MB ChB Programme

Year 1 Effective Consulting

Clinical Contact in the Foundations of Medicine

A Study Guide

Academic Year 2017-2018

University of Bristol, 2017

WELCOME FROM CLINICAL CONTACT LEAD

Welcome to Clinical Contact in Year 1.

As part of your Effective Consulting course over the coming year you will be placed in general practice (primary care) and hospital (secondary care) settings and get to meet and talk with patients and the doctors that care for them, practice your consulting skills, and make links to your theoretical learning on the medical course. You are introduced to this element of your course during the Foundations of Medicine with four visits to GP surgeries.

When you visit your general practice in the Foundations of Medicine you will have the opportunity to observe doctors in their clinics and to spend time with patients in their homes. Previous students appreciated being immersed in real life clinical practice at this early stage in training. It is one of the huge privileges of medical training that you get to hear patient's personal stories and learn from them. Patients really value being able to share their experiences of life, health and illness with you. This handbook and your GP tutor will help you get the most out of these visits.

I hope you enjoy this valuable experience.

Jessica Buchan

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INTRODUCTION

This is your very first chance in the curriculum to meet patients and health care professionals who are working at the coalface. The low teacher to student ratio allows interactive teaching, the enthusiasm of GPs to teach and the relaxed learning environment means that you generally have a very successful placement.

GP consultations are a place where the art of caring for patients is interwoven with the science of medicine. GPs deal with a great variety of clinical presentations and problems of all kinds. They tend to build relationships with patients over time, through multiple consultations and operate within a more level doctor-patient playing field. It is often the first point of contact for the public with the medical profession.

STUDY GUIDE

This study guide is designed to give you key information about the Clinical Contact placement in Foundations of Medicine. There is information about each of the four sessions in Foundations of Medicine in the session plans section of this guide This includes extra information and questions to stimulate your thinking, read when you have some spare time, and to provide a basis for discussions with your GP teacher. It can be helpful to keep a log of your cases you have seen, learning points and identify further learning you need to do.

At the end of each of your clinical contact sessions you will be asked to complete an online reflective form to record your experiences and learning. This will be uploaded to your e-portfolio "*My Progress"* and should be shared with your clinical tutors by entering their email address on the form. There is a copy of this form at the back of this guide. Some students like to keep additional notes on their experiences and cases they've seen, so there is a case log and home visit reflective template at the back of this guide (Appendix 4). You will be expected to draw on your experience with patients in your Human Sciences tutorials and Effective Consulting lab sessions.

We recommend you don't use the online portfolio form for your ***first*** Clinical Contact session—just keep written notes, you will be shown how to upload your notes into the online reflective form e-portfolio in your training session on using the portfolio on **Tuesday 10th October**.

It is helpful to have access to this guide during the Clinical Contact session. The study guide is available on line through Blackboard (**MEDI10007_2017: Year 1 MB ChB 2017**).

KEY DATES

Effective consulting starts with an introductory lecture on **27th September 2017.** This is followed by small group sessions for consultation skills teaching and learning about communication on **28th September 2017.** **Y**ou will be emailed the detail of your placements. There will be time in the small group session to meet the other students in your group and discuss the placement. The

following are the GP placement dates in Foundations of Medicine:

Morning **9 am – 12 pm** or Afternoon **2 - 5pm**
Thursday 5th October
Thursday 19th October
Thursday 2nd November
Thursday 16th November

Wednesday afternoons are meant to be reserved for extracurricular activities. However, if students are happy to attend on a Wednesday, we will offer some placements on Wednesday afternoons, to accommodate GP teachers who can only teach at this time. This group start on the afternoon of Wednesday 4th October and then attends on 18th October, 1st November and 15th November.

TRAVEL EXPENSES

You can claim reimbursement for travel expenses if you attend a placement in zone 2 or 3 (Bristol City bus networks). There is information in your year 1 handbook the MB ChB Program Rules, Policies and Procedures regarding eligibility and the claim process or see the web link below. You can use this link to download a form to complete and then return it (with bus tickets) to Joe McAllister, MBChB Year 1 Administrative Lead in the Medical Undergraduate Programme Team Office, 1st Floor, Senate House. For GP placement, travel claims should be made within 30 days of the end of the placement. The travel expenses claim form can be found on the Medical School student intranet.

If your placement is in one of the following practices:

BACKWELL & NAILSEA MEDICAL GROUP

CHEW MEDICAL PRACTICE

DR JOHN & PARTNERS (WINSCOMBE & BANWELL FAMILY PRACTICE)

SUNNYSIDE SURGERY

ST JAMES'S SURGERY, BATH

then Bristol Medical School will pay a joint taxi shared with the other students placed at the practice, but this must be agreed in advance. One of the students at that practice will need to reclaim the costs as part of their travel claim. They will need a receipt and the names of the other students.

Otherwise only bus fares are reimbursed; but if a group of students are travelling together and choose to take a taxi, the university would consider re-funding part of the cost to the value of your joint bus fares and the students would be expected to pay the difference between the bus

and taxi fares, which must be agreed in advance. Please contact the Year 1 co-ordinator for further details.

Please discuss with Joe McAllister if you have any queries regarding what can be claimed and do try to club together with your group to share costs – all arrangements regarding taxi/alternative transport must be agreed in advance.

A useful website is https://www.firstgroup.com/bristol-bath-and-west/plan-journey/journey-planner

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ATTENDANCE

Absence and Illness Reporting

Student attendance should be 100% for all teaching. Any absence through sickness or another reason must be communicated to the GP by phone or email prior to the session you will be missing. Please also contact phc-teaching@bristol.ac.uk and your Year administrative lead (Joe McAllister via medadmin-1@bristol.ac.uk). Your GP will also inform us of absences at the end of the placement.

On the first day of absence you **must** complete a **Student Absence Reporting Form**. On your return from absence please let us know that you are back by completing a **google self certificate form by 5pm within 2 working days of your return from absence.**

STUDENT SUPPORT

Students in Years 1&2 can access support by emailing healthsciences-support@bristol.ac.uk

The Deputy Senior Tutor is Dr David Morgan, D.J.Morgan@bristol.ac.uk. David Morgan (Premedical, Years 1-2 and intercalating students) is available to discuss academic and welfare issues. Appointments can be made by contacting your **administrative year lead** (Joe McAllister, via medadmin-1@bristol.ac.uk).

You will all be allocated an Professional Mentor who will meet with you three times a year throughout your course. Their role is to focus on your educational progress and professional and career plans.

Galenicals Welfare: foundation@galenicals.org.uk

University central student support services are available at: http://www.bris.ac.uk/studentservices/

You should all register with a local General Practice. Bristol University has a dedicated NHS GP practice Student Health Services: 0117 330 2720 http://www.bristol.ac.uk/students-health/

Student Counselling. 3rd Floor, Hampton House, St. Michael's Hill, Cotham, Bristol, BS6 6AU.

http://www.bristol.ac.uk/student-counselling/ 0117 954 6655

The student's union provides advice on a range of issues from academic to housing. Contact: https://www.bristolsu.org.uk/justask/ or email bristolsu-justask@bristol.ac.uk

PROFESSIONAL BEHAVIOUR

On clinical placement patients are at the heart of all that you do and their needs and safety are paramount. Your GP should brief you on Health and Safety Issues in the workplace and it is important that you carefully follow their instructions.
Students should adhere to the professional code of practice at all times which can be found at:

https://www.ole.bris.ac.uk/bbcswebdav/institution/Faculty%20of%20Health%20Sciences/MB%20ChB%20Medicine/Handbooks/Rules%20and%20Regs/MB%20ChB%20Rules%20Policies%20and%20Procedures%20Handbook%2017-18

This includes:

- Treating all patients with respect (including respecting confidentiality)
- Treating all staff and colleagues with respect (including not disrupting their teaching)
- Attending all teaching on time and adhering to the clinical dress code i.e. ladies – no cleavage or midriff; men – trousers, shirt +/- tie.
- Being honest
- Hand in all required paperwork/assessments to deadlines
- Taking care of your health and seeking help if your health may impact on patient care

The GMC has produced interactive case studies on professionalism in action and some of which are relevant to the GP placements. You can find them at:
www.gmc-uk.org/studentvalues

See also "Confidentiality" further on in this handbook on page 13.
Your GP should have asked all patients in advance for permission for you to observe consultations or to visit patients in their homes.

MEDICAL INDEMNITY

Students on clinical placements **should have their own professional indemnity** (you can obtain free membership of the MDU/MPS). Students are covered vicariously by the GP/practice indemnity and the MDU, MPS and MDDUS have confirmed that this cover is provided without individual notification of the students' presence in practices. As one would expect, the supervising GP/nurse/healthcare professional retains responsibility for all patient encounters, decisions and treatment. It is advised that you the surgery has an honorary contract between student and supervisor setting out the responsibility of each party; this can include data protection, confidentiality and other individual practice specifics. There is a sample document (see Appendix 3) that can be used for this titled General Practice: Medical Student Undertaking – also available on the PHC website at:

http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/documents/General%20Practice%20Medical%20Student%20Undertaking%20(2).pdf

and this is also available in Appendix 3.

CONTACT INFORMATION

Bristol Medical School, Primary Healthcare Teaching Office, 1st Floor, South Wing, Senate House, Tyndall Avenue, Bristol BS8 1TH
www.bris.ac.uk/primaryhealthcare

Element Lead	Dr Jessica Buchan	Jessica.buchan@bristol.ac.uk
Element Admin	Alison Capey	All enquiries to be directed to phc-teaching@bristol.ac.uk 0117 331 6824

CLINICAL CONTACT AS A PART OF THE EFFECTIVE CONSULTING COURSE IN YEAR ONE

Your first year of MB21 starts with a 10-week introductory block. The aim of the teaching in Foundations of Medicine (FoM) is to introduce you to an integrated approach to learning on the medical degree programme, and to prepare you for case-based learning. It is an introduction to the knowledge, skills and attitudes that you will need to succeed both as a student and in your role as future doctor. This includes, but is not limited to: Basic Life Support, learning skills, and the foundations of the biomedical science and human science knowledge you need to get the most out of your learning for the rest of the year.

You will attend clinical placements throughout your first year. This is part of a course called "Effective Consulting." Effective Consulting is a course where you gain experience in:

- Clinical Reasoning (how to think like a doctor)
- Clinical Communication (how to effectively communicate with patients and others in a clinical situation)
- Clinical Skills (how to take a history, and examine patients).

The Effective Consulting course is delivered in two parallel strands:

- **Effective Consulting "labs"** are lecture-based and small group experiential sessions where you will learn to consult by practicing skills with each other and sometimes with actors. There is one lecture and 2 group sessions in Foundations of Medicine, and one session every Case Based learning cycle in the rest of Year One.
- **Clinical Contact.** In Foundations of Medicine you will make 4 visits to Primary Care to meet patients and the primary healthcare team. You will consider the meaning of health and consider what makes good healthcare. In the Case Based learning cycle you will alternate between primary care and secondary care visits and consider the patient and clinical aspects of the system you are learning about.

At the end of the Foundations of Medicine you will be assessed on a group presentation of an aspect of your learning. Your GP will not be assessing you but you may be inspired by a patient that you have met on Clinical contact. If you use any patient information it is important that they not identifiable and that you gain appropriate consent (see confidentiality page 13).

AIMS AND LEARNING OBJECTIVES

AIMS OF CLINICAL CONTACT IN YEAR ONE

1. Introduce students to the clinical environment
2. Introduce professionalism and how to behave according to ethical and legal principles
3. Inspire learning from clinical experience and help students contextualize their learning on the Foundations of Medicine Course and in the 7 Case based learning cycles.
4. Introduce communication skills through observation of doctors and other health care professionals in practice, and through experience of meeting with and speaking to patients.
5. Introduce students to broad elements of taking a history, and the approach to a clinical examination
6. Enable students to reflect on the patient perspective and the wider context of health
7. Introduce students to the principles of self-care and resilience

LEARNING OBJECTIVES FOR CLINICAL CONTACT IN YEAR ONE

At the end of year one, students will be able to:

1) Demonstrate appropriate professional behaviour for a clinical medical student.
2) Be comfortable introducing themselves to, and talking with patients in a hospital and general practice environment.
3) Understand how to approach the examination of patients and have been introduced to examining aspects of the Cardiovascular, Respiratory and Gastrointestinal systems.
4) Demonstrate communication skills such as active listening and acknowledgement, building rapport, information gathering, and the appropriate use of open and closed questions.
5) Understand how physical, social and psychological factors impact on health and wellbeing
6) Develop themselves as active learners including reflecting on their learning from clinical contact and making links with their theoretical learning.

HELICAL THEMES IN CLINICAL CONTACT

Helical themes are aspects of the curriculum that run throughout all five years of MB21. Each of the themes captures an aspect of medical education that is a) not exclusive to any particular speciality and b) considered essential in the formation of the well-rounded medical graduate. Further information about each theme is available on Blackboard. The main 4 domains of the Helical Themes are aligned with the framework provided by the GMC's "Outcomes for Graduates" (commonly referred to as Tomorrow's Doctors). The Person and Citizen domain is unique to Bristol's MB21 course.

Meeting patients and doctors in Clinical Contact will bring the Helical Themes alive, and you will start to see their importance to the practice of medicine and how the various themes are interwoven. In

any one clinical encounter with a patient, a doctor has to draw on their biomedical knowledge and apply evidence to a clinical situation, they have to communicate effectively with patients (and the patient's family or carers, as well as other health professionals), perform procedures, and understand the patient's psychology and social context (behavioural and social sciences) to provide effective and holistic (whole person) care. Doctors must act in a professional manner (world of work) with concern for patient safety, work effectively with a diverse range of people and advocate for them (3D), and practice within an ethical and legal framework in an increasingly digitised environment. To do any of this effectively doctors need to look after themselves (self-care and resilience). You will see all of this unfolding in front of you when you observe doctors working with patients, sometimes in a single consultation. Of course, the doctor's work is wider than the individual patient in front of us—a doctor also needs to consider the global and public health implications of practice. It is through the Arts and Humanities that we can make sense of what we do, bring meaning, deepen understanding, and help manage the emotional work of caring for patients.

A. *Doctor as scholar and scientist*	B. *Doctor as practitioner and educator*
1. **Biomedical sciences [TD8]** 2. **Behavioural and Social Sciences [TD9&10]** 3. **Evidence Based Practice [TD11&12]**	1. **Effective Consulting [TD13&15]** 2. **Procedural Skills [TD18]** 3. **Pharmacology and Therapeutics [TD17]** 4. **Learning and Teaching [TD21]** 5. **Whole Person Care**
C. *Doctor as professional and agent of change*	D. *Doctor as person and citizen*
1. **Ethics and Law [TD20]** 2. **World of Work [TD22 and 23g]** 3. **Patient Safety and QI [TD23]** 4. **The Digital Environment [TD19 and21 b]**	1. **Self-care and resilience** 2. **Arts and Humanities** 3. **3D — Disability [TD15 b-c], Disadvantage [TD11 a] and Diversity [TD20 d]** 4. **Global and Public Health**

PREPARING FOR YOUR CLINICAL CONTACT SESSIONS

When you are given details of your placement you will find out who else is in your group, **one student will be the lead (the 'Contact Student') for the group**. This student should contact your GP prior to your arrival to check times, directions and whether you need to bring anything in particular. **If the Contact Student is absent from your session on 28 September, please nominate someone else from amongst your group to take on this role**. We do not expect you to have your own medical equipment at this stage. Please dress appropriately (see professional behaviour page 8).

Please take your University ID badge and this study guide (or online access to this guide) with you.

ORGANISATION OF PRIMARY CARE

General practice can be seen as central to the NHS with the average person consulting their GP more than five times per year[1]. Each general practice belongs to a Clinical Commissioning group (CCG). There are more than 200 CCGs who have a strategic role in implementing government health care policy and management of funding in primary care and commissioning services from secondary care and other providers.

PRIMARY HEALTH CARE TEAMS

The primary health care team includes a variety of professionals including: doctors, practice nurses, district nurses, health visitors, physiotherapists, podiatrists, counsellors and more. The patient/carer is also part of that team. It is important that the team surrounding a patient communicate and work well together in order to provide seamless care e.g. a patient with diabetes may see both a nurse and a doctor for different aspects of their follow up. Each needs to know the care the other provides. The nurses will often work to protocols that have been agreed for monitoring chronic illness conditions such as diabetes, hypertension, cardiovascular disease and asthma.

KEY FEATURES OF GENERAL PRACTICE

Apart from working within multidisciplinary teams as explained above, general practice also means caring for individuals within their local community, coordinating patient care, offering continuity of care, dealing with a great variety of patient presentations during a single surgery and dealing with uncertainty. The GP is the person with whom the "buck stops". Those patients who are discharged from hospital or specialist care return to the care of their GP.

STYLE OF LEARNING ON PRIMARY CARE PLACEMENTS

Sitting in with the GP touches on many aspects of medical care; some are important, specific features of general practice, and some are generally important topics whatever aspect of medicine you work in. If medical training is viewed like painting and decorating, this attachment is part of the undercoat—a thin but essential overview of many topics that provides an excellent base for you to return to and add depth to during the rest of your training, and career.

Your learning will more interactive than sitting in lectures or reading textbooks. You will learn through meeting and listening to patients including visiting patients at home with another student, observing your GP "in action" and importantly through discussion with your peers and with your tutor. Your GP has unique experience in these areas that they can share with you.

Your learning in clinical practice will be experiential (direct encounters with patients and doctors), collaborative (opportunities for dialogue with your GP tutor and colleagues) and (reflective) you will be regularly asked to consider your experiences in more detail. This kind of

[1] Hobbs F D et al Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14 The Lancet 2016;**387**:2323-330.

learning depends upon your own level of interest and curiosity. GP tutors enjoy enthusiastic and dynamic groups of students who ask questions, share their perspectives and learn together.

CONFIDENTIALITY

Respecting patient confidentiality is very important for you to be aware of during your GP attachment. From now on you will be meeting patients and they may talk to you and trust you as a member of the medical profession.

Confidentiality is enshrined in law through the right to privacy, and is an important part of the doctor-patient relationship. This trust extends to those who work as part of the primary health care team, and would include nurses, physiotherapists and social workers. It also extends to receptionists and medical students. It is very important that you understand this privileged position when you observe patients consult or visit patients in their home.

Whenever you meet a patient during your medical training it is wise to check that the patient knows who you are and that you will keep all information confidential. If you keep notes these should be anonymous and kept in a secure place. There should be no patient identifiable information on notes. Please note that often patients can still be recognized from discussion about them even if you don't use names so do not discuss patients outside of the course, or to each other (unless in a confidential learning capacity) and certainly not in public (e.g. on the bus back from your placement).

Although the preservation of confidentiality is important, it does have limits, for instance, to protect third parties from harm. An example would be a psychiatrist who is told by a patient that they will murder someone. Whilst the responsibilities of the psychiatrist are clear, there are many grey areas that are still subject to debate. These sorts of issues will be dealt with in more detail in your Ethics & Law course. Please discuss any concerns with your GP Tutor.

The General Medical Council provides up to date guidance on the duty of confidentiality and the circumstances under which doctors can disclose information without consent. Visit the website: http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

OBSERVING THE GP CONSULT

Whilst observing the GP, you may consider if there are any consultations that strike you as challenging or particularly interesting. You can discuss these consultations further with the GP and with your Effective Consulting and Human Sciences tutors.

When you watch someone consult often a lot happens in a short space of time and it can be hard to know what to focus on. To help you, each week has a theme and this guidebook gives you suggestions of things to consider while you observe consultations. See "Clinical contact sessions" on page 20. There are also general things about consulting to think about whilst observing consultations to help relate your learning to the Effective Consulting sessions:

1. How long does the patient talk for before the GP speaks?
2. Find examples of closed and open questions as the GP consults with patients and reflect on the effect this has on the consultation.
3. How did the patient make you feel?
4. What body language did you observe?
5. Use of verbal/non-verbal communication
6. Consultation structure/flow
7. Any cues/hidden agenda/elephant in room
8. Patient satisfaction

When you are sitting in with the GP you may get the opportunity to practice clinical skills such as taking a pulse or blood pressure (see clinical skills page 32). **This year there has been a national shortage of Hepatitis B vaccine. Please make sure that if you are not fully immunised against Hep B you do not handle sharps or take blood.**

HOME VISITS

Home visiting has always been an important part of British General Practice. GPs in the UK visit patients at home when they are too sick or unable to come to surgery. As a student, we have asked GPs to find patients that kindly agree to spend time talking with you about their health and medical experiences for your learning. By visiting patients in their homes, you have the opportunity not only to hear their story in detail, but also to see something of their lives in context. Your GP tutor will know the patient well and will brief you on the patient's background and what issues might come up. The patient will have been briefed as to why you are visiting, and should've received a copy of the letter in Appendix 1. It is important you show respect for confidentiality and sensitivity towards the use of a patient's story so please also take a copy of the letter in this handbook out with you on visits. Please wear your ID badges and start by introducing who you are and why you have come to talk to them.

The purpose of your home visit is to practice listening to and being with patients and hearing about the patient perspective on the NHS. The home visit is an opportunity to help you to think about your use of body language, tone of voice and questions, similarly to notice the patient's verbal and non- verbal communication.

A lot of students feel quite nervous about the home visit. They worry that they might get emotional or not know what to say. Reading through this section as well as the section on "Integration with Effective Consulting" in this study guide (page 29) will help you talk to patients and your GP tutor will support you. The GPs choose patients who are either experienced in, or would enjoy, speaking to students. It is also worth bearing in mind that anxiety can be a normal emotion to new situations. To help you record your learning and inform discussions with your GP and peers you can take notes. You might say something like; *"I want to write a few things down to remind me of what we talk about today. I won't put your name on them. Is that okay?"* or it might seem more appropriate to just listen. An alternative is that one student mainly asks questions and the other mainly writes.

A useful website where you can watch patients' accounts of their illness is:
www.healthtalkonline.org

It may be useful to look at this before or after your home visit session. If before, you could note down some of the things you might try and find out from your patient. Afterwards, it could be help you understand different perspectives from other patients with the same condition.

Talking with patients on the home visit:

You may want to start by listening attentively to their story. Many patients will be happy to talk at length about their health – it may even be in some way cathartic or therapeutic for them to share their experiences. Patients generally feel very comfortable talking to medical students. They may see you as open and as more sympathetic and less threatening than doctors. They may also be pleased to help in the education of future doctors. You may be surprised at patients' willingness to tell you about very personal aspects of their life and their illnesses. They may not have discussed such things in detail before – not even with family, friends or doctors.

Handling emotion: It is possible that the patient may become emotional during your conversation. This is a normal response to relating an emotional experience. They may need time out and to be silent, or be tearful. In such situations, it is valuable to you and the patient, to learn to be comfortable in the silence or the expression of emotions. After giving space, you may want to acknowledge their frustration, fear, and sorrow or grief e.g. 'It sounds like it has been a very lonely time for you?' 'It must be very difficult going through this illness'.

Finishing the interview: When you have finished the interview, thank the patient for their time and for helping you to learn about the impact of illness. Let them know that conversation with them has been helpful and that you will try to remember the issues they discussed as you care for patients in the future. After the visit you will have the opportunity to tell your GP tutor about your experience with your patient, what you learnt and what surprised you. You may have some questions for your GP.

SOME EXAMPLE PHRASES WHEN INTERVIEWING PATIENTS

The following has some useful phrases for the home visit and when you talk with patients. You can adapt phrases to ones they are comfortable using, they also might like to have it to hand when you watch your GP consult so that you can compare to the phrases you hear your GP use.

STAGE OF CONSULTATION	EXAMPLE PHRASES
The very beginning	Introduce yourselves. Thank you for agreeing to speak to us today. As Dr X told you, we are year 1 medical students, here to learn about your health problems and how these may have affected your life. We are also interested in hearing about your experiences with the health services and what you think makes a good doctor. (Use silence as a tool and try not to interrupt, unless becoming very awkward!)

Active listening **Encouraging the patient's contribution**	Tell me more… I see… yes… right…mmm… go on… etc If you treat it as a story, when did it all start? Could you explain more about it? What do you mean by...?
Responding to cues **Acknowledging emotions**	You appear to be in a lot of pain … That must be really hard for you. Is it something that you want to discuss with me? You seem very … upset/frustrated/angry/annoyed/ambivalent/negative/elated. You mentioned about ….
Empathy	You have an awful lot to cope with. I think most people would feel the same way. You've clearly been through a lot. I appreciate it's been a difficult time for you. It sounds like a very difficult situation.
Information gathering	I need to ask you a few more questions if that's okay … Would you mind if I ask you a few more questions to clarify things? Can I ask few more specific questions? (Start with open questions, move to closed questions, avoid leading questions)
Exploring patient's narrative about their illness	How were you given the diagnosis? Do you remember your reaction? What was the impact of the illness on …. your self-image? Your relationships with friends and family? Your roles at home? Your ability to work? What do you think the impact was on your friends and family? How has your life changed? What has helped you most to adjust to the illness? What has been the most difficult part of adjusting to the illness?
Exploring patient's health understanding/knowledge	You mentioned lumbago? What do you mean by that? You mentioned that you thought you might be depressed. What do you understand by depression?

	What do you know about X? (referring to something the patient has mentioned). How do you feel about taking medication? What advice would you give another person who had just been diagnosed with this illness?
Obtaining social and psychological information to enable the doctor to put the complaints in context (holistic approach)	How is this affecting your job or life? How has it made you feel? Is it having an impact on what you are doing? How is it affecting you as a … (builder)? What have you been unable to do due to your symptoms? How has this problem restricted what you can do? Help me to understand …
Exploring interaction with the health care service	How do you find communicating with health professionals in the GP surgery or in the hospital – nervous, relaxed? What aspects of your doctors' care have been most/least helpful? How would you describe a good doctor?
Ending with positive statement	Thank you very much for spending so much time with us. We have learned such a lot, which will really help us to be better doctors in 5 years' time.

CLINICAL CONTACT SESSIONS IN THE FOUNDATIONS OF MEDICINE

Intended learning outcomes	Related GMC Outcomes for graduates
Session one: • Introduce yourself to a patient • Listen to a patient talking about their healthcare experiences • Consider the patient perspective of health and wellbeing • Appreciate the importance of professional conduct in a healthcare environment • Appreciate patient confidentiality	9a. Explain normal human behaviour at an individual level 20c: Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients' dignity and privacy, and understand the importance of appropriate consent.
Session two to four: • Consider the factors that affect why individuals seek medical advice	13a: Take and record a patient's medical history, including family and social history, talking to relatives or other carers where appropriate.

<table>
<tr>
<td>• Appreciate different patient perspectives
• Communicate in a professional, respectful manner
• Maintain patient confidentiality

And either:
• Observe doctors consulting
• Identify how the doctor finds out the reason for the patient’s presentation
• Observe any differences between the patient’s and the doctor’s agenda.
• Consider the skills that contribute to good verbal and non-verbal communication
• Identify the different resources doctors use to answer clinical questions in practice
Or:
• Interview a patient or carer about their healthcare experiences
• Practice verbal and non-verbal skills to help patients explain their personal story</td>
<td>13b: Elicit patients’ questions, their understanding of their condition and treatment options, and their views, concerns, values and preferences.
14b: Make an initial assessment of a patient's problems and a differential diagnosis. Understand the processes by which doctors make and test a differential diagnosis.
15a: Communicate clearly, sensitively and effectively with patients, their relatives or other carers, and colleagues from the medical and other professions, by listening, sharing and responding. 19c: Keep to the requirements of confidentiality and data protection legislation and codes of practice in all dealings with information. 19d: Access information sources and use the information in relation to patient care, health promotion, advice and information to patients, and research and education.
20b: Demonstrate awareness of the clinical responsibilities and role of the doctor, making the care of the patient the first concern. Recognise the principles of patient-centred care, including self-care, and deal with patients’ healthcare needs in consultation with them and, where appropriate, their relatives or carers.
20c: Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients’ dignity and privacy, and understand the importance of appropriate consent.</td>
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<td>In session three you should also:
• Discuss the importance of self-care and resilience in providing care for others
• Reflect on how to improve and maintain health and well-being</td>
<td>9b. Discuss psychological concepts of health, illness and disease</td>
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<td>In session four you should also:
• Discuss the practice demographic with their GP tutor and the potential needs of that population
• Consider how a patient’s social and cultural context influences their health</td>
<td>10a. Explain normal human behavior at a societal level
10d. Explain sociological factors that contribute to illness, the course of the disease and the success of treatment including issues relating to health inequalities, the links between occupation and health and the effects of poverty and affluence.
11a. Discuss basic principles of health improvement, including the wider determinants of health, health inequalities, health risks and disease surveillance.
11b. Assess how health behaviours and outcomes are affected by the diversity of the patient population.</td>
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SESSION ONE THEME: PATIENTS AND HEALTH

Session one overview: This session is a chance to get to know your GP and group and an introduction to general practice. As a group, you will discuss the course and the plan for future weeks. You are likely to be shown around the practice, you may meet other members of the healthcare team. The GP is asked to bring in at least one patient so that you can hear their story and healthcare experiences.

Session one further information: Today you will meet a patient who has had significant interaction with the healthcare services. They may see the primary health care team regularly to help them manage a long-term physical or mental condition, or they may have been in and out of hospital. Your GP will interview them so that you can hear their story of their illness, the health care professionals they have met and their experience of the healthcare system. You will be expected to introduce yourselves and contribute and ask some questions. *You might like to think about what makes a good doctor in their view? Or what helps them manage their illness?*

If you think back to your lecture on "*What is health?*" You will recall that ***illness*** was defined as a subjective experience with perceived symptoms, and ***disease*** defined as objective, medically explained pathological changes.

Your GP will have met many patients who have a discrepancy between how they perceive their health and the severity of their underlying disease. Some patients worry that they are unwell when their doctor thinks they are healthy, the so-called "*worried well*." Other patients live with very disabling conditions yet perceive themselves as healthy, others may not recognise ill health and dismiss new and important symptoms to the detriment of their health. Patients tend to think of themselves as healthy or not despite having, or not having, a disease. They may consider themselves healthy because they are not unwell (absence of symptoms) or healthy because they can do the things they want to do (functional fitness), because they are able to cope (resilience) or because they have a sense of wellbeing (this may be different for different people and encompasses things like energy, physical fitness, connection with others, feeling happy, or even looking healthy).

A basic medical model of thinking about health prioritised the absence of disease. This negative, and limited view was updated by the World Health Organisation (WHO)[2] in their 1948 constitution when they defined health as "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*." Huber et al have subsequently argued that the word "complete" would leave most of us unhealthy most of the time, and such an emphasis on complete well-being contributes to the medicalisation of society[3]. The WHO definition also doesn't account for the ageing population living for longer with chronic disease.

We need to appreciate that many of our patients live with disease, and health and ill-health can

[2] WHO. Constitution of the World Health Organization. 2006. www.who.int/governance/eb/ who_constitution_en.pdf.

[3] Huber Machteld, Knottnerus J André, GreenLawrence, Horst Henriëtte van der, JadadAlejandro R, Kromhout Daan et al. How should we define health? *BMJ* 2011; 343 :d4163

sit alongside each other perfectly well. Huber et al[3] compare maintaining health to the physiological homeostasis found in systems in nature; when a system is stressed adaptive mechanisms act to protect the system and restore integrity or equilibrium. They propose that we should look at health as the ability to "*adapt and self-manage*."

In our patients, the things that may help patients adapt to ill-health and maintain wellbeing include their self-awareness, their ability to find and act on information to help them prevent illness, recover or manage their condition, their connectedness for example to friends, family and their community, and having a sense of meaning and purpose in their lives. Doctors and healthcare can help them maintain well-being, even in the event of serious or chronic disease.

When you are with your GP think about the patient/s you have met and discuss what aspects of the patient's life helps them maintain health and well-being, and what aspects make it harder. You can use the following questions to help guide your discussions:

- When the patient told their story what other parts of their lives were connected to their medical problems? For example, they might have talked about the impact on their ability to work, or felt that work contributed to their illness.
- Do you think the patient saw themselves as healthy or not? What aspects of their lives did they see as contributing to their well-being?
- How much responsibility do you think a patient has for her own health? (It may be interesting to repeat this question with different cases, depending on the causes of the health problems).
- How might the patient's experiences of healthcare affect their experience of being ill?
- Discuss if you think doctors should get involved in advising patients about diet, exercise or support networks. If so, why? If not, why not?
- What is the role of the GP in helping patients live with long term conditions? How might a doctor help a patient cope better with their illness?
- How might you, as a future doctor, enable a person with a long-term condition e.g. Parkinson's or chronic lung disease live their lives in a fulfilling and independent way?

SESSION TWO THEME: PROFESSIONALS AND HEALTH—The doctor patient relationship

Session two overview: This session looks at the professional relationships doctors have with their patients and meeting patient needs. 1-2 students will sit in with GP while the others visit patients in their homes in pairs. After visits and surgery there should be opportunity for feedback and questions as a group with the GP teacher. You may have an opportunity to practice clinical skills. Your GP is asked to make links between the patients you have seen, their clinical experience and the Foundations of Medicine theme. Those students visiting a patient at home may meet a patient who is, or has a carer to prepare for session three, these students can still consider what sort of relationship the patient they have met has with their doctor.

Session two further information: Today you will meet patients either in the surgery or in their own homes. You will be considering the relationship between patients and their doctors, what patients need from health care professionals and how doctors meet those needs.

Patient-centered practice: In consulting with patients, the doctor's agenda may include making a diagnosis, finding the right treatment and detecting any serious illness. It may also include getting through the consultation quickly because they are running behind or trying to make a patient change a behaviour that is harmful to their health. This can result in a doctor-centred relationship. The concept of patient-centred practice means discerning the patient's agenda and addressing this, interwoven with a clinically competent practice. Addressing does not mean being able to meet all patient desires, but to take their hopes into consideration, explaining where these go beyond possibilities of what we can offer today as their GP.

The patient's agenda may become obvious within the first minute of arrival, such as wanting more treatment for their eczema. However, it may also not be so clearly formulated in the patient's mind (they just don't feel well and want some kind of help to feel better) or it may be hidden – they are afraid to mention their real concern (for example not mentioning their thoughts that their cough may be due to lung cancer or asking the doctor about their sore throat but really wanting to talk about their panic attacks). What our patients tell us will depend on our questions, the space we give them to talk and the trust between us. Helpful questions that might uncover more of the patients' perspective can be remembered with the acronym I.C.E:

IDEAS – what does the patient think is going on?
CONCERNS – what is the patient's main concern about their problem?
EXPECTATIONS – what was the patient hoping that you would do today?

Patient-centred practice is more than just asking the right questions though. In the words of Roger Neighbour (Ex-President of the Royal College of General Practitioners):

'*Patient-centeredness is not a performance: it is a frame of mind, a value system. Patient-centred consulting flows naturally from a mind-set of respectful curiosity about individual patients – curiosity about what matters to them, what they are experiencing, what is going on in the consulting room*[4].'

The Therapeutic Alliance: The quality of the doctor-patient interaction is not just affected by how much you know as a doctor or what technical or consultation skills you have developed but also your attitudes, maturity, kindness, emotional intelligence. It's not just what you do, but also who you are. The personal impact of the doctor upon his patient was examined by the psychoanalyst Dr. Michael Balint (1957)[5] who pointed out that by far the most frequently used drug was the doctor himself, i.e. that it wasn't only the medicine that mattered, but the way the doctor gave it to his patient.

[4] Neighbour R 2nd Ed. The Inner Consultation. Oxford: Radcliffe Publishing, 2004

[5] Balint M. The doctor, his training and the illness. New York: International University Press, 1957

When you observe your GP consult, think about the patients that came in and what their relationship was like with the doctor, why they came and what they needed or wanted. If you visited a patient at home you might consider their past and present relationships with their doctors and what, in their view, makes a good doctor? You can use the following questions to help guide your discussions:

If you are observing consultations consider the following:

- What was the doctor's relationship with that person like?
- What did you think about the doctor's and the patient's attitude?
- Why do you think they came today?
- I wonder what they really wanted today?
- Did you ever sense an elephant in the room (a major issue that is palpably present though not directly voiced)?
- Did a patient ever present with as simple problem but go on to reveal a deeper one (symptom iceberg)?
- How do you think the consultation went?
- Do you think the doctor and patient reached a shared understanding?
- How do you think a student being present alters the consultation?

If you are interviewing a patient on a home visit you may get a chance to explore their relationship with their doctors (past or present) and consider the following:

- What qualities does the patient think makes a good doctor?
- What do they need from their doctors?
- Has a doctor helped them understand or cope with their illness better?
- How does the GP relationship with a patient affect their experience of being ill?
- How important is it to them that a doctor knows them and their medical history?

As a group you may like to discuss:

- Is it important for patients to make decisions about their treatment? What are the limits of this?
- Can a patient pass a decision about their treatment to the GP or to carers/family? What are the issues when a patient says, "I don't mind doctor, whatever you think is best."
- When might a GP break confidentiality?

SESSION THREE THEME: PROFESSIONALS AND HEALTH—Caring for the carers; maintaining health & wellbeing as a medical student, doctor and carer.

Session three overview: The format of this session is similar to session two. 1-2 students will sit in with GP while the others visit patients in their homes in pairs. Those going on home visits will ideally visit a patient who is, or who has, a carer. It is important that carers look after themselves in order to care for others. It is just as important that those in the health care professions know how to self-care. After visits and surgery there should be opportunity for discussion with your GP tutor about

the challenges of caring for others either in a professional role or in a personal capacity, and how doctors can support carers, and support their own well-being too.

Session three further information: During your time in primary care in Foundations of medicine we have asked your GP to help at least some members of the group meet a carer, or a patient who needs a carer. We want you to consider the impact of caring for others, and the importance of the carer maintaining their own health to provide effective care to others. We want you to draw parallels between the patients and professionals you meet and how you will maintain your own health and wellbeing as a medical student.

Looking after carers

It is estimated that as many as 10% of patients on a GP's list are carers[6]. Many carers do not even think of themselves as "carers". Someone might just keep an eye on their neighbour, pop in to keep them company and do their shopping, someone else may just see it as part of their relationship to look after an ill or disabled loved one. A carer is defined as anyone (children included) who provides unpaid support to another person who couldn't get by without their help[7]. Informal carers contribute hugely to society and are a large unpaid workforce[8].

Carers have certain rights, if they provide a substantial amount of care for someone they are entitled to a carers assessment--which looks at financial support that the carer may be entitled to, and assesses the impact that caring has on their life. A number of local and national organisations can advise on emotional and practical support and put carers in touch with each other through carer networks.

Caring for others can be rewarding, but it can also be hard work physically and emotionally and it can be isolating. It can be very difficult to become a carer when it shifts the dynamic in a relationship. People get used to their role in a relationship and those roles become integral to the way the relationship works. For instance, in a marriage one person may take on more of the practical roles around the house, the other may provide more emotional support. When one person in the relationship needs more support, or is unable to fulfil their role it can be very hard on the carer who may feel a range of emotions from guilt (that their partner is unwell while they are not) to loss, or frustration. Even if someone has been a carer from the start (such as a parent of a disabled child) there is often a sense of loss before there is adjustment to their situation.

The carers trust http://www.carers.org/suggests 5 tips to help carers adjust:

1. Make sense of the situation: Find out as much information as you can about the condition and what it might mean for you and contact carer organisations.

2. Be ready to adapt: Many chronic illnesses deteriorate over time, children with disabilities grow up, so carers have to be able to adapt to new situations.

3. Look for the positives. The trust acknowledges that this is not always easy but difficult times may help people focus on what is important to them about their relationship

[6] The Health and Social Care Information Centre. Survey of carers in households 2009/2010. 2010

[7] Supporting Carers: An action guide for general practitioners and their teams. 2nd ed.2011; London, RCGP

[8] RCGP supporting carers in General Practice: Summary report on GP practice journeys towards improved carer identification and support. 2013; London, RCGP

4. Social support networks

5. Look after yourself

The GP has a role in identifying patients who are carers and assessing their physical and mental health, offering annual flu vaccination and providing support. The surgery can set up their own carer groups, advertise information for carers in the practice and offer more flexible appointments for carers who struggle to time away from their caring responsibilities. GP's can advise carers on health information and signpost carer support organisations and networks. They can help the patient access adaptations to help the carer manage their condition and can help access to respite care to give the carer a break.

There is strong evidence that carers often neglect their own health and experience health inequalities[9]. The time and energy spent caring for another person can mean they don't prioritise their own health needs such as taking exercise or seeking medical advice for themselves. They may feel isolated and are more prone to depression and stress. Carers are also at risk of physical problems such as backache which may be exacerbated if the person they care for requires physical help with mobility, dressing, washing or feeding.

Self-care as a professional in a caring role

There are some parallels between being an informal carer and being a professional in a caring role such as a being a doctor. The main parallel is that to be most effective in a caring role you must look after your own health and well-being, yet there are a number of barriers to doing so. The General Medical Council's (GMC) guidance to doctors "Good medical practice" says that you must protect patients and colleagues from any risk posed by your health[10]. You should be registered with a GP outside your family, you should seek advice if you know or suspect you have a condition that you could pass onto patients or that would affect your performance or judgement and you should be vaccinated against common serious communicable diseases.

Sometimes it can be hard to recognise when you should seek a medical opinion, particularly for mental health problems. Being a medical student or doctor is inherently stressful which can make it difficult to recognise the impact it is having on you. It's all too easy to put being "tired" or "on edge" down to the amount of study you have to do and the difficult patient experiences you observe or hear about. Some pressure can improve performance but persistent stress can result in difficulty making decisions, tiredness, poor concentration and irritability, and feeling overwhelmed. Many doctors and medical students also cite barriers to seeking help such as finding the time and fears about confidentiality or impact on their career prospects. However, if you think that your symptoms are impacting on your patients or training (or ability to do the job) it is important to get a proper assessment and we would encourage you to speak to your own GP. Rather than negatively impact on your career it is more important that you can show that you are able to self-regulate and seek appropriate help and support.

Before that point, there are a number of things you can do to support your own well-being such as:

- Look after your own physical health through following a healthy diet, enjoy regular exercise and have a good sleep routine
- Maintain social connections

[9] Boyce T et al. A pro-active approach. Health promotion and ill-health prevention. The Kings Fund, London 2010 available from: https://www.kingsfund.org.uk/sites/files/kf/field/field_document/health-promotion-ill-health-prevention-gp-inquiry-research-paper-mar11.pdf (accessed July 2017)

[10] Good medical practice 28-30 p12 2013, London, GMC http://www.gmc-uk.org/guidance/good_medical_practice.asp

- Time management; set regular achievable learning goals, and prioritize your workload. It can be difficult to set boundaries with the workload of medical training, it can help to seek academic help to clarify the expectations for your particular stage of training.
- For academic work seek help early if you are falling behind or don't understand a topic as well as you think you should.
- Balance your work with other things you enjoy such as sport, music or creative pursuits. You may need to prioritize but don't give up everything you enjoy.

QUESTIONS TO THINK ABOUT:

- How can GPs identify carers? You might like to think about the role of the whole practice including patient information on the website or waiting room.
- If you met a carer, how do they look after their own health?
- What are the threats to carers mental and physical health?
- What is the GP role in supporting carers? What other services can you GP access on behalf of or signpost carers to?
- What would happen if a full time carer had to go into hospital?
- How does your GP maintain their own health and well-being?
- In what ways does the GPs job promote their well-being and in what ways does it threaten their wellbeing?
- Did you witness consultations that seemed stressful for the doctor? Why were they stressful? What did you see the doctor doing to manage those stresses?
- What key take home messages from today will help you look after your own health and well-being as a medical student?

SESSION FOUR THEME: POPULATIONS AND HEALTH

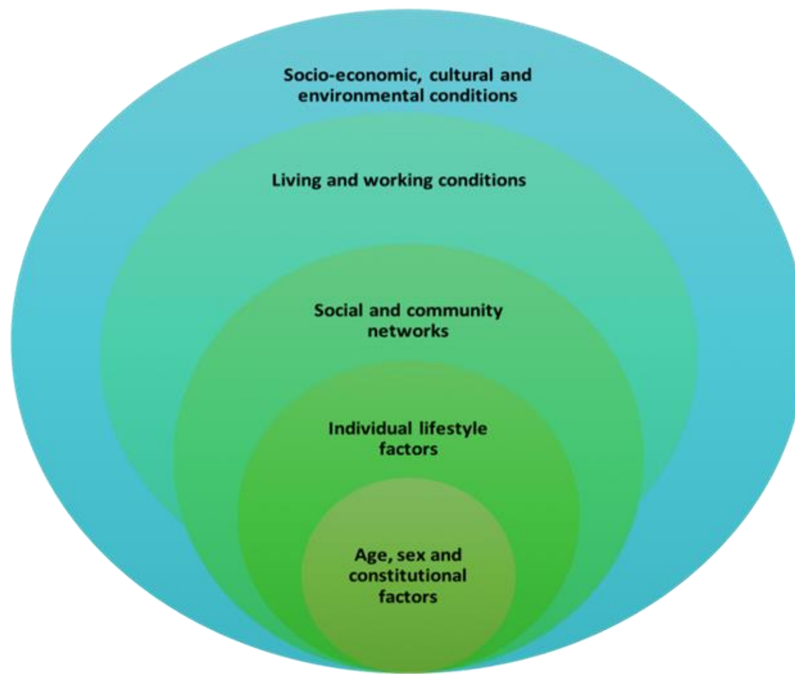
Session four overview: This session is an opportunity for students who have not sat in and observed surgery to do so and students who have not done a home visit to do so. If you have had a chance to do these once, it is a further opportunity to meet patients. The focus of the discussion this week is populations and health. You will discuss the demographic of the practice you are placed in and consider any particular health needs of that community, and may visit the practice area if you have not already done so.
GPs not only have a role with individual patients but with the health of the community, and the population. This was highlighted by the World Health Organisation (WHO) in 1978 in the Alma-Ata declaration:

"*Primary health care is essential health care…It forms an integral part both of the country's health care system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuous health care process.*"

Article IV, Alma-Ata Declaration, WHO, 1978[11]

[11] Declaration of Alma-Ata. International conference on Primary Health Care, Alma-Ata. USSR. 6-12 September. 1978. Available from: www.who.int/publications/almaata_declaration_en.pdf (accessed July 2017)

In your role as a medical student and future doctor, you must think beyond the patient in front of you to the wider role of health improvement and prevention. You need to consider the wider determinants of health; a helpful way to view the levels at which a doctor can intervene is to consider Dahlgren and Whiteheads model of the social determinants of health.



Adapted from Dahlgren and Whitehead's model of the social determinants of health, 1991[12]

GPs see each of their patients several times per year and are seen as "key agents" in promoting public health[13]. Doctors can promote health by addressing lifestyle and modifiable risk factors for disease in individual patients, promote health in their surgeries through health promotion literature or running health promotion clinics such as smoking cessation clinics. They work with other members of the primary health care team such as district nurses and health visitors to target high risk patients that may find it hard to access healthcare. They deliver health prevention activities such as vaccination, screening programs such as the cervical smear program and early detection of illness, and monitor health through initiatives such as child health surveillance. GPs often know their population well and are well placed to understand the particular health needs of their community and can act as advocates for members of that community. However, they also have to balance ethical tensions between the needs of an individual and the needs of a community or wider population[13].

QUESTIONS TO THINK ABOUT:

- What ways do GPs ration resources (including GP time), did you see any examples?
- Which patients have seemed to be more 'empowered' than others?
- Why do the children of poorer parents get more illnesses than the children of richer parents?

  What are some of the barriers to patients accessing health care?

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[12] Dahlgren G, Whitehead M European strategies for tackling social inequities in health: levelling up, Part 2. Copenhagen: WHO Regional Office for Europe, 2007.

[13] Bambra C, Gibson M, Sowden A, et al Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews Journal of Epidemiology & Community Health 2010;64:284-291.

- Do you think parents should be allowed to decline vaccination for their children? Why or why not?
- Should GPs sign sick notes? What might the tensions be for GPs signing their patient off work?

Session 4

- Your teacher will give you verbal feedback on your time in general practice so far and may ask for your feedback on their teaching or organization of the sessions.

CASE BASED LEARNING SESSIONS:

Many of you will be placed in the same practice for your case based learning sessions although some of you will go to a different practice or have a different GP tutor. In Primary Care these sessions will follow a similar format to the sessions in the Foundations of Medicine and you will either visit patients at home or sit in and observe your GP consulting with patients. Your GP will help you make links between the patients you meet and the system of the case you are learning about. You will also visit secondary care on your Clinical Contact sessions. You will be given further information about this part of the course near the end of the Foundations of Medicine.

INTEGRATION WITH EFFECTIVE CONSULTING IN FOUNDATIONS OF MEDICINE

Development of good consultation skills is an essential part of your undergraduate medical education. Learning to communicate effectively with patients is one of the aims of the Effective Consulting course. Obviously, we do not expect you to be able to conduct a consultation at this stage, but you will be introduced to the purpose of the medical interview and the communication skills that are used by doctors. Communication skills can be divided into verbal (e.g. open questions: "Can you tell me more about your pain?") and non-verbal (e.g. nodding head or good eye contact). The point of good communication is to be able to develop a shared understanding of the patient's problem and what management they hope for. You will learn more about specific communication skills, such as active listening, in your Effective Consulting lab sessions but Clinical Contact is an opportunity for you to see how doctors communicate in practice, and for you to practice your communication skills by talking with and listening to patients.

ACTIVE LISTENING

Why do we emphasis listening as a consultation skill? Dame Cicely Saunders, founder of the Hospice movement in this country, said, "When someone is in a climate of listening he'll say things he wouldn't have said before[14]."

Listening is a key "tool" you can use as a doctor to help draw out the history from the patient. The

[14] Long A, 1990. *Listening.* London: Darton, Longman and Todd Ltd.

history is key in making an accurate diagnosis, and in many cases the clues are in what the patient tells you rather than high tech investigations (although they have their place.) In your training, you will learn about the medical history—a systematic way of finding out why the patient has presented (come to see you, called you or come into hospital) to give you the clues as to what the diagnosis might be and where to go next e.g. reassure, order further investigations, treat or refer the patient. However, often the patient tells you the answers if you just allow them to open up and show that you are really listening, interested and engaged. Above all remember developing our listening and dialogue skills is an ongoing process. Listening is also therapeutic for the patient; the patient feels heard and understood.

The personal impact of the doctor upon his patient was examined by the psychoanalyst Dr. Michael Balint (1957)[15] who pointed out that by far the most frequently used drug was the doctor himself, i.e. that it wasn't only the medicine that mattered, but the way the doctor gave it to his patient. Listening is giving yourself to the patient. The quality of the doctor-patient interaction is not just affected by how much you know as a doctor or what technical or consultation skills you develop but also your attitudes, maturity, kindness, emotional intelligence. It's not just what you do, but also who you are.

"I see no reason or need for my doctor to love me, nor would I expect him to suffer with me. I wouldn't demand a lot of my doctor's time, I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness…"
Anatole Broyard, literary critic and an editor of The New York Times Book Review, died of prostate cancer in October 1990

Listening can improve relationship between doctor and patient and can aid reaching a joint understanding of the person and their situation leading to more relevant information gathering and joint problem solving. For example, a GP may find a patient frustrating as they attend with a lot of vague symptoms that the doctor can't get to the bottom of and often don't turn up for booked appointments. When the doctor asks why, and really listens, the patient opens up about their alcohol problem. The patient and doctor now share the understanding of the problem, and can work together on it.

QUESTIONS TO THINK ABOUT:

- How do you know if you are really being listened to?
- How does being listened to affect your ability to talk?
- How does it feel when you are really being listened to?
- What other things encourage you to talk? What blocks listening?

[15] Balint M. *The doctor, his training and the illness.* New York: International University press, 1957

OBSERVING OTHERS OR YOURSELF (SELF-REFLECTIVE) LISTENING

HEADSPACE

- To truly make someone feel listened to is to give them your full attention. Only you really know if you are focused on what they are saying and not thinking about other things, but often the person talking can easily pick up on whether they have your attention or not.

VERBAL

- What is tone and volume of voice? Does this help or hinder listening?
- Look for clarifying questions “You said it hurts, can you tell me more about the pain?” but this can just be a word asked in a questioning tone to encourage more detail: “Painful?”
- Look for summarising what was said “So let me see if I’ve got this right? The pain came on gradually over the last 3 weeks but it started hurting before you did the gardening.” this demonstrates understanding and gives the patient the opportunity to correct you.
- Use of silence. Silence can be a very powerful tool to allow the patient time to say what they really want to say, but it can feel hard to hold at first, concentrate on non- verbal listening skills such as nodding and waiting attentively rather than what you are going to say next.
- Look for encouraging phrases e.g. “umm”, “I see” that show listening

BODY LANGUAGE

- Eye contact, no fiddling, nodding, smiling, open posture

THINGS THAT BLOCK LISTENING

- Your mood: being tired, stressed, or having your mind on something else
- Thinking of next question
- Looking at the computer or your notes
- Making judgments about the person or assumptions about the scenario

OPEN AND CLOSED QUESTIONS

When we gather information from the patient we want to use a variety of questioning styles. Usually in the GP consultation open questions are used initially to find out why the patient is consulting or what is going on for them. Although GP’s use listening skills they need to be focused, and open questions help the patient know what aspect of their story the GP wants to hear about. Usually the GP focuses down on the extra information to be clear about what is going on or to form a differential diagnosis with closed questions. Closed questions can be particularly useful to rule things out. For example if you ask about patient if “there is anything else you’ve noticed?” they may still not think their weight loss is relevant or anything to worry about so “Have you noticed any weight loss recently?” clarifies for the doctor whether this is the case or not.

Open questions

- Helpful when exploring the problem e.g. "tell me about your sore throat"
- Allow the patient to direct the conversation and the history to flow in a non-threatening way, helpful at the start of the consultation.
- Too many open questions might lead to an unorganized tangle of information and digression away from issue at hand.

Closed questions

- Usually result in a narrow yes/no or brief statement response
- Helpful to clarify responses and explore possible diagnoses
- Can rule out symptoms
- Too many closed questions might lead to missing what the patient wanted to say, also if used too early in the consultation rather than letting the patient tell their story

Clinical Skills (adapted from year 2 competence forms)

- You should have an opportunity to learn and practice these and other skills during your placement. In year 2, you will be given a logbook, and during the following 4 years you will be observed and signed off for successfully carrying out these and other skills.

Taking a temperature

- Explain procedure and obtain consent
- Ask patient if they have any ear problem
- Wash hands
- Check thermometer is working
- Apply new cover for ear probe
- Hold pinna and pull backwards and upwards (for adult)
- Insert ear probe into auditory canal and press record button
- Share reading with patient
- Dispose of ear probe
- Document reading in notes
- Interpret reading and discuss with patient. Decide if further action/investigation is necessary

Measuring pulse rate and rhythm

- Explain procedure and obtain consent
- Wash hands
- Ensure that patient is comfortable and rested, with arm supported
- Ensure that site of radial pulse is exposed
- Position fingers (2 or 3) correctly over radial pulse
- Use pads of fingers to assess rate and rhythm of pulse over a period of at least 15 seconds (one minute if irregular). This time must be recorded accurately.
- Calculate rate, expressed as beats per minute
- Describe rhythm of pulse
- Explain findings and their significance to patient
- Record pulse correctly in notes
- Decide if further examination/action is necessary

Competence in measuring blood pressure

- Explain procedure and obtain consent.
- Ensure that patient has rested.
- Check sphygmomanometer and stethoscope are clean and in good working order.
- Select arm that is most comfortable for patient (if equally comfortable student should chose right arm).
- Ensure that patient's sleeve is rolled up high enough for cuff to be applied.
- Ensure that patient is comfortable with arm extended and supported, so the brachial pulse is at the same level as the heart.
- Choose correct size cuff. Length of bladder should be >2/3 of circumference of arm. Width (height) of bladder should be >1/2 circumference of arm.
- Inflate the cuff with the hand bulb until the brachial pulse can no longer be felt and make a mental note of this pressure
- Inflate the cuff by another 20-30mmHg
- Quickly place diaphragm of stethoscope over the brachial pulse and begin deflating the bladder, whilst listening with the stethoscope.
- Deflate the bladder at a speed which is proportionate to the patient's pulse, so that the blood pressure can be measured to 2mmHg. So if patient's pulse is 60bpm, deflate by 2mmHg every second.
- Note the pressure at which the 1st Korotkoff sounds appear (systolic)
- Note the pressure at which Korotkoff sounds completely disappear (diastolic)
- Wrap cuff around patient's arm so that the centre of the bladder is above the brachial artery and the lower border of the cuff is 2-3cm above the antecubital fossa.
- Position sphygmomanometer so that it is facing them (the student) with the gauge level with their eye.
- Palpate the brachial artery and make a rough assessment of its rate and rhythm. Keep thumb or fingers on the brachial pulse
- Release the valve in order to deflate the bladder completely
- Remove the bladder from the patient's arm
- If Korotkoff sounds did not disappear repeat the measurement but this time note the point of muffling (the 4th Korotkoff sound)
- Repeat the reading if first reading is abnormal
- Explain the result to the patient and record the result in the patient's notes

REFLECTIVE LEARNING

It is a requirement of the General Medical Council (GMC) that you learn to reflect on your knowledge, skills and performance and that you look for ways to improve[16]. In their guidance for medical students they say:

"*At its core, reflection is thinking about what you've done, what you did well and what you could do better next time. To do this, you need to think about what effect your actions have on yourself and others, including patients and colleagues across all aspects of your education and training*."

When you first start it can feel like there is so much to learn or that you could do differently that trying to reflect on your knowledge and performance can feel overwhelming. It can feel uncomfortable to think about your actions, but the last thing we want is for you to become too self-critical or become self-conscious. The whole point of your clinical contact sessions is that they are experiential and that you "have a go." Your GP tutor knows that you are right at the beginning of your training and will also choose patients that are happy to chat to you, some of the patients are very experienced in talking to Year 1 students.

There are two times you can reflect; either during the event "reflection-in-action" or after the event "reflection-on-action." To a certain extent we all reflect in action all the time, when we talk to someone we pick up subtle clues from their body language or words that make us adjust our behaviour or we wonder about what to say or do next. It's helpful to be subtly aware of your reflections in action as it can give you important information and make you realise what you are curious about and want to know more about, but If you become too conscious and drawn into your own thoughts and feelings it can interrupt your flow and ability to listen. If you find yourself blocked by your own thoughts or observations it can help to acknowledge what you are experiencing out loud "I can see that you are upset when you talk about that." or "I can't remember what I was going to ask you next—can you give me a minute?" As you progress through medical training you will gradually find your reflections-in-action become more informed by your knowledge and experience. "I noticed she clenched her fist when she described the pain—I wonder if that's what the pain feels like to her?"

To learn to reflect, and enhance your ability to reflect-in-action, it is helpful to get into the habit of formally reflecting on your experiences after the event. And it is especially helpful to write your thoughts down or discuss them out loud, it's surprising how quickly you can forget insights or goals for your learning if you don't record or go over them.

A good place to start is to reflect on your *experiences* and learning. Reflecting on the patient's story can help you think critically without feeling personal. When you consider what was happening with a patient, what they said and did, what situation they were in, what they needed, and your perspective you can sometimes have an "ah-ha" moment. You might recall things you didn't notice at the time, or something you need more information about; either something you want to look up or discuss with your tutor, or something you wish you'd asked the patient about or a change that has occurred within you. The table below gives you some examples of areas to reflect on, how did the

[16] Achieving good medical practice: guidance for medical students. General Medical Council and Medical Schools Council. 2016. London. http://www.gmc-uk.org/education/undergraduate/achieving_good_medical_practice.asp

patient's story make you feel? What can you learn? This applies both to clinical learning and what can you learn about yourself and your attitude or perspective.

The other issue is time. Especially at the start of your training there can be so much you could reflect on you might not know where to begin. A good filter is to be aware of the things that stood out for you. What really interested, or surprised you or concerned you? Also, you will be guided by your tutors, especially when it comes to the level of the knowledge that you need at any particular stage. We have designed a reflective form for you to complete at the end of every clinical contact session and upload to your e-portfolio. This will help structure your reflections on your experiences. You can access the form by logging into your *MyProgress* account on a computer or by downloading the app. There is a copy of the form at the back of this guide (see Appendix 2) that you can print off for the first session (as your training for the *MyProgress* e-portfolio is after your first clinical contact session) You can continue to use the form to make notes by hand during the session if you would rather but it is essential that the GP tutor can see your reflections to help them guide your learning and give you meaningful feedback so please make sure that you enter the information on the form on your *MyProgress* account as soon as possible after a session.

EXAMPLES OF STUDENT REFLECTION

Imagining self in situation	*I can't imagine what I would do if it had happened to me. It seems so unreal that I can't mentally relate myself to that situation*
New way of seeing	*She made me think about addiction in a new way; society and her background contributed, it wasn't just a result of her personal choices.*
Awareness of language	*She didn't call it an abortion and this made me think carefully about how to ask her about it… to use her own words and a more gentle and less scientifically based vocabulary.*
Change in attitude	*Before I visited this patient, I admit that I had a stereotypical view of alcoholics as people who had chosen to be irresponsible drinkers. However, as I listened to the patient's story I learned that lots of stressful social factors had contributed to making her resort to drinking alcohol as a means of escaping from it all. I have learned that as a doctor you need to be aware of a patient's history and major life events as the way the patient copes with them can affect their health.*
Self-awareness	*I looked at him with pity and felt sorry for him, but I was unable to empathise with him …. I couldn't stop blaming him inside my head for what had happened to him even though I knew I shouldn't judge him. I felt he was responsible for everything that had happened to him* Are there any other ways you might see the situation, how might you try to understand this patient and their life? How you might have coped given similar difficult living circumstances?

Use of metaphor	*Perhaps, referring back to the metaphor of the cocoon, survival depends on life cycles. Catching someone when they are on the verge of a natural internal renewal is indicative of the skill, patience and sheer luck required for the job*
Learning from the patient	*…the more I spoke to them, the more I realised that this is a story of hope and inspiration for others. His recovery is a miracle and it has changed them into more beautiful people who love life, for they have been so close to losing it*
Applying your learning to yourself as a future doctor	*I would like to try to remain aware when seeing patients, that they may not feel comfortable enough with me to be telling me things as they are, especially if they are ashamed or afraid of my reaction. No one likes to be told off.*

FEEDBACK ON THE COURSE:

You will also be asked for your feedback on the course. Your GP puts in a lot of work into organizing the placement; giving your views on what went well and where you think it could be improved is valuable and respects the effort your tutors put in. Giving feedback is a skill; it is most helpful when it is constructive, specific, non-judgmental, and you offer observations not assumptions.

Your written feedback regarding this course and your GP teacher will be done via the Bristol Online Survey system (BOS) – you will be emailed the link for this prior to the end of your placement. This should be completed within 1-2 days after finishing your GP attachment. Some GPs may have an available computer for you to complete your feedback during the session in week 8.

Your GP will likely also have their own feedback too for you to fill in and discuss during week 8.

<u>Points to think about when giving feedback on the course:</u>

- Were the aims and objectives for the course achieved?
- Why do people come to see the GP? Did you think the same at the beginning of the placement?
- What have you got out of this experience?
- What was the best thing/worst thing on the course?
- How can we improve for next year?
- What really helped you to learn?
- What surprised you?
- Did the course meet expectations?

Appendix 1: Letter to give to patients

The letter to give to patients appears on the following page

University of BRISTOL
BRISTOL MEDICAL SCHOOL
1st Floor, South Wing, Senate House, Tyndall Avenue,
BRISTOL BS8 1TH
Centre for Academic Primary Care
Primary Care Teaching Office
T +44 (0)117 331 16824
phc-teaching@bristol.ac.uk
http://www.bristol.ac.uk/primaryhealthcare/

October 2017

To patients who have agreed to help with first year medical student education

Thank you for agreeing to talk with first year medical students from the University of Bristol.

We have asked your GP to find some patients who are willing to spend time talking with new medical students for two very important reasons. First, so that students may learn from your experiences of illness and your experiences with doctors and the NHS and second, so that the students can begin to learn how to talk with patients about their health.

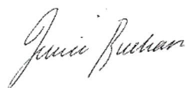
Some students will be very shy. If you are chatty and open this will really help to keep the conversation going! Please remember that these students are in their first few weeks of their course. The majority of them have only very recently finished school and they will not be able to answer any medical questions that you might have about your health.

After meeting a few patients, the students are asked to reflect on what they have heard and may be discussed with the GP and the group of students placed with them (up to 6 students).

Over the course of the year students are also asked to do an assignment about a patient they have met. They will choose one patient's experience to explore in more detail through an essay or creative piece of work. Often students write well about patient experiences and we like to use some of these accounts in our teaching. This means allowing other students to see the work, uploading the assignment on our teaching website and in our course handbooks. Occasionally edited pieces of student art or written work and their reflections are collected into small books for wider distribution. We always keep your information confidential by changing key identifying factors such as names, ages and places.

Please inform the GP or the student if you would not like them to consider your story and experiences for their assignment.

With many thanks,



Dr Jessica Buchan
Teaching Fellow in Primary Care

Appendix 2: My Progress and Reflective Template

Your Medical e-Portfolio, MyProgress, provides a framework for your personal and professional opment. For more information on how to use MyProgress, guidance is available within your portfolio in the 'Resources' section as well as this guide for students. See following pages.

Reflective Account for Clinical Contact Year 1

Part A > Reflective Account during placement > Clinical Contact Reflective Account

1

Clinical Contact Reflective Account

Click here to download Clinical Contact Reflection Guide _20170817T082245.pdf

GP/Clinical teaching tutor email

Today I:

- Attended
- Did not attend

Comments (please share your thoughts about your attendance or non-attendance):

Reflection on a patient encounter

In each clinical contact session you should have the opportunity to talk with, or observe your tutor talking with, at least one patient.

Choose one encounter and briefly describe the key information. (Make sure you do not use any personally identifiable information)

Was there anything about the clinical encounter that particularly surprised, interested or affected you?

<u>Communication:</u>

In this clinical encounter were there any communication challenges and how were they handled by you or the person you observed?

Did you have the opportunity to speak with a patient directly?

- Yes
- No (move to next question)

Medals and missions : If you had the opportunity to speak with a patient directly, please comment on at least one communication skill that went well and one that you want to practice or do differently.

Clinical Skills Log (if appropriate):

Did you have the opportunity to practice a clinical skill today?

- ◯ Yes
- ◯ No (move to next question)

Medals and missions: Please describe what skill you did and comment on at least one aspect that went well and one aspect that you want to practice or do differently.

Further thoughts:

Tell us at least one (and up to 3) things you have learnt today?

Tell us at least one (and up to 3) things you would like to learn more about?

« First ← Previous Next → ? Help

Appendix 3: General Practice: Medical Student Undertaking

Centre for Academic Primary Care

Faculty of Health Sciences
First Floor, South Wing, Senate House,
Tyndall Avenue, BRISTOL, BS8 1TH

phc-teaching@bristol.ac.uk

General Practice: Medical Student Undertaking

As a practice we are committed to contributing to teaching and training medical students in a safe environment and will ensure our medical students have adequate supervision. The supervising registered healthcare professional retains overall responsibility for all patient encounters, decisions and treatment.

Medical students have a duty to follow the guidance in Good Medical Practice: http://www.gmc-uk.org/education/undergraduate/29214.asp

In addition, Bristol medical students should adhere to the MBChB rules which can be found at: https://www.bris.ac.uk/medicalschool/staffstudents/rulesandpolicies/mbchbprogrammerulespoliciesproceduresandstandingorders201617v2.pdf

Medical students should have defence union membership which provides important benefits.

Please read the following statements and sign at the end to confirm that you understand them and agree to abide by them during your time at the GP surgery.

You are bound by the principle of confidentiality of patient records and patient data. You should not discuss patients outside the clinical setting. It may be appropriate to discuss anonymised cases in general terms for learning or improvement of patient care. Any personal notes you make must be anonymised. Explicit consent should be gained from a patient if you disclose identifiable information about them.

You are expected to listen to patients and respect their views, privacy and dignity and their right to refuse to take part in teaching.

It must be clear to patients that you are a “medical student” and not a qualified doctor, it is best to avoid the term “trainee doctor” as this may cause confusion.

You should not allow personal views about a person’s age, disability, lifestyle, beliefs, origin, gender or sexual orientation to prejudice your interaction with patients, teachers, or colleagues.

I confirm that I have read and understood the practice medical student policy

Name: **Signature:**

Year of study: **Date:**

Appendix 4: Case Log and Home Visit template

The following is an example of the how you might structure your notes about any cases that are interesting or may spark debate – either within your GP attachment or as cases you can bring up in tutorials in your Foundations of Medicine teaching.

Patients you observed your GP consulting with in Surgery				
Age/ sex	**Problem**	**Consultation skills used/needed**	**How GP dealt with**	**Learning points**
36F	Failed contraception	Closed questions for details	Discussed options	Missed pills, action of contraceptive pill, efficacy
30M	Depression	Open questions, listening, explored patient's desires and beliefs. Empathy and non-verbal listening	Plan: Cut back alcohol Reading material Review in 2 weeks.	Risks of depression. Prevalence in general practice. How to assess suicidal risk. Effect of alcohol on mood.

Age/ sex	Problem	Consultation skills used/needed	How GP dealt with	Learning points

Home visit reflective template - Background information	
Date	
Patients age/sex/ethnicity	
Brief summary of patients’ story.	
Any other issues raised.	

Reflection	
One word to summarise this visit experience.	
What did I do well?	
Anything I will do differently on the next home visit?	
One thing which challenged me.	
One thing which surprised me.	
What have I have learned?	
How did this visit make me feel?	