cue how frightening this episode was for the patient

Invite patient to provide feedback

- What did you think of the questions?
- What worked well for you?
- What suggestions do you have for the students to further develop their history taking?

The Epley Manoeuvre for BPPV– A demo by Otto Marsingh

Otto is an academic GP from Amsterdam and has done a lot of research into the Epley manoeuvre. With the help of a volunteer he demonstrated the procedure. A few of you already regularly use this technique. After the demo more of us felt encouraged to give it a go. One delegate advised to have a sick bowl handy as some patients may feel sick.

Otto also pointed out that there is a video on YouTube of a patient carrying out the manoeuvre unassisted. I found one at http://www.youtube.com/watch?v=pa6t-Bpg494

Transitions by Barny Hole, presented by Natasha Ward and Amy Thompson

We are all aware that students undergo significant personal changes between starting Year 1 and leaving the medical school to take up their first post. Barny Hole had prepared an overview of key transition phases which Natasha and Amy contributed to and presented. This showed the structure of the five year curriculum and highlighted the abrupt change from lectures in Years 1 and 2 to clinical learning on the wards between Years 2 and 3.

Lectures and 'behaviourist theory'

They highlighted theories underlying teaching at different stages. In Years 1 and 2 the teaching tends to follow a behaviourist pattern: stimulus-response-feedback. The students reap a reward in the shape of praise or good marks when they get the answer right. This predominantly behaviourist and fact focused teaching in years 1 and 2 may impair the transition of students to a more humanistic and patient focused learning approach.

Teaching also tends to be organised into neat thematic 'parcels' which then make it hard for the students to apply their learning in clinical situations. This is something that we repeatedly observe in the Year 3 OSCE stations.

Two videos highlighted how students struggle to apply their knowledge in a consultation

Hypoglycaemia
The Teaching Fellows showed a video in which they role played a 3rd year student taking an OSCE exam. They had observed the problems demonstrated by the student in the real exam. The student was given the task to check the blood sugar of a patient and advise on initial management. The blood sugar was 2.4mmol. The student confidently identified that this level represented hypoglycaemia. The aspects she struggled with

- Management decision - taking action regarding the hypoglycaemia
- Safety netting

Headache
This was a video of a real 3rd year student. She seemed professional in her approach to the patient and showed a number of consultation skills competencies. The aspects she struggled with were

- Asking too many closed questions early on
- Poor differentiation of the headache symptom
  - Rule in/rule out
  - Red flags
- Asking leading questions
- Signs of not taking responsibility-using ‘we’ rather than ‘I’
- Inadequate safety netting
- Lack of expressed empathy

Assertive questioning
Students work to meet expectations. We therefore need to make it clear to the students that we have high expectations of them

In their feedback students frequently tell us that they feel welcome and safe in the GP environment. This makes them an ideal place for asking challenging questions. Think Maslow’s hierarchy; basic needs of safety need to be satisfied before we can develop our higher functions.

Maslow’ hierarchy of needs	**Maslow applied to GP sessions**
Self actualisation	Personal development, PDP
Esteem needs	Feedback from teacher and group
Belongingness and love needs	Being a member of a small group
Safety needs (order, stability, protection…)	Structured sessions, group rules
Biological and physiological needs	Teaching room, tea and biscuits

Lead a structured discussion

- Ask difficult questions even if they are not expected to know all the answers
- We need to really them and make them think
- Think about basic principles then apply them to other clinical scenarios
    - What causes CO_2 to be low?
    - What conditions are there with a low CO_2?
- Think about Bloom's taxonomy of the cognitive domain and aim for higher level questions (see appendix)
- Translating information gathering into clinical management is difficult for students
- Don't leave them with uncomfortable questions - Take them to the next level

Powerful questions

Questions with high predictive value

- Two question screening for depression
- Use of clinical decision rules (DVT)

The importance of knowledge

- Otto reminded us that knowledge acquisition is very important. Otherwise we could end up reflecting on our gaps! Perhaps there is sometime too much 'How does that feel?'

Effective teaching = Challenge+Questioning+Feedback

Portfolios **by Natasha Ward**

Students in year 3 have to complete a 'clerking portfolio'. They have to write up 32 patient clerkings and are asked to reflect on what they have learned.

Natasha observed that portfolios are frequently not very well done. Students seem to give us what we want to hear rather than using it as a genuine development tool. We saw some t examples of portfolios which showed that students are not automatically able to reflect but need to learn this.

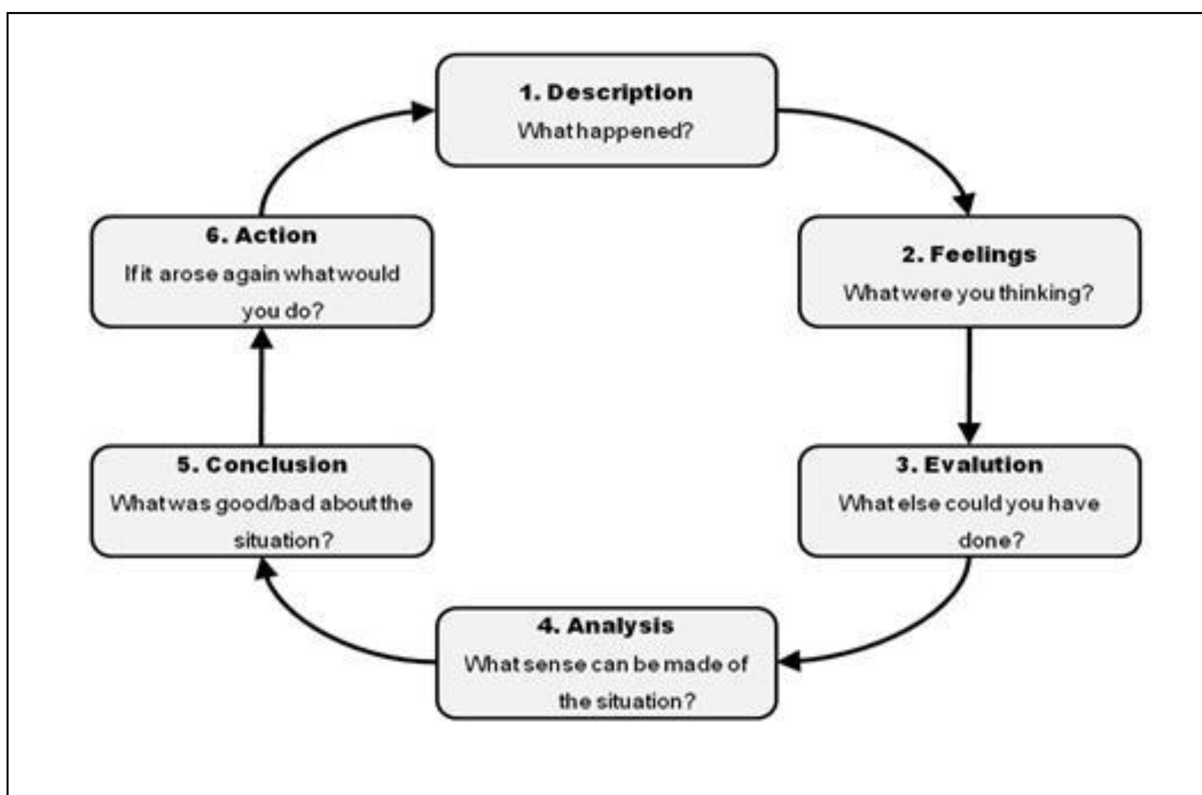
Help the students reflect on what motivates them, get in touch with their inner motivation. Are they a 'pleaser'?

Tools for reflection

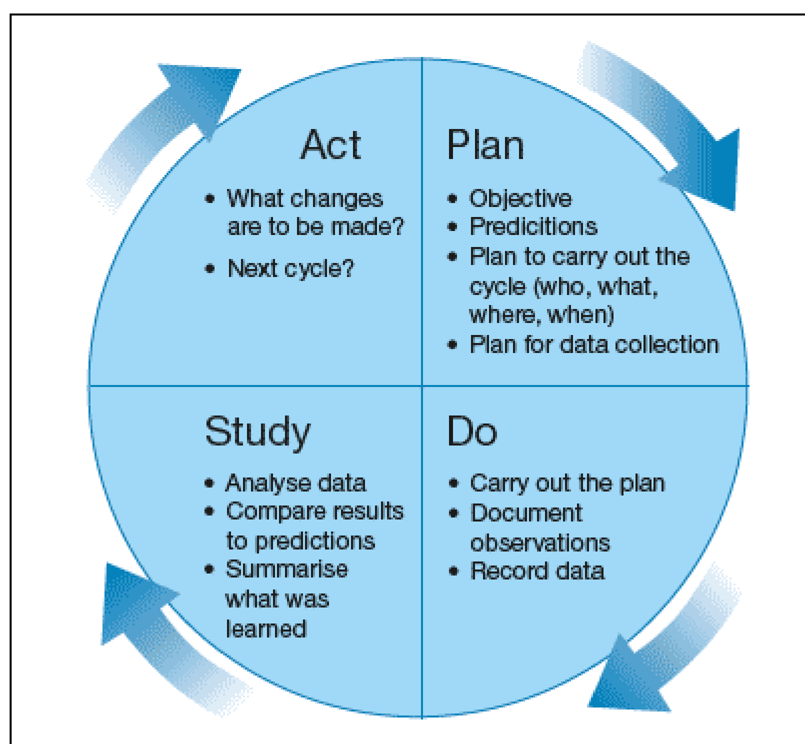
SET GO method

S	Saw you do something
E	What else?
T	What do you Think about it?
G	Goals: What would you like to achieve?
	What will you do by next Tuesday?
	- Motivates people into action
O	Offers – suggestions for options and improvements

Gibb's reflective cycle



Cycle for action



Feedback

Feedback is essential for learning. Students tend to be fed up with 'over delicate' feedback

- Try and be more critical (within the good feedback rules)
- Get the students to critique each other
- Cite good and bad examples
- Introduce new ideas
- Use stories and anecdotes

Teaching prescribing by Amy Thomson

The GMC conducted some research which showed that recently qualified doctors make a significant number of prescribing errors. (Fortunately most of these are picked up by the dispensing pharmacists.)

Changes

- This has highlighted the importance to 'teach prescribing as a skilled procedure' rather than just knowledge of pharmacology.
- A national prescribing exam is being developed and tested. There will be another pilot exam this year. From 2014 onwards all final year students will have to take and pass the National prescribing skills assessment prior to qualifying.

<u>Example of prescribing teaching session</u>

1. Brain storm 'causes of SOB'
2. Go and see patients
3. Look at investigations, X-rays etc
4. What medications might we use?
5. Practical exercise – write prescription using the NICE COPD guidelines and BNF

Use 'Graphic organisers' (mind map) as a tool for teaching pharmacology

Teaching otoscopy **prepared by Fiona Lyall, presented by Natasha Ward**

Please see presentation for more info

<u>Background</u>

- ENT 4th largest surgical specialty
- 1 in 6 adult GP consultations
- Half of paediatric GP consultations

<u>Current challenges</u>

- There is no national curriculum for ENT teaching at present (It is being developed)
- At Bristol students only have 1 week of ENT teaching. This includes maxfacs. This means that students have very little opportunity to practice otoscopy. This is something that we can teach our students
- Evidence that qualified doctors are not able to use an otoscope

<u>Key learning objective for our students</u>

Research has shown that a small amount of teaching can significantly increase diagnostic otoscopy skills (Fisher & Pfeiderer, 1992)

- Be able to use an otoscope and recognize a normal ear drum

<u>A model for teaching clinical skills incl. otoscopy</u>

Mental rehearsal combined with physical practice: increase speed of learning skill Doheney MO (1993). Effects of mental practice of performance on a psychomotor skill. *Journal Mental Imagery*. 17 111-11

- Conceptualisation – where skills fit & how important
- Visualisation – seeing the skill
- Verbalisation – talking the skill
- Physical practice – doing the skill
- Correction & reinforcement – feedback on the skill

Appendix

Teaching 'history taking', scenario for role play

Bloom's taxonomy of the cognitive domain applied to video of student diagnosing but not acting on Hypoglycaemia

Workshop feedback from you

Reflective template

Teaching 'history taking'

Scenario 1 2nd year student, first session, CVS

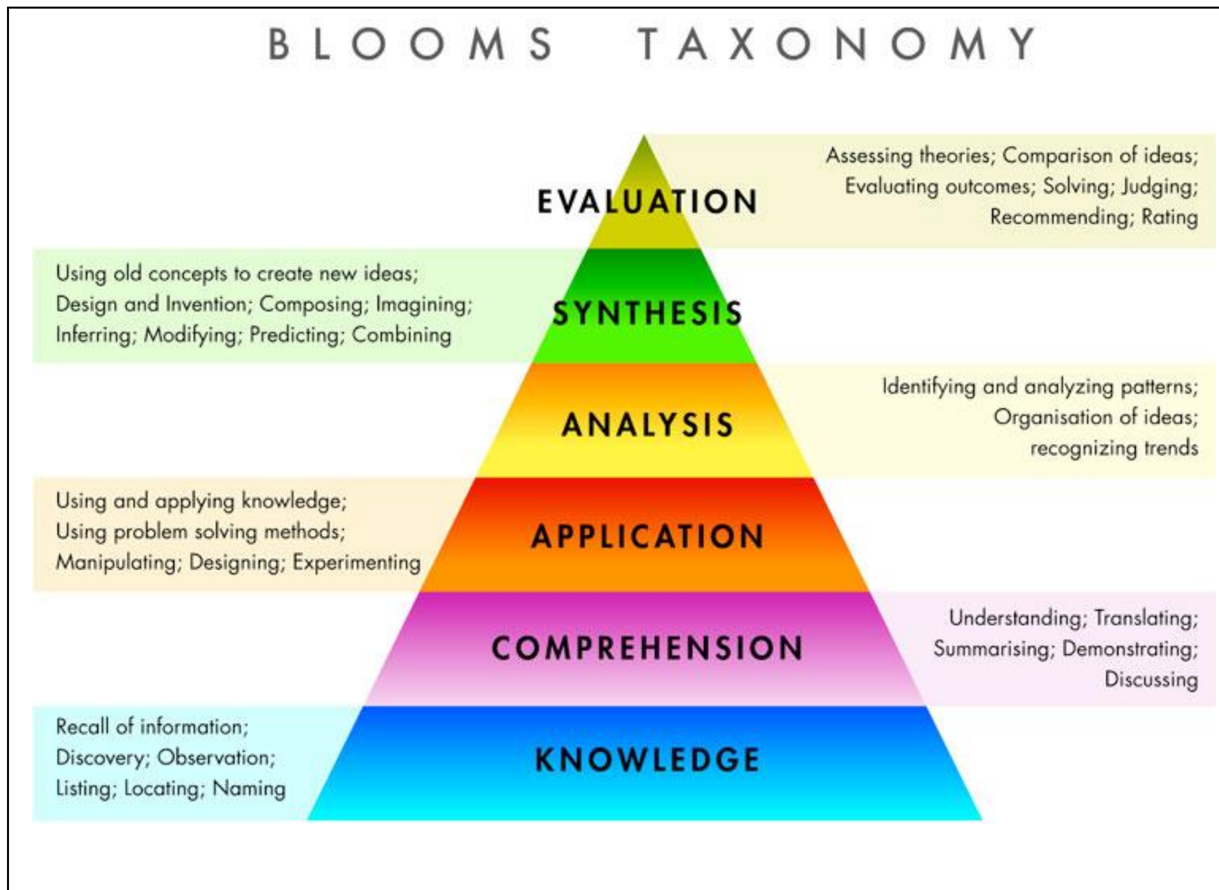
GP	Scene setting 'Your next patient is Mr./Mrs. Hatfield with a heart condition. The notes have not yet arrived. You need to find out enough information so you could manage this patient effectively. Start by asking 'I understand that you have a heart condition. Could you please take me back to when it started and tell me about it'?
S	'Hello Mr/Mrs Hatfield. I am Jon/Joanna, a second year student. Is it ok if I ask you about your medical condition? I understand that you have a heart condition. Could you please take me back to when it started and tell me about it'?
P	I was at work when I had this really bad indigestion.
S	When was that?
P	A year ago.
S	Had you had it before?
P	No
S	On a scale of 1-10, how severe was it?
P	Really bad, at least 10, I thought I was going to die.
S	Did you take anything?
P	No, I was at work; I didn't really know what to do.
S	Were you short of breath?
P	I felt like I couldn't breathe, my chest felt like it was being squeezed
S	Do you smoke
P	I stopped 10 years ago
S	How many did you smoke?
P	Never smoked that many, may be 10 a day
S	What is your job?
P	Supervisor at Sainsbury's
S	Did you take time off?
P	Well, I got taken into hospital and didn't really get back to work till 6 weeks later.
S	6 weeks, what happened?
GP	Thank you for that, just stopping you here to ask you and the group what you think was happening to Mr/Mrs Hatfield.
S	Well, the patient said indigestion but I think it was probably a heart attack as he had severe chest pain and went into hospital and was off for a long time.

Questions in teaching – aim questions at different levels of Bloom's cognitive domain

- Contribute to creating a good learning atmosphere
- Demonstrate knowledge
- Show understanding
- Interaction with new information (analysis, synthesis, evaluation)

Student fails to apply knowledge of hypoglycaemia to the patient in front of her

Student recalls information how to use a test strip to measure blood glucose



Student understands that 2.4mmol is a low blood sugar

Video of OSCE station

Task: checking blood glucose , interpretation of result and patient management

Applying Bloom's taxonomy to analyse the students' actions

Your evaluation of the workshop based on 15 replies received by 3.5.13

1. Which Academy is your practice attached to?			
Bath:		0.0%	0
Gloucester:		33.3%	5
North Bristol:		26.7%	4
South Bristol:		13.3%	2
North Somerset:		0.0%	0
Somerset:		13.3%	2
Swindon:		13.3%	2

2. Which year do you teach in?			
Year 2:		n/a	4
Year 3:		n/a	10
Other *(please specify)*:		n/a	5

3. Welcome, update and review of Year 2 and 3			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		13.3%	2
Good:		66.7%	10
Excellent:		20.0%	3

4. Learning needs analysis and planning a teaching session (small groups)			
Poor:		0.0%	0
Below average:		6.7%	1
Satisfactory:		13.3%	2
Good:		60.0%	9
Excellent:		20.0%	3

5. Teaching information gathering - 'building' a history rather than 'taking' one (small groups)			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		20.0%	3
Good:		53.3%	8
Excellent:		26.7%	4

6. 'Transitions': The journey of the medical student from knowledge to focused application			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		26.7%	4
Excellent:		73.3%	11

7. Clerking portfolios - Reflective learning - Teaching for understanding?			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		26.7%	4
Good:		53.3%	8
Excellent:		20.0%	3

8. Prescribing skills			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		26.7%	4
Good:		53.3%	8
Excellent:		20.0%	3

9. Otoscopy - CAPS logbook			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		33.3%	5
Good:		53.3%	8
Excellent:		13.3%	2

10. Otto's demo of Epley's manoeuvre			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		20.0%	3
Good:		46.7%	7
Excellent:		33.3%	5

Please rate the workshop overall			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		6.7%	1
Good:		60.0%	9
Excellent:		33.3%	5

Many thanks for completing the survey and also for your many helpful comments

Reflective Template

University of BRISTOL

Year 2&3 GP Teacher Workshop		
Date/Venue/Hours	17th April 2013, Engineers' House, Clifton, Bristol	**6 hours**
Description		

Reflection and Feedback	
What did I enjoy? What have I learned for my teaching and for my GP work?	

Forward Planning	
How can I use the ideas from this workshop in my teaching? How could I share the ideas from today with my colleagues?	
Key points to remember	
Name, date, signature	