University of BRISTOL

Report

Teaching Inspirations

primary Care unboxed

Summer workshop 2012

Engineers' House, Clifton, Bristol
Tuesday 26th June

- **Welcome and update**
- **Ethics and beliefs unboxed**
- **Metaphors for healing**
- **SSC presentation – heart murmurs**
- **Teaching awards**
- **Teaching prescribing**
- **Asking the right question – using frontline epidemiology to focus on what really matters**

Guest lecturers
Caroline Yandell
Ellayne Fowler
Chris Payne
Clare Whettleton

Workshop contributors
Andrew Blythe
Trevor Thompson
Lindsay O'Kelly
Jessica Buchan
David Memel

Created by Barbara Laue

Dear GP Teachers, 9.7.12

This workshop was intended to 'unpack' some of what we do in our GP work and student teaching. Our speakers guided us to take a deeper look at the ethics, the language and the evidence that underpin our work. Caroline Yandell reminded us of ethical frameworks and we put them to use with cases and thought games. Ellayne Fowler raised our awareness of the metaphors doctors and patients use in consultations, how these can be a window to a person's view of the world and how awareness of this can help us to choose words that connect better with that world. Chris Payne presented a master class in using evidence to question what we do and how we think about it.

We were delighted that Clare Whettleton a 4th year medical student was able to come and present her year 3 SSC (Student selected component). Clare had identified a gap in useful interactive learning resources for heart murmurs and so decided to create an e-learning resource herself. We were all impressed with her confident presentation, her grasp of the topic and mastery of the technology to create this resource. Hopefully this will be on Hippocrates soon (online learning environment for Year 3). You will be sent the link as soon as this has been done.

A highlight of the day was the teaching awards. This academic year was the first time that we have asked our students to nominate their GP teachers for the best GP teacher of their year. Students logged about ninety nominations. We selected the winners by the number of nominations and what the students said about their teachers.

Congratulations to

Year 1	Lucy Jenkins	**Year 2**	Cheryl Atter
Year 3	Kerrin Masterman	**Year 4**	Bernard Newmarch
Year 5	Simon Tucker		

In the afternoon we took a close look at how we teach prescribing. Andrew Blythe introduced the topic and informed us about the new undergraduate national prescribing exam which has been trialled this year. Many thanks to you all for all the suggestions and ideas how to teach prescribing in an enjoyable and challenging way.
Trevor Thompson rounded off the day with some rethinking of years 1 and 2. The aim is to have better integration of HBOM (Human Basis of Medicine) with other parts of the curriculum. Thank you to all of you who contributed to that discussion.

Thank you to all of you who have already completed our online survey. Early results at the end of this report.

Thank you for coming to this workshop. We hope that you enjoyed meeting GP teachers from other academies and teaching in different years.

We are always interested to hear what you think about our workshops and keen to hear your ideas. If you have any teaching tips or information you would like to pass on to other GP Teachers, we would be pleased to publish them in our newsletter.

Kind regards

Barbara Laue

What is new in the medical school?

- Finals brought forward to December
- European Exchange programme (ERASMUS) has been stopped
- Academic mentor scheme
- Clinical and procedural skills logbook

Academic mentor scheme

For some years there was only the faculty student adviser for medical students to turn to with problems and queries and students have been saying that they go through the five year curriculum without anyone knowing them.

To improve on this situation the new academic mentor scheme was launched in February this year. Rev. Mr. Nigel Rawlinson who is the director for student affairs has been leading this change. University teachers have been asked to take 5 students for mentoring. Mentors meet students twice a year face to face and keep an eye on their academic achievements by logging on to the student eportfolio. The focus is the students' academic work, progression and career plans. If pastoral problems come to light they should be passed over the director for student affairs. There has already been some positive feedback from students and mentors.

Rev. Nigel Rawlinson

Students' eportfolio

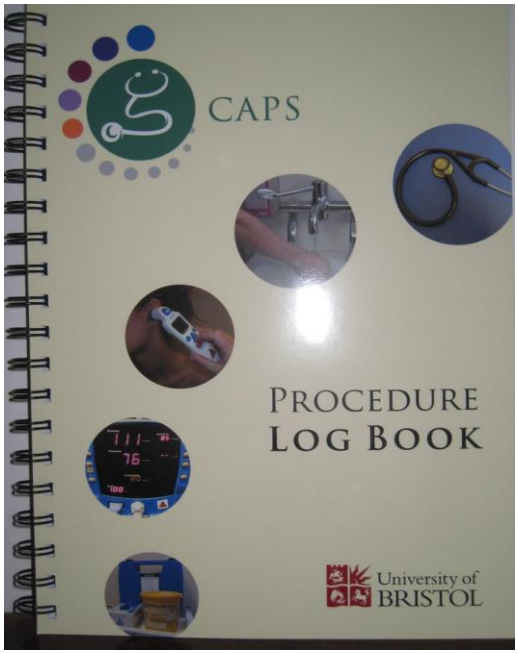
This year students in Years 1 and 2 have been assigned mentors. In 2012-13 the new Year 1 and year 4 will have mentors. After that mentors will be assigned each year to the new arrivals. This means from the academic year 2013-14 every medical student at Bristol will have an academic mentor.

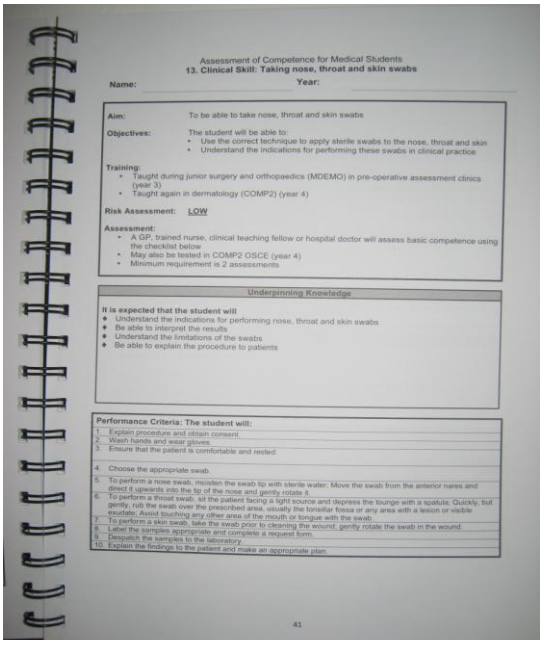
If you would like to become an academic mentor please email Chris Cooper: Chris.Cooper@bristol.ac.uk

CAPS logbook

This logbook has descriptions and sign off spaces for the 32 skills the GMC expects students to be competent in by the end of their training. Trusts also increasingly ask for reassurance regarding the skills and competencies newly qualified doctors bring to the job. The logbook will provide the evidence to show that students have achieved the competencies.

We have already emailed pdf copies to GP teachers but will do so again at the start of the academic year. Students will be asking their GP teachers to sign them off for some of the skills they learn in the practice.




Assessment of Competence for Medical Students
13. Clinical Skill: Taking nose, throat and skin swabs
Name:
Year:
Aim: To be able to take nose, throat and skin swabs
Objectives: The student will be able to:
• Use the correct technique to apply sterile swabs to the nose, throat and skin
• Understand the indications for performing these swabs in clinical practice
Training:
• Taught during junior surgery and orthopaedics (MDEMO) in pre-operative assessment clinics (year 3)
• Taught again in dermatology (COMP2) (year 4)
Risk Assessment: LOW
Assessment:
• A GP, trained nurse, clinical teaching fellow or hospital doctor will assess basic competence using the checklist below
• May also be tested in COMP2 OSCE (year 4)
• Minimum requirement is 2 assessments
Underpinning Knowledge
It is expected that the student will
• Understand the indications for performing nose, throat and skin swabs
• Be able to interpret the results
• Understand the limitations of the swabs
• Be able to explain the procedure to patients
Performance Criteria: The student will:
1. Explain procedure and obtain consent.
2. Wash hands and wear gloves.
3. Ensure that the patient is comfortable and rested.
4. Choose the appropriate swab.
5. To perform a nose swab, moisten the swab tip with sterile water. Move the swab from the anterior nares and direct it upwards into the tip of the nose and gently rotate it.
6. To perform a throat swab, sit the patient facing a light source and depress the tounge with a spatula. Quickly, but gently, rub the swab over the prescribed area, usually the tonsillar fossa or any area with a lesion or visible exudate. Avoid touching any other area of the mouth or tongue with the swab.
7. To perform a skin swab, take the swab prior to cleaning the wound, gently rotate the swab in the wound.
8. Label the samples appropriate and complete a request form.
9. Despatch the samples to the laboratory.
10. Explain the findings to the patient and make an appropriate plan.
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What is new in Primary Care?

- New name – we are now the **Centre for Academic Primary Care**
- Shared inbox **phc-teaching@bristol.ac.uk** As all the admin staff work part time this will help to answer your emails promptly.
- Sian, Year 4 lead, has gone to Adelaide with her family. She will be working in general practice once her family has settled in and has already made links with the local medical school. We are hoping for some ‘dispatches from down under’ for the teaching newsletter.
- Jessica Buchan has taken over Year 4.
- Lucy Jenkins (Tisdale) is the new Year 1 lead.
- Mary Yarwood and Julia Carver have joined our admin team.
- Year 2 teaching in the Swindon academy.
- Thank you to all the Swindon GPs who took this on as a new teaching task in Swindon.
- New Core Teaching Practice - thank you to Concorde Medical centre in Bristol.
- Teaching awards for GP teachers in Years 1-5 and SSCs.
- 22 new successful applications to become an Honorary Clinical Teaching Fellow.

Primary Care Teaching Office

Canynge Hall - new extension

Canynge Hall, old facade – the front door some of you may remember

Teaching in the Academies and GP Academy leads

GP teaching in the Academies and GP Leads

	N. Bristol	S. Bristol	N. Somerset	Bath	Glouc./ Chelten.	Somerset	Swindon
Year	Barbara Laue	Sarah Jahfar	TBA	Melanie Blackman	Anne Hampton	Andrew Tresidder Charles Macadam	Lindsay O'Kelly
1							
2							2011-12
3							
4							
5							

Ethics and beliefs unboxed Revd. Dr.Caroline Yandell

Caroline is an ordained priest in the Church of England, a practicing GP and has also done some research and completed a PhD. Her particular interest is the interface between faith (theology) and medicine.

She has created an SSC for second year students which explores the interface between personal beliefs, ethics and theology. Here are some questions she asks her students

- What's your core set of beliefs? (life, the universe and everything)
- What is the relationship between ethics and beliefs?
- What might be some of the tensions between medical ethics and belief for you as a practicing doctor?

She reminded us of common ethical frameworks and theories (see her brief summary below). We explored some cases and thought experiments.

The four principles framework

- Autonomy
- Non-maleficence
- Beneficence
- Justice

<u>Thought experiment</u>
You are witnessing a lorry on fire. Your best friend is trapped inside. There is no chance for him to get out. He is begging you to shoot him before he burns to death. You have a gun in your hand. What do you do?
List reasons for shooting and reasons against shooting

Recommended Reading some books for the practice library as resources for teaching

- Wendy Rogers and Annette Braunack-Mayer (2009), *Practical Ethics for General Practice,* 2nd ed. Oxford University Press: Oxford.
- Tony Hope et al (2008), *Medical Ethics and Law: The Core Curriculum,* 2nd ed. Churchill Livingstone: Edinburgh
- Tony Hope (2004), *Medical Ethics: A Very Short Introduction,* Oxford University Press: Oxford

Ethical Theories - a brief reminder **Caroline Yandell**

Deontological Theories (deon – duty)

The approach that starts with and stresses norms is the deontological approach. It comes from the Greek word *deon* – duty – and refers to the study of duty and moral obligation. Some would say it is about 'oughts'. Within duty based ethical theories the key belief is that there are certain acts that are wrong in themselves, regardless of their foreseeable consequences. In order to guide acts the duties that are morally relevant must be specified (and often they are phrased as prohibitions). According to deontological theories the rightness or wrongness of an action does not depend on how much good it brings about. An action can be wrong, even if it does a great deal of good, or averts a great deal of harm, because it violates a moral duty.

According to deontologists I ought to act according to my duty. Duties, though, can come in different shapes and sizes. They can be duties either to do something ('honour your father and mother') or not to do something ('do not murder'). I can have duties that clearly prescribe my actions or those that leave me with a lot of working out to do. In some theories, duties are concerned with individual *acts.* (If I meet a homeless person it might turn out to be my duty to give him my last ten pounds but I cannot generalize this into a rule to always give money to homeless people I meet). In other theories duties are expressed as *rules* which may be quite specific such as 'do not murder' or very general such as 'love your neighbour'. Of course, one of the problems with the notion of absolute duties is that they can conflict (famously – I have a duty to care for my children and also have a duty not to steal – but if my children are starving I am in difficulty). Some philosophers would argue that caring for my children does not extend to stealing for them. Another position is to say that there are plenty of things that *can* be duties, but not all of them will actually turn out to be my duty in a particular situation (and I may decide that I do not in fact have a duty to avoid stealing in this situation) In essence this is what 20th century English moral philosopher W D Ross articulated in his theory of *prima facie* duties. A *prima facie* duty is something that matters morally – eg not stealing – and which we know should guide our actions if there are no conflicting moral obligations but that may turn out not to be binding in a particular situation.

Consequentialist Theories

In Consequentialist theories actions are to be judged by their consequences. Thus, whilst deontological theories give priority to what is 'right,' consequentialists in contrast give priority to the good and define the right in terms of the good. The right action then is the one that will bring about the greatest good (however good is defined – and consequentialists vary widely on this). It is not uncommonly summed up as 'the end justifies the means'.

Consequentialism is not in itself a specific ethical theory, but rather defines a type of theory. As an ethical theory it is incomplete. To be a complete ethical theory we need to know how to value, ethically, different consequences.
The best known specific consequentialist theory is Utilitarianism
Utilitarianism was first set out systematically by philosopher and social reformer Jeremy Bentham in 1789. He proposed the moral principle that we ought to act so as to maximize happiness, both others' and our own. Decisions are to be guided by choosing the course of action that will bring about the greatest happiness of the greatest number of those affected by our action. In 1861 John Stuart Mill refined the theory, acknowledging there are different kinds of pleasure and some have more intrinsic value than others (for him this was those that employ the higher faculties).
Contemporary utilitarianism comes in many forms. For example preference utilitarianism holds that we should act so that the preferences of all concerned should be maximized as far as possible. Or welfare utilitarianism proposes that we should act to maximize people's (long-term) welfare or interests not just their (possibly short term) preferences.

Virtue Ethics

Sometimes known as areteological from Greek *arete* (virtue – original meaning any kind of excellence and later meaning some praiseworthy trait of character or intellect).
Whereas deontology and consequentialism focus on acts and decisions, virtue ethics is at least as interested in moral character. A more fundamental question for virtue ethics than 'what should I do' or 'how do I know what I should do'' is 'what sort of person ought I to be?'. My choices and actions will flow from my character (but of course my choices will also help to form and develop my character). If I have a virtuous character then my judgments about what I should do will be more sound and reliable than it I do not.
Virtue has Classical roots. One of Plato's great contributions to the tradition was his list of the most important virtues – the 'cardinal' virtues

- courage
- temperance (drives and instincts in right balance properly controlled by reason)
- prudence (practical wisdom – sound judgment)
- justice

To these were later added the 'theological virtues': Faith, Hope and Love based on St Paul's Epistle to the Corinthians (1 Cor 13:13). Virtue theory was further developed by Thomas Aquinas whose thinking continues to be important in the ethics taught by the Roman Catholic Church.

According to Alisdair MacIntyre (in his seminal work *After Virtue*) the Enlightenment thinkers largely cast aside these ways of thinking. However in the past couple of decades there has been a resurgence of interest in the ethics of virtue and character - largely inspired by MacIntyre – from a range of ethicists, theologians and philosophers.

The four principles (Beauchamp and Childress)

It is now over 30 years since the publication of the first edition of Beauchamp and Childress' groundbreaking book *Principles of Biomedical Ethics* (first published 1979). Now in its 6th edition (2009) it continues to hold a dominant place in the teaching and practice of medical ethics. Throughout its many editions the core chapters are given over to the well known and oft cited four key principles, which the authors claim are the essential norms on which many other moral claims and judgements depend. More specific rules for health care ethics, they say, can be formulated by reference to these four principles:

- Autonomy
- Beneficence
- Non-maleficence
- Justice

Metaphors for healing Dr. Ellayne Fowler, TLHP

Ellayne is a lecturer on the TLHP master's course and has a background in English literature.
For more information about the TLHP (Teaching and Learning for Health Professionals) please go to
http://www.bristol.ac.uk/medical-education/tlhp/tlhp-programme/apply/

What are metaphors?

- a figure of speech in which an expression is used to refer to something that it does not literally denote in order to suggest a similarity
- We understand one thing in terms of another
- Metaphors are organised systematically
- There are underlying conceptual metaphors
- Links between metaphorical systems
- Up = positive Down = negative
- Metaphorical systems are associated with cultural preoccupations

If you would like to read more

- Lakoff, G. (2008) '*The neural theory of metaphor*' in Gibbs (ed) **The Cambridge Handbook of Metaphor and Thought**. Cambridge, CUP.
- Lakoff, G. & Johnson, C. (1980) **Metaphors We Live By**. Chicago, University of Chicago Press.
- Reisfield & Wilson (2004) '*Use of Metaphor in the Discourse on Cancer*' Journal of Clinical Oncology. 22:19

Example texts: metaphors Can you identify the conceptual metaphors used?

A. Let's start looking at the building blocks of the brain. As previously stated, the brain consists of about 100 billion cells. Most of these cells are called neurons. A neuron is basically an on/off switch just like the one you use to control the lights in your home. It is either in a resting state (off) or it is shooting an electrical impulse down a wire (on). It has a cell body, a long little wire (the "wire" is called an axon), and at the very end it has a little part that shoots out a chemical. This chemical goes across a gap (synapse) where it triggers another neuron to send a message. There are a lot of these neurons sending messages down a wire (axon). By the way, each of these billions of axons is generating a small amount of electrical charge; this total power has been estimated to equal a 60 watt bulb.[1]

B. The body is a battlefield, and the invading organisms and proliferating cells are an enemy to be destroyed. Even the chemo destroys healthy cells. This imagery must contribute greatly to the climate of fear that surrounds cancer, and is a "particularly inapt metaphor for the peace-loving," such as myself. I felt I must approach my chemo in a cooperative way. Discovering the taxol agent was made from yew needles, I accepted it gratefully as a plant cure—and thus began to feel more in control.[2]

[1] http://www.tbiguide.com/howbrainworks.html downloaded 19.3.10

[2] Gill Reeve, BMJ | 20 JUNE 2009 | VOLUME 338

C. "My oncologist said my skin might not cope with the onslaught. The cancer nurse came round to my house to read out the side effects of my treatment - using words like 'toxic' and 'burning'. " I wanted the life-saving treatment but I felt strongly these images were not helpful."
Jan told the nurse that she did not want to know about the side effects of her treatment and instead developed her own detailed metaphorical landscape located in a favourite bluebell wood - a refuge from the fears, anxieties and frustrations that accompanied her hospital treatment. Here, the chemotherapy became "a beautiful golden liquid which my veins opened up to receive with gratitude", while a metaphorical pool of water cooled her skin after radiotherapy.
At the very least, she says, developing these positive metaphors made a difference to her ability to endure her treatment. [3]

Doctors told to use positive language in managing pain
Christopher Zinn *Sydney*

New national guidelines in Australia on managing acute back and musculoskeletal pain advise GPs to use neutral and nonthreatening terms to avoid frightening patients and delaying their recovery. Terms such as inflammation, degeneration, instability, rupture, and even arthritis should be avoided, said the draft report, as they "carry connotations of erosion, destruction and inevitable chronic pain."

The report, which was funded by the federal government and which sought comment from healthcare professionals and patients, continues: "Effective communication of information is fundamental to the success of any treatment plan." Project leader Professor Peter Brooks, executive dean of the Faculty of Health Sciences at the University of Queensland, said doctors could help recovery by putting a positive spin on their language and using neutral terms such as back pain. "I feel it's an awful thing for a doctor to tell a patient they have a ruptured disc. They imagine they have their disc splattered on the inside of their spinal cord," he said. "If you don't explain to patients relatively quickly and have a pretty good idea what the diagnosis is . . . then they are the patients who will slip over to become chronic pain patients."

The draft report—the result of a multidisciplinary review of the scientific literature—aims to promote partnership between clinicians and patients to manage pain and reduce disability. The review focused on the treatment of pain in the lower back, neck, thoracic spine, knee, and shoulder, and it is described as one of the first comprehensive reviews to draft guidelines aimed at curtailing the use of "alarming, inappropriate or incorrect terms."

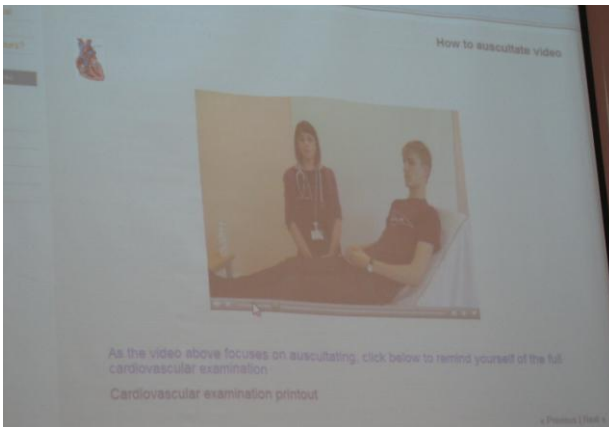
But the report has provoked some hostile media reports, with headlines such as "Spin Doctors: What GPs Don't Want to Tell You." It has also led to some angry editorials, with Sydney's *Daily Telegraph* (31 January, p 24) claiming that the project aimed to "sugarcoat" bad news to patients. But Professor Brooks said there was never any suggestion of sugarcoating. The aim was effective communication with consumers.
BMJ VOLUME 326 8 FEBRUARY 2003 bmj.com

Unacceptable words	Acceptable words
Failure of organ	Compromise of organ
Degenerative	Wear and tear
Ruptured	Prolapsed

[3] Story from BBC NEWS: http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/8326171.stm Published: 2009/10/27 10:55:52 GMT

Student SSC presentation Clare Whettleton

An elearning module for heart murmurs



Clare created this elearning module for her Year 3 external SSC. She impressed us all with her confident presentation and the number and range of IT skills she mastered to put this together. We particularly liked the mix of high tech videos and hand drawn diagrams and handwritten notes.

This learning package will be placed on 'Hippocrates' the Bristol learning site for year 3 students. Unfortunately this may take a while. Most of 'Hippocrates' it is open access. You can take a look here http://www.bristol.ac.uk/medical-school/hippocrates/why-hippocrates/

Teaching awards – Congratulations to the winners

A pill for every ill **Andrew Blythe**

Teaching and assessment of prescribing

Andrew informed us about the introduction of a national prescribing exam for undergraduates. This is the remedy for the finding that newly qualified doctors are not very good at prescribing. Every student will have to pass this exam as well as finals. They can take it repeatedly if needed. Bristol medical school took part in a pilot this year. Next year there will be a national pilot and the exam will be introduced for real in the academic year 2013-14.

This year's pilot showed which the students' weakest areas are.

The GMC publication 'Tomorrow's Doctor' prescribes what medical schools teach. You can request a free copy or download one from here
http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors.asp

Outcomes relating to prescribing

- **Doctor as Scholar & Scientist**
  - Select appropriate forms of management of common diseases
  - Demonstrate knowledge of drug actions
- **Doctor as Practitioner**
  - Critically appraise trials
  - Formulate treatment plans
  - Diagnose & manage acute medical emergencies
  - Prescribe drugs safely, effectively & economically
- **Doctor as Professional**
  - Critically appraise prescribing of others

Teaching and learning domains for prescribing

Prescribing	Calculation Skills
Prescription Review	Adverse Drug Reaction
Planning Management	Drug Monitoring
Communicating Information	Data Interpretation

Results from pilot

Prescribing	82%	Calculation Skills	81%
Prescription Review	76%	Adverse Drug Reaction	84%
Planning Management	76%	Drug Monitoring	79%
Communicating Information	**64%**	Data Interpretation	**45%**

Prescribing Skills Assessment Blueprint

Domain	General Practice
Prescribing	Hypercholesterolaemia Hypertension. UTI
Prescription Review	Patients presenting with common symptoms
Planning Management	
Communicating Information	Antihypertensives, nicotine replacement therapy, NSAIDs, latanoprost, sildenafil, vaccinations
Calculating Skills	
Adverse Drug Reaction	Headache, ankle swelling, dizziness, lethargy
Drug Monitoring	Statins, ACE inhibitors, antibiotics
Data Interpretation	Cholesterol, BP, diuretics & potassium

Teaching prescribing – Top tips from the small groups

Students are each given their own BNF at the start of Year 3. Not all students make good use of it. We find that they struggle to use it in finals; some look as if they have hardly ever opened it. Here are some tips how we can help them to familiarise themselves with the BNF.

<u>General teaching principles for teaching prescribing</u>

- Keep it relaxed
- Assess students particular learning needs
- Teaching should make things simple
- Need to give them structures and frameworks, hooks to hang knowledge on, for example start with classes of drugs, names with classifiable endings (-olos, -prils)
    - Provide structures because structureless information is hard to retain and use
- Good for them to have authentic experiences, get them involved in actually writing the prescription on the computer
- Humanise and normalise it, boost confidence
- Interactive – concrete examples
- Share golden rules
    - Always ask about pregnancy if a woman is of childbearing age
- Use questions to show them what they already know, get them to guess – give them their intelligence back
- Asking questions
    - How is this drug used?
    - How does this drug work?
    - Tell me about a drug for HT and 2 side effects

<u>Teach the bigger picture</u>

- Medicine mx teams/clinical pharmacists
- Give them an electronic copy of your practice/PCT formulary
- Ethics
    - Ask the students to look around your practice to see what they can find with a drug company logo or name on and then throw it out

The BNF

- Take them through the BNF to show them the wealth of useful information
- Tell students -read the BNF whenever you have a moment (i.e. waiting around for ward round to start)
- Read instructions in the BNF how to write a prescription
- Ask them to get a highlighter pen and go through some chapters to highlight the commonest drugs used
- Get the students to practice looking things up. They may have to prescribe in an OSCE station and are usually given a BNF in these stations. They can look up the dose
- Go through the BNF and teach them how to use it with patients, in exams and for revision
- Think of groups of drugs
- Teach details for common things

Teaching prescribing in Year 1

- Importance of prescribing
- Cost
- Ethics
    - Discuss drug reps
    - Rationing
    - Generic prescribing /cheaper substitutes
- Mechanics – what is involved I turning something written on a script into a treatment in or on the patient
- Concordance
    - How do we know whether patients are taking their medication?
    - Important to encourage patients to be honest with GP
- Access to medication
    - Can patients collect prescriptions themselves, do they need help?
    - Can patients remember how to take medication?
    - Dossette box etc

- Role in condition
- Role in doctor patient relationship
- What does the patient want?
- What does the doctor think the patient wants?
- As time mx tool?

Teaching prescribing in Year 2

- Ask them what they already know about medication
    - What painkillers do you know?
    - If they say they don't know any ask them what they have you taken themselves.

Teaching prescribing in Year 3

- Go through list of drugs and ask – which ones do you already know?
- Get them to think about classes of drugs
- Get them to actually write a script – on computer and handwritten
- Hands on, for example with inhaler and insulin preparations – how do they work, what does the patient have to do
- Look at drug list
    - What classes of drugs do you recognise?
    - How do the drugs relate to the history?
    - 1 drug – name 2 side effects

Teaching prescribing in Year 4

- Opportunistic depending on patients coming in
- Student to explain need for a medication to the patient
- Try to provide some structure to the prescribing process – make visible the processes you subconsciously go through
- Discuss prescriptions issues
    - Is it the most appropriate script?
    - Should there have been a prescription at all?
    - Consider pros and cons of choices

Teaching prescribing in Year 5

- Medication reviews
- Familiarise themselves with a 'normal' medication list
- Do the prescribing on the computer
    - If contraindications flash up ask them where the drug is metabolised and draw conclusions from that how to respond to warnings, can look up metabolic pathways for drugs in the data sheet compendium
    - Consider the warnings that come up, use judgement, balance risk
- When you are signing a box of prescriptions at the end of surgery
- Get them to think through side effects/cautions/contraindications from first principles
- Encourage them to get the bigger picture – here is somebody with DM and HT
- Teach the bigger picture
    - Medicine mx teams/clinical pharmacists
    - Give them an electronic copy of your practice/PCT formulary

How should we teach prescribing?

- Through consultations
- Medication reviews
- Repeat prescriptions
- One medical student surgery concentrate on prescribing
- When observing students consult, concentrate more on management/prescribing, and less on history taking/examination.
- Make them actually use the BNF
- Use the 10 stages of prescribing proforma
- Assess students particular learning needs

Shadowing in surgery/ own surgery

- Look up drugs in BNF / after surgery
- Discuss Rx plan – pros and cons/ side effects
- Get into habit of moving beyond just making diagnosis to discuss rx options with students
- Get student to commit to a rx plan – then discuss (year 4/5)
- Review patient list of medications – any interactions / cautions etc - in surgery or after
- Get student to write script – then check
- Book patient for medication review with student first

Outside surgery

- Give student selection of repeat scripts to review
- Give students homework (after surgery – Y 3,4) reviewing class of drug – actions / interactions / side effects
- Show student test results – and discuss relevance to medication

Involving others

- Time in dispensary with pharmacist if appropriate – review repeat meds/ observe dispensing issues and drug formats etc.
- Students to observe the dispensing process if you are dispensing, or send them to a local willing pharmacy
- Asthma clinic with nurse – discuss medications / side effects / compliance etc
- Smoking cessation clinic – with nurse – discuss rx options and indications etc

Further discussion

We felt it was useful for GP tutors to see examples of Prescribing Skills assessment questions to understand the level and nature of questions that students will need to answer – to help us be more aware of useful teaching points when they arise. We looked at a small sample and felt that the questions were very fair and practical.

How should we teach data interpretation?

- Monitoring medication, use of blood tests, review systems
- Computer warnings re interactions etc. When useful/when ignore
- Qrisk charts to decide re initiating medication

How should we teach communication re prescribing?

- Right amount at right time, may need to repeat
- Ask students for 3-4 points to communicate re particular drugs
- Written info ?get students to write
- Use of community pharmacists –medication reviews

Asking the right questions – using frontline epidemiology to focus on what really matters

A talk by **Chris Payne**, recently retired Director for Public Health for South Gloucestershire

Chris reminded us that we are often 'asking whether we are doing things right' but we should also stop to ask 'whether we are doing the right things'. He critically appraised data and shared with us his thinking on 9 things we could do less of and 9 things we should do more of. In the process a few 'holy cows' were slaughtered.

Some of you have requested his slides and they have been emailed out with this workshop report.

Workshop evaluation – did you enjoy it?

Section 1: Your Academy

1. Which Academy is your practice attached to?			
Bath:		13.6%	3
Gloucester:		4.5%	1
North Bristol:		31.8%	7
South Bristol:		9.1%	2
North Somerset:		13.6%	3
Somerset:		18.2%	4
Swindon:		9.1%	2

2. Which students did you teach in this academic year?			
Year 1:		n/a	5
Year 2:		n/a	5
Year 3:		n/a	5
Year 4:		n/a	15
Year 5:		n/a	13
SSC:		n/a	2
WPC:		n/a	0
Consultation skills:		n/a	5
Other *(please specify)*:		n/a	2
Cons skills - all years. Disability			
teaching fellow			
2.a. Comment			
Did not get chance to have any year 5 students this year			

Section 2: Please rate the following workshop sessions

3. Welcome and Update of Primary Care Teaching			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		9.1%	2
Good:		50.0%	11
Excellent:		36.4%	8
Did not attend:		4.5%	1
3.a. Comment			
v relevant			
Very useful update and also highly enjoyable and thought provoking.			

4. Ethics and beliefs unboxed			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		4.5%	1
Good:		36.4%	8
Excellent:		54.5%	12
Did not attend:		4.5%	1
4.a. Comment			

5. Metaphors for healing			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		31.8%	7
Excellent:		63.6%	14
Did not attend:		4.5%	1
5.a. Comment			

6. Student SSC presentation			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		4.5%	1
Good:		31.8%	7
Excellent:		59.1%	13
Did not attend:		4.5%	1
6.a. Comment			

7. Teaching awards			
Poor:		0.0%	0
Below average:		4.5%	1
Satisfactory:		18.2%	4
Good:		59.1%	13
Excellent:		13.6%	3
Did not attend:		4.5%	1
7.a. Comment			
although it does make one feel that I must be a very poor teacher. It's alright just the green eyed monster rearing its head.			
Good idea			

8. Teaching prescribing			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		4.5%	1
Good:		63.6%	14
Excellent:		27.3%	6
Did not attend:		4.5%	1
8.a. Comment			

9. Asking the right questions - using frontline epidemiology to focus on what really matters			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		18.2%	4
Excellent:		63.6%	14
Did not attend:		18.2%	4
9.a. Comment			

10. Discussion of proposals for change in Years 1 and 2			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		4.5%	1
Good:		27.3%	6
Excellent:		0.0%	0
Did not attend:		68.2%	15
10.a. Comment			
but how useful was it? too short to reach conclusions			
interesting ideas on how GP surgeries can be utilised.			

Section 3: The Workshop Overall

11. Please rate the workshop overall			
In truth, not really very useful:		0.0%	0
Picked up one or two useful things:		9.1%	2
Plenty of relevant stuff for me as a GP teacher:		45.5%	10
I came away feeling highly informed and inspired:		45.5%	10
11.a. Comment			