Year 3 GP Attachments

GP Teacher Guide 2013-14

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*Please refer to p10 for local contacts*
Welcome

Thank you for teaching in Year 3 and welcome to the GP teacher guidebook 2013-14.

The main focus for students in their GP attachments should be on consolidating and extending their clinical skills and diagnosis making. They should learn how to investigate and manage conditions including prescribing. Please guide your students to keep the focus on the patient experience so they can develop a thorough understanding of what it is like to live with a condition or chronic disease.

Teaching office info
We currently have four part time administrators in post. Mel Butler manages the Teaching Office and also oversees Years 3-5. Alison Capey who is standing in for Jacqui Gregory manages Years 1 and 2. Jacqui is still on maternity leave. Stephanie Burke manages SSCs (student selected components) and provides support for all years. Julia Carver is supporting our teaching workshop programme and year 3.

To make sure that your emails are answered promptly our admin team are using a shared email inbox. Please send all communications to phc-teaching@bristol.ac.uk.

Professional indemnity for students
Students are advised to join a medical defence organisation. The MPS and MDU offer students free membership. It is important that students are covered when they are on clinical placements. Please check that your students have indemnity.

Learning objectives (LO)
We have described some overall learning objectives for the Year 3 GP sessions and suggested teaching topics for each Unit.

The way Year 3 sessions are organised makes it much easier to ask patients with ongoing conditions to attend rather than those with acute problems. This makes Year 3 an ideal place to learn about chronic diseases. To ensure a fairly comparable experience for the students and to be able to base an exam on what they have learned we have more closely defined the learning objectives for a number of chronic diseases in the Junior Medicine and Surgery Unit.

Prescribing
Prescribing is an important and frequent task for most doctors. To make sure that students can prescribe safely when they qualify a national prescribing exam has been developed. It has been trialled for a couple of years and now 5th year students will take it for real for the first time in 2014.

Students will already have learned a bit about drugs in their physiology tutorials. The year 3 GP placements are a good place to help students develop a sound understanding of commonly used medications in common chronic conditions. This guidebook has a section on prescribing with some practical teaching suggestions.

‘Tomorrows’ Doctor’ (TD)
The Bristol medical curriculum is based on the ‘framework’ set by the GMC for all UK medical schools. This ‘framework’ is described in ‘Tomorrow’s Doctor’ (TD) which you can access at http://www.gmc-uk.org/TomorrowsDoctors_2009.pdf_39260971.pdf. It is organised into three ‘Outcomes’ - ‘The doctor as scholar and scientist’, ‘The doctor as a practitioner’ and ‘The doctor as a professional’ and further divided into paragraphs. I have referenced most of the learning objectives to the relevant outcomes and paragraphs in TD, i.e. TD Outcome 2 13a) refers to ‘take and record a medical history etc.’ This shows which aspects of the curriculum are covered in the Year 3 GP attachments.
References to Vertical Themes (VT)
There are 6 VTs - Ethics and law in medicine, Evidence based medicine, Medical humanities and whole person care, Personal and inter-professional development, Consultation and procedural skills, 3Ds -disability, disadvantage and diversity

The teaching in Primary Care will touch on the VTs in many ways. I have identified obvious connections to the VT by placing the relevant symbols in the text.

Professional behaviour assessment
In Year 3 you do not need to complete a professional behaviour form for each of your students. Instead you need to notify the university and the Primary Care Teaching Office when a professional behaviour issue occurs. Please complete a student concern form if any of your students behave in an unprofessional or concerning manner. Please read more in the section on assessment in this guide.

Primary Care OSCE exam station (summative assessment)
There will be one Primary Care OSCE station in the Junior Medicine and Surgery OSCE exam. This is a 10 minute station with an actor role playing the patient. The station will be based on the Junior Medicine and Surgery learning objectives in this handbook. Students are expected to be able to ‘put it all together’. This means to make a diagnosis on the basis of the history, examination and test results, tell the patient the diagnosis and outline a brief initial management plan. To help students prepare for this station we have created a mock OSCE. You can find this in the Year 3 GP placement course in Blackboard. This is a video of a mock OSCE which puts the viewer in the shoes of an examiner. There is a mark sheet to complete and students can compare their marks with that of experienced examiners. This gives the students insight into how Primary Care OSCEs are being marked.

Hippocrates
This is an online learning resource for 3rd year medical students which you can access without a password. You can find it at http://www.bris.ac.uk/medical-school/hippocrates

Blackboard
Blackboard is the virtual learning environment (VLE) used by Bristol University which you can find at www.ole.bristol.ac.uk. You have been enrolled in the Year 3 GP placement course and need the usual GP login and password. Please note, you need to use the guest login

Student creative work
The images in this guide have been created by Bristol medical students. Please visit http://www.outofourheads.net for more examples.

Wishing you an enjoyable teaching time

Barbara Laue (GP Lead for Year 3) 28.8.13
What 3rd Year students say about their GP teaching

We were able to ask to see patients, which we struggled to find in the hospital, but want to see to learn about the effects of that disease on the patient's life e.g., Diabetes type 1

Really great to teach each other and be taught by the GP. Very encouraging. Love the stories of patients - helps me remember things!

Enormously! Practising examinations in front of a doctor very useful for OSLER prep. More confident

Very interactive and unintimidating - v friendly. Good patients each week - useful, interesting and appropriate for us

Everything was so good! Teacher, session planning and content were all brilliant.
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Introduction to General Practice Attachments for 3rd year medical students

Overview of year 3
Year 3 is organised into 3 Units as follows (please also see diagram in the appendix)

**Junior Medicine and Surgery**
Cardiac, respiratory, otolaryngology, maxillofacial surgery, vascular surgery, abdominal, breast, endocrine, renal/urological, neurological

**MDEMO**
Musculoskeletal diseases, emergency medicine and ophthalmology

**Psychiatry and Ethics**

Unit timetable

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<th>Unit timetable</th>
<th>Psychiatry &amp; Ethics</th>
<th>Junior Medicine &amp; Surgery</th>
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<td>MDEMO</td>
<td>2.9.13-1.11.13</td>
<td>4.11.13-17.1.14</td>
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<tr>
<td>Psychiatry &amp; Ethics</td>
<td>2.9.13-1.11.13</td>
<td>4.11.13-17.1.14</td>
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Students are divided into streams and rotate through these units in varying order, spending 18 weeks in Junior Medicine and Surgery and 9 weeks each in MDEMO and Psychiatry and Ethics. This means that students bring different levels of experience and knowledge to their General Practice attachments. Students will spend two consecutive Units in a Bristol Academy and the other two in an 'out-of-Bristol' Academy such as Gloucester/Cheltenham or Somerset.

**GP attachments in year 3**
For their GP attachments students are organised into groups of 4-5 students. Group sizes vary for a number of reasons: total number of students in an academy, available practices, geographical location, and hospital teaching timetable. Occasionally there are last minute changes to group sizes, which are out of our control and we would like to apologise for this in advance.

Students stay in the same group and with the same practice for four sessions. They then move to a different Academy and have a further four sessions with a different GP.

Most of the students' time is spent in hospital, on ward rounds, in clinics and in teaching sessions within each of the clinical specialities. About 15% of their time is for SSCs (Student selected components).
To provide a coherent learning experience for the students the GP sessions should cover some of the common Primary Care based problems and diseases that are relevant to the students’ current unit, i.e. when the students are rotating through MDEMO they should see patients with musculoskeletal, ENT or eye problems in General Practice.

**GP teaching sessions**
- 8 half-day GP sessions over the academic year
- 2 half-day sessions in MDEMO and Psychiatry and Ethics, 4 half day sessions in Junior Medicine and Surgery
- 2 different GPs, one in each Academy (4 sessions with each GP)
- Groups of 4 or 5 students
- Session length 2.5-3 hours

Attendance at the GP sessions is compulsory and students should contact their GP teacher ASAP when the problem arises and tell them why they are not attending. GP teachers need to keep an attendance register.

If a student misses a session without contacting you or sending a message you need to complete a ‘Student Concern form’ (see under professional behaviour) and inform the Primary Care Teaching Office.

**How to organise the GP teaching sessions – Academy information**

**Bath Academy**
Danielle Fawker-Corbett in the Undergraduate office at the RUH liaises with individual GP teachers to find their preferred dates and coordinates them with the hospital timetable. The students deal directly with Danielle and not the GPs to organise the sessions. This gives flexibility for GP teachers to choose days / dates that work out best for them and Danielle checks for compatibility with hospital teaching.

**Gloucester/Cheltenham Academy** Year 3 teaching dates have been fixed. GPs can choose from the following
- Unit 1&2
  - 17th or 19th September 2013 and
  - 15th or 17th October 2013
  - 19th or 21st November 2013 and
  - 2nd or 7th January 2014
- Unit 3&4
  - 4th or 6th February 2014 and
  - 4th or 6th March 2014
  - 8th or 10th April 2014 and
  - 13th or 15th May 2014

**North Bristol, South Bristol, North Somerset and Somerset Academies**
Your Academy administrator will send you the names of your students. A lead student will have been identified for each group. The name of this student is underlined or highlighted on the list. It will be this student’s responsibility to liaise with you regarding session dates and times for the group.
Teaching dates
Please liaise with your academy administrator to find out about fixed teaching dates for tutorials etc. so you can avoid these dates for your teaching sessions. Please do this at the beginning of September.

Junior Medicine and Surgery
The larger Unit of Junior Medicine and Surgery has 3 Core Teaching Sessions on specific days each week and fixed teaching dates for Diabetes. Please ask your academy administrator for the dates of these teaching sessions and avoid these dates.

MDEMO
Please avoid the Ophthalmology weeks commencing
Unit 1 w/c 7th October 2013
Unit 2 w/c 9th December 2013
Unit 3 w/c 24th February 2014
Unit 4 w/c 28th April 2014

Dates for central study days (CSD)
These are central teaching days in Bristol for all students
CSD A: 2nd September 2013
CSD B: 4th November 2013
CSD C: 5th November 2013
CSD D: 20th January 2014
CSD E: 21st January 2014
CSD F: 24th March 2014
CSD G: 25th March 2014

Wednesday afternoon for sport
In year 3 students are entitled to have Wednesday afternoon off (from 1.00pm) for sport. If nobody in your group is involved in sport you could arrange a GP teaching session for Wednesday afternoon if that suited you and your students.

Over the academic year you need to identify two dates for a half day teaching session for the MDEMO and Psychiatry Units each and 4 dates for the Junior Medicine and Surgery Unit. Please send dates for the first few sessions to your lead student and academy administrator by 9th September.

Communication with your students
At the Year 3 introductory lecture, on Monday 2nd September, I will tell the students how to organise their GP sessions.

At the first contact, please agree with the lead student how you can best communicate with each other, i.e. email, mobile, landline etc. and how quickly you and they will respond to calls or emails.

It is a good idea to get a mobile phone number from your lead student
When the students start a new Unit, in the first week after receiving their hospital timetable, the lead student should ensure that there are no timetable clashes, and contact you to rearrange the session if necessary.

GP teaching sessions are compulsory for students. In case of communications breakdown between you (the GP) and your students, please contact your academy GP lead. Please do this as soon as you become aware of a problem. The Units pass quickly and in the past some students have missed out on sessions due to a breakdown in communication.
Queries about placements
Queries about specific student placements should go to your Academy administrator and GP Academy lead in the first instance or the Primary Care Teaching Office. The first point of contact for teaching issues or problems with students is your GP academy lead. For academies with no GP lead please contact Barbara Laue if your administrator cannot help you.

Support for students
For support outside the Units students can contact the Faculty Student Advisor Emma Teakle 0117 928 8444 or med-support@bristol.ac.uk or the Director of Student Affairs, Reverend Mr. N. Rawlinson Nigel.Rawlinson@bristol.ac.uk. Tel 0117 928 9057.

The Role of the Director of Student Affairs (Clinical) (Previously Clinical Dean)
Nigel Rawlinson has a pastoral role and is in the unique position of knowing each student’s academic record as well as knowing about their special circumstances such as personal or family illness/bereavement etc. For reasons of confidentiality though, he cannot pass this information onto future teachers of a particular student.

If Mr. Rawlinson becomes concerned about a particular student’s behaviour or attitude he can refer that student to the Senior Academic Tutor who in turn has to decide whether the student needs special help, referral to the Fitness to Practice Committee or immediate removal from the Fitness to Practice Register. There are clearly defined protocols at http://www.bris.ac.uk/medical-school/staffstudents/

On starting their clinical studies all students have to sign a Code of Practice for Clinical Student, see http://www.bris.ac.uk/medical-school/staffstudents/. When students sign this document they are entered onto the Register of Fit Persons, which the University is obliged to keep. In addition to this all students are given a copy of the Dress Code for Clinical Areas and the Medical School’s Policy on Intimate Examinations. If you are concerned about a particular student you should complete a ‘Student Concern Form’ (more about this under ‘assessment’, please see the appendix for flow chart and form).

Incident & Accident Reporting
In the past there has been an incident where a student was assaulted by a patient with learning difficulties following a failed attempt at venepuncture. The student was unharmed but the incident raised several issues regarding student safety:
Consider the individual student’s previous experience and confidence in procedures. Carefully select patients for students to take blood from and carry out other clinical procedures e.g. Flu vaccinations. Consider who is supervising the students – is it yourself or a practice nurse? Each student should have personal medical indemnity insurance with either the MPS or MDU. This is free for medical students if they sign up. It is essential to check that they have done this.

If an injury or incident of any kind occurs involving your medical student at your practice, this needs to be reported to the Primary Care Teaching Office. To do this, please complete the Accident Reporting Form which can be found on our website at: http://www.bristol.ac.uk/primaryhealthcare/teachingtutors/usefuldocs/ accessed 29.8.13

The completed form should be sent as soon as possible to the Primary Care Teaching Office (via email, fax or post) who will inform the relevant Academic Lead in Primary Care, the Director of Student Affairs and the Health & Safety Office.

Primary Care Teaching Office: Room 1.01, Canynge Hall, 39 Whatley Rd, Clifton, Bristol, BS8 2PS. phc-teaching@bristol.ac.uk
Tel 0117 331 4544 Fax: 0117 928 7325
Contact Details
Within the University of Bristol, the overall administrator for Year 3 Primary Care student placements is Melanie Butler [phc-teaching@bristol.ac.uk](mailto:phc-teaching@bristol.ac.uk) Tel: 0117 331 4544. The GP lead for Year 3 is Dr. Barbara Laue [barbara.laue@bristol.ac.uk](mailto:barbara.laue@bristol.ac.uk)

For student support outside their units please see above ‘Student support’

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<tr>
<th>GP ACADEMY LEADS</th>
<th>ACADEMY ADMINISTRATORS</th>
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<tr>
<td><strong>Bath</strong></td>
<td>Academy Dean: Clare Taylor <a href="mailto:Clare.Taylor3@NHS.net">Clare.Taylor3@NHS.net</a></td>
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<tr>
<td>Melanie Blackman</td>
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<td>Daniele Fawkner-Corbett <a href="mailto:Danielefawkner-Corbett@nhs.net">Danielefawkner-Corbett@nhs.net</a> Tel 01225 82 5486</td>
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<td><strong>North Bristol</strong></td>
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<td>Rosalind Shoebridge <a href="mailto:Rosalind.Shoebridge@nbt.nhs.uk">Rosalind.Shoebridge@nbt.nhs.uk</a> Tel Southmead 0117 323 2368 Tel Frenchay 0117 340 6764</td>
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<tr>
<td><strong>Gloucester and Cheltenham</strong></td>
<td>Academy Dean: Peter Fletcher <a href="mailto:Peter.Fletcher@glos.nhs.uk">Peter.Fletcher@glos.nhs.uk</a></td>
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<td><strong>Taunton</strong></td>
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<td>Caroline Bayliss <a href="mailto:Caroline.bayliss@ydh.nhs.uk">Caroline.bayliss@ydh.nhs.uk</a> Tel: 01935 384585</td>
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Payment

Payment is linked to completing the attendance and payment form for each group at the end of the final session with each group (session 4 and 8). Payment will be triggered when the Teaching Office receives the form. This means that you will receive payment twice a year, after session 4 and 8. For more information about these forms and assessment please see below.

Payment for missed sessions

There have been instances where, through misunderstanding, sessions have been missed. The department can only honour payment for missed sessions if you can show that the session had been arranged and cancelled at short notice by the students.

Payment for extended and whole day sessions

Please note that a session is expected to last 2 ½ to 3 hours and would normally include two patients. A session lasting four hours with three patients would not normally attract two session fees.

In some more remote localities it has been more convenient to the GP Teacher and students to organise a whole day session. This would attract two session fees if it consisted of 2x2 ½-3 hours teaching with four or more patients in total for the sessions.

Assessment

Giving students feedback is one of the most important things we do as teachers and does make a difference (there is good evidence for this). Assessment is a form of feedback and can be formative or summative.

Formative assessment tells the students how they are doing and how to develop further. Summative assessment determines whether a student is fit and ready to progress to the next stage or to qualify as a doctor (licensing exam). All hospital and GP teachers need to assess their students’ professional behaviour and clinical knowledge and skills.

Assessing clinical skills and knowledge

We ask you to comment whether you have concerns about the student’s level of clinical skills based on the short time you have had with the student. We are not asking you to make a comprehensive assessment but to draw on previous teaching experience and comparison with the other students in the group. Remember that students will be very different in their level of skills depending whether you see them at the start or the end of the year. They may be very knowledgeable and skilled in one area and not in others.

We are trying to pick up students who are consistently struggling in order to give them support rather than wait till they fail their exams. If you have any concerns that a student is significantly and consistently less skilled and knowledgeable than their peers please speak to or email your GP Academy lead or myself, the year 3 GP lead.

Exams

There are assessments at the end of each unit, and these take different forms. At the end of the Junior Medicine and Surgery Unit there is an OSCE (Objective Structured Clinical Examination). Each student rotates through a number of stations and is assessed according to a structured mark sheet. The OSCE will be based on the core syllabus that the students will receive from the hospital at the start of each unit.

There will be one GP station as part of the Junior Medicine and Surgery OSCE. An actor portrays a common clinical problem seen in General Practice and the student role
plays an F2 in General Practice. The GP station will be based on the learning objectives for chronic diseases in this guidebook.

There are also OSLERs (Objective structured Long Examination Record). As part of the Junior Medicine and Surgery Unit students also have to complete a clerking portfolio (32 patients) which is assessed.

Attendance record

The GP sessions are compulsory and attending GP sessions as required is part of the professional behaviour you are assessing in your students.

Over the last 3 years there has been a slow upward trend for missed sessions. It is important for us to have accurate figures of missed sessions and reasons for students missing sessions. Please keep good records of your students' attendance and note the reason for all missed sessions.

If a student misses one session and informs you in a timely fashion and has a good reason (illness etc) you do not need to report this. If the student does not inform you or does not apologise for forgetting to inform you, or does not have a valid reason, even one missed session should trigger a student concern form (see above).

If a student misses two sessions (50% of the teaching for that GP placement) you should report this even if the student gives a valid reason. There could be situations where this is a sign that a student needs additional help or may be ill. Please notify the Primary Care Teaching Office if a student misses 2 sessions or more, even if there is a valid explanation.

Assessing professional behaviour

In Year 3 you do not need to complete a ‘Professional behaviour form’ for each student any longer. Instead we would like you to report any concerns about your students’ professional behaviour by completing a student concern form (SCF). You can find a copy of this form under Forms at the back of this guidebook.

Student concern form (SCF)

Please see the information sheet and flow diagram below

Managing concerns about students – Good practice

- **KEEP GOOD NOTES**
- Familiarise yourself with the code of practice for clinical students
- Talk to the student about your concerns and complete a student concern form if indicated
- Contact your Academy GP lead or the GP Year 3 lead
Dealing with Concerns about Students
A protocol for GP tutors

What do we want to achieve?

1) Help you identify the students that cause concern.
   a) To enable students to receive the most appropriate support
   b) To prevent risk to patients/colleagues.

2) Clarify the route for you to report a concern about a student.

3) Outline the action that you can expect from the primary care teaching team or GP academy leads.

4) Outline the role of the Academy Dean in concerns you may have about your students.

5) Keep the pathway for reporting concern as straightforward as possible involving the minimal number of people on a need to know basis.

Frequently Asked Questions:

1. When should I be concerned about a student?

The following are common areas of concern (in bold) with a list of possible examples. This list is not exhaustive.

Professional behaviour/attitude e.g.
- Compulsory session missed without explanation or recurrent absence with explanation. (<80% attendance)
- Rude to peers, patients, teachers or staff.
- Inappropriate dress persists after request to make changes.
- Consistently late, disorganised or unprepared for the sessions.
- Not contributing to group discussions/group activities/bored/disinterested.
- Breach of confidentiality e.g. heard discussing patients/leaving computer switched on with records visible etc.

Pastoral e.g.
- NB/ Discussion about any of the above may reveal a pastoral care issue.
- Low mood/mental health issues interfering with ability to study/attend course.
- Physical health issue interfering with ability to study/attend course.
- Conflict of roles interfering with ability to study/attend course e.g. dependants, paid employment, outside interests, family issues.
- Uncertainty about course/career in medicine/geographical location.

Safety e.g.
- You consider that the student has acted above their level of knowledge/skills and not sought appropriate help.
- You consider that the student has put a patient or colleague at risk.

Clinical knowledge/skills, including communication e.g.
- In your opinion the student does not have the minimally acceptable clinical knowledge or skills for their stage of training.
- In your opinion the student does not have the minimally acceptable communication skills (including language) for their stage of training.
2. I am concerned about a student what should I do?

- Initially you may want to discuss amongst your primary care team, has anyone else taught or had contact with the student and shares your concerns?
- Keep good notes.
- Always try to discuss your concerns with the student concerned.
- If you are not easily able to resolve your concerns with the student try to inform the student that you will be seeking further advice.

3. Who should I contact if I am concerned about a student?

- We encourage you to phone or email the GP year lead in the Primary Care Teaching team (see contacts in your handbook or www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/year/) or the GP academy lead, in recognition that it can be helpful to discuss what constitutes “minimally acceptable” knowledge, clinical skills or an attitudinal concern.

4. What happens after this?

- The GP year lead (or GP academy lead) will be able to discuss your concerns, and advise. They are likely to ask you to put your concerns in writing (email) and from year 2 onwards they will forward this to the Academy Dean. This should not be seen as a punitive measure, but to enable a high level overview of individual students. The Academy Dean will make the decision to cascade information as appropriate on a need to know basis. You should decide between you who should complete the student concern form (see below).
- If the student is in year 1 the GP element lead may discuss the concerns with the Pre-Clinical Programme Director (Dr Eugene Lloyd) as the Academy Deans have little involvement with year 1.

5. So what about “Student Concern Forms”?

See http://www.bris.ac.uk/medical-school/staffstudents/student/forms
The forms should also be in your tutor handbooks. The medical school encourages teachers to have a low threshold for filling these in, please submit to the address on the form, with a copy to the Primary Care Teaching Office and the Academy Dean (to keep them in the loop). However we recognise that every circumstance with a student is different and are happy to discuss the situation with you first.
Flowchart for communicating concern about students

Written: November 2012
Review date: September 2013
Responsible: Primary Health Care Teaching Office
Email: phc-teaching@bristol.ac.uk for more information or queries

Student concern form (SCF) at:
http://www.bristol.ac.uk/medical-school/staffstudents/student/forms

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GP tutor has concern about student

GP tutor discusses concern with student

Concern resolved and minor. No further action

Concern upheld

Option 1: Discuss with GP Year lead (see handbook) or GP academy lead.
- Lead checks that student knows concern is taken further.
- GP tutor puts concern in writing – email to lead.
- Flag in correspondence whether student is or is not aware that concern is being taken further.

Option 2: Complete and submit student concern form (please also copy to Academy Dean and Primary Care teaching office).

Concern minor, strategy for management agreed.

Concern unresolved, poor student response to remedial action.

Concern upheld (option 1)
- Lead forwards email to Academy Dean detailing concern with request to follow up.
- Copies in GP tutor for info.
- Decide who to complete student concern form e.g. tutor, GP lead or request that Academy Dean does so.

Concern resolved No further action
Assessing your students in General Practice- some examples for guidance

Example – professional behaviour

- Student A, male, 22, turns up with his skateboard under his arm, his hair appears unkempt, trousers are scruffy and very low slung with the top of his pants showing, he wears a baseball cap, which he keeps on all through the first consultation with the patient. He put the skateboard down when it was his turn to talk with the patient. His consultation skills were adequate and he appeared to engage with the patient.

- You feel that his appearance and skateboard in the consulting room are inappropriate. Over coffee you speak to him alone. He accepts that he is too casual and apologises. At the next session his trousers cover his pants and the skateboard is put away, no baseball cap. He seems to fully engage with the tasks in hand. This student has responded to feedback and should not be flagged as causing concern.

- If he had been unwilling to change his behaviour or dress this should have been flagged up as an area of concern.

Example - Clinical skills and knowledge

- We also ask you to comment when students are seriously underperforming with their clinical skills for their stage of year 3 compared with average year 3 students.

- Students vary how quickly they become confident with their clinical skills and we expect them to have “pockets” of lack of knowledge and skills.

- Moderate underperformance is best addressed with feedback from you in the surgery. We would however like you to flag up any students whose knowledge and skill for their stage of year 3 give you serious concern; see below for an example.

- If you are uncertain and would prefer to discuss your concerns prior to completing the form, please contact your GP academy lead or GP Year 3 lead.

Example – poor clinical skills and knowledge

- This is the 4th GP session near the end of year 3. Student B has been asked to find out about the history and management of patient X’s DM. The student appears uncomfortable with the patient and makes poor eye contact. Her history taking is random and she fails to respond to cues and questions from the patient. After 10 minutes of talking with the patient she is unable to give a coherent account.
Forms for 2012-13

Please see appendix and website. Please photocopy as needed.

Student concern form (SCF)
Please see information above. You should have a low threshold for completing this form.

Attendance and payment form
This form is a record of the sessions and attendance by the students. We need you to complete this form to request payment from the university on your behalf. Please record the reason if students are missing sessions and inform me the Year 3 GP lead if students are not giving you an explanation for missed sessions or are missing more than one session even if there is a good reason for this.

There are many legitimate reasons for non-attendance (sickness etc). Some may be due to perceived difficulty of attending GP sessions and we need to know about those or any other reasons. GP teaching sessions are compulsory for the students.

An attendance and payment form needs to be returned to the Teaching Office at the end of session 4 and 8, i.e. one per group. Receiving the forms will trigger payment.

Student Evaluation form
All students in your group should complete an evaluation form at the final session (4&8). Forms should be placed in an envelope and the envelope should be sealed. Please post this envelope to the Teaching Office.

Forms to help with feedback giving (these are not to be returned to the Teaching Office)

Log of students’ performance and your reflections on the sessions
We are asking you to provide individual verbal feedback to your students at the end of your last session with each group. As the sessions are spread over several months it can be difficult to remember how they performed in each of the sessions. This form is intended to help you keep track of your students’ achievements and with providing feedback. It should not take long. Please do not return this to the department. Students also increasingly ask their GP teachers for references and you may find it helpful to have this record.

Student checklist
This form is intended to help the students focus on their skills and knowledge. Students have been asked (at the introductory lecture and in their Year 3 GP Placement Guidebook) to complete this at the start of Unit 1 and at the end of Unit 2 and 4. Please ask them to share their form with you. A copy of the form is in the appendix. The student should keep this form.

Student self-assessment form
This form is intended to help you and your students to focus on what they are learning and to provide continuity and connections between GP placements. Reflection and self-assessment are important skills, which students need to learn and develop. Please remind the students in their 3rd session with you to remember to complete this form and bring it to the final session. Students should write down what they think their strengths are in relation to their clinical skills. The students’ reflections and your own observations should form the basis for the brief individual feedback at the end of their final session. Please ask the students to write down your feedback on their form. Please help the students to formulate a learning plan on the basis of this feedback and encourage them to show it to their next GP teachers. The student should keep this form.
Teaching in Year 3

What you need to do as a GP teacher
- To communicate effectively with the students to organise the sessions
- To be welcoming
- To start the sessions on time
- To show your enthusiasm for teaching and patient care
- To invite 2 or more patients per session
- To teach history taking, communication and examination skills
- To observe students directly consulting with patients and examining patients
- To give students feedback during the sessions and individual feedback at the end of session 4 and 8
- To complete an attendance and payment form per group and return them to the Teaching Office after session 4 and 8
- To complete a student concern form for students behaving unprofessionally

What you can expect of your students
- To communicate promptly regarding the organisation of the sessions
- To arrive on time for the sessions
- To show professional behaviour towards patients, staff and peers
- To actively contribute to the session
- To give constructive feedback to you and the other students in the group
- To reflect on their own learning

At first contact

Things to tell the students
- How to get to your practice
- What you expect them to bring to your practice
- What the dress code is at your practice
- What time they should arrive on the first day

Things to check with the students
- Have they registered with either the MDU or MPS? (Free for students, important cover for procedures such as venepuncture undertaken in the practice)

Good basic structure for each session
- Tell them what you are going to do/teach
- Do/teach it
- Tell them what you have done/taught
### Brief outline of what you need to do in each session

| Session | Welcome students | Brief intro to your surgery (recep., toilets etc.) | Brief outline of GP attachment | Brief outline how and when you will be giving feedback to the students | Brief outline and learning objectives for the session | Review and summing up of session, plan for next session | Reminding students to complete self assessment form and checklist to plan their learning and to prepare for the feedback in session 4 and 8 | Review own reflections with them, brief individual feedback for each student, encourage students to write this down on their form | Ask students to complete feedback form, put them in an envelope, seal it, post it to the Teaching office | Complete the payment and attendance form for your group and return to the teaching office for prompt payments |
|---------|------------------|--------------------------------------------------|--------------------------------|---------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------|
| 1st     |                  |                                                  |                                |                                                                     | 1st patient                                      | 2nd patient                                               | 1st patient                                               | 2nd patient                                               | 1st patient                                               | 2nd patient                                               | 1st patient                                               |
| 2nd/3rd | Welcome          | Discuss and set learning outcomes for the session| 2 (or more) patients          | Revisit learning outcomes | Plan for next session | Session 3 - Ask students to complete the checklist and self assessment form and to bring this to the final session | | | | | |
| 4th     | Welcome, find out how they are getting on | Agree and set learning outcomes, run session with 2 (or more) patients as before | Revisit learning outcomes | Individual feedback session including planning learning for next attachment. Students should have completed a self assessment form and a checklist. They can add useful information to the discussion. Encourage them to write down your feedback. | | | | | | | | |

### Suggested structure for teaching sessions in greater detail

**1st**
- Allow ½ hour for welcome, introductions, quick look round the surgery (loos, where to get a drink etc)
- Find out their specific learning agendas for the unit (knowledge, skills)
- Ask students to think about their knowledge and clinical skills, encourage them to use the self assessment form and checklist (back of student guidebook)
- What do they want to focus on? Learning agenda?
- Explain how and when you will give feedback and how to give feedback to each other (see section on feedback)
- Agree and set learning outcomes (learning objectives) for the session
- See 2 (or more) patients
- Revisit learning outcomes and plan for the next session, stress punctuality
- Agree communication between sessions (email, mobile etc)

**2nd/3rd**
- Welcome
- Discuss and set learning outcomes for the session
- 2 (or more) patients
- Revisit learning outcomes
- Plan for next session
- Session 3 - Ask students to complete the checklist and self assessment form and to bring this to the final session

**4th**
- Welcome, find out how they are getting on
- Agree and set learning outcomes, run session with 2 (or more) patients as before
- Revisit learning outcomes
- Individual feedback session including planning learning for next attachment. Students should have completed a self assessment form and a checklist. They can add useful information to the discussion. Encourage them to write down your feedback.

- Complete the Attendance & Payment Form and return to the Teaching Office (pg 83)
- All Students to complete the Student Evaluation Form and teacher to return these to the Teaching Office with the Attendance & Payment Form (pg 84)
Transitions
In years 1 and 2 most teaching is lecture based. This means that learning may be quite passive. This type of learning is ill suited to the clinical environment. In Year 3 students need to actively identify their own learning needs and plan how to meet them. The small group GP sessions can help them make that transition.

How much clinical knowledge and experience the students will bring to your sessions depends when in the year your group is starting. At the beginning of Year 3 students will not have had any patient contact since their last clinical week in May, i.e. they will not have taken a history or examined a patient for 4 months or even 16 months if they intercalated.

What you can do to help the students reconnect with their clinical skills and making the transition from lecture based teaching to learning in the clinical environment

- Be aware of the Year 2 core curriculum for the clinical weeks in Year 2 (see appendix). This will tell you what clinical skills they have covered in Year 2
- Build ‘revision time’ into the timetable for your first session
- Email students before the session with information regarding the patients you are going to invite
- Ask students to revise specific skills, medical conditions etc prior to the session
- Invite students to self assess their skills – it might be useful for them to use the self-assessment checklist (copy in the student guide, see also this appendix)
- Discuss and agree learning objectives with your students at the start of each session
- Revisit learning objectives at the end of each session and prompt students to note key learning points and their reflections in the GP patient log (in their guidebook and in this appendix)
- Help students to plan further learning to build on the patients seen
- You may want to share your own learning experiences and preferences with your students, for example how do you manage your PUNs and DENs, what helps you learn, learning resources – books, websites, online learning modules, workshops, discussions with colleagues etc.
- Ask ‘higher level’ questions. Move from asking knowledge questions to encouraging students to apply their knowledge and evaluate it against real patient stories.

Applying Bloom to COPD

- Knowledge: List signs of COPD, name drugs used in the treatment of COPD
- Comprehension: Explain how Salbutamol improves symptoms in COPD
- Application: What medication would you prescribe for this patient with COPD?
- Analysis: Why is this medication not working in this patient?
- Synthesis: Finding a compromise between patient preference and recommended treatment
- Evaluation: What would be the most cost effective way of managing this patient with COPD?
Connecting up with clinical learning from Year 2

Please remember that when they come to you in September most students will not have taken any histories or examined patients since the end of May 12 or even May 11 if they intercalated. It may be helpful to revise some of the principles of history taking, consultation and examination skills (having a system, not ignoring cues, exploring symptoms in full, looking and noticing before laying hands on the patient etc).

For your information the appendix has learning objectives from the Year 2 ‘Introduction to Clinical Skills Course’ and the Cambridge Calgary Guide (CCG) which provides the structure for consultation skills teaching in Year 2. Please use the ‘language’ and structure of the CCG when feeding back on the students’ consultation skills to provide continuity in their teaching.

Choosing patients, flexible learning and ‘progression’

You need to gauge the learning challenge in your sessions to the stage the students are at in Year 3 and to the ability of your individual groups. For example, in the first session you may want to tell the students in advance via email what problems the patients have whom they will be seeing in their next session and ask them to read up about history taking, examination and conditions relevant to those patients.

You may want to progress to not giving any prior information for the last two or three sessions. This would be more challenging but also better preparation for being a doctor seeing patients in casualty or General Practice.

Please discuss these different options and the students’ specific learning objectives with your students and plan the sessions accordingly. Students really appreciate practicing skills such as using an otoscope or ophthalmoscope.

During the MDEMO and Psychiatry Units we would like you to invite patients with conditions relevant to that Unit.

Junior Medicine and Surgery

For the four sessions during this Unit we would like you to invite at least 8 patients. Four to five of these patients should have one or more of the following conditions. You are free to choose the other patients for the sessions in this Unit.

- Hypertension
- Cerebrovascular disease (stroke, TIA)
- Ischaemic heart disease (Angina, MI, heart failure)
- Diabetes
- COPD/Asthma

There are two main reasons for asking you to provide students with the opportunity to see patients with these conditions

- We need to know that students will have seen patients relating to these learning objectives so we can base the Primary Care OSCE exam on that
- It is very important that students develop solid knowledge and skills for understanding and managing these conditions

Mixed groups

Only very rarely, for administrative reasons and shortages of placements do we occasionally have to mix students from different Units and place them as one group with a GP. This could mean that students may be learning about musculoskeletal problems in General Practice while being on the Psychiatry Unit at the hospital. Students have been asked to be flexible, they can learn something from every single patient encounter whether they were prepared for it or not.
Giving and receiving feedback

To maximise learning and make it enjoyable it is essential that teachers know how to give feedback. The following summarises evidence based guidance for good feedback giving. It is essential that you are familiar with these rules and follow them.

Students, just as teachers, are keen to know how they are doing. Feedback needs to be given in a constructive and timely way that allows students to accept and consider it.

It is important to clarify with each group of students at the beginning of the first session how and when feedback will be given.

- Regular and frequent feedback to individual students and the whole group during each session.
- We would like you to give brief individual feedback to each student at the end of the final session. To help you and your students to make this as relevant and effective as possible we have asked the students to complete a self-assessment form and to bring this to the final session. Please remind them at the end of session 3 to bring this form. A sample of this form is in the Appendix.
- Please encourage the students to write down your feedback on their form, or you may want to write this yourself.
- Some students say they prefer group feedback to individual feedback. Please insist on individual feedback as there are few opportunities for them to experience this. It will help to prepare them for future feedback situations, for example professional appraisals.

Students learn much from their peers and it is therefore important to encourage the students to be specific in the feedback they give to each other. Giving feedback can be learned as a skill and it may be helpful to discuss effective feedback giving with the students in their first session with you. Students also have the ‘good feedback rules’ in their GP attachment handbook.

Feedback rules

Educational research has crystallised out some basic rules for effective and non-threatening feedback giving. The following is a brief summary of those evidence based rules.

**Giving feedback**

- Well timed
- Be descriptive
- Be specific
- Direct feedback at behaviour that can be changed
- Check understanding
- Check group understanding

**Receiving feedback**

- Listen carefully
- Accept the feedback as genuine
- Consider the feedback
- Tell giver of the feedback how they can help
- Thank the person giving you feedback

**Good practice when giving feedback**

- Be non-judgemental
- Offer your observations (not assumptions or personal comments)
- Offer ideas rather than advice
- “Sandwich” negative feedback
- End feedback session on a positive note
- Be aware of your body language; is it leaking a message that is different to the verbal one?
Examples

- Based on direct observation
  - Poor: “Dr. X said you spend time taking a careful history yesterday....”
  - Good: “I noticed that you allowed the patient a lot of time to....”

- Phrased in as non-evaluative language as possible
  - Poor: “Your history taking was poor...”
  - Good: “I noticed that you did not ask the patient about side effects...”
    “I noticed that you did not make eye contact with the patient...”
    “I noticed that you interrupted the patient several times...”

- Specific not generalised
  - Poor: “You seem to have a problem establishing rapport with your patient...”
  - Good: “I noticed that you do not greet your patients at the start of the consultation....”
    “I noticed that you looked at your notes and not the patient for most of the interview

- Focused on behaviour not personality
  - Poor: “You are very paternalistic with your patients....”
  - Good: “I noticed that you chose the treatment option for your patient....”

Asking students for feedback on the organisation and delivery of your teaching

Students are generally unschooled in giving feedback and may be reticent to do so and as GP teachers we may be anxious about possible criticism and antagonism. A relaxed atmosphere facilitates feedback.

Request feedback early

- Early requests convey to the students that their contributions are expected and welcome

Creating a supportive atmosphere

- Asking for feedback in itself can help to foster a relaxed atmosphere
- Questions such as “how are your studies going?” show interest and foster a sense of shared endeavour.

leading by example – start with self-evaluation

(“I demonstrated the whole examination, what did you think about that....”)  
- It can introduce non-judgemental language
- It can focus on behaviour rather than personality
- It shows openness to feedback
- It provides a starting point

Sticking to specifics

- Begin the discussion with particular elements of the teaching in mind “I am not sure that I made it really clear how to use the ophthalmoscope?”
- Ask about the effect of a particular teaching technique “With this patient two of you took the history. What did you think about doing it that way?”

Evaluate the feedback

- Evaluate feedback before you act on it
- Important points can be clarified by restating them
- Comments from one learner can be put into perspective by asking others

Complete the loop

- Potentially useful suggestions can be incorporated into the teaching and re-evaluated

How to make sure that you get student feedback

- Students to complete the teaching evaluation form at the end of their final session in your practice, put them in an envelope and seal it (confidentiality)
- You need to give your students a SAE for posting the forms
- Teaching Office will return collated and individual results to you twice a year.
Feedback - More thoughts and tips  FB = ‘Catch someone doing something right’

Research shows that learners expect FB but also ignore it. If they receive a good mark ‘smile and file’. If they receive a bad mark ‘bin and forget’.

Feedback should
- Help learners to make sense of what they have done
- Clarify and help learners take ownership of the need to learn
- Ideally enhance learners ‘want’ to learn
- Help learners to move forward into their next episode/stage of learning and apply and integrate the past learning into future learning
- Feedback gained while they were teaching or assessing or feeding back to peers can help enormously with their own learning

Feed-forward
- Details of what they could have done better to help them apply that with their next attempt
- Praise relating to what they did well so they continue doing it
- Direct suggestions what to try out to overcome difficulties
- Suggestions about sources to explore

Using FB to make learning happen
- Help learners to want FB
- Timing
  - ‘This is how I saw you when you started, this is how I see you now.’
  - Provide learners with a list of feedback comments given to other students in a similar situation prior to the learning event
- Make it interesting
- Give at least some FB straight away
- Get learners to look back positively after receiving your FB – identify most successful part
- Link FB directly to intended learning outcomes
- Provide most of the feedback at the beginning – scaffolding approach
- Be aware of the language you use – avoid being judgemental
- Ask learners to build on your feedback, how did they incorporate your FB from last time into this learning event
- Ask learners to respond selectively to your feedback by starting a reflection with one of the following sentences or similar
  - The part of the feedback that puzzles me the most...
  - The comment that rang the truest for me was...
  - I don’t get what you mean when you say...
  - I would welcome some advice on...
- Create opportunities to help student make informed judgements about their own learning – self assessment. Self assessment all the time
- Recognise that learning by doing is how it happens
- Think questions – any important concepts is just the answer to a quest
Learning objectives in Primary Care

General learning objectives
By the end of the GP sessions students should have
1. Been observed practicing clinical skills and received feedback from peers and your GP teachers
2. Understood the relationship between medical history taking and consultation skills
3. Gained experience with common clinical problems and chronic conditions which are mainly managed in Primary Care
4. Practiced clinical reasoning and making a diagnosis
5. Developed knowledge of appropriate investigations and initial management of common conditions.
6. Developed knowledge of medications used for common conditions including contraindications and common side effects
7. Reflected on and deepened your understanding how social, psychological and environmental factors interact with physical health
8. Discussed and reflected on how presentations and management approaches differ between hospital and Primary Care and how longitudinal care differs from acute management
9. Gained some understanding of the skill mix and inter-professional working in General Practice
10. Added to your knowledge and experience of the vertical themes
11. Participated in self-assessment and the feedback process and reflected on your own learning, including learning styles

The main focus is on the consolidation and extension of clinical skills. In addition we would like students to acquire sound knowledge about some chronic diseases.

Learning objectives for common chronic diseases and their management
The chronic diseases listed above are all huge topics. To help students learn how to manage patients with these conditions we have described learning objectives and produced succinct summaries for these conditions.

This material is not exhaustive and students need to be advised to read them in conjunction with textbooks, hospital based teaching and resources in Blackboard and Hippocrates.

CAPS logbook (Communication and procedural skills)
This logbook details the 32 practical and diagnostic competencies described in the GMC document ‘Tomorrow’s Doctor’ which you can find at http://www.gmc-uk.org/TomorrowsDoctors_2009.pdf. The other driver for this logbook was the request from Trusts for evidence that new doctors would have these competencies. Students need to be observed and signed off for these competencies.

Some competencies are part of teaching for certain conditions, for example Peak Flow measurements in Asthma. Students may be very keen to have their competencies signed off. This should not dominate the GP teaching sessions and should not be done instead of history taking and examination. The students will have many opportunities over the five year course for being signed off.
Cardiovascular risk assessment and QOF
We also feel that students need to have a good grasp of cardiovascular risk assessment and a general idea of QOF (quality outcome framework) and its purpose. Students do not need to know any detailed QOF criteria.
Please teach your students how and when you carry out cardiovascular risk assessments, how you communicate risk to the patient and how you and your patients manage it.

Suggested teaching topics
This is a list of suggestions for General Practice based teaching. They tend to be more chronic or stable conditions. Possible teaching areas are grouped in rows (Complaint – Condition – Skill). If there is an area you would especially like to cover, discuss this with your GP and your group.

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Condition</th>
<th>Relevant Clinical Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>Hypertension</td>
<td>Cardiovascular examination</td>
</tr>
<tr>
<td>Ankle swelling</td>
<td>Angina/MI</td>
<td>Respiratory examination</td>
</tr>
<tr>
<td>Leg pains on walking</td>
<td>Cardiac Failure</td>
<td>Taking a pulse and BP</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>CCF</td>
<td>Measuring ABPI</td>
</tr>
<tr>
<td>Ear discharge</td>
<td>Chronic Otitis Media</td>
<td>Using an otoscope</td>
</tr>
<tr>
<td>Blocked nose</td>
<td>Allergic Rhinitis</td>
<td>Applying nose drops</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Irritable Bowel Syndrome</td>
<td>Abdominal examination</td>
</tr>
<tr>
<td>Heartburn</td>
<td>Gastro-oesophageal Reflux</td>
<td></td>
</tr>
<tr>
<td>Tiredness</td>
<td>Hypothyroidism</td>
<td>Screening questions for depression</td>
</tr>
<tr>
<td>Thirst, high sugars</td>
<td>Diabetes</td>
<td>Blood glucose testing</td>
</tr>
<tr>
<td>Tremor</td>
<td>Parkinson’s Disease</td>
<td></td>
</tr>
<tr>
<td>Tingling legs</td>
<td>Multiple Sclerosis</td>
<td></td>
</tr>
<tr>
<td>Facial or limb weakness</td>
<td>TIA/Stroke</td>
<td></td>
</tr>
<tr>
<td>Vertigo</td>
<td>Menières Disease</td>
<td>Using an otoscope</td>
</tr>
<tr>
<td>Dizziness</td>
<td>BPPV</td>
<td>Measuring BP</td>
</tr>
<tr>
<td>Nausea</td>
<td>Chronic Renal Failure</td>
<td>Dipstick urinalysis</td>
</tr>
<tr>
<td>Joint pain</td>
<td>Osteoarthritis</td>
<td>Hip examination</td>
</tr>
<tr>
<td>Stiff shoulders</td>
<td>Polymyalgia Rheumatica</td>
<td>Knee examination</td>
</tr>
<tr>
<td>Back pain</td>
<td>Mechanical Back Pain</td>
<td>Spine examination</td>
</tr>
<tr>
<td>Spinal deformity</td>
<td>Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Poor vision</td>
<td>Macular Degeneration</td>
<td>Using an ophthalmoscope</td>
</tr>
<tr>
<td></td>
<td>Cataracts</td>
<td></td>
</tr>
<tr>
<td>Crying all the time</td>
<td>Depression</td>
<td>Risk assessment</td>
</tr>
<tr>
<td>Unable to sleep</td>
<td>Anxiety</td>
<td>PHQ-9 questionnaire</td>
</tr>
<tr>
<td>Hearing voices</td>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Forgetting things</td>
<td>Dementia</td>
<td>Mental state examination</td>
</tr>
<tr>
<td>Alcohol/drug abuse</td>
<td></td>
<td>Mini-mental state exam.</td>
</tr>
<tr>
<td>Unable to lose weight</td>
<td>Obesity</td>
<td>CAGE/AUDIT questionnaire</td>
</tr>
<tr>
<td>Stress</td>
<td>A carer, redundancy, resources</td>
<td>Calculating BMI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Four principles ethics</td>
</tr>
</tbody>
</table>
Teaching prescribing
From 2013-14 onwards final year students will have to pass the **national prescribing skills assessment**. This should ensure systematic testing of prescribing knowledge and focus learning and teaching to make sure that newly qualified doctors are safe prescribers.

Here is a sample question from the exam

![Sample Question](image)

**Question A**
Identify the ONE prescription that is *most likely* to be a cause of his sore mouth. *(mark it with a tick in column A)*.

**Question B**
Identify the THREE prescriptions that are *most likely* to be contributing to his low blood pressure. *(mark them with a tick in column B)*.

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**Teaching prescribing – Top tips from the small groups**
At the summer teaching workshop in June this year we discussed in small groups how we could best teach prescribing in years 1-5 in General Practice. The following practical teaching tips came out of that workshop.

**The BNF**
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:

- 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
- Go through some chapters with a marker pen and 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.
- Go through the BNF and teach them how to use it with patients, in exams and for revision
General teaching principles for teaching prescribing

- Keep it relaxed
- Assess students particular learning needs
- Teaching should make things simple – stick to simple drugs
- Need to give them structures and frameworks, hooks to hang knowledge on because structure less information is hard to retain and use, i.e. start with classes of drugs, names with classifiable endings (-olos, -prils)
  - Provide structures
- Good for them to have authentic experiences, get them involved in actually writing a 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
- Teach details for common things
- Asking questions
  - How is this drug used?
  - How does this drug work?
  - Tell me about a drug for HT and 2 side effects

Teach the bigger picture

- 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 there 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
- Medicine mx teams/clinical pharmacists
- Invite students to search for the evidence on a particular prescribing situation and report back to other students/tutor or practice team
- Give them an electronic copy of your practice/PCT formulary
- Ethics
  - As 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

Prescribing

- 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 3

- Ask them what they already know about medication
  - What painkillers do you know?
- 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
- 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
- Review patient list of medications – any interactions / cautions etc - in surgery or after
- 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

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

10 Stages of Prescribing

You may find it a useful exercise to give each student a copy of the form on the next page and ask them to have a go at completing it for a patient. Early on in their Unit they may have little knowledge of drugs and you could do this as a group exercise to pool knowledge. When they are more experienced, especially at the end of the longer Junior Medicine and Surgery Unit they could have a go individually and then discuss the result.

Here are some practice scenarios (if you have time)

**Patient 1**
65 year old retired postman, overweight, diagnosed 3/12 ago with Type2 Diabetes mellitus. He has made some changes to his diet including reducing sugar. He has not increased his physical activity, doesn’t like sport. His fasting sugar is usually 15 and his HbA1c is 74.9 (9mmol/l).

**Patient 2**
A 72 year old black Afro-Caribbean retired lawyer was found to have a BP of 180/108 when he came for his routine Asthma check. His ABPM was 160/98 (see chapter on Hypertension how to diagnose HT)
Patient 3
A 47 year old female bank clerk had been found to have a BP of 182/108 when she attended for a cervical smear test. Her ABPM is 169/100 (see chapter on Hypertension how to diagnose HT)

Patient 4
A 62 year old cleaner who had taken early retirement because of COPD attended with shortness of breath, increased cough and brownish/greenish thick phlegm. Temp. 38, P100/regular, Chest examination: resonant with scattered wheezes, Peak flow rate 160 (260 when her chest is good). Current medication Salbutamol MDI 2 puffs prn, Seretide 500 Accuhaler 1 puff bd.

10 Stages of Prescribing

<table>
<thead>
<tr>
<th></th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Make a diagnosis</td>
</tr>
<tr>
<td>2</td>
<td>Establish therapeutic goal</td>
</tr>
<tr>
<td>3</td>
<td>Choose therapeutic approach</td>
</tr>
<tr>
<td>4</td>
<td>Choose the drug</td>
</tr>
<tr>
<td>5</td>
<td>Choose dose, route &amp; frequency</td>
</tr>
<tr>
<td>6</td>
<td>Choose duration of therapy</td>
</tr>
<tr>
<td>7</td>
<td>Write prescription</td>
</tr>
<tr>
<td>8</td>
<td>Inform the patient</td>
</tr>
<tr>
<td>9</td>
<td>Monitor drug effects</td>
</tr>
<tr>
<td>10</td>
<td>Review/alter prescription</td>
</tr>
</tbody>
</table>

From British Pharmacological Society 2012
Prescribing (info page from the Year 3 GP student guidebook)

You may have heard from more senior students that a national prescribing exam is being trialed. When you get to Year 5 this will be mandatory. The purpose of this national exam is to ensure that newly qualified doctors have a sound grasp of common medications and are safe prescribers when they start their F1 posts.

You will have been given a BNF and will have noticed that it has been printed on very thin paper, has very small print and weighs in at about 668g (Sept.11 edition). There is an awful lot of information in this book! The good news is that you don’t need to know all of it by heart. But you do need to develop a good grasp of what safe prescribing means, common drugs and their indications, contraindications, precautions and side effects.

Here are some suggestions to develop your prescribing skills and knowledge

- Please take a good look at your BNF. It has masses of concise essential information including how to write a prescription, brief summaries of NICE guidance for certain conditions, prescribing in special situations, i.e. pregnancy, renal failure etc and much more. It is really helpful to take an hour early in Year 3 and leaf through the pages so you know how it is organised and how to look up information.

- When you clerk a patient get a full list of medications including over the counter medication (OTC) and look up the drugs in your BNF
  - What are they for?
  - What class of drugs do they belong to?
  - Common side effects?
  - Monitoring requirements?
  - Precautions and contraindications? Any monitoring blood tests needed?

- Have an in depth conversation with the patient about the medication
  - How is the patient taking them?
  - Is the patient taking it as prescribed?
  - Any side effects?
  - What concerns does the patient have about the medication?

Try and do this for each patient you clerk. It won’t take too much time looking up the drugs and the knowledge will stick better because you are associating it with a specific patient. You will gradually build up a good knowledge base of drugs for common conditions and begin to recognise what class a drug belongs. You are not expected to know all drugs in detail but need to be familiar with drugs commonly used and their commonest side effects.

Using the BNF

Please read the relevant chapter in the BNF for each chronic disease you encounter in a patient. There is a lot of information there incl. NICE guidelines for some of them. You do not need to remember fine detail at this stage but it will give you a good overview of medications used for these conditions.

There are more drugs listed in the BNF than you will find in common use.

Task – In relation to the chronic conditions you will encounter discuss with your GP or hospital teacher which drugs are most commonly used and why. Considerations may be cost, side effect profile, interactions with other drugs, patient issues, i.e. renal failure etc.
Hypertension

Learning objectives

Skills - You should
- Be able to take a comprehensive cardiovascular history
- Be able to perform a competent cardiovascular examination
- Be able to assess cardiovascular risk
- Be able to competently assess a pulse and take a blood pressure reading
- Be able to explain HT to a patient without using jargon

Knowledge – You should
- Understand the importance of detecting and treating hypertension
- Have an understanding of some of the common causes of hypertension
- Be able to investigate a patient with raised BP appropriately
- Be able to diagnose Hypertension on the basis of BP readings
- Have an understanding of what malignant hypertension is and be aware that this is a medical emergency
- Be able to outline the management of hypertension including commonly used medications
- Know which different drugs we use as first, second, third and fourth line dependent on the patient’s age and ethnicity (NICE guidelines)
- Know examples of the main classes of drugs used to treat hypertension as well as their common contraindications, side effects and blood monitoring (if indicated)
- Have an understanding of “treating to target” and what those targets are
- Know when to consider starting statins in a hypertensive patient
- Be able to outline how HT should be monitored
- Be aware that there are QOF points available for meeting treatment targets

Why it is important for us to know about hypertension
It is a major risk factor for cardiovascular disease and is often asymptomatic until it has caused end organ damage. It is very common and the aim is to detect and treat before any end organ (heart, brain, kidneys, eyes) damage can occur. The higher the blood pressure, the greater the cardiovascular risk. Patients sometimes struggle with being told they are hypertensive as they often have no symptoms. You need to be able to explain that hypertension does not mean they are ill but that we need to treat it to reduce their risk of having a serious problem (i.e. stroke etc.) later.

How to measure blood pressure
  - The patient should be at rest. Seat the patient and support their arm at the level of the heart
  - Use a right size cuff. If the cuff is too small the measured BP will be falsely higher
  - Measure BP in both arms (use arm with higher measurement for future readings)
  - Measure when standing as well if any symptoms suggest postural hypotension
  - Systolic is the level at which the sounds appear, diastolic is the level at which the sounds disappear completely
  - Use a calibrated sphygmomanometer

For more information on validated BP measuring devices, how to take BP with different devices, the right cuff sizes and a tutorial go to http://www.bhsoc.org//index.php?cID=162 accessed 1.8.13
Should we measure BP in both arms?
Definitely yes, when you take the BP for the first time in a patient. Research has shown that an interarm difference of ≥10mmHg predicts increased all cause mortality and cardiovascular events (BMJ2012;344:e1327)
Measuring BP in both arms should be part of a cardiovascular assessment (Lancet 2012;379;872)
For follow up measurements and monitoring of patients on anti hypertensive treatment measure BP in the arm with the higher reading.

How to diagnose HT
Some patients feel quite nervous when they have their BP measured and the BP can be falsely raised. This is called “white coat hypertension” which has a prevalence of around 10%. This makes it tricky to diagnose HT in clinic settings and can lead to overtreatment of blood pressure. Therefore new guidelines for making a diagnosis of HT have been developed.
You can read the guidelines at http://www.nice.org.uk/nicemedia/live/13561/56015/56015.pdf accessed 1.8.13

A good investment of learning time
Taking and interpreting BP and taking action (investigating and prescribing) is a common and important job we do. It is therefore essential that you have a firm understanding how to take a BP, how to interpret the results and when to diagnose HT. We suggest that you read the above NICE quick reference guide. It is clearly written and easy to read.

If the first reading is ≥140/90 repeat the reading. If this is still ≥140/90 offer ABPM (ambulatory BP monitoring) or HBPM (home BP monitoring).

Stage 1 hypertension
Clinic blood pressure is 140/90 mmHg or higher and subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg or higher.

Stage 2 hypertension
Clinic blood pressure is 160/100 mmHg or higher and subsequent ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher.

Severe hypertension
Clinic systolic blood pressure is 180 mmHg or higher, or clinic diastolic blood pressure is 110 mmHg or higher.

If HT is not diagnosed offer to measure the patient’s BP every 5 years

Causes
- Unknown/ essential hypertension (up to 95%).
- Renal disease (chronic pyelonephritis, diabetic kidney disease, glomerulonephritis etc)
- Commonest cause, least amenable to treatment
- Endocrine diseases (Primary Hyperaldosteronism (low K⁺ high Na), Acromegaly, Cushings, Phaeochromocytoma etc.)
- Pregnancy
- Coarctation of the aorta
- Connective tissue disorders (scleroderma, vasculitis)

Examination and investigations to look for causes of HT and to identify end organ damage
Examination: BP, heart size, heart sounds, look for any evidence of heart failure, check peripheral circulation, examine fundi
Bloods: FBC, U&E, glucose, lipid profile, urine dip for blood and protein, consider GGT if excess alcohol consumption
ECG 12 lead ECG, look for LVH (left ventricular hypertrophy)
Some patients need additional investigations such as an Echocardiography
Management of hypertension

- Education (explaining HT, the causes and risk factors and what can be done)
- **Non drug treatments** such as smoking cessation, weight loss, decreasing alcohol, salt and caffeine intake, increasing fresh fruit and vegetables, relaxation and stress management
- Complete a formal cardiovascular risk assessment for the patient, see page 34
- Treat modifiable risk factors for cardiovascular disease
- Medication

**DASH diet** (Dietary Approaches to Stop Hypertension)
The DASH diet is a diet low in sodium and fat and rich in fruit and vegetables. A trial showed impressive reductions of BP on this diet – 11.4 systolic and 5.5 diastolic (NEJM2010;362;2102).
In this study the aim was to keep Sodium <2.3g/day=5.8g of salt/day
The authors of this trial concluded that ‘borderline hypertensive’ patients should have a 6 months trial of lifestyle changes before starting medication.

**Advice on salt for patients**
- 80% of dietary salt is hidden in processed food. Bread, cereals and table sauces tend to be high in salt.
- Advise patients to read food labels and look for <300mg salt/100g

**When to start medication for HT**

### Stage 1 hypertension
Offer antihypertensive drug treatment to people aged under 80 years with stage 1 hypertension who have one or more of the following:
- Target organ damage (retinopathy, proteinuria etc)
- Established cardiovascular disease (MI, stroke etc)
- Renal disease
- Diabetes
- A 10-year cardiovascular risk equivalent to 20% or greater.

### Stage 2 hypertension
Offer antihypertensive drug treatment to people of any age with stage 2 hypertension. For people aged under 40 years with stage 1 hypertension and no evidence of target organ damage, cardiovascular disease, renal disease or diabetes, consider seeking specialist evaluation of secondary causes of hypertension and a more detailed assessment of potential target organ damage. This is because 10-year cardiovascular risk assessments can underestimate the lifetime risk of cardiovascular events in these people.

### Severe hypertension
Consider starting antihypertensive drug treatment immediately, without waiting for the results of ABPM or HBPM, for people with severe hypertension.

Refer people to specialist care the same day if they have: – accelerated hypertension (blood pressure usually higher than 180/110 mmHg with signs of papilloedema and/or retinal haemorrhage) or – suspected phaeochromocytoma (labile or postural hypotension, headache, palpitations, pallor and diaphoresis).

Consider the need for specialist investigations in people with signs and symptoms suggesting a secondary cause of hypertension.

For a simple flow diagram of when to treat HT see page 6 of the NICE HT guideline at [http://www.nice.org.uk/nicemedia/live/13561/56015/56015.pdf](http://www.nice.org.uk/nicemedia/live/13561/56015/56015.pdf)
Treat to target

**Blood pressure targets**

Clinic blood pressure
- People aged under 80 years: lower than 140/90 mmHg
- People aged over 80 years: lower than 150/90 mmHg
- In patients with diabetes, chronic renal disease or established CVD aim for <130/80 (these are NICE guidance targets).

Daytime average ABPM or average HBPM blood pressure during the person’s usual waking hours
- People aged under 80 years: lower than 135/85 mmHg
- People aged over 80 years: lower than 145/85 mmHg

**Medications used for treating Hypertension**

Four different classes of anti-hypertensive medication
- Calcium channel blockers (Amlodipine, Felodipine…)
- Thiazide diuretics (Indapamide, Chlortalidone)
- ACE inhibitors (Ramipril, Lisinopril, Perindopril…)
- ARB Angiotensin II receptor blockers (Losartan, Candesartan…)

Please read the BNF sections about these different classes of drugs. With some of them it is easy to know what class they belong to as the names have the same ending, i.e. -pril. Get to know the commonest side effects for these classes of drugs and any precautions and monitoring requirements. Carefully check the lists of drugs for the patients you are clerking and look up any drugs you don’t know. This will help you to familiarise yourself with the medication for the common chronic conditions.

When you are clerking patients, ask them about their medication. What are they taking? How is the medication affecting them? How do they feel about taking medication? How do they remember to take it? What is the most difficult thing about taking medication for them?

Try and answer the following questions
- What factors increase adherence to taking medication?
- What factors interfere with adherence to taking medication?

Few patients’ BP is controlled on only one drug, most will need more. The following shows the currently advised algorhythm for choice of drugs.

**Summary of antihypertensive treatment**

<table>
<thead>
<tr>
<th>Step</th>
<th>Age &lt;55</th>
<th>Age &gt;55 Or black person of African or Caribbean descent of any age</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>A</td>
<td>C</td>
<td>A – ACE inhibitor or angiotensin II receptor blocker (ARB)</td>
</tr>
<tr>
<td>Step 2</td>
<td>A+C</td>
<td></td>
<td>D – Thiazide-like diuretic</td>
</tr>
<tr>
<td>Step 3</td>
<td>A+C+D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 4</td>
<td>Resistant HT</td>
<td>A+C+D+ consider further diuretic, alpha blocker or beta blocker</td>
<td>Consider seeking expert advice</td>
</tr>
</tbody>
</table>

Don't give ACE and ARB together
Follow up

Once blood pressure is controlled, a patient with Hypertension needs at least annual reviews. At the annual review

- Discuss symptoms and medications
- Reinforce non drug treatments – lifestyle factors
- Pulse (check for arrhythmias, especially AF)
- BP
- Look for signs of end organ damage
  - Eyes – check fundi for changes secondary to HT, for example ‘av nipping’
  - Kidneys – test the urine for blood and protein
  - Heart – exam: check for enlargement, ECG if indicated: Left ventricular hypertrophy
  - Brain – check history for TIA/Stroke, if positive carry out appropriate neurological examination
- Assess and treat other modifiable CVD risk factors (i.e. cholesterol, smoking)
- Blood test for U+E, Cholesterol, others if indicated

Cutaneous markers of increased cardiovascular risk

BMJ2011;343:d5497
This study asked whether cutaneous lipid based deposits (xanthelasma and arcus senilis) were predictive of higher cardiovascular risk.

<table>
<thead>
<tr>
<th>Xanthelasma</th>
<th>Arcus senilis</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Xanthelasma" /></td>
<td><img src="image2.png" alt="Arcus senilis" /></td>
</tr>
</tbody>
</table>

Results: Xanthelasma are predictive of higher cardiovascular risk independent of blood lipid levels. In contrast, arcus is not an important predictor of risk.

QOF
There are QOF points available for diagnosing and treating HT

References
- www.nice.org.uk
  - Accessed 1.8.13
- British National Formulary
Cerebrovascular disease - Stroke and TIA

Learning objectives

Skills - Students should
- Be able to take a coherent history including assessing ability in activities of daily living and psychosocial factors.
- Be able to assess cardiovascular risk factors
- Be able to perform a complete neurological examination including cranial nerves
- Be able to assess the possibility of a stroke using the FAST model
- Be able to assess a possible TIA with the ABCD2 scoring system
- Be able to explain stroke and TIA in non-jargon language

Knowledge - Students should
- Know the typical presentation of a stroke and a TIA and differential diagnoses
- Be able to define stroke and TIA
- Have an understanding of how strokes are classified depending on pathogenesis (infarct vs. haemorrhage) and/or the specific anatomical area affected
- Be aware of current treatment guidelines for stroke and TIA
- Have an understanding of prognosis and the possible psychosocial consequences following a stroke or TIA
- Have an understanding of primary and secondary prevention and when treatment is indicated
- Be aware of QOF points in stroke/TIA management.

Stroke

Definition
Focal or global disturbance of cerebral function lasting for 24 hours or more or leading to death with no other apparent causes other than that of vascular origin

Statistics
- One in four people can expect to have a stroke if they live to 85 years
- Strokes account for 11% of deaths in England and Wales
- Around half of stroke sufferers are left dependent on others for everyday activities

Risk factors for infarction
Hypertension, diabetes mellitus, AF, previous CVA or TIA, previous MI, heart failure, artificial heart valves, hyperviscosity syndromes, smoking, alcohol, obesity, low physical activity

Classifications
85% caused by infarction i.e. atherosclerotic occlusion or emboli
- Posterior (vertebrobasilar) circulation (20%)
- Anterior (carotid) circulation (65%)
15% of strokes accounted for by intracerebral or subarachnoid haemorrhages (SAH)
- Primary cerebral haemorrhage (10%) High mortality, often poor functional outcome
- Subarachnoid haemorrhage (5%) High chance of early recurrent stroke
SAH – frequently fatal (10-15% die prior to reaching hospital). 70% due to Berry aneurysm rupture.

Rare causes of infarction: sudden drop in blood pressure, sickle cell crises, vasculitis, venous sinus thrombosis, carotid artery dissection.
Presentation
Sudden onset of central nervous system symptoms or stepwise progression of symptoms over a period of days. Conscious level may be normal or decreased. There will be neurological signs.
SAH Thunderclap headache, often occipital, with vomiting, possible LOC (loss of consciousness), sometimes seizures and possibly focal neurology

Triage – FAST quick check for diagnosing a stroke advertised to the public.
- F facial weakness (can they smile, has mouth or eye dropped)
- A rm weakness (can they raise both arms)
- S peech (can the person speak clearly and understand what you say)
- T ime (get help fast, get the person to hospital fast for consideration of thrombolysis)

Key examination
Pulse (rate and rhythm), BP, listen for heart murmurs and carotid bruits, assess consciousness level, exclude low blood sugar

Differential diagnosis
Space occupying lesion, trauma, epileptic seizure/post ictal, migraine, MS

Acute management
Admit to hospital, speed is imperative, needs imaging urgently to rule out a haemorrhage
Thrombolysis within 4.5 hours of onset of symptoms reduces death and long term disability. It has also been found that thrombolysis within 6 hours improved functional outcomes, including in patients aged >80. Lancet2012;379:2352

Patients should be admitted to a specialised stroke unit

Screen the person’s swallowing before giving any oral food, fluid or medication

Prognosis
Loss of consciousness at the time of stroke, severe motor deficit, cognitive deficit, lack of early improvement and poor swallowing ability after 3 weeks are poor prognostic signs.
Outcome tends to be worse in patients with diabetes, heart disease, previous stroke or disability, incontinence, visual or other sensory loss or an abnormal ECG.

After care needs to cover
Secondary prevention, psychosocial issues, aids and appliances, benefits, specialist rehabilitation, depression screen

Secondary prevention post ischaemic stroke

Antiplatelet therapy
- If in AF, for anticoagulation
- Otherwise Clopidogrel 75mg firstline
- Dipyridamole MR plus Aspirin if Clopidogrel contraindicated
- Dipyridamole MR alone if both Aspirin and Dipyridamole contraindicated

Statins
- Irrespective of cholesterol level

BP lowering
- Evidence supports offering antihypertensive therapy to all patients irrespective of their starting BP (PROGRESS trial- ACE and Indapamide), appropriate target 130/80
- Initiate 2/52 post stroke, do not lower BP acutely in CVA

Carotid endarterectomy
All patients without significant disability should have urgent (within a week) carotid imaging and offered surgery if stenosis of >50% in men and >70% in women
TIA

**Definition** Focal or global disturbance of cerebral function lasting less than 24 hours
- History of TIA gives you a 20% risk of stroke in the first 72 hours.
- Amaurosis fugax is a form of TIA due to emboli passing through the retina. It leads to a brief loss of vision described by patients as a “curtain descending”.

**In patients with ‘TIA’, if they have ongoing symptoms (>24 hours) however mild, treat as CVA and admit.**

**Risk scoring system for TIAs – ABCD2 score**
- **A**ge 1 point if 60 years old or more
- **B**lood pressure 1 point if systolic 140 or more or diastolic 90 or more
- **C**linical features 1 point for speech disturbance without weakness
  - 2 points for unilateral weakness
- **D**uration 1 point if 10-59 minutes, 2 points if 60 or more minutes
- **D**iabetes 1 point if diabetic

High risk score = 6 or more. Medium risk score is 4 or more. Low risk score 3 or less.

**How to manage patients with TIA**
1. Assess risk of stroke after TIA using the ABCD2 scoring system

<table>
<thead>
<tr>
<th>High risk of stroke</th>
<th>Lower risk of stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ABCD2 score of 4 or more</td>
<td>• ABCD2 score of 3 or below</td>
</tr>
<tr>
<td>• people with crescendo TIA’s</td>
<td>• presenting more than 1 week after symptoms have resolved</td>
</tr>
</tbody>
</table>

Specialist assessment within 24 hours of symptom onset, including decision on brain imaging (admission to hospital)

Specialist assessment within 1 week of symptom onset, including decision on brain imaging

If vascular territory or pathology is uncertain, refer for urgent brain imaging

If vascular territory or pathology is uncertain, refer for brain imaging

2. **Start daily aspirin (300 mg) immediately if not admitting the patient**
3. Introduce measures for **secondary prevention** as soon as the diagnosis is confirmed, including discussion of individual risk factors.

**Investigations**
- Bloods - FBC, renal and liver function, lipid profile, Plasma viscosity or ESR, glucose, clotting screen
- ECG, ECHO if indicated
- Brain imaging
- Carotid dopplers
Primary and secondary prevention of stroke and TIA

- Lifestyle measures – smoking, diet and obesity, alcohol, exercise
- Antiplatelet drugs
  - *Secondary prevention* – start once haemorrhagic stroke excluded
    - Give Dipyridamole MR 200mg bd and Aspirin 75mg Longterm
    - Aspirin alone if Dipyridamole not tolerated
- Anticoagulation
  - Primary prevention - start if identified potential causes of cardiac thromboemboli (rheumatic mitral valve disease, prosthetic heart valve, dilated cardiomyopathy, AF associated with valvular heart disease or prosthesis and possibly lone AF if high risk
  - Secondary prevention – all patients who have had a stroke and have persistent or paroxysmal AF or a major source of cardiac embolism should be anticoagulated
- Hypertension – treat to target as defined by NICE guidelines, no need to wait 2 weeks as in stroke patients
- Cholesterol – treat to target.
- Diabetes – treat to target.
- Carotid endarterectomy improves outcome in some patients

NB. Patients disabled following stroke are at risk of pneumococcal infection and influenza – offer annual influenza and five yearly pneumococcal vaccination
Atrial fibrillation and risk assessment

- AF is the commonest sustained cardiac arrhythmia you will see in clinical practice. Prevalence is estimated around 5% in 65 year olds and 10% in the >80 year olds.

**It is not a benign condition**

- AF confers a 5-fold risk of stroke, and one in five of all strokes is attributed to this arrhythmia
- CHADS\(_2\) is a tool for scoring and stratifying stroke risk in patients with AF
- AF is classified into 5 categories, each with particular evidence based management protocols.

**Principles of treatment**
- Rhythm or rate control
- Prevention of thrombotic complications

**Rhythm control**
- Medication – (Flecainide, Sotalol, Amiodarone)
- Cardioversion

**Rate control**
- Medication (βblockers, Calcium channel blockers or Digoxin)

AF can cause emboli which can lead to stroke and TIA. The degree of risk of embolic complications depends on what other risk factors may be present, i.e. high blood pressure. To stratify the risk for thrombotic events and the need for anticoagulation the CHADS\(_2\) criteria have been developed (a risk assessment tool)

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<thead>
<tr>
<th>CHADS(_2) criteria</th>
<th>Score</th>
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<tbody>
<tr>
<td>C Congestive heart failure</td>
<td>1</td>
</tr>
<tr>
<td>H Hypertension</td>
<td>1</td>
</tr>
<tr>
<td>A Age ≥ 75</td>
<td>1</td>
</tr>
<tr>
<td>D Diabetes mellitus</td>
<td>1</td>
</tr>
<tr>
<td>S(_2) Stroke or TIA</td>
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<table>
<thead>
<tr>
<th>Score</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>0=low risk</td>
<td>Start Aspirin</td>
</tr>
<tr>
<td>1=intermediate</td>
<td>Start Aspirin or Warfarin</td>
</tr>
<tr>
<td>2=high risk</td>
<td>Start Warfarin</td>
</tr>
</tbody>
</table>

**QOF points**
Points for primary and secondary prevention and offering vaccinations (influenza and pneumococcal)

**Prescribing**
Please note that some classes of drugs can be used for multiple indications, i.e. calcium channel blockers can be used for Hypertension, pulse rate control, Angina and some other indications

**References**
NICE guidelines quick reference guide for AF

Ischaemic heart disease and heart failure

Learning objectives and essential skills

Skills - Students should
- Be able to take a cardiac history including assessing acute chest pain and breathlessness
- Be able to perform a competent cardiovascular examination including assessment of JVP and measuring blood pressure
- Be able to assess cardiovascular risk

Knowledge - Students should
- Be able to diagnose and differentiate between different causes of chest pain including an MI, unstable angina, stable angina, oesophageal reflux
- Understand what is implied by the term acute coronary syndrome and be able to outline a management plan
- Be aware of appropriate investigations to assess chest pain
- Be able to spot major ECG abnormalities
- Be able to outline long term treatment following an MI
- Understand the difference between primary and secondary prevention and be aware of appropriate interventions
- Be able to outline management of an acute MI, stable angina and unstable angina
- Be able to appropriately diagnose heart failure and to understand investigations that may be helpful
- Be able to outline the management of heart failure.
- Be able to name examples of drugs used to treat MI, Angina and heart failure and also some common side effects, contraindications and any appropriate blood monitoring that is required.
- Be aware that QOF points are available for appropriate treatment targets.

Stable angina
Diagnosis is based on history and Investigations. The type of investigation depends on the estimated probability of coronary artery disease (CAD) being present.

Anginal pain
- Typical features
  - Constricting discomfort in the front of the chest, neck, shoulders, jaw or arms
  - Precipitated by physical exertion
  - Relieved by rest or GTN in about 5 minutes

Assessing probability of Angina
- People with typical angina have all the above anginal pain features
- People with atypical angina have two of the features
- People with non-anginal chest pain have one or none of the features

Patients may have associated palpitations, sweating and breathlessness and there will most likely be cardiovascular risk factors present

Factors making stable angina more likely (than a non-cardiac cause) include increasing age, male gender and the presence of cardiovascular risk factors, including smoking, diabetes, hypertension, dyslipidaemia, family history of premature CAD, a history of established CAD (e.g. previous myocardial infarction, coronary revascularisation), and other cardiovascular disease
Features which make a diagnosis of stable angina unlikely
- Chest pain is continuous or very prolonged
- Unrelated to activity
- Worse on inspiration
- Associated with symptoms such as dizziness, palpitations, tingling or difficulty swallowing

Symptoms that should prompt urgent hospital admission
- Pain at rest (may occur at night)
- Pain on minimal exertion
- Angina that seems to be progressing rapidly despite increasing medical treatment

Specifically ask for these symptoms in your history

Investigations
- The diagnosis of stable angina is based on clinical assessment alone or clinical assessment with diagnostic testing (i.e. anatomical testing for obstructive coronary artery disease (CAD) and/or functional testing for myocardial ischaemia).
- If there are typical features of angina based on clinical assessment and their estimated likelihood of CAD is greater than 90% further investigation is unnecessary and the patient should be managed as having angina.

The NICE guidelines for Chest pain of recent onset show a table for assessing the likelihood of CAD and flow diagrams for choosing the most appropriate investigation.
or http://www.nice.org.uk/guidance/cg95 then click Quick reference guide (PDF) acc. 29.8.13
(You are not expected to know the details of this guideline)

Treatments for angina
The management of angina includes modification of cardiovascular risk factors and specific treatment for angina. Treatment of angina should not wait for exercise testing or referral to a cardiologist, even if the drugs have to be stopped for the test.

Management of angina symptoms
- The patient must be informed of the diagnosis and its implications
- The patient should be advised that, when an attack of angina occurs, they should
  - Stop what they are doing and rest.
  - Use glyceryl trinitrate (GTN) spray or tablets as instructed
  - Take a second dose of GTN after 5 minutes if the pain has not eased
  - Take a third dose of GTN after a further 5 minutes if the pain has still not eased
  - Call 999 for an ambulance if the pain has not eased after another 5 minutes (i.e. 15 minutes after onset of pain), or earlier if the pain is intensifying or the person is unwell

Prevention of angina symptoms
- Offer either a beta-blocker or calcium-channel blocker as first-line treatment
- If the symptoms are not adequately controlled (or the patient cannot tolerate one option) consider switching to the other option, or using a combination of the two
- If a patient's symptoms are not adequately controlled on one drug and the other is either contra-indicated or not tolerated, consider adding
  - A long-acting nitrate.
  - Ivabradine (a selective inhibitor of sinus node pacemaker activity)
  - Nicorandil
  - Ranolazine (reduces myocardial ischaemia by acting on intracellular sodium currents)
Acute coronary syndromes (ACS) (MI and unstable angina)

You will learn more about the diagnosis and management of acute coronary syndromes in hospital.

If patients phone the GP surgery with symptoms suggesting an acute coronary syndrome GPs will advise them to dial 999 for an emergency ambulance. This is to reduce the time to thrombolysis should that be indicated.

MI
- Band like chest pain around the chest or central crushing chest pain/dull ache possibly radiating to shoulders, arms (mainly left arm), neck and/or jaw
- Associated nausea, sweating and/or SOB
- May have risk factors for CV disease (smoking, diabetes, dyslipidaemia, family or personal history of CV disease)
- Examination often normal but may be hypo- or hypertensive and may have signs of LVF
- ECG – typically ST elevation, may show arrhythmias see relevant textbook for ECG changes

Unstable angina
- Pain on minimal or no exertion
- Pain at rest or at night
- Angina which is rapidly worsening in intensity, frequency or duration

Differential diagnosis of acute chest pain
Pericarditis, dissecting thoracic aneurysm, PE, pleurisy, pneumothorax, oesophageal spasm or oesophagitis, other intra-abdominal causes, musculoskeletal pain, shingles, Bornholm’s disease (Coxsackie virus infection), idiopathic chest pain.

Acute treatment: MONA
M orphine/pain relief
O xygen (if sats<94%)
N itrates (GTN spray)
A spirin 300mg orally stat unless contraindicated
- Admit to hospital via 999. In hospital, investigations include serial ECGs and cardiac enzymes. Thrombolysis may be indicated
- In the community do an ECG if possible and send ahead or with the patient but do not delay transfer

Drug treatment following acute coronary syndrome - SAAB
- S tatin e.g. simvasatin
- A spirin
- A CE inhibitor e.g. ramipril
- B eta blocker e.g. atenolol
All have proven benefits to prevent future events.

Remember to tell the patient to inform the DVLA if they drive
Heart failure

Causes
Hypertensive heart disease, IHD, valvular disease, primary cardiac muscle diseases, high output states (i.e. chronic anaemia, hyperthyroidism, nutritional deficiencies).

Presentation
Symptoms - lethargy and fatigue, breathlessness, reduced exercise tolerance, orthopnoea, paroxysmal nocturnal dyspnoea, ankle swelling
Signs - peripheral oedema, crepitations at lung bases, raised JVP, increased adrenergic activity (tachycardic, cold clammy peripheries), hepatomegaly, pleural effusion, ascites

Diagnosis
Mainly clinical. Blood tests mainly to exclude other causes of symptoms (FBC, U and E’s, LFTs, TFTs, lipid profile, BNP or N-terminal pro-BNP), ECG, CXR, ECHO.

Classification
- ECHO - uses ejection fraction to grade severity
- NYHA – uses symptoms to grade severity (grade I to IV)
  At http://www.abouthf.org/questions_stages.htm accessed 22.8.13

<table>
<thead>
<tr>
<th>Class</th>
<th>Patient Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I (Mild)</td>
<td>No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnoea (shortness of breath).</td>
</tr>
<tr>
<td>Class II (Mild)</td>
<td>Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnoea.</td>
</tr>
<tr>
<td>Class III (Moderate)</td>
<td>Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnoea.</td>
</tr>
<tr>
<td>Class IV (Severe)</td>
<td>Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.</td>
</tr>
</tbody>
</table>

Management
- General advice – cardiac rehabilitation, vaccination (influenza and pneumococcal), inform DVLA.
- Non drug measures – diet and weight, smoking, alcohol, exercise, reduce salt
- Drug treatment.
  - Stage 1 – loop diuretic (such as furosemide) and ACE inhibitor (e.g. ramipril).
  - Stage 2 – add in beta blocker (such as Bisoprolol) and then possibly spironolactone
  - Stage 3 – increase loop diuretic and consider digoxin (digoxin should be first line treatment if heart failure is due to AF)
- If symptoms persist despite the above then refer. Loop diuretics just provide symptom control but all the other drugs offer prognostic benefits.

QOF Points are available for appropriate treatment and vaccinations if necessary.

References

NB. You need to be aware of examples of drugs used to treat cardiac conditions. You also need to be aware of common contraindications and side effects of these drugs. This information is not given here, please refer to the BNF
Type 2 diabetes

Learning Objectives

Knowledge - Students should
- Understand the basic mechanism of the disease and be aware of secondary causes
- Be able to diagnose type II diabetes on the basis of history and blood tests
- Be able to describe tests including random glucose, fasting glucose and the glucose tolerance test.
- Be able to give relevant lifestyle advice
- Be able to list possible complications from diabetes and know how to check for them
- Understand the importance of controlling blood pressure and cardiovascular risk factors
- Be able to list medication used in the management of Type2 DM, their common side effects and interactions
- Be able to list what tests and examinations are carried out at the annual DM check
- Understand the importance of patient education

Skills - Students should
- Be able to identify emergency and chronic presentations of type II diabetes
- Be able to assess cardiovascular risk
- Be able to use and interpret urine dipsticks
- Be able to carry out a finger prick test for glucose and interpret the result

Presentation

Acute: Ketoacidosis or hyperosmolar non-ketotic coma.

Sub-acute: Weight loss, polydipsia, polyuria, lethargy, irritability, infections, genital itching, blurred vision, tingling in hands/feet. Beware – can be a very slow insidious onset

With complications: Skin changes including necrobiosis lipoidica, neuropathy, nephropathy, arterial or eye disease

Asymptomatic: i.e. picked up on screening tests

Diagnosis This can be based on plasma glucose or HbA1c
- HbA1c of 48 mmol (6.5%)
- Random plasma glucose of ≥11.1mmol/l
- Fasting plasma glucose ≥ 7mmol/l
- Glucose tolerance test (GTT)
  - Glucose ≥ 11.1mmol/l 2 hours after 75g of glucose the patient is diabetic
  - 7.8mmol/l to <11.1mmol/l patient has impaired glucose tolerance
  - < 7.8mmol/l the patient is not diabetic

Causes
- Impaired insulin secretion and insulin resistance in the liver, adipose tissue and skeletal muscle.
- Secondary causes – drugs (steroids and thiazides), pancreatic disease (pancreatitis, surgery, cancer, haemochromatosis, cystic fibrosis), endocrine disease (Cushing’s disease, acromegaly, thyrotoxicosis, phaeochromocytoma), others (glycogen storage diseases, insulin receptor antibodies).
Treatment and treatment targets

Glucose and HbA1c
Aim for an HbA1c of 48 mmol (6.5%). Agree the blood glucose target with your patient.

- Education – Patients need to understand their condition and how they can best manage it
- All patients with Type 2 DM need lifestyle advice – diet, exercise, weight, smoking, alcohol
- Discuss that the patient needs to notify the DVLA if they are starting medication.
- There is an algorithm for the treatment of Type 2 DM which you can find on page 9 at http://www.nice.org.uk/nicemedia/pdf/CG87QuickRefGuide.pdf accessed 2.8.13

There is stepwise progression to treatment

1. Attempt to control the blood sugar with diet and other lifestyle measures
2. Add in Metformin (or Sulphonylurea)
3. Add second drug, a Sulphonylurea if you started with Metformin or add a DPP4 inhibitor (Gliptin) if Sulphonylurea not tolerated
4. Add insulin or Exenatide to Metformin and Sulphonylurea

NB. You should be aware of mode of action and common side effects of some drugs commonly used for Type 2 DM i.e. Biguanide (Metformin), Sulfonylurea (Gliclazide) and DPP4 inhibitors (Gliptins – Sitagliptin) Please refer to the BNF.

Glucose lowering – to what level? How tight should glucose control be?
- Several trials have looked at this
- Target of 59 (7.5%) is optimal if it is appropriate and achievable
- Lower levels may be appropriate for some individuals in the early stages
- Lifestyle change is always the first and also ongoing intervention

Blood pressure
- Blood pressure target
  - <140/80 if no complications
  - 130/80 if microalbuminuria, cerebral vascular disease or retinopathy present
- Lifestyle measures then add an ACE inhibitor then add in a calcium channel blocker or a diuretic or both if needed, next step would be an α blocker, β blocker or potassium sparing diuretic or all if needed and refer
- ACE inhibitors are thought to be extremely beneficial if microalbuminuria present.

Lipids
- Statins for most patients
- If <40 years and poor risk factor profile → offer statin
- If >40 years and Low cardiovascular risk → use CV risk calculator and offer statin if risk>20%
- If >40 years and normal to high CV risk → offer statin

Aspirin for cardiovascular disease prevention?
- Yes if established cardiovascular disease (secondary prevention)
- For primary prevention guidelines recommend low dose Aspirin if high cardiovascular risk but benefit not proven

Assess cardiovascular risk factors and treat if indicated
Complications

- **Cardiovascular disease**
  Diabetics are at increased risk of MI, stroke and peripheral vascular disease. Be vigilant to cardiovascular risk factors but remember you are unable to use the usual cardiovascular risk prediction charts on diabetics! Consider aspirin, statins and blood pressure treatment.

- **Eye disease**
  Blurred vision may occur if there is poor glycaemic control. Cataracts are more common in diabetics. Diabetes is a risk factor for developing glaucoma. A large concern is retinopathy. This is the most common cause of blindness of people of working age in industrialised countries. Small retinal blood vessels become blocked, swollen or leaky leading to exudate formation, oedema or new vessels. Diabetic retinopathy is classified as background retinopathy, mild non proliferative retinopathy, severe no proliferative retinopathy, proliferative retinopathy and advanced diabetic eye disease. Diabetics therefore require formal eye examinations annually.

- **Renal disease**
  Urinary tract infections are more common in diabetics and could possibly lead to renal scarring. Nephropathy is the most common cause of end stage renal failure in adults starting dialysis in the UK. It is characterised by proteinuria, hypertension and a progressive decline in renal function. Prior to overt nephropathy, there is a phase where the urine contains traces of protein not detected by dipsticks, send urine samples to the lab for microalbumin:creatinine ratios and be vigilant. Be aware that diabetic nephropathy is nearly always associated with retinopathy. Ensure tight diabetic control, treat hypertension, modify diet and use an ACE I even if not hypertensive as they are renal protective. Refer to secondary care.

- **Neuropathy**
  Symmetrical sensory progressive polyneuropathy (glove and stocking distribution); mononeuritis multiplex/mononeuropathies; amyotrophy (painful wasting of quadriiceps muscles); autonomic neuropathy (can lead to postural hypotension, urinary retention, diarrhoea, erectile dysfunction, gastric paresis, gustatory sweating).

- **Skin changes**
  Infections, pruritis, neuropathic and ischaemic ulcers, fat atrophy if injecting, necrobiosis lipoidica (small dusky red nodules usually on shin that then flatten and turn brownish), dermopathy (pigmented scars over shins), granuloma annulare (link with diabetes controversial), diabetic cheirothropy (waxy skin thickening on the hand).

**The diabetic foot**

Foot problems are very common among patients with diabetes. 5% develop a foot ulcer in any given year. Foot problems are due to

- Peripheral neuropathy with decreased foot sensation and
- Peripheral vascular disease leading to pain and ulceration. Patients need to self care and self monitor. Patient education is key.
The annual review

Much research has been carried out to assess whether very tight blood sugar control with HbA1c readings ≤6.5 improves outcomes. The result showed that the risk of hypoglycaemia outweighs the potential benefit. It is important to involve the patient in the decision what level of glucose control to aim for.

Most patients with Diabetes die from macrovascular complications – stroke and MI. It is therefore very important to reduce the risk factors for macrovascular disease as much as possible – no smoking, lipid and blood pressure control, exercise and weight control.

The main aim of the annual review is to check patient understanding, check control and prevent complications. There is a strong evidence base that good control of blood glucose levels, blood pressure levels and the use of statin therapy reduces the risk of developing microvascular (retinopathy, nephropathy and foot problems) and macrovascular (MI and strokes) complications.

- Blood tests to be completed prior to the annual review
  - U& E’s and eGFR (estimated glomerular filtration rate), LFTs, HbA1c, Lipid profile
- Welcome – general questions, ask regarding smoking status.
- Educate – ensure they have been referred to a structured group education programme, update education on one to one basis.
- Measure – blood pressure, dip urine for proteinuria, send of first pass urine sample for an albumin: creatinine ratio if the dipstick is positive for protein
- Check feet and give foot education – any ulceration? Inspect with shoes and socks off. Palpate peripheral pulses. Use 10g nylon monofilament to detect any loss of protective pain sensation. Consider podiatry.
- Check no underlying symptoms of depression (common with chronic disease).
- Ask about attendance for eye screening – Screening for retinopathy is by digital retinal photography through dilated pupils. Check results are on computer system.
- Discuss glycaemic control, blood pressure control and lipid control results. Discuss any changes needed.
- Agree targets to achieve
- Ensure appropriate follow up is arranged
Patient education

You need to address many topics with a patient with newly diagnosed Diabetes

- General knowledge - discuss
  - Diagnosis, potential complications and how to delay or prevent them
  - Aims of treatment
  - All the local diabetic services and how to access them
  - If requiring medication, they are entitled to free prescriptions
  - How to get an alert bracelet
  - Diabetes UK – membership, information
  - Possible medical equipment that they may wish to use such as Glucometer

- Diet
  - 50% or more of their dietary intake should come from fibre rich carbohydrate with minimal fat, refined carbohydrate and alcohol
  - Low salt
  - Encourage consumption of fresh fruit and vegetables
  - Advise them to look at diet sheets online from Diabetes UK. Warn about hidden sugar in processed foods and readymade meals

- Offer immunisations (pneumococcal and influenza).

- Psychological problems: Patients may struggle with the diagnosis and this may impact on their mental health – be vigilant.

- Exercise: Encourage regular exercise.

- Smoking: Always offer smoking cessation assistance if required.

- Foot care: discuss worrying signs to look out for and podiatry services

- Patient to inform DVLA especially if on insulin. Also be aware that if requiring insulin, certain jobs such as working on scaffolding, operating certain machinery, police, armed services and driving heavy good vehicles will no longer be possible.

References

Type 2 Diabetes NICE Guidelines at http://www.nice.org.uk/nicemedia/pdf/CG87QuickRefGuide.pdf
accessed 2.8.13, they are currently being reviewed
British National Formulary
Assessing risk for the prevention of cardiovascular disease

Learning objectives
Knowledge - Students should
- Understand the difference between primary and secondary prevention
- Understand risk factors for cardiovascular disease
- Be aware of cardiovascular risk prediction scores
- Understand the limitations of the current risk prediction charts
- Be aware that there is a new cardiovascular risk prediction tool called the QRISK2
- Understand how cardiovascular risk scores affect our clinical practice.

Skills - Students should
- Be able to use the cardiovascular risk prediction charts in the back of the BNF and the online QRISK2 calculator

A number of risk calculators are in use. The one at the back of the BNF is based on the Framingham study. To make the risk calculation more accurate newer tools have been developed which include additional information i.e. ethnicity, postcode

An online Framingham calculator for both coronary heart disease risk and cardiovascular risk can be found at www.framinghamheartstudy.org/risk/hrdcoronary.html accessed 2.8.13

Try assessing risk with the table at the back of the BNF and the online QRISK2 tool, how do they compare? You can find QRISK2 at http://www.qrisk.org

Primary prevention
Aims to prevent the development of disease
- Population based strategies try to influence factors throughout a whole population i.e. smoking ban in public places, increasing the cost of smoking above inflation etc
- Targeting individuals: Identify those patients at high risk and attempt to decrease their risk, for example identify smokers and offer smoking cessation advice
- Consider opportunistic screening for CV risk factors of all patients > 40 years old
  - If cardiovascular risk over 10 years is 20% or more, intervention is justified (for example modification of lifestyle, starting statin therapy etc)

Secondary prevention
Aims to stop progression of existing cardiovascular disease
- Smoking – Drug therapy increases smoking cessation rates by nearly 2 times. Refer patients to a “smoking cessation” service.
- Blood pressure control – the higher the BP the greater the risk of CVD
- Hyperlipidaemia – lowering cholesterol is of proven benefit in primary and secondary prevention of CHD. Weight loss can also lower lipid levels – if a person with a BMI of 30 loses 10kg in weight, this would result in a 7% decrease in LDL and 13% increase in HDL. Currently, start a statin if CV risk over 10 years is ≥20%. If patient is diabetic then start statin at 40 years or older or when younger if the patient has one or more cardiovascular risk factors such as retinopathy or family history of premature CHD. If intolerant of statins, consider fibrates.
- Control of diabetes. Patients with Diabetes are at 2-5 times increased risk of MI. Control their blood pressure to the recommended guideline, consider statin and consider aspirin.
- Diet and obesity
- Exercise
COPD

The impact of COPD is immense. It is the fifth commonest cause of death in the UK, the second biggest cause of emergency admissions to hospital and accounts for 9% of certified sickness (BMJ 2011;342:d1674).

Learning objectives
Knowledge - Students should
- Understand causes of COPD
- Understand the role of smoking in COPD
- Know about smoking cessation services and how to refer patients

Skills - Students should
- Be able to complete a competent history and examination of the respiratory system
- Be able to demonstrate use of a peak flow meter and interpret results
- Be able to demonstrate how to use an MDI with and without spacer device
- Be able to diagnose COPD
- Be able to demonstrate use of a nebuliser

Definition
COPD is a mixture of small airways disease and emphysema leading to reduced airflow. ‘Small airways disease’ is the narrowing of small airways due to chronic or repeated inflammation, scarring and hypersecretion. Emphysema is the breakdown of alveoli leading to a reduction of the area available for gas transfer. The airflow obstruction is not fully reversible and tends to get worse over time.

Prevalence
- COPD accounts for 1 million hospital bed days per year.
- An estimated 3 million people have COPD in the UK.
- Most people are not diagnosed until they are in their fifties.

Causes
~95% of COPD are due to smoking. 10-20% of smokers develop COPD. A rarer cause is Alpha 1 antitrypsin deficiency. Consider this if patient with COPD is <40 years old.

Symptoms
- Chronic cough
- Regular sputum production
- Wheeze
- SOBOE
- Frequent ‘winter bronchitis’

Signs
- Hyperinflated chest
- Poor chest expansion
- Reduced crico-sternal distance
- Hyperresonant chest with reduced cardiac dullness
- Use of accessory muscles
- Pursing of lips on expiration
- Cyanosis
- Peripheral oedema
- Raised JVP
- Cachexia

Diagnosing COPD
- There is no single diagnostic test for COPD. The diagnosis is made on the basis of the history, physical examination and spirometry showing airflow obstruction. COPD should be considered in all smokers >35 who have at least one of the symptoms in the box.
- Red flag symptoms of acute SOB, haemoptysis, hoarse voice, chest pain and rapid weight loss are not often found in COPD – you need to consider other diagnoses and exclude malignancies.
- If there is a suspicion of lung cancer the patient should be referred to a specialist under the ‘2 week wait system’
Investigations

Spirometry can be used to diagnose COPD and to assess severity and predict prognosis. It is not so good at measuring quality of life. Measurements are taken after bronchodilator therapy has been given and repeated 3 times. At least 2 readings should be within 100mls or 5% of each other (good technique needed)

- **FEV<sub>1</sub>** Volume of air patient can exhale in the first second of forced expiration
- **FVC** Total volume of air the patient can forcibly exhale in one breath
- **FEV<sub>1</sub>/FVC** Ratio of FEV<sub>1</sub> to FVC expressed as percentage

A diagnosis of airflow obstruction can be made if

- FEV<sub>1</sub>/FVC is < 0.7 (70%) (even if FEV<sub>1</sub> is >80%)
- CXR for all patients suspected to have COPD to exclude other diagnoses

Blood tests

- FBC (anaemia can make SOB worse, polycythaemia) and U+E (Salbutamol can lead to hypokalaemia)

BMI

Other tests as indicated by history, for example Alpha-1 antitrypsin

### Classification of COPD (NICE guidelines)

<table>
<thead>
<tr>
<th>FEV&lt;sub&gt;1&lt;/sub&gt;/FVC</th>
<th>FEV&lt;sub&gt;1&lt;/sub&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>&lt;0.7</td>
</tr>
<tr>
<td>Moderate</td>
<td>&lt;0.7</td>
</tr>
<tr>
<td>Severe</td>
<td>&lt;0.7</td>
</tr>
<tr>
<td>Very severe</td>
<td>&lt;0.7</td>
</tr>
</tbody>
</table>

Management

**Non drug therapy**

- **Advise patient to stop smoking**
- Pulmonary rehab – to improve exercise capacity and reduce breathlessness
- Influenza and pneumococcal immunisation

<table>
<thead>
<tr>
<th>Severity</th>
<th>Symptoms</th>
<th>FEV&lt;sub&gt;1&lt;/sub&gt;</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Breathlessness and/or exercise limitations</td>
<td>≥50</td>
<td>LABA or LAMA</td>
</tr>
<tr>
<td>Moderate</td>
<td>Exacerbations or persistent breathlessness</td>
<td>&lt;50</td>
<td>LAMA or LABA+ICS in combination inhaler</td>
</tr>
<tr>
<td>Severe</td>
<td>Persistent exacerbations or breathlessness</td>
<td>&lt;30</td>
<td>LAMA+LABA+ICS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consider Theophylline</td>
</tr>
</tbody>
</table>

- Consider mucolytic therapy if patient has chronic productive cough. Assess and stop if no improvement
- Long term oxygen therapy is indicated if arterial partial pressure of oxygen is <7.3 kPa when stable and requires assessment by a respiratory physician

Stopping smoking is the single most important intervention
Routine review for patients with COPD

Symptoms

Include objective measures such as MRC dyspnoea scale
- Improvements in symptoms
- Activities of daily living
- Exercise capacity
- Speed of symptom relief (short-acting bronchodilators only)

Smoking status

Record and advise

Exacerbations

Numbers and circumstances

Medication

Use, problems, side effects, inhaler and spacer technique

Examination

Objective measures of lung function – spirometry, O2 saturation, BMI

Education

Treatment, smoking, exercise, diet

Immunisation

Offer flu and pneumococcal immunisations

Goals and review

Management of exacerbations

- Careful history and examination including oximetry if available
- Increase frequency of bronchodilators, use nebuliser if needed
- If sputum is purulent use antibiotics
- Prednisolone 30mg for 7-10 days if significant increase in breathlessness

Medical Research Council dyspnoea scale

At
http://www.nice.org.uk/usingguidance/commissioningguides/pulmonaryrehabilitationserviceforpatient
swithcopd/mrc_dyspnoea_scale.jsp  accessed 2.8.13

Grade Degree of breathlessness related to activities

1 Not troubled by breathlessness except on strenuous exercise
2 Short of breath when hurrying or walking up a slight hill
3 Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4 Stops for breath after walking about 100m or after a few minutes on level ground
5 Too breathless to leave the house, or breathless when dressing or undressing


Reference

Accessed 2.8.13
Asthma (Adults)

Learning objectives
Knowledge - Students should
- Be able to explain asthma in non jargon language to a patient
- Understand how to diagnose asthma
- Know how to manage asthma including drug therapies
Skills - Students should
- Be able to complete a competent history and examination of the respiratory system
- Be able to demonstrate use of a peak flow meter and interpret results
- Be able to demonstrate how to use an MDI with and without spacer device
- Be able to demonstrate use of a nebuliser

Definition
Asthma is a condition of paroxysmal, reversible airways obstruction caused by an underlying inflammatory process with characteristic features of reversible airway narrowing and airway hyper-responsiveness to many stimuli.
- Asthma varies from mild symptoms to a mortal illness. 1100 patients died from Asthma in the UK in 2005
- Asthma is a clinical diagnosis and there are tests that can aid the diagnosis. Diagnosis can be difficult as there are no symptoms that are exclusive to asthma
- Personal history of atopy makes a diagnosis of asthma more likely in patients with respiratory symptoms
- More than 200 industrial materials are known to cause occupational asthma

Diagnosing Asthma
- Objective tests should be carried out before starting long-term medication
- A normal test when the patient is asymptomatic does not exclude the diagnosis

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Signs (in symptomatic patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheeze</td>
<td>Wide spread bilateral polyphonic wheeze, more pronounced on expiration</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>Hyperinflated chest in chronic severe asthma</td>
</tr>
<tr>
<td>Chest tightness</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
</tr>
<tr>
<td>Symptoms worse at night/early hours of the morning</td>
<td></td>
</tr>
<tr>
<td>Symptoms in response to triggers (pollen, cold air etc)</td>
<td></td>
</tr>
</tbody>
</table>

Peak flow measurement
- Ask the patient to stand up, hold PF meter horizontally, check indicator is at zero
- Ask the patient to take a deep breath and blow out forcefully into the peak flow meter. You need to make sure that the patient’s lips are firmly sealed around the PF meter.
- Read the PEFR off the meter. Record best attempt and compare with expected reading for age, sex and height.

Interpretation of PF measurements
- 50-80% of predicted or best – moderate exacerbation
- 33-50% of predicted or best – severe exacerbation
- <33% of predicted or best – life threatening asthma

Spirometry
Patients with asthma may have a reduced FEV₁/FVC ratio (an obstructive picture). This is expected to fluctuate much more than in COPD where it tends to be fixed.
CXR Consider this for patients with new, atypical or additional symptom
Management
The aim of asthma management is to control the disease. Good control means

- No daytime symptoms
- No night time awakening due to asthma
- No need for rescue medication
- No exacerbations
- No limitation on activities including exercise
- Normal lung function (FEV₁ or PEF >80% predicted or best)

Non drug measures

- Advise patient to stop smoking as this can exacerbate or trigger symptoms
- Advise obese patients to lose weight – there is some evidence that weight loss can lead to improved symptoms
- Allergen avoidance

Prescribing
Medication is prescribed in a stepwise fashion and can be stepped up or down.

Step 1
Inhaled short acting bronchodilator as required (Salbutamol)

Non responsive control↓

Step 2
Add inhaled corticosteroid 200-800mcg (start at dose that is appropriate for symptoms/patient, 400mcg is a good starting dose for most patients)

Non responsive control↓

Step 3
Add inhaled long acting beta₂ agonist LABA (Salmeterol)
- Poor response to LABA – increase dose of inhaled corticosteroid to 800mcg
- Add 3rd drug (Leukotriene receptor agonist (Montelucast) or SR Theophylline)

Non responsive control↓

Step 4
- Consider increasing inhaled corticosteroid to 2000mcg
- Add 4th drug (LRTA, SR Theophylline, oral beta agonist)

Non responsive control↓

Step 5
- Use daily steroid table in lowest dose in addition to inhalers
- Refer for specialist care

Routine review for patients with asthma

- Check symptoms since the patient was last seen. See list above for good control, ask the Royal College of Physicians ‘three questions’¹
  - In the last month
    1. Have you had difficulty sleeping because of your Asthma symptoms (incl. cough)?
    2. Have you had your usual Asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?
    3. Has your Asthma interfered with your usual activities (work, school etc)?
- Record smoking status and ask about smoking in other members of household
- Review effectiveness and acceptability of medication with patient
- Be prepared to step up or down with treatment according to symptoms
- Offer influenza and pneumococcal immunisation
- Review objective measures – PFR
- Check inhaler/spacer technique
- Plan review and formulate written action plan what to do if asthma gets worse

Management of exacerbations
Assess patient’s level of distress, clinical examination and pulse oximetry
- High doses of Salbutamol via nebuliser, add nebulised ipratropium if poor response to Salbutamol, give 100% oxygen via non-rebreath mask, give oral steroids 40-50mg

Psychiatry

Low mood and depression

Learning objectives

Knowledge – you should

- Be able to recognise symptoms of depression
- Know the screening questions for depression
- Know how to assess the severity of depression
- Know how to assess suicide risk
- Understand when and why to prescribe medication
- Know treatments for depression
- Have basic knowledge of medication commonly used in depression
- Know the symptoms of Lithium toxicity

Skills – you should

- Be able to use a depression questionnaire, for example the PHQ9

It is estimated that 2.3 million people in the UK suffer from depression at any one time and that 1 in 10 people attending a GP have it. Depression is a heterogeneous condition and often associated with anxiety.

When you suspect depression ask these screening questions
During the last month have you often been bothered by
- Feeling down, depressed and hopeless?
- Having little pleasure or interest in doing things?

If the answer is ‘yes’ to either question you need to carry out a further assessment which you will learn about in your Psychiatry Unit.
- When making a diagnosis of depression, do not rely on symptom count alone, make a holistic assessment.
- If the answer is ‘no’ to both questions this does not necessarily exclude depression.

Several questionnaires are being used to assess the severity of depression. In General Practice the most commonly used questionnaire is the PHQ9. You can find it here http://www.integration.samhsa.gov/images/res/PHQ%20Questions.pdf accessed 2.8.13

Prescribing
You need to have basic knowledge of drugs commonly used for depression
- SSRIs (Citalopram for example)
- Tricyclics (Amitriptyline for example)
- Mirtazepine
- Venlafaxine
- Lithium
- OTC (over the counter) – St John’s Wort
Discussion points for your GP sessions

- It is estimated that 30-50% of depression are not detected. What do you think may be the reasons for that?
- How would you assess suicide risk?
- Problems with St. John’s Wort?
- The consultation as a therapeutic intervention
- How to manage mental health problems in the 10 minute consultation
- First assessment and use of time for diagnosis and management
- Compliance/adherence
- Role of empathy in understanding the patient experience

Reflection
To be truly empathetic, do we need to have experienced the things that our patients go through? As a white 23 year-old female, can I fully understand what it is like to be a black, obese woman with diabetes, or a 93 year-old who cannot walk because of heart failure? This is a visual representation of the impossible task that we endeavour to overcome to become fully empathetic doctors.
Anon
At http://www.outofourheads.net accessed 27.8.13

Alcohol and drug dependence

Learning objectives

Skills – you should
- Have a basic understanding of the principles of motivational interviewing.

Motivational interviewing
This is designed to help people make behaviour changes and is another tool to add to your ‘consultation skills toolbox’. It has strong links with counselling approaches.

Schizophrenia

In your GP attachment you may be seeing patients who have lived and struggled with Schizophrenia for many years. Try and
- Focus on their ‘stories’ rather than ‘taking a history’ (a conversation)
- Find out from them how the approaches to management and medication may have changed over the years
- What has been the effect on their lives?
- How have they coped with it?
- What has helped them the most?
- How do they view the care they have received and the services they have used?
- What medication have they taken?
- Any therapies?
- How are they now? etc
Quality and Outcomes Framework (QOF)

Please note: You are not expected to memorise any details of the QOF and there will not be any exam questions on the QOF but you should understand in broad terms what it is.

The Quality and Outcomes Framework (QOF) is a voluntary programme for Primary Care and is based around target driven pay. Targets are set and practices score points if they achieve them. Its basic aim is to "reward good practice" and was first introduced in 2004. It is under continual review and updates including new targets are introduced at regular intervals.

The QOF contains five main domains and each domain consists of a set of indicators, against which practices score points depending on their level of achievement. The total number of available points is 1000.

- **Clinical care** This domain consists of indicators across clinical domains. It involves achieving preset standards in the management of: smoking, CHD, heart failure, atrial fibrillation, stroke and TIA, hypertension, hypothyroidism, diabetes, chronic kidney disease, dementia, learning difficulties, depression, mental health, COPD, asthma, epilepsy, cancer, obesity, palliative care.

- **Organisational** This domain consists of five organisational areas – records and information; information for patients; education and training; practice management and medicines management.

- **Patient experience** This domain relates to length of consultations and to patient satisfaction surveys.

- **Additional services** This domain consists of four service areas which include cervical screening, child health surveillance, maternity services and contraception.

- **Holistic care** – This domain reflects the range of achievement across clinical indicators – calculated by ranking clinical indicators in terms of proportion of points gained (1-10). The proportion of the points gained by the third lowest indicator (i.e. indicator ranked 7) is the proportion of the holistic care points obtained.

**Scoring**

The QOF system is then used to give a practice a performance score based on the indicators defined in each domain. The higher the score, the higher the financial reward for the surgery. The mean value of one point in 2007-2008 was £124.60.

**Availability to the public**

The NHS Information Centre for health and social care (The NHS IC) has an online database to allow the public access to this data and see how well their surgery is scoring.

**Exception reporting**

Of note, there is exception reporting where patients can be excluded from QOF so that the practice is not penalised for failing to meet targets because of factors beyond their control. For example, if the patient does not attend for review, where medication cannot be prescribed due to a side effect, terminal illness, newly diagnosed to recently registered patients, patients on maximal tolerated therapy, informed dissent where a patient does not agree to a treatment or where investigations or secondary care is unavailable.

**Annual reports and reviews**

Each year, every practice must complete a standard report recording their level of achievement in the last year and the appropriate evidence. Please note: QOF targets are sometimes slightly different to NICE targets.

**References**


http://www.hscic.gov.uk/qof accessed 27.8.13

- What effect do you think QOF has on individual consultations?
- Ask your GP teacher how they manage QOF in their own consultations.
Teaching consultation skills in Year 3

The year 3 GP attachments are an excellent opportunity for students to practice, observe and reflect on consultation skills. Consultation skills are one of the five vertical themes of the Bristol curriculum. At Bristol we use the Cambridge-Calgary Consultation skills guide (CCG) as the basis for this teaching. You can find a copy of the CCG in the Appendix.

Students start to talk with patients in their Year 1 GP attachments and in Year 2 they have formal consultation skills training with actors. In Year 3 and 4 they only have one formal consultation skills session in each year. It is therefore important that clinical teachers, including GP teachers, provide constructive feedback on these skills.

Communication skills handbook
Students are given a communication skills handbook in year 2 and encouraged to write down the feedback they receive after their role plays, to reflect on it and to develop a learning plan for communication/consultation skills from that. Please ask them to bring their consultation skills handbook to the sessions and encourage students to write a learning plan regarding consultation skills.

Medical history taking and consultation skills
Students often feel confused by the apparently conflicting models of medical history taking (Presenting complaint, PMH etc) and the Cambridge-Calgary consultation skills guide. Here are some diagrams to highlight the relationships between the two.

- The medical history template relates to the content you are trying to unearth
- The CCG is a model of the process of gathering this information effectively by establishing rapport and good communication

Content and process of the consultation

<table>
<thead>
<tr>
<th>Medical model</th>
<th>The patient model (Helman)</th>
<th>Cambridge/Calgary Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>What has happened?</td>
<td>Initiating the session</td>
</tr>
<tr>
<td>Examination</td>
<td>Why has it happened?</td>
<td>Gathering information</td>
</tr>
<tr>
<td>Hypothesis</td>
<td>Why to me?</td>
<td>Providing structure</td>
</tr>
<tr>
<td>Tests</td>
<td>Why now?</td>
<td>Building the relationship</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>What if nothing were done?</td>
<td>Explanation and planning</td>
</tr>
<tr>
<td>Treatment</td>
<td>What should I do?</td>
<td>Negotiation and discussion</td>
</tr>
<tr>
<td></td>
<td>Who should I consult?</td>
<td>Closing the session</td>
</tr>
</tbody>
</table>

Students may find it helpful to consider the different agendas being addressed in a consultation. The following diagram to highlights the different agendas

### Bringing together the patient and doctor agenda

**Meaning of illness for patient**
- Understanding of illness, beliefs, expectations
- Feelings, fears, effect on life

**Doctor agenda**
- Traditional workup
- History, examination, tests
- Clinical diagnosis
- Management plan

**Shared decision making and negotiation**
- Safety netting

#### Why me?
- What is the diagnosis?
- What tests should I order?
- What if I miss something serious?
- Why now?
- What can be done?
- Why me?

**Year 2 students are taught how to take a systematic and comprehensive history and carry out an equally systematic and comprehensive examination. This familiarises students with all aspects of history and examination and will hopefully be “burned into their hard disc” for future reference.**

The disadvantage of this approach is that it does not encourage students to think about what they are doing and the meaning that is being created. This can sometimes lead to inappropriate questions. Here is an example:

- **Student:** “Are there any diseases running in the family, for example heart attacks?”
- **Patient:** “My mother has had a problem with her memory for some time and last week we were told that she definitely has Alzheimer’s”.
- **Student:** “Do you smoke?”

The student was following a list rather than responding to the information or “cue” from the patient. A diagnosis of Alzheimer’s disease has many implications and it would have been more helpful to the patient if the student had expressed empathy:

- **Student:** “That must have been a shock for you. Would you like to talk about it?”

It is easy to see that asking one medical question after another, without taking account of the patient’s responses, can hinder our interaction with patients.
From “checklisting” to “problem solving” and whole person care (WPC)

Some helpful questions for students to become more focussed in their history taking from Elwyn Davies, GP Teacher and Trainer, Cheddar Medical Centre

When you have run through your checklist of relevant symptoms and are wondering what to do with the information ask yourself some simple questions
- Can you summarise what you have been told so far?
- Does it tell a story from beginning to end?
- Is the story unique to the individual and their situation?
- Can you tell what the probable diagnosis is (main problem)?
- And what it isn’t (differential diagnosis)?
- What is the worst thing it could be (What you must not miss)?
- Do you know what the patient thinks is wrong and worries about? the key to a happy consultation

Specific consultation skills students may like to practice

- Attentive listening, picking up cues
- Empathy, open and closed questions, appropriate language
- Clarification, time framing, summarising

...and Rest.

'Touching Patients'
Lauren van Lancker
Appendix

Clinical reasoning – Hypothetico-deductive model

Turning a symptom into a diagnosis

Sample teaching session – Psychiatry

Teaching clinical skills – different methods

Some learning and teaching concepts
  ▪ How adults learn
  ▪ Learning styles
  ▪ Kolb’s learning cycle

Year 2 curriculum for ICS (Introduction to clinical skills)

Cambridge Calgary Consultation skills guide (CCG)

Poetry in teaching

Textbooks and references
Clinical reasoning

Hypothetico-deductive model

Students in Year 2 are being taught how to take a systematic and comprehensive history and to carry out an equally systematic and comprehensive examination. This familiarises students with all aspect of the history and examination and will hopefully be burned into their “hard disc" for future reference. The disadvantage of this approach is that it does not encourage students to think about what they are doing, leading them to ask inappropriate questions. This hinders their interaction with patients, and also means they over-emphasise rare diagnoses while missing the obvious. In busy hospital and GP practice experienced doctors take “short cuts” and fall back on this basic method when the short cuts don't work.

In real life experienced doctors have a hypothetical-deductive approach, generating ideas about possible diagnoses within the first minute or two of the consultation. Symptoms are put into “ballparks", i.e. whether SOB is more likely to be a chest or heart problem. They then concentrate their questioning on attempts to confirm or refute the diagnosis. The experienced doctor starts with general open questions then narrows down to more detailed and specific questions. He or she may then open up a further area of questioning with another open question; again narrowing down to closed detailed questions. This process of ‘funnelling' may happen several times in one consultation.

The funnelling process in clinical problem solving

It is useful to discuss this model with the students and to make it visible to them in their consultations. After a student has asked the patient one or two questions stop the student and ask him/her and the group what they think the most likely diagnosis is at this point. Let the student continue and stop him/her again after a few more questions. Ask what they think the diagnosis now is and what they need to ask to confirm or refute their hypothesis.

It is important to tell the students that you will stop them in this way before they start consulting. Otherwise they could possibly feel that they are not doing well enough and are therefore being stopped.
Illness scripts
Through clinical practice we also acquire our personal “illness scripts” which we draw on for making diagnoses. These are composite pictures of all the patients we have seen with a particular problem or condition. For example we may be better able to pick up signs of MND if we have encountered it before in different guises. These “illness scripts” provide shortcuts, which are enormously helpful in 10-minute consultations but can also leave us stranded. It is then that we need to be able to dip into a more systematic approach. We need to make these different processes and approaches visible to our students.

What you can expect from your students
Here are some comments and observations from GP teachers on their students in the 2005/6 academic year. You may find it helpful to look at this list to gauge how your own students are doing.

Please note, these were comments about the students and some would need phrasing appropriately (see rules) if they were fed back to the students verbally or in writing. For example, “needs to learn to smile” could be phrased as “I noticed that the patient smiled at you but you did not smile back”

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Areas for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Very good, more than expected</td>
<td><strong>Attitude, behaviour</strong></td>
</tr>
<tr>
<td>• Excellent communication and examination skills</td>
<td>• Lack of confidence</td>
</tr>
<tr>
<td>• Enthusiasm</td>
<td>• Jumping to conclusions</td>
</tr>
<tr>
<td>• Professional approach</td>
<td>• Shyness, being quiet</td>
</tr>
<tr>
<td>• Good level of knowledge</td>
<td>• Lacks rapport with patients – poor eye contact</td>
</tr>
<tr>
<td>• Willing to improve</td>
<td>• Needs to learn to smile</td>
</tr>
<tr>
<td>• Able to assimilate complex information</td>
<td>• Reluctant to get involved as “has done it all before”</td>
</tr>
<tr>
<td></td>
<td>• Can dominate small group, tries to answer everything</td>
</tr>
</tbody>
</table>

Consultation skills
• Tends to “close off the history” from the patient, needs to ask more open questions
• Jumping to complex conclusions
• Focussing on minor side issues
• Not picking up cues

Knowledge
• Needs more systematic approach, needs to develop a “framework”
• Prompting with psychiatric history
• Lack of knowledge of the presentation of common conditions in General Practice

Students value the feedback they receive from their GP teachers very highly and we appreciate the effort you put into providing this.
Turning a Symptom into a Diagnosis

- Consider all possible diagnoses (Diagram 1)
- Narrow it down to a likely “ballpark” (Diagram 2)
- Then, using all available information, reduce your differential diagnosis down to the one(s) that best fit your patient (Diagram 3)

Example: Shortness of breath

Diagram 1

- **Physiological**
  - Exercise
  - Unfit
  - Altitude

- **Psychological**
  - Hyperventilation
  - Air hunger
  - Panic disorders

- **Metabolic**
  - Anaemia
  - Acidosis
  - DM
  - Liver failure
  - Renal failure

- **Cardiovascular**
  - Heart failure
  - Valvular heart problems
  - Arrhythmias
  - Pericarditis
  - Cardiac tamponade
  - Cardiomyopathy
  - Myocarditis

- **Respiratory**
  - Asthma/COPD
  - Infections
  - TB
  - Pneumonia
  - Bronchitis
  - Pleuritis
  - Pleural effusion
  - Pulmonary embolus
  - Bronchiectasis
  - Pneumothorax
  - Cystic fibrosis
  - Alveolitis

Diagram 2

- Many possible diagnoses for SOB
  - All possible diagnoses for shortness of breath

Cardiac cause

Ballpark

Mitral regurgitation

Patient
### Diagram 3

<table>
<thead>
<tr>
<th><strong>The Clinical Process</strong></th>
<th><strong>Example</strong></th>
<th><strong>Findings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st level questions – “ballpark”</strong> (e.g. SSSTOP)</td>
<td>Tell me more about your breathlessness. Have you been coughing or wheezing? Have you had any chest pain? How does your breathing restrict you? Does anything make things worse? How long have you had this for? Any other medical problems?</td>
<td>Puffed easily these days No ‘Niggles’ Can’t play tennis now No A year or so Not really</td>
</tr>
<tr>
<td><strong>2nd level questions – “detail”</strong></td>
<td>Do you get palpitations? Have you had any heart problems before? Have you ever had rheumatic fever? Any heart problems in the family? Do you smoke?</td>
<td>Occasionally No No No Father MI aged 60 No</td>
</tr>
<tr>
<td><strong>Differential diagnosis</strong></td>
<td>Heart Failure Valvular Heart Problem Arrhythmia Cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td>Cardiovascular Examination</td>
<td>P 90, BP 130/85 Pansystolic murmur</td>
</tr>
<tr>
<td><strong>Review differential diagnosis</strong></td>
<td>Valvular Heart Problem likely</td>
<td></td>
</tr>
<tr>
<td><strong>Investigations</strong></td>
<td>ECG FBC/U&amp;E/Lipids</td>
<td>Flat T-waves inferolaterally NAD</td>
</tr>
<tr>
<td><strong>Review differential diagnosis (+/- further investigations)</strong></td>
<td>Echocardiogram</td>
<td>Slightly enlarged L heart Mitral valve prolapse Mod. mitral regurgitation</td>
</tr>
<tr>
<td><strong>Diagnosis or Acceptable Uncertainty</strong></td>
<td>Mitral valve prolapse causing moderate mitral regurgitation</td>
<td></td>
</tr>
<tr>
<td><strong>Management plan</strong></td>
<td>Watch and Wait Aspirin</td>
<td></td>
</tr>
<tr>
<td><strong>Follow up</strong></td>
<td>GP + Cardiology reviews</td>
<td></td>
</tr>
</tbody>
</table>
Sample teaching session – Psychiatry

Here is an idea for a teaching session. The session could be expected to last approximately 2 ½ hours. As mentioned above, the focus of the tutorial should be based around the specialities in which the students are currently placed.

- Invite 2 or 3 patients approximately an hour apart with clinical problems relevant to the hospital block the students are in. (see above for suggestions)

- Brief the patient beforehand that these are junior students and will be discussing a number of diseases and possibilities, but that you will clarify any confusion that has arisen for the patient.

- Discuss any learning needs or issues researched by the students from the previous session.

- It is important that the teaching is tailored to what the students need/want. Enthuse the students by finding out what they hope to achieve and specific ideas on how they want to run the session (i.e. GP takes history or one student or alternating students etc.) Inquire about specific learning needs e.g. examination of a particular body system, or any core clinical problems not yet met. List these on a flipchart and return to them at the end of the session.

- You may like to brainstorm the topic (see below) before seeing the patient i.e. symptoms, possible diagnoses and questions to differentiate between alternative diagnoses. (It can be useful to use a flip chart to list the differential diagnosis, which the students can refer to during the consultation). Highlight how relevant questions and diagnoses may differ significantly between primary and secondary care.

<table>
<thead>
<tr>
<th>A psychiatry session example: a patient who is low or tearful:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brainstorm:</strong></td>
</tr>
<tr>
<td>Low/tearful</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Alcohol abuse/ Drug addiction</td>
</tr>
<tr>
<td>Bereavement</td>
</tr>
<tr>
<td>Parkinson’s</td>
</tr>
<tr>
<td>PHYSICAL</td>
</tr>
<tr>
<td>PSYCHOSOCIAL</td>
</tr>
</tbody>
</table>

- Ask one student to student to start the consultation, asking the patient about their problem. After a few minutes, ask the student what they are thinking so far. E.g. if the problem is breathlessness, what are the possible causes of breathlessness? Which are most likely with this kind of patient, taking account of their age, sex, and any other medical conditions? What are the differences between, say, asthma and heart failure? What might be good questions to differentiate between them? Involve all the students in this discussion

- Then ask the student to carry on, asking the patient the relevant questions
- When students are getting a bit stuck encourage them to ask for help from the group. Ask students to swap around so that all have a go at different parts of the process.

- Highlight communication/consultation skills – active listening, body language, timing and phrasing of questions, the use of open questions and allowing pauses without interruption. Talk about the need to clarify the patient’s agenda.

- When they have taken the history, discuss with the students what they think the diagnosis is now. What findings on examination might help to confirm or refute the diagnosis?

- Having listed the key examination points, ask the students to examine the relevant systems. Show them how to do it yourself, and then make sure they all have a go.

- After the examination, ask the students if there are any investigations that might confirm or refute the diagnosis, and what results they would expect. Look up in the notes if these test were done, and the results.

- Try to involve the patient in teaching the students and ask them for any feedback. How did they feel about the questions? Has anything been left out? What could have been done differently?

- Make sure the patient is happy and not left feeling confused. Let them go home, then move on to the next patient.

- At the end of the session, ask the students what they have learned. Ask the students for feedback on the session. To encourage the students it may be helpful to start off by sharing your reflections on the session – what went well, what you would like to change.

- Ask them “What is the most important thing that you will take away from this session?”

- Go over the learning needs listed by the scribe. Get the students to share them out, with a view to finding the answers over the coming weeks (remember to ask the students about these learning needs next time, or they will not bother to look things up!).

- Agree problems, types of patients the students would like you to try to invite for the next session. Particularly important problems that they have not experienced in hospital.

**General points about the session**

- Try to ensure that all students get plenty of opportunity to be watched taking histories and performing examinations

- Consider ‘problem formulation’ as well as ‘diagnosis’ i.e. what is the problem from the patient’s point of view, what are they worried about, what do they want to know, what impact does it have on them, what needs to be done apart from arriving at the diagnosis.

- Discuss the advantages and disadvantages of a ‘check-list’ approach to taking histories

- Try to be encouraging, specific and constructive in commenting on students performance

In the final session you may want to feedback to the students how they have been doing over the four sessions. This could involve each student doing a case presentation followed by GP feedback.
Teaching clinical skills

Clinical skills are complex and it is helpful to consider different models for teaching this complexity. The model we use should be tailored to the students’ prior experience. Teaching textbooks often suggest demonstrating the whole, then breaking it down into stages and for learners to practice the stages before putting it all together. This model probably suits complete novices.

Year 3 students have already been taught examination and consultation skills in year 2 and may feel bored by observing a demonstration. At the year 2/3 GP teacher workshop in May this year the two Teaching Fellows from the North Bristol Academy (Tom Pelly and Ashley Southall) demonstrated different ways of teaching clinical skills, which are reproduced here. You may find these useful for year 3 teaching.

Examination of the peripheral nervous system – by Tom Pelly (Clinical Teaching Fellow 2005/06)

Method: Overlapping stages
Tom demonstrated his way of teaching a complex skill. Key elements are breaking the complex task into small stages, overlapping stages, repeated praise and involving the group.

Student 1 (Introduction, inspection, assesses tone)
- Starts examination
  - Teacher praises and makes suggestions
    - Teacher praises and asks group how the performance could be improved

Student 2 (Introduction, assesses tone, tests power)
- Repeats part of the examination student 1 did, modified by the suggestions from teacher and group
- Student does a new bit of the examination
- Teacher praises, makes suggestions
- Teacher asks group how performance can be improved

Student 3 (Introduction, tests power, tests co-ordination)
- Repeats part of the examination student 1 did, modified by the suggestions from teacher and group
- Student does a new bit of the examination
- Teacher praises, makes suggestions
- Teacher asks group how performance can be improved

Student 4 etc

There was general agreement that this method engendered a relaxed atmosphere, reduced performance anxiety and established good rapport between the teacher and the students.

Key teaching techniques were
- Overlapping what the students did
- Repeated positive re-enforcement
- Asking the group for suggestions how to improve
- Asking the other students in the group to suggest how the student could improve/develop appeared to have a number of effects
  - Not setting the teacher up as the example, or somebody who holds all the knowledge
  - Acknowledging that students have expertise and knowledge they can draw on and share – peer teaching
Examination of the cardiovascular system – Ashley Southall (clinical Teaching Fellow 2005/06)

Method: Walking a student through the examination
Ashley put particular emphasis on helping the students to take in the whole situation and to set the scene, summarised in a mnemonic known as Ashley’s “NIPPLE”

N  necessary equipment
I  Introduction
P  Permission, Privacy
P  Position
L  Light
E  Exposure

Ashley talked one student through the examination. He broke the examination down into discrete tasks, which he asked the student to perform. He praised the student repeatedly, and showed humility through comments such as “I sometimes do that too”, followed by “this may be a better way”. He repeatedly involved the group, asking for help and suggestions

Key teaching techniques were
- Repeatedly involving the group
- Praising
- Showing humility as a teacher
- Acknowledging challenges

We discussed the pros and cons of demonstrating the whole examination first before asking students to do it in stages. There seemed to be a consensus that this might set up the teacher as the perfect model, which could be inhibiting. It would be better to ask the students whether they wanted to see the whole examination or ask a student to demonstrate the complete examination

Humility, praise and involving the group repeatedly were key elements in both styles of teaching
These sessions were followed by group discussion, which highlighted the challenges of student numbers, involving all students, demonstrating a holistic approach to neuro examination, balance between keeping students on their toes and making them anxious.

To be appreciated from the patient management within the consultation
- Partnership and joint decision making
- Coping with uncertainty, and safety netting
- Using time as a diagnostic tool
- The wider role of the GP outside medical diagnosis and cur
Some learning and teaching concepts

Here are some ideas, concepts and principles about teaching and learning which you may find useful in your role as teacher.

Comparison of traditional and current view of learning

<table>
<thead>
<tr>
<th>Traditional/input</th>
<th>Current/active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive</td>
<td>Active</td>
</tr>
<tr>
<td>Receiving</td>
<td>Searching</td>
</tr>
<tr>
<td>Fill a deficit</td>
<td>Seeking satisfaction</td>
</tr>
<tr>
<td>Responsive to outside stimulus</td>
<td>Initiated by inner drive</td>
</tr>
<tr>
<td>Transfer of knowledge</td>
<td>Problem-solving</td>
</tr>
<tr>
<td>Need for teacher</td>
<td>Self-learning</td>
</tr>
<tr>
<td>Keyword: “give, impart”</td>
<td>Keywords: “discover, create”</td>
</tr>
</tbody>
</table>

How adults learn

Adults are highly self-directed in their learning. There is evidence that what adults learn on their own initiative they learn more deeply and permanently.

Adult learners

- Bring with them a package of experience and growth
- Come to education with intentions
- Bring expectations about the learning process
- Have competing interests
- Already have their own patterns of learning
- Are self directed in their learning
- Are in a continuing process of growth

Students may demonstrate different levels of adult learning and our teaching needs to support them in their development as independent learners.

How we can help students to become adult learners

- Help students define needs
- Help students define objectives
- Help students use resources
- Organise learning in relation to needs
- Foster student decision making
- Encourage self evaluation
- Foster a reflective approach
- Facilitate problem posing and solving
- Reinforce student self concept
- Emphasise experimental methods (hands on)
- Decrease teacher dependency (encourage students to give each other feedback and suggestions how to improve, ask students to demonstrate etc)

A good teacher is

- enthusiastic,
- good communicator/listener
- prepared
- knows the subject matter
- punctual

Motivation

People respond with greater motivation and enthusiasm if they feel someone is taking an interest in them as individuals as well as students. It is helpful to find out where the students are at and what they hope to achieve.
Learning styles
We all have preferred ways of learning, which we call learning styles. This concept synthesises personality traits and information processing preferences. It helps us understand why different learners prefer and seek different learning experiences and may feel more comfortable at the stage in the learning cycle that corresponds to their preferences.

Probably the best-known classification is the one by Honey and Mumford

Activist
Open-minded, try anything, like new challenges, but get bored quickly

Pragmatist
Down to earth, like problem solving, gets impatient with open ended discussion

Theorist
Likes to adapt and integrate observations into logical maps, like to project, analytical

Reflector
Likes to thoroughly examine information and take time to think things through, cautious, appear tolerant

The Honey and Mumford learning styles questionnaire costs about £6-10/copy. The following learning styles questionnaire is similar and free. Your students may find it fun to do and it might stimulate an interesting discussion about learning in General Practice. http://www.ncsu.edu/felder-public/Learning_Styles.html

Kolb’s Experiential Learning Cycle (applied to a year 3 GP session)

Learning is generally more effective if it is based on experiences.

**Experience**
Consulting, examining patients, giving and receiving feedback

**Planning**
Practice giving bad news in role play
Observe GP consultation
Practice using the ophthalmoscope, otoscope
Practice examination of cranial nerves on peers

**Reflection**
Guided by teacher
Reflecting on consultation/examination of patient, what went well, what needs further work, incorporating feedback from tutor and other students.

**Thinking**
Revisiting communication skills handbook
Literature on special skills, i.e. giving bad news, motivational interviewing
Reading up on clinical skills

Reflection
Often teachers are good at providing experiences but may forget to consolidate the learning by encouraging reflection by the students. One way to do this is to ask the students to summarise 2 things learned during that session or to discuss what overall concepts or principals have been learned.
**Year 2 Core curriculum—what students should have learned in Year 2**

**Cardiovascular system**

### Common symptoms of cardiovascular disease

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>Explore basic characteristics including site, radiation, precipitating,</td>
</tr>
<tr>
<td></td>
<td>relieving and associated factors</td>
</tr>
<tr>
<td></td>
<td>Identify specific history and assoc features of angina and myocardial</td>
</tr>
<tr>
<td></td>
<td>infarction pain, and distinguish from other causes of chest pain</td>
</tr>
<tr>
<td></td>
<td>Assess severity (nil, ordinary exertion, severe exertion, rest)</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>See Respiratory Curriculum</td>
</tr>
<tr>
<td></td>
<td>Identify specific history of Shortness of Breath on Exertion, Orthopnoea</td>
</tr>
<tr>
<td></td>
<td>and Paroxysmal Nocturnal Dyspnoea</td>
</tr>
<tr>
<td></td>
<td>Identify assoc symptoms of cardiac failure</td>
</tr>
<tr>
<td>Palpitations</td>
<td>Identify history of frequency and rhythm of heart beat and associated</td>
</tr>
<tr>
<td></td>
<td>symptoms</td>
</tr>
<tr>
<td>Dizziness/blackouts</td>
<td>Identify history of sudden faintness, with or without ensuing loss of</td>
</tr>
<tr>
<td></td>
<td>consciousness, which may be cardiovascular in origin</td>
</tr>
<tr>
<td>Leg pain</td>
<td>Identify specific history and assoc features of intermittent claudication,</td>
</tr>
<tr>
<td></td>
<td>acute ischaemia of leg and deep vein thrombosis</td>
</tr>
</tbody>
</table>

### Examination of the cardiovascular system

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>General examination</td>
<td>Recognise clear pallor, central and peripheral cyanosis</td>
</tr>
<tr>
<td></td>
<td>Identify the constellation of signs of cardiac failure</td>
</tr>
<tr>
<td>Pulse</td>
<td>Ability to measure radial pulse, rate and rhythm</td>
</tr>
<tr>
<td></td>
<td>Compare radial and apex pulses</td>
</tr>
<tr>
<td></td>
<td>Examine radial, brachial, femoral, popliteal, posterior tibial and dorsalis</td>
</tr>
<tr>
<td></td>
<td>pedal pulses and classify correctly as normal, weak or absent.</td>
</tr>
<tr>
<td></td>
<td>Identify clear deep vein thrombosis in calf and thigh</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Demonstrate correct method of measuring blood pressure, including</td>
</tr>
<tr>
<td></td>
<td>applying cuff, inflating and deflating at right rate, and identifying</td>
</tr>
<tr>
<td></td>
<td>Korotkov sounds</td>
</tr>
<tr>
<td></td>
<td>Identify clearly raised level of blood pressure</td>
</tr>
<tr>
<td>JVP</td>
<td>Demonstrate correct method of measuring JVP</td>
</tr>
<tr>
<td></td>
<td>Identify clearly elevated JVP</td>
</tr>
<tr>
<td>Murmurs</td>
<td>Detect clear cardiac murmur and classify as systolic or diastolic</td>
</tr>
<tr>
<td>Lungs</td>
<td>See Respiratory Curriculum</td>
</tr>
<tr>
<td></td>
<td>Recognise clear basal crackles</td>
</tr>
<tr>
<td>Oedema</td>
<td>Identify ankle and sacral oedema</td>
</tr>
</tbody>
</table>

### Diagnostic tests/medication of cardiovascular system

<table>
<thead>
<tr>
<th>Test/medication</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Xray</td>
<td>Ability to measure cardiothoracic ratio, and recognise cardiomegaly</td>
</tr>
<tr>
<td></td>
<td>Recognise clear pulmonary oedema</td>
</tr>
<tr>
<td>ECG</td>
<td>Recognise features of a normal ECG, rate and rhythm</td>
</tr>
<tr>
<td></td>
<td>Identify cardiac arrhythmia’s: AF, ectopic beats</td>
</tr>
<tr>
<td></td>
<td>Identify clear myocardial infarction</td>
</tr>
<tr>
<td>Use of GTN</td>
<td>Describe use as diagnostic test, technique, side effects</td>
</tr>
</tbody>
</table>

**Respiratory system**

### Common symptoms of respiratory disease

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathlessness</td>
<td>Explore precipitants, relieving factors, speed of onset and progression</td>
</tr>
<tr>
<td></td>
<td>of breathlessness, and associated symptoms. Associate type of</td>
</tr>
<tr>
<td></td>
<td>breathlessness and assoc symptoms with common</td>
</tr>
<tr>
<td></td>
<td>causes: asthma, COPD, pneumonia, pulmonary embolism, lung cancer</td>
</tr>
<tr>
<td></td>
<td>Assess severity (nil, ordinary exertion, severe exertion, rest)</td>
</tr>
<tr>
<td>Chest pain</td>
<td>See cardiovascular curriculum</td>
</tr>
<tr>
<td></td>
<td>Identify specific features of pleuritic chest pain</td>
</tr>
<tr>
<td>Cough</td>
<td>Explore nature of cough (dry, productive) precipitants, relieving</td>
</tr>
<tr>
<td></td>
<td>factors, speed of onset and progression, and associated symptoms</td>
</tr>
<tr>
<td>Sputum/Haemoptysis</td>
<td>Explore nature of sputum (mucoid, purulent, haemoptysis) and</td>
</tr>
<tr>
<td></td>
<td>associated symptoms</td>
</tr>
<tr>
<td>Wheeze/Stridor</td>
<td>Identify clear description of wheeze and stridor and associate with</td>
</tr>
<tr>
<td></td>
<td>common causes</td>
</tr>
</tbody>
</table>
Examination of respiratory system

<table>
<thead>
<tr>
<th>General examination</th>
<th>Identify noisy breathing, clubbing, cyanosis, cervical lymphadenopathy, signs of smoking, recent weight loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shape of chest wall</td>
<td>Identify barrel, pigeon and funnel chests and clear thoracic scoliosis</td>
</tr>
<tr>
<td>Respiratory movements</td>
<td>Assess respiratory frequency and depth. Identify clear tachypnoea, intercostal recession and hyperventilation</td>
</tr>
<tr>
<td>Percussion</td>
<td>Identify dullness and resonance over different lung areas Identify clear pleural effusion and pneumothorax</td>
</tr>
<tr>
<td>Breath sounds</td>
<td>Identify normal breath sounds. Identify clear cases of localised and generalised wheezes (rhonchi) and pitch (high medium, low), crackles (crepitations) and pleural rub, and associate with common causes. Identify localised or generalised reduced breath sounds</td>
</tr>
<tr>
<td>Voice sounds</td>
<td>Identify normal, and clearly increased and decreased voice sounds</td>
</tr>
</tbody>
</table>

Diagnostic tests/medication of respiratory system

| Chest X-ray | Recognise clear cases of pneumonia, pneumothorax, pleural effusion, lung mass and fractured ribs Appreciate absence of radiological signs in some serious conditions – asthma, pulmonary embolus |
| Peak Flow meter | Demonstrate correct technique for measurement of Peak Flow |
| Use of bronchodilator | Demonstrate correct technique for use of bronchodilator MDI and adult spacer device |

Gastrointestinal system

Common symptoms of gastrointestinal disease

| Abdominal pain | Explore basic characteristics including site, radiation, precipitating, relieving and associated factors. Identify specific history and assoc. features of heartburn, ‘ulcer-pain’, intestinal colic, and intestinal obstruction. |
| Weight loss | Explore amount, duration, dieting and associated anorexia. |
| Vomiting | Explore amount, frequency, description of vomit, presence of blood, assoc. factors |
| Diarrhoea | Assess frequency, description of stool, presence of blood, associated factors. Obtain contact and travel history. |
| Constipation | Assess duration, severity (stool or flatus or both), description of stool, straining, associated symptoms. |
| Rectal bleeding | Explore amount, frequency, appearance of blood, associated factors, description of stool including melaena |
| Jaundice | Identify duration, colour of stool and urine, associated pain, change weight. Explore contacts or travel, alcohol or drug use/abuse |
| Dysphagia | Assess duration, severity (food or fluid or both), associated features such as weight loss or pain. |

Examination of the gastrointestinal system

| General inspection | State of nutrition, cachexia |
| Hands | Look for clubbing, palmar erythema, Dupytren’s contracture, flap with jaundice |
| Face/mouth | Look for anaemia, jaundice, oral ulcers, appearance of tongue, spider naevi |
| Lymph nodes | Identify enlarged supraclavicular and groin LNs. |
| Abdominal inspection | Define different regions of the abdomen. Look for distension, scars, masses, |
| Abdominal palpation | Careful light and deep palpation, correct approach to palpate liver, spleen, kidneys and the ability to differentiate between these. Recognise both localised and generalised tenderness and guarding. |
| Abdominal percussion | Percuss appropriately the liver and spleen and understand how to detect ascites by shifting dullness. |
| Abdominal auscultation | Recognise normal and clearly abnormal bowel sounds |
| Hernias | Identify direct and indirect inguinal hernia, including reducibility. |

Diagnostic tests / medications of gastrointestinal system

| Plain abdominal X-ray and CXR | Recognise free gas aand bowel obstruction |
**Renal/Urology system**

**Common symptoms of ren/urology disease**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>Identify the specific history, radiation and associated features of renal/ureteric colic. Identify burning pain of dysuria, and association with increased urinary frequency in bladder/urethral inflammation.</td>
</tr>
<tr>
<td>Urinary frequency</td>
<td>Identify clearly abnormal urinary frequency and distinguish from polyuria. Identify oliguria/anuria.</td>
</tr>
<tr>
<td>Urinary stream</td>
<td>Identify the constellation of symptoms associated with bladder outflow obstruction.</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>Distinguish urge and stress incontinence.</td>
</tr>
<tr>
<td>Haematuria</td>
<td>Identify blood in the urine. Recognise that it may be the only manifestation of serious urinary tract disease.</td>
</tr>
</tbody>
</table>

**Examination of renal/urology system**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal palpation</td>
<td>Correct technique of bilateral examination for renal enlargement. Identify clearly enlarged bladder by palpation and percussion.</td>
</tr>
<tr>
<td>Scrotum</td>
<td>Identify normal and clearly abnormal testicles by palpation. Identify scrotal swelling, and distinguish testicular and epididymal swelling and hydrocele, varicocele and spermatocele. Distinguish from inguinal hernia. Demonstrate transillumination of hydrocele. (See lumps and bumps curriculum).</td>
</tr>
<tr>
<td>Oedema</td>
<td>Identify constellation of symptoms and signs associated with nephrotic syndrome, and distinguish from cardiac failure.</td>
</tr>
</tbody>
</table>

**Diagnostic tests of renal/urology system**

| Urine testing               | Identify haematuria, proteinuria, glycosuria and ketonuria on urine stick testing. |

**Nervous system**

**Common symptoms of neurological disease**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>Take history and identify specific and associated features of migraine, tension headache and subarachnoid haemorrhage.</td>
</tr>
<tr>
<td>Weakness/Immobility</td>
<td>Identify history of generalised, localised and hemiplegic weakness. Identify slow progressive history and typical features of Parkinson’s Disease. Identify acute onset of stroke and TIA.</td>
</tr>
<tr>
<td>Unconsciousness</td>
<td>Know major causes and identifying features of unconsciousness. Identify clear history of generalised epileptic seizure.</td>
</tr>
</tbody>
</table>

**Examination of the nervous system**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General examination</td>
<td>Identify constellation of signs of major hemiplegic stroke and Parkinson’s Disease. Distinguish constellation of signs of upper and lower motor neurone lesion.</td>
</tr>
<tr>
<td>Tone</td>
<td>Examine upper and lower limbs, and identify clearly increased and decreased muscle tone, and pattern (generalised, localised, hemiplegic, bilateral). Distinguish spasticity and rigidity.</td>
</tr>
<tr>
<td>Power</td>
<td>Examine limbs and identify clearly decreased power and pattern. Identify clear facial palsy, and distinguish upper from lower motor neurone lesion.</td>
</tr>
<tr>
<td>Muscle wasting</td>
<td>Identify clear muscle wasting and pattern.</td>
</tr>
<tr>
<td>Reflexes</td>
<td>Examine the biceps, triceps, supinator, knee and ankle and plantar reflexes. Identify clearly increased and decreased/absent tendon reflexes.</td>
</tr>
<tr>
<td>Tremor</td>
<td>Recognise the tremor of Parkinson’s Disease and distinguish from hyperthyroidism/anxiety.</td>
</tr>
<tr>
<td>Gait</td>
<td>Examine patient’s gait, and identify clear neurological abnormality due to major hemiplegic stroke and Parkinson’s Disease.</td>
</tr>
<tr>
<td>Speech</td>
<td>Recognise clear speech abnormality. Identify expressive and receptive dysphasia, dysarthria and dysphonia.</td>
</tr>
<tr>
<td>Sensation</td>
<td>Examine limbs and trunk for fine touch and pain sensation. Identify clearly reduced sensation and pattern.</td>
</tr>
</tbody>
</table>
### The Whole Patient

| Social and personal history | Take a comprehensive history including:  
|                            | • Employment and housing  
|                            | • Personal relationships  
|                            | • Lifestyle  
|                            | • Alcohol, smoking and drugs  
|                            | Identify social factors in causation and effects of physical illness |

| Family history | Take a family history of age and health, or cause of death of close relatives.  
|               | Understand the significance of a family history regarding inherited and environmental factors and patient anxiety.  
|               | Identify family history of a clear dominant or recessive inherited disorder |

| Psychological history | Identify major symptoms and signs of generalised anxiety disorder and panic attack, and differentiate from physical illness  
|                      | Recognise patient who is clearly anxious  
|                      | Identify major symptoms and signs of depression, and differentiate from physical illness  
|                      | Recognise patient who is clearly depressed  
|                      | Identify suicidal ideas and plans  
|                      | Identify psychological factors in causation and effects of physical illness |

| Integration of body systems | Take history and examine patient with common diseases affecting different body systems e.g. diabetes  
|                            | Explore history including related symptoms, examine and apply clinical problem-solving in patient with problems that can have various causes in different body systems  
|                            | • tired all the time  
|                            | • weight loss  
|                            | • fever  
|                            | Apply clinical reasoning where problems affecting one body system have effects on other body systems e.g. gastrointestinal bleeding causing anaemia causing breathlessness and worsening angina |
The Calgary-Cambridge consultation skills guide

This is used as a framework for teaching students about consultation skills in Year 2. It may seem a very long list at first glance. Please do not be daunted by it and take a closer look. You will find that it all makes a lot of sense. This guide provides a detailed language to reflect on and discuss consultation skills and to feedback on the students' performance.

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**TASK ONE: INITIATING THE CONSULTATION**

<table>
<thead>
<tr>
<th>Establishing Initial Rapport</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. GREET patient and obtains patient’s name</td>
</tr>
<tr>
<td>2. INTRODUCES self, role and nature of interview; obtains consent if necessary</td>
</tr>
<tr>
<td>3. DEMONSTRATES RESPECT and interest, attends to patient’s physical comfort</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identifying the Reason(s) for the Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. IDENTIFIES PROBLEMS LIST or issues patient wishes to discuss (e.g., “What would you like to discuss?; “What questions did you hope to get answered today?”)</td>
</tr>
<tr>
<td>5. LISTENS attentively to the patient’s opening statement without interrupting or directing patient’s response</td>
</tr>
<tr>
<td>6. CONFIRMS LIST AND SCREENS for further problems (e.g., “so that’s headaches and tiredness; anything else?”)</td>
</tr>
<tr>
<td>7. NEGOTIATES AGENDA taking both patient’s &amp; doctor’s perspectives into account</td>
</tr>
</tbody>
</table>

**TASK TWO: GATHERING INFORMATION**

<table>
<thead>
<tr>
<th>Exploration of Patient’s Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. ENCOURAGES PATIENT TO TELL STORY of problem(s) from when first started to the present in own words (clarifies reason for presenting now)</td>
</tr>
<tr>
<td>9. USES OPEN-ENDED AND CLOSED QUESTIONS, appropriately moving from open-ended to closed</td>
</tr>
<tr>
<td>10. LISTENS ATTENTIVELY, allows patient to complete statements without interruption, leaves space for patient to think before answering, go on after pausing</td>
</tr>
<tr>
<td>11. FACILITATES PATIENTS RESPONSES VERBALLY &amp; NON-VERBALLY (e.g., uses encouragement, silence, repetition, paraphrasing)</td>
</tr>
<tr>
<td>12. PICKS UP VERBAL AND NON-VERBAL CLUES (i.e., body language, speech, facial expression, affect); CHECKS OUT &amp; ACKNOWLEDGES as appropriate</td>
</tr>
<tr>
<td>13. CLARIFIES PATIENT’S STATEMENTS that are unclear or need amplification (e.g. “Could you explain what you mean by light headed?”)</td>
</tr>
<tr>
<td>14. USES concise, EASILY UNDERSTOOD QUESTIONS AND COMMENTS, avoids or adequately explains jargon</td>
</tr>
<tr>
<td>15. ESTABLISHES DATES AND SEQUENCE of events</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Skills for Understanding the Patient’s Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Actively DETERMINES AND APPROPRIATELY EXPLORES:</td>
</tr>
<tr>
<td>• PATIENT’S IDEAS (i.e., beliefs re cause)</td>
</tr>
<tr>
<td>• PATIENT’S CONCERNS (i.e., worries) regarding each problem</td>
</tr>
<tr>
<td>• PATIENT’S EXPECTATIONS (i.e., goals, help patient expects re each problem)</td>
</tr>
<tr>
<td>• EFFECTS ON PATIENT: how each problem affects the patient’s life</td>
</tr>
<tr>
<td>17. ENCOURAGES PATIENT TO EXPRESS FEELINGS</td>
</tr>
</tbody>
</table>
Task Three: Providing Structure to the Consultation

**Making Organization Overt**
18. **Summarizes at End of a Specific Line of Inquiry** (e.g., HPI) to confirm understanding & ensure no important data was missed; invites patient to correct

19. **Progresses from one section to another using Singposting, Transitional Statements; includes rationale for next section**

**Attending to Flow**
20. **Structures interview in logical sequence**

21. **Attends to Timing and keeping interview on task**

Task Four: Building the Relationship - Facilitating Patient’s Involvement

**Using Appropriate Non-Verbal Behaviour**
22. **Demonstrates Appropriate non-verbal behaviour**
   - eye contact, facial expressions
   - posture, position, gestures & other movement
   - vocal cues, e.g., rate, volume, tone, pitch

23. **If reads, writes notes or uses computer, does in a manner that does not interfere with dialogue or rapport**

24. **Demonstrates appropriate confidence**

**Developing Rapport**
25. **Accepts legitimacy of patient’s views and feelings; is not judgmental**

26. **Uses empathy to communicate understanding and appreciation of patient’s feelings or situation; overtly acknowledges patient’s views & feelings**

27. **Provides support: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership**

28. **Deals sensitively with embarrassing or disturbing topics and physical pain, including when associated with physical examination**

**Involving the Patient**
29. **Shares thinking with patient to encourage patient’s involvement (e.g., “What I am thinking now is ….”)**

30. **Explains rational for questions or parts of physical examination that could appear to be non-sequiturs**

31. **When doing physical examination, explains process, asks permission**

Task Five: Closing the Consultation (Preliminary Explanation & Planning)

32. **Gives explanation at appropriate times (avoids giving advice, information, opinions prematurely)**

33. **Gives information in clear, well-organized fashion**
   - without overloading patient, avoids or explains jargon

34. **Contracts with patient re: next steps for patient and physician**

35. **Checks patient’s understanding and acceptance of explanation and plans; ensures that concerns have been addressed**

36. **Summarizes session briefly**

37. **Encourages patient to discuss any additional points and provides opportunity to do so (e.g., “Are there any questions you’d like to ask or anything at all you’d like to discuss further?”)**

**Forward Planning**
38. **Contracts with patient re steps for patient and physician**

39. **Safety nets, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help**

**Ensuring Appropriate Point of Closure**
40. **Summarizes session briefly and clarifies plan of care**

41. **Final check that patient agrees and is comfortable with plan and asks if any correction, questions or other items to discuss**
Providing the Correct Amount and Type of Information

42. INITIATES: summarizes to date, determines expectations, sets agenda

43. ASSESSES PATIENT'S STARTING POINT: ask for patient's prior knowledge early, discovers extent of patient's wish for information

44. CHunks AND CHECKS: gives information in chunks, checks for understanding, uses patient's response as a guide on how to proceed

45. ASKS patient WHAT OTHER INFORMATION WOULD BE HELPFUL: e.g. aetiology, prognosis

46. GIVES EXPLANATION AT APPROPRIATE TIMES: avoids giving advice, information or reassurance prematurely

Aiding Accurate Recall and Understanding

47. ORGANIZES EXPLANATION: divides into discrete sections, develops logical sequence

48. USES EXPLICIT CATEGORIZATION OR SIGNPOSTING: (e.g. “There are three important things that I would like to discuss. 1st…Now we shall move on to…”)

49. USES REPTITION AND SUMMARIZING: to reinforce information

50. LANGUAGE: uses concise, easily understood statements, avoids or explains jargon

51. USES VISUAL METHODS OF CONVEYING INFORMATION: diagrams, models, written information and instructions

52. CHECKS PATIENT'S UNDERSTANDING OF INFORMATION GIVEN (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary

Incorporating the Patient's Perspective - Achieving Shared Understanding

53. RELATES EXPLANATIONS TO PATIENT'S ILLNESS FRAMEWORK: to previously elicited beliefs, concerns, and expectations

54. PROVIDES OPPORTUNITIES/ENCOURAGES PATIENT TO CONTRIBUTE: to ask questions, seek clarification or express doubts, responds appropriately

55. PICKS UP VERBAL AND NONVERBAL CUES: e.g. patient's need to contribute information or ask questions, information overload, distress

56. ELICITS PATIENT'S BELIEFS, REACTIONS AND FEELING: re information given, decisions, terms used, acknowledges and addresses where necessary

Planning: Shared Decision Making

57. SHARES OWN THOUGHTS: ideas, thought processes and dilemmas

58. INVOLVES PATIENT by making suggestions rather than directives

59. ENCOURAGES PATIENT TO CONTRIBUTE their IDEAS, suggestions, preferences, beliefs

60. NEGOTIATES a MUTUALLY ACCEPTABLE PLAN

61. OFFERS CHOICES: encourages patient to make choices/decisions to level they wish

62. CHECKS WITH PATIENT: if accepts plans, if concerns have been addressed
### TASK SIX (continued): OPTIONS IN EXPLANATION & PLANNING

**IF Discussion Opinion And Significance of Problem**

63. OFFERS OPINION of what is going on and names if possible

64. REVEALS RATIONALE for opinion

65. EXPLAINS causation, seriousness, expected outcome, short & long term consequences

66. CHECKS PATIENT’s UNDERSTANDING of what has been said

67. ELICITS PATIENT’s BELIEFS, REACTIONS AND CONCERNS e.g. if opinion matches patient’s thoughts, acceptability, feelings

**IF Negotiating Mutual Plan Of Action**

68. DISCUSSES OPTIONS e.g. no action, investigation, medication or surgery, non-drug treatments (physiotherapy, walking aids, fluids, counselling), preventative measures

69. PROVIDES INFORMATION on action or treatment offered
   a) name
   b) steps involved, how it works
   c) benefits and advantages
   d) possible side effects

70. ELICITS PATIENT’s UNDERSTANDING REACTIONS AND CONCERNS about plans and treatments, including acceptability

71. OBTAINS PATIENT’s VIEW of NEED for action, BENEFITS, BARRIERS, MOTIVATION; accepts and advocates alternative viewpoint as needed

72. TAKES PATIENT’s LIFESTYLE, BELIEFS, cultural BACKGROUND and ABILITIES INTO CONSIDERATION

73. ENCOURAGES PATIENT to be involved in implementing plans, TO TAKE RESPONSIBILITY and be self reliant

74. ASKS ABOUT PATIENT SUPPORT SYSTEMS, discusses other

**IF Discussing Investigations and Procedures**

75. PROVIDES CLEAR INFORMATION ON PROCEDURES including what patient might experience and how patient will be informed of results

76. RELATES PROCEDURE TO TREATMENT PLAN: value and purpose

77. ENCOURAGES QUESTIONS AND EXPRESSION OF THOUGHTS re potential anxieties or negative outcome
Poetry and Medical Student Teaching

By Dr. Marion Steiner
You can contact Marion on marion.steiner@gp-L81067.nhs.uk

Using poetry to help medical students become good doctors may not be an obvious thing to do, and may not suit all teachers or all students. However, the art of medicine is a subtle one, and the teaching of that art is not easy—poetry can be a stimulating and enjoyable tool to enrich the experience of students, teachers and patients. Sir William Osler’s advice to doctors was “Nothing will sustain you more potently than the power to recognize in your humdrum routine…the true poetry of life”

Dylan Thomas said "Poetry is what makes me laugh or cry or yawn, what makes my toenails twinkle, what makes me want to do this or that or nothing"

Students are encouraged to develop their creative sides during the year 1 whole person care course and at the end of COMP2 teaching in year 4. Some do choose to write poetry as their creative reflection of experience in general practice. However, it is also possible to find space for poetry in teaching students throughout their clinical course. It seems to be particularly good at stimulating right-brain learning.

“Overall, poetry can enhance clinical learning by honing emotion, psychological insights, and observational skills” Caroline Wellbery (2006)


Famous poet doctors
The most famous poet doctor was probably John Keats, who apparently tended to scribble verses during lectures at Guy’s. Others include William Carlos Williams, Dannie Abse (see the appendix) and Oliver Wendell Holmes.

Before books were common, symptoms and treatments were often put into verse. These are some dropsy symptoms from Erasmus Darwin’s “The Botanic Garden”:

. . . Bolster’d with down, amid a thousand wants, Pale Dropsy rears his bloated form, and pants; "Quench me, ye cool pellucid rills," he cries, Wets his parched tongue and rolls his hollow eyes.

Patients as Poets
There have been several initiatives encouraging patients to write poetry to improve well-being, especially in the field of mental health. One of these was a poet-in-residency project run by the Poetry Society, in which Dean Lane practice in Bristol participated. Lapidus is a national organisation which seeks to promote healing and personal growth through writing and reading http://www.lapidus.org.uk/

Poems for Patients
“Poems in the Waiting Room” started several years ago as a joint initiative by the Arts Council and the King’s Fund, providing poems printed on high-quality A4, for display in the waiting room. The on-going project is run by a charity, Poems in the Waiting Room, and produces 4 seasonal pamphlets for patients to read and take away.

http://www.pitwr.pwp.blueyonder.co.uk/

It’s interesting to see which patients pick up the pamphlets, and they can be a useful discussion point during the consultation. One of our patients takes and photocopies one for her family and friends, another, a single parent, collects and keeps them all. Poetry about difficult subjects, for example death, can be very useful, and poems shared between patients and their carers can help mutual understanding. There are several anthologies of poems around dying and death, which can be lent, or recommended, to patients (see bibliography).
Particular poems sometimes seem appropriate for individual patients, as a way of expressing empathy, or of nurturing understanding.

“The Poetry Cure” is an excellent anthology of poems for patients. One of the editors was a poet who had breast cancer (see bibliography).

**Poems for Students**

As an adjunct to more conventional methods, I give students copies of poems during teaching sessions (I can’t offer any evidence that this makes them better doctors, but feedback is good). Some of these have a physical theme e.g. when teaching CVS to 2nd years, some deal with communication skills, others with emotions relating to diagnoses. A selection is included here, and may be reproduced for teaching purposes only. Copyright is covered by a central NHS licence.

**Poems for Doctors**

We all need to look after ourselves, and poetry can help refresh the parts of a doctor that the BNF cannot reach. Sharing poetry with patients, students and colleagues is one of many ways of keeping general practice interesting.

**Bibliography**


**Examples of poems useful in teaching**

**Green Tomatoes**

Down the high street, past the post box, 
Doris, whose husband suddenly died
At the weekend, called me over.
She was mowing the lawn to make it all tidy
Before the funeral. Arms and legs
Bare in the heat, skin sagging
Like washed-out, faded longjohns,
She led me into the steamy warmth of
A greenhouse crowded with green tomatoes
As hard and vivid as malachite.
“Would you like some?” she asked.
“They won’t stop ripening.”

*Ruth Fainlight*
**The Stethoscope**

Through it, 
over young women’s tense abdomens, I have heard the sound of creation 
and, in a dead man’s chest, the silence before creation began.

Should I 
pray therefore? Hold this instrument in awe 
and aloft a procession of banners? 
Hang this thing in the interior of a cold, mushroom-dark church?

Should I 
kneel before it, chant an apophthegm from a small text? Mimic priest or rabbi, 
the swaying noises of religious men? 
Never! Yet I could praise it.

I should 
by doing so celebrate my own ears, 
by praising them praise speech at midnight 
when men become philosophers; 
laugher of the sane and insane;

Night cries 
of injured creatures, wide-eyed or blind; 
moonlight sonatas on a needle; 
lovers with doves in their throats; 
the wind 
traveling from where it began.

Dannie Abse

**The Moon**

You can take the moon by the spoonful or in capsules every two hours. 
It’s useful as a hypnotic and sedative and besides it relieves those who have had too much philosophy. 
A piece of moon in your purse works better than a rabbit’s foot. 
Helps you find a lover or get rich without anyone knowing, 
and it staves off doctors and clinics. 
You can give it to children like candy when they’ve not gone to sleep, 
and a few drops of moon in the eyes of the old helps them to die in peace.

Put a new leaf of moon under your pillow and you’ll see what you want to. 
Always carry a little bottle of air of the moon to keep you from drowning. 
Give the key to the moon to prisoners and the disappointed. 
For those who are sentenced to death and for those who are sentenced to life there is no better tonic than the moon in precise and regular doses.

Jaime Sabines (trans. W. S. Merwin)
Names

She was Eliza for a few weeks
When she was a baby-
Eliza Lily. Soon it changed to Lil.

Later she was Miss Steward in the baker’s shop
And then 'my love', 'my darling', Mother.

Widowed at thirty, she went back to work
As Mrs Hand. Her daughter grew up,
Married and gave birth.

Now she was Nanna. 'Everybody
Calls me Nanna,' she would say to visitors.
And so they did- friends, tradesmen, the doctor.

In the geriatric ward
They used the patients’ Christian names.
'Lil' we said, 'or Nanna,'
But it wasn’t on her file
And for those last bewildered weeks
She was Eliza once again.

Wendy Cope

When Someone Deeply Listens to You

When someone deeply listens to you
It is like holding a dented cup
you’ve had since childhood
And watching it fill up with
cold, fresh water.
When it balances on top of the brim,
you are understood.
When it overflows and touches your skin,
you are loved.

When someone deeply listens to you
the room where you stay
starts a new life
and the place where you wrote
your first poem
begins to glow in your mind’s eye.
It is as if gold has been discovered!

When someone deeply listens to you
your bare feet are on the earth
and a beloved land that seemed distant
Is now at home within you

John Fox
Books and References

Clinical Examination
**Introduction to Clinical Examination**, Munro and Ford (Churchill Livingstone, 2000)
Short succinct textbook, good for quick revision

Clinical skills, Oxford Core Texts, Cox and Roper (Eds.) (Oxford University Press, 2005)
This is a more recent book on clinical skills with detailed descriptions of examination techniques, almost 500 pages. It also rates the difficulty of an examination from 1-5, which can be helpful.

An Introduction to the Musculoskeletal System – a handbook for medical students, Professor Paul Dieppe (www.arc.org.uk)
This free handbook from the Arthritis Research Campaign covers the 5 minute GALS (gait, arms, legs, spine) examination.

Clinical medicine
The chapters in this book are organised by symptoms. The authors present a list of possible causes of each symptom in order of likelihood and list the red flags that must not be missed. This is a very useful book for all practicing doctors and clinical students.

General practice
This book, edited by our current external examiner for Year 4, is good at explaining what general practice is all about. It discusses the organisation of general practice, prescribing, chronic disease and health promotion. It contains less information on the management of particular clinical problems.

Whole Person Medicine
**Suburban Shaman – tales from medicine’s front line**, Helman, C (Hammersmith Press, 2006)
A succession of colourful stories emphasising a humanistic approach to medical practice from the author’s experiences around the world. Good therapy for information overload.

Evidence Based Medicine
**How to read a paper: the basics of evidence-based medicine**, Greenhalgh, (BMJ Books, 2006). Very helpful when presenting papers or researching. I wish I had read it earlier!

Ethics
**The duties of a doctor registered with the General Medical Council**
http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp

**Medical Students: Professional Behaviour and Fitness to Practice**
www.gmc-uk.org/education/undergraduate/undergraduate_policy/professional_behaviour.asp

Disability

Consultation and procedural skills
**Communication skills that heal**, BUB, B. (Oxford: Radcliffe Publishing 2006)
A different look at the consultation, pattern recognition of ‘types of consultations’, for example ‘the lament’. Easy and enjoyable to read with hands on suggestions

Wider Interest
Fascinating, well-illustrated account of medicine’s development. Includes plague costumes, barber-surgeons and hydrotherapy! Puts today’s medical practice into perspective.

For further textbooks, please see the Primary Care website
http://www.bristol.ac.uk/primaryhealthcare/
Forms

Year 3 Attendance and Payment Form 2013-14
Student evaluation of the Year 3 GP attachments in 2013-14
Student concern form
Year 3 - Log of Students and Reflections on teaching 2013-14
Year 3 - Student Self-Assessment Form
Year 3 - Student Self Assessment Checklist
Reflective diary/log of patients seen in the GP sessions
ATTENDANCE & PAYMENT FORM (one form per group)

3rd Year GP attachments 2013-14

Please return this form and the student feedback forms at the end of the attachment to:

Student names

<table>
<thead>
<tr>
<th>Primary Health Care Teaching Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Bristol</td>
</tr>
<tr>
<td>Room 1.01, Canynge Hall</td>
</tr>
<tr>
<td>Whatley Road</td>
</tr>
<tr>
<td>BRISTOL</td>
</tr>
<tr>
<td>BS8 2PS</td>
</tr>
</tbody>
</table>

Please give details of any absences or concerns:

<table>
<thead>
<tr>
<th>Year 3 Teaching</th>
<th>Name of Student</th>
<th>Date of absence</th>
<th>Reason for absence</th>
<th>Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1:</td>
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<td>Session 2:</td>
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<td>Session 3:</td>
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<td>Session 4:</td>
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</table>

Did you have any concerns about any of your students? Yes/No

If yes, please refer to our protocol ([http://www.bristol.ac.uk/primaryhealthcare/teachingtutors/](http://www.bristol.ac.uk/primaryhealthcare/teachingtutors/)) which directs you to complete a Student Concern Form (below) and return it to the address on the form. Please also send a copy to the Primary Care Teaching Office. (NB We are aware that there will be a time lag between your potentially filling in a Student Concern Form and filling out this Attendance & Payment form.)

GP Teacher: ..........................................................................................................................................................

GP Practice: ..........................................................................................................................................................

I confirm that I taught the above medical students for ........ sessions.

GP teacher's signature: ......................... Date: .................
Centre for Academic Primary Care

Student evaluation of the Year 3 GP attachments in 2013-14

Academy ..................................................

GP attachment (please tick)  1st GP practice  2nd GP practice

GP’s name and practice (please print clearly or use stamp)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our GP teacher made us feel welcome</td>
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<td></td>
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<tr>
<td>Our GP was an enthusiastic teacher</td>
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<tr>
<td>Our sessions were well organised</td>
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<td>(started on time, well planned, well</td>
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<td>structured)</td>
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<tr>
<td>We saw 2 or more patients in each session</td>
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<tr>
<td>The GP teacher observed me taking a</td>
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<tr>
<td>history and examining a patient</td>
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<tr>
<td>The GP teacher commented on our skills</td>
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<td>during the sessions</td>
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<td>The GP teacher gave me individual</td>
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<td>feedback at the end of the last session</td>
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<td>I found the feedback from my GP teacher</td>
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<td>helpful</td>
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</table>

What was good about the sessions in this practice?

How could this GP Teacher improve the sessions?

How have these sessions improved your clinical skills?

Thank you for taking the time to complete this form

Please place your form and those from the other students in the envelope provided by your GP teacher and seal the envelope.

Please ask your GP teacher to post to:

Primary Care Teaching Office, Room 101, Canynge Hall, 39 Whatley Rd, Clifton, Bristol BS8 2PS

PTO for further comments
Faculty of Medicine and Dentistry

Student Concern Form

This form is for use by any University of Bristol or NHS staff members, University of Bristol students, patients or members of the public who feel that a particular medical student's standard of professional behaviour and/or their state of health is a cause for concern.

It is hoped that most professional behaviour issues can be dealt with informally, by discussing the concern with the student, so that the student is given the opportunity to address the issues raised. Please consider this course of action, if appropriate, before you complete this form.

Your concern may relate to a number of areas:

- **Relationships with patients** – e.g. not respecting confidentiality, being impolite to patients, not informing patients they are a student, persistently not complying with the Clinical Dress Code
- **Working with others** – e.g. failing to follow instructions, being disrespectful towards other healthcare students, persistently disrupting teaching
- **Probity** – e.g. fraudulent or dishonest behaviour, requesting money/gifts from patients
- **Learning** – e.g. persistent lateness or non-attendance, not responding constructively to feedback
- **Health** – e.g. a drinking or drugs problem or mental or other health issues

Any concern you raise may be discussed with you prior to the student being contacted. Your concern will then be considered by the Fitness to Practise Case Investigator who will decide what appropriate action should be taken.

For further information on the procedures, please see the Rules, Policies & Procedures Handbook (available online at [http://www.bris.ac.uk/medical-school/staffstudents/rulesandpolicies](http://www.bris.ac.uk/medical-school/staffstudents/rulesandpolicies))

**Patient Safety**

If you are very concerned about a student's behaviour and feel that patient safety is at risk you should immediately contact either the Director of Student Affairs or the Faculty Education Manager or, if they are not available, the Medicine & Dentistry Faculty Dean who will take action as appropriate.

If you wish to discuss your concern before you submit this form, please contact the Fitness to Practise Case Investigator, via the Faculty Education Manager on (0117 3318317).

This form should be completed in full and returned marked ‘Private & Confidential’ by e-mail to: t.l.chapman@bristol.ac.uk or sylvia.elliott@bristol.ac.uk. Or sent by hard copy to Mrs Syl\`{a}via Elliott, Faculty Education Manager, C/O Tracey Chapman, Level 1 Senate House, Tyndall Avenue
Student Concern Form

Name of Student:  

Year on Medical Programme (please circle if known): 1  2  3  4  5  

Please describe the nature of your concern about the above student’s professional behaviour (please use additional sheets of paper if required)  

If possible, please specify the date/s & time/s on which the incident/s you refer to occurred:  

Please Note:  
All concerns must be made by a named individual. You should be aware that under the Data Protection Act it is very unlikely that if a written concern is received that the identity of the reporter can remain anonymous as students have a right to see information held about them by the University. Please be aware that a copy of the SCF as completed by you is sent to the student if it is agreed that further action is required.  

University staff or students who make malicious or deliberately misleading statements concerning a student may be referred to the relevant University disciplinary procedures. No action will be taken against a member of staff or student who raises a concern in good faith.  

Name:  .................................................. Signature: .............................................  

Date:  ..................................................................................................................  

Role (Please circle as appropriate): NHS Staff / University Staff / Student / Other ......................  

Contact Details  
(so you can be contacted to discuss the concern - these will not be released to the student and will be kept confidential)  

Telephone: .................................................. Email: ..................................................
Year 3 - Log of Students and Reflections on teaching 2013-14

This form is intended for GP teachers to make notes about sessions, individual students and their own reflections - an aide memoire. You may find this form helpful when giving feedback to your students.

<table>
<thead>
<tr>
<th>Student</th>
<th>Session 1</th>
<th>comments</th>
<th>Session 2</th>
<th>comments</th>
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**Teacher reflection**

What went well
What needs changing

<table>
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<tr>
<th>Student</th>
<th>Session 3</th>
<th>comments</th>
<th>Session 4</th>
<th>comments</th>
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<tbody>
<tr>
<td>1</td>
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</table>

**Teacher reflection**

What went well
What needs changing

This form is for you to keep. Students increasingly ask their GP teachers for references
Year 3 - Log of Students and Reflections on teaching 2013-14

This form is intended for GP teachers to make notes about sessions, individual students and their own reflections - an aide memoir. You may find this form helpful when giving feedback to your students.

<table>
<thead>
<tr>
<th>Unit(s) and Dates</th>
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</thead>
<tbody>
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<td>Student</td>
<td>Session 1 comments</td>
<td>Session 2 comments</td>
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<tr>
<td><strong>Teacher reflection</strong></td>
<td>What went well</td>
<td>What needs changing</td>
<td></td>
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<table>
<thead>
<tr>
<th>Unit(s) and Dates</th>
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<tbody>
<tr>
<td>Student</td>
<td>Session 3 comments</td>
<td>Session 4 comments</td>
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<tr>
<td><strong>Teacher reflection</strong></td>
<td>What went well</td>
<td>What needs changing</td>
<td></td>
</tr>
</tbody>
</table>

This form is for you to keep. Students increasingly ask their GP teachers for references.
Year 3 - Student Self-Assessment Form  *(Not to be returned to the teaching office)*

<table>
<thead>
<tr>
<th>Date</th>
<th>GP teacher/practice (stamp)</th>
</tr>
</thead>
</table>

**Unit**

Please take some time to reflect on your professional development. Areas for consideration: medical history taking, consultation skills, knowledge, “putting it all together” and others. You may also want to consider how you feel in different medical environments (hospital wards, General Practice) and how you are handling emotions – those of patients, people around you and your own.

<table>
<thead>
<tr>
<th><strong>Own reflections</strong></th>
<th><strong>Feedback from your GP teacher</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
<td></td>
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<tr>
<td><strong>Areas in which I have improved</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Areas for development</strong></td>
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</tbody>
</table>

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Year 3 Student Self Assessment Checklist

This checklist is based on the suggested teaching topics. It is designed to help tailor your learning to your needs. It can also help assess progress in acquiring skills and knowledge. The checklist is yours. It does not form part of a formal assessment process. Be honest. Try to complete it on 3 occasions

- Before GP session 1 (at the start of year 3)
- Before GP session 4 (end of 1st GP attachment)
- Before GP session 8 (end of 2nd GP attachment)

Score | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9
Confidence | Nil | Little | Moderate | Very | Total

<table>
<thead>
<tr>
<th>Skill/Knowledge</th>
<th>Start Year 3</th>
<th>Before GP session 4</th>
<th>Before GP session 8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMUNICATION/CONSULTATION</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Introductions</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Developing rapport</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Non-verbal communication</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Attentive listening</td>
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<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
</tr>
<tr>
<td>Open/closed question use</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Clarifying</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Empathy</td>
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<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Explaining clearly</td>
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<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Summarising</td>
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<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Sharing decisions</td>
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<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
</tr>
<tr>
<td>Interview structuring</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
</tr>
<tr>
<td>Time management</td>
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<td>1.2.3.4.5.6.7.8.9</td>
<td>1.2.3.4.5.6.7.8.9</td>
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<tr>
<td>Average (1-9)</td>
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<table>
<thead>
<tr>
<th><strong>CLINICAL KNOWLEDGE</strong></th>
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</thead>
<tbody>
<tr>
<td>Overall</td>
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<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>ENT</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Musculoskeletal</td>
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<td>Average (1-9)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CLINICAL EXAMINATION</strong></th>
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</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
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<tr>
<td>Respiratory</td>
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<tr>
<td>Abdominal</td>
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<tr>
<td>Neurological</td>
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<tr>
<td>ENT</td>
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<tr>
<td>Mental State</td>
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<td>Knee</td>
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<tr>
<td>Hip</td>
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<tr>
<td>Back</td>
</tr>
<tr>
<td>Shoulder</td>
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<tr>
<td>Average (1-9)</td>
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</table>

<table>
<thead>
<tr>
<th><strong>PRACTICAL SKILLS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>BP measurement</td>
</tr>
<tr>
<td>Dipstick urinalysis</td>
</tr>
<tr>
<td>Blood glucose testing</td>
</tr>
<tr>
<td>Using an auriscope</td>
</tr>
<tr>
<td>Using an ophthalmoscope</td>
</tr>
<tr>
<td>Measuring ABPI</td>
</tr>
<tr>
<td>Demonstrating inhalers</td>
</tr>
<tr>
<td>Measuring PEFR</td>
</tr>
<tr>
<td>Using a thermometer</td>
</tr>
<tr>
<td>Average (1-9)</td>
</tr>
<tr>
<td>Overall Average (1-9)</td>
</tr>
</tbody>
</table>

Please write your reflections and comments on the back of this form.
Reflective log of patients seen in my GP attachments
Please keep a list of the patients you have seen in General Practice and reflect on what you have learned from them. This should help you to plan your studies. You, the other students in your group and your GP teacher could also use this learning log for planning the next session.

<table>
<thead>
<tr>
<th>Patient (age, gender)</th>
<th>Diagnosis/Problem(s)</th>
<th>Learning points</th>
<th>Plan for further learning</th>
</tr>
</thead>
</table>
| Example F, 65         | Type 2 DM, depression, Obesity | ▪ Learned how to stay focussed with a complex history  
▪ 2 question screening tool for depression  
▪ How to check for peripheral neuropathy | ▪ When to start medication in Type 2 DM  
▪ Guidelines for treatment in Type 2 DM  
▪ Learn more about motivational interviewing |

1

2

3

4

5

There are more pages in the student’s guidebook