Year 2 GP Teacher Guide

2024-25

GP2

University of BRISTOL

Centre for Academic Primary Care

Contents

Introduction

Thank you for teaching Clinical Contact Primary Care to Year 2 students. This is your teacher's guide for this part of the course.

1.1 How this fits in

The Bristol medical undergraduate curriculum is organised around case-based learning. In the first year the cases are system based (cardiovascular, musculoskeletal and so on). In the second year the students move from systems to symptoms, such as chest pain.

Clinical Contact is part of Effective Consulting, which spans the whole five years of the MBChB curriculum at Bristol Medical School. It provides integrated learning opportunities in Clinical Reasoning, Clinical Communication and Clinical Skills. In years 1 and 2 Effective Consulting comprises a half-day of campus-based teaching (Effective Consulting Labs) and a half day of Clinical Contact alternating between primary and secondary care.

Clinical Contact in the early years aims to develop students in a community of practice:

- Year 1 introduces students to the healthcare environment through Clinical Contact and Healthcare Assistant shadowing; students meet and talk with patients to gain skills and confidence in clinical communication, understand the patient perspective, and meet clinicians and other members of the clinical team to understand professionalism and the role of healthcare in health and wellbeing.
- Clinical exposure in Year 2 starts with the Effective Consulting Clerkship, a three-week attachment to a clinical team in secondary care. The clerkship emphasizes history and examination in four key systems (cardiovascular, respiratory, abdominal and neurological) and introduces students to clinical reasoning skills. All students also do a three- week student choice project; some of these projects include a clinical placement. The rest of Year 2 builds on this, and aims to develop students as self-directed, reflective learners; and compassionate, patient-centred practitioners who can consult with patients, practice clinical skills, and think critically about the clinical problems they encounter.

Year 2 students should learn how to talk with and examine patients to find out what is wrong with them, apply their understanding of anatomy and physiology, and practice forming problem lists and making diagnoses. They are not expected to form detailed management plans but should, over the course of the year, understand how common conditions are usually investigated and treated.

Over the coming year students cover the following in their Case Based learning:

- In the Autumn term (Teaching Block One) the cases cover the following systems: Skin; Body Defence; Pharmacology and Therapeutics; and Anaemia, Blood and Clotting.
- After Christmas (Teaching Block Two) the cases cover specific symptoms: chest pain; breathlessness; abdominal symptoms; urinary symptoms and thirst; joint (including back) pain; low mood; headache; and collapse.

During each two-week case-based learning cycle, Year 2 students also have a clinical & consulting skills lecture on the case-based theme, they meet actors to practice their skills (observed by clinical tutors) and can access to online learning resources around holistic assessment of patients related to their case.

1.2 Clinical contact in General Practice

Students come out to primary care, in groups of between four & six; five or six times during year 2. They alternate each fortnight between primary and secondary care. Please check all the teaching dates (Appendix 1) and put them in your diary now. If there are there any you can't manage, please arrange cover with your colleagues.

GP tutors should invite patient(s) with conditions relevant to the systems or symptoms the students are covering in that two-week block, and help students practice gathering clinical information through history, and examination using the "COG Connect" Consultation model. This handbook is designed to give an overview of GP2 – we will email you with more information:

- Before the start of each teaching block, with a list of the types of patients we suggest you seek to invite to each session, e.g. someone with a long-term skin inflammatory condition, such as atopic eczema, acne or psoriasis, for the skin case.
- Two weeks before each contact morning/afternoon session, with details about what to cover.

The administration team will be available by phone or email for any urgent queries on the day.

While students appreciate and usually enjoy being immersed in real life clinical practice at this early stage in training, it can also challenge some and raise anxieties. We know you understand this and will make the students feel welcome. For the occasional student who needs more support please familiarize yourself with the support available for students.

I hope you enjoy the sessions and please let us know if there is anything we can do to help!

Dr Jess Buchan

Lead for Year 2 GP Clinical Contact and Year 2 co-lead with Dr Charlotte Bradbury

2nd September 2024

1. Further information, help and contact details

The GP teaching section of the Centre for Academic Primary Care website www.bristol.ac.uk/capc contains information and links about medical student teaching in general practice, materials to support this (e.g. description of COG Connect, Teaching policies and standards) and information specific to year 2.

We circulate regular teaching newsletters with information, updates and workshops. If you do not already receive these, please ask to join the mailing list. Finally, if you are on "X" (Twitter), follow @capcbristol.

Please contact Alison Capey regarding administrative matters. If you have any questions or comments about the format or delivery of the teaching, please email the clinical lead, Matthew Ridd.

Main Contact		
Miss Alison Capey	Primary Care Teaching Senior Administrator	phc-teaching@bristol.ac.uk 0117 42 82987
Year 2 GP Clinical Contact Lead		
Dr Jess Buchan	Year 2 GP Lead	jessica.buchan@bristol.ac.uk

2. Overview of Clinical Contact in GP, Year 2

3.1 Key facts

- Four to six students per group, 5 to 6 sessions each
- Morning (0900-1200) or afternoon (1400-1700) session on Thursdays (see Appendix 1 for dates)
- Session duration: 4 hours (GP 1 hour preparation, 3 hours contact time)

If, with agreement from your students, you alter the time of sessions, the morning should finish by 1200 (to enable them to get to other teaching), and the afternoon should finish by 1700.

3.2 Suggested timetable

AM	PM	Activity	Details
0900	1400	**Introduction** 30 mins	● Take register ● Check in with your students ● Review the session plan and learning objectives ● Brainstorm topic
0930	1430	**Clinical interview** 45 mins	Students practise taking a clinical history with a patient and presenting this to the GP/group, considering clinical reasoning.
1015	1515	**Break** 10 minutes	
1025	1525	**Examination** 45 mins	Students consider/practice relevant clinical examination and summarising findings to the GP/group
1110	1610	**Break** 10 minutes	
1120	1620	**Debrief** 30 minutes	● Discuss the day's cases & draw out learning points ● Tutor Feedback
1150	1650	**Wrap up** 10 mins	● Summarise learning points and identify new learning needs ● Plan for next time
1200	1700	**Close**	● Submit register

On the first session, please set aside some time to meet with each student individually for a few minutes, both to get to know them and their needs, and specifically to ask if they have anything relevant to a clinical placement on a Student Support Plan (SSP).

3.3 Effective Consulting

At the heart of general practice is the consultation, and integral to an effective consultation are the core skills of clinical reasoning, clinical communication, and clinical skills. At Bristol Medical School, students learn these skills on the Effective Consulting course which spans the whole 5 years of the MB21 MBChB curriculum. When students are with you, they should have many opportunities to practise speaking with and examining patients, and receive feedback from you, based on your direct observations. We have developed a unique visual teaching and learning tool called COG Connect to help students consult, and help you structure and communicate your observations and feedback.

Please see Appendix 4 for a visual overview of COG Connect and the COG Connect observation guide. The visual overview, observation guide and more information on COG Connect can also be found on our website.

Using the observation guide will help students prepare for their assessments e.g. OSCEs (observed structured clinical examinations) and clinical competency assessments that start in Year 3.

If you would like to learn more about using COG Connect in your teaching, please see this e-learning module which contains lots of teaching tips.

3. Teaching session detail

4.1 Preparation and administration

We have allowed one hour preparation/administration time for each three-hour contact session. You will need to use some of this time in advance of the session and on the day to:

- Read this handbook and the session plan that relates to that day.
- To identify and invite patient(s) to attend; and to prepare them (see below)
- To liaise with students about where to report to (and what time, if you need to modify the start time).

You may want to set-up a group email, WhatsApp or similar with your students to facilitate communication.

After the session you will need time to:

- Submit the register (a link will be emailed to you on the day of the session)
- Make notes to yourself on anything you want to follow-up with the group next time
- Deal with any queries or issues

4.2 Identifying and preparing patients

Invite patients to help with the teaching, who:

- Are willing and able to discuss their health, healthcare and lifestyle with early years medical students, to help them practice talking to and examining them.
- Have symptoms or a story that students can learn from. We ask that you link the patient to the case the students are learning about.
- Can attend in person. However, if circumstances mean some valued patients can only contribute by MS Teams or AccuRx, that is also acceptable if you can make the technical and practical logistics work.

Prime the patient before the session on where to start their story and what to focus on. For example:

- If the patients have multiple problems, you may need to tell the patient that the students are particularly interested in when they were admitted to hospital with <Symptom>.
- You may also want to say how much information to give, for example "Please don't tell them straight away that you had <Diagnosis>, just start by saying what symptoms you had and how you felt. They will ask you some questions and try and work out what might have happened to you."

4.3 Introduction

Take the register.

Check in: get everyone to speak, by asking after them and their case-based learning this fortnight

- How are they/how has this teaching block been?
- What they have been doing and what they have learnt so far in this block/since you last met?
- Any learning, reflections, issues, or concerns from previous teaching/this session?

At the first session of the year, find out who knows each other in the group, and spend 5-10 minutes agreeing some ground rules. Make it a "safe" space, where it is okay:

- to take "time out" and to ask you/the group if they get stuck.
- to make mistakes

Review the session plan and learning objectives:

- How did the students work together/what did they do last time?
- Rotate people between groups and assign tasks as appropriate (see later).
- Brainstorm what the students know before the patient comes in: what do they want to find out and why?

4.4 Clinical interview/examination

We want students to have as much opportunity as possible talking to patients and gathering information about their presentation, symptoms, and health. We aim for students to have a holistic approach to the people that they talk to; we want them to consider the patient's lifestyle, their perspective on their health, and the impact of their health upon them and their families.

We want to give you the flexibility to configure your sessions in the way that works best for your situation. Depending on your room availability/size and number of patients:

- One group of four, five or six students could all take turns to interview/examine one or two patients. **or**
- Two groups of two or three students could interview two patients in parallel, in groups of 2 or 3; or one group interview and another group examine the same patient.
  and/or
- One group of two or three students could interview/examine a patient; while another group of two or three students watch/summarise a "live" or pre-recorded consultation.

Students also value observing doctors consult. For example, there may be a patient on the urgent surgery list with a problem pertinent to the week's case – see if they would be willing to be seen by you, with medical students observing; and debrief medical students on what they saw and heard after the patient has left.

You may want or need to vary the format over the weeks. The important thing is over the different sessions all students get an opportunity to practice different skills.

Tasks To ensure everyone is engaged and contributes to the presentations/debrief, assign (and rotate as appropriate) specific tasks from COG Connect to individual students:

- Consulting: one person to "Prepare and open", another to "Gather and formulate", another to note non-verbal behaviours and cues etc.
- Examining the respiratory system, for example: one person to inspect, another to palpate, and third to percuss/auscultate and one to observe and guide.

You may find the list of COG Connect tasks in Appendix 4 helpful to draw on. This does not bar students from doing anything other than their allotted task; it's just their focus for when conducting/summarising the interview or examination.

Teaching tip

In year 2 when students have limited clinical knowledge, they can find it difficult to meet both the doctor's and patient's agendas. Consequently, they can fire a lot of questions at a patient, trying to remember what to ask next, without really thinking about what they are hearing.

● It can help to encourage the students to voice summaries of what they have heard and "stop and think". What is going on, why might this patient be presenting at this time?

● Also, encourage students to ask patients what it is like to live with their condition, and what helps them manage their symptoms.

Clinical examination: Ideally, on a patient, but as appropriate/with consent from the group, on each other.* Students should appreciate that most diagnoses are made from the patient's narrative combined with the focused information the doctor gathers, with physical examination secondary, and investigations least important. So, they can still learn a lot from talking to the patients without doing an examination. If time/circumstances mean examination is not possible or appropriate, do ask what examinations would be pertinent, and what they would be looking for.

** The MBChB protocol on "developing clinical skills by examining each other" remind us that this excludes invasive examinations; and should only be done if the examinee has consented to being told should any possible, unknown abnormality be identified – in which case, they should seek advice from their own GP.*

Presenting: Ask your students to summarise their findings to you and the group so that they consider what is important from all the information that they have heard. The following prompts may help:

- Can you summarise what you have found so far? What are the important features/ absence of features here?
- Does it tell a story from beginning to end?
- 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 this after the patient has left, to avoid inducing unnecessary health anxiety)
- Do you know what the patient thinks is wrong and worries about?

After discussion can you help them summarise: [Demographic] with a background of [PMHx] presented with a [duration] history of [symptom/s] with/in the absence of [associated symptoms]

e.g. *Mr Smith is a 64-year-old builder with a 20-pack year smoking history who presents with a three week history of non-productive cough with weight loss in the absence of fever.*

4.5 Debrief

This is an opportunity to draw the threads of the session together. If you would like and the patient is willing, you could ask them to stay for this part. Things to consider here, if not covered already:

Symptom-orientated learning: Doctors largely use a "pattern recognition" or "hypothetico-deductive" model focusing in on what they think is the likely cause of the problem at an early stage. It is useful for students to understand this. A good way to teach the focused approach is to take a common symptom, e.g. breathlessness, and explore how a doctor decides whether this is likely to be due to cardiovascular disease, respiratory disease, anaemia, anxiety etc.

Students should also learn the importance in aiding diagnosis of symptom:

- timing, e.g. sudden onset of symptoms in a stroke, compared to slow insidious onset of symptoms with Parkinson's disease, compared to intermittent symptoms in epilepsy.
- combinations, e.g. the likely diagnosis of pleuritic chest pain in a young thin man is different from pleuritic chest pain in an older person with a temperature and purulent sputum, and different again in a pregnant woman.

Link to students' anatomy knowledge: For example, draw an abdomen and ask the students to think of the organs in the abdomen and add '-itis' to the name. This is a fun way to make them think about abdominal problems and draws on what they already know.

Feedback: It is important students are observed by you and given feedback and the opportunity to have another go. Invite self-assessment, ensuring the learner lists positive things rather than focusing immediately on what they may be worried they got wrong. Good feedback is:

- Non-judgmental
- Well timed
- Descriptive
- Specific
- Directed at behaviour that can be changed.

"Sandwich" suggestions for change, starting and ending on a positive note.

Encourage them to identify learning needs and find the answers themselves; you can verify or build on their learning, but do not spoon feed them.

Role model being a professional: Show them that you are continuously learning (PUNs and DENs, appraisal portfolio, etc). Talk about what you do if you don't know, how common uncertainty is and how you manage it. Share the resources you routinely use – BNF, EMIS mentor, websites, books etc.

4.6 Wrap up

Summarise learning points and identify new learning needs: Get each student to say something they have either learnt or understand better now; and something they need to revise or read-up on before next time, to bring back to the group if appropriate.

Planning for next time: Think ahead to the next session and how they will spend their time.

5. Attendance, assessment, and concerns

5.1 Attendance

In order to pass Effective Consulting, a minimum 80% attendance (including GP placement) is required. Please report attendance using the form that will be emailed to you every week.

5.2 Clinical and experiential learning diary

Students are asked to complete the clinical and experiential learning diary for Year 2, a reflective diary on their portfolio where they can record patients (anonymised) that they have seen, to keep a record of their learning. As GP tutor, you don't need to "do" anything but do need to be aware that students may opt to write up a little about the patients they see with their GP this year (equally they might choose a patient from secondary care), and they will use this to form a piece of creative reflective work.

5.3 Multi-source feedback via Team Assessment of Behaviour (TAB)

As part of Personal and Professional Development within the MBChB Programme, students are requested to undertake Multi-Source Feedback through a Team Assessment of Behaviour (TAB). The main purpose of TAB is for students to gain feedback on their professional development and reflect on the attributes and professional behaviours necessary in becoming a doctor. This includes those skills that are less easily defined, such as working in a team, listening, participation and communicating both face to face and electronically.

Students may ask you for feedback and the email sent to you will contain a link to a form. TAB feedback should take no more than 10 minutes to complete and is structured around four domains:

- Maintaining Trust/Professional Relationships
- Verbal Communication Skills
- Teamworking
- Accessibility

Students should ideally communicate their intention to request feedback from you before sending their feedback request email to you. Feedback is anonymous. You may be asked for your 'position' (how you have worked with this student in the context of their course). This will not be shared with the student, but the student's Professional Mentor will see your name, email address and your position.

Students then meet with their Professional Mentor to discuss their feedback which is released anonymously to the students. Students must complete their TAB to progress to their next year of study on the MBChB programme.

TAB is designed to be a positive process affirming a student's professional development. Please ensure feedback is constructive and relevant to their year group and how far along their journey of becoming a doctor they are. TAB should not be used as a mechanism to report issues such as continued absence or instances of gross misconduct/professional behaviour.

5.4 Assessment

Students sit a summative written exam at the end of the year. The written exam at the end of the year includes questions on clinical assessment. A year two clinical assessment is in development but this will be pilot assessment in 2024/25 and formative (not a pass/fail) which aims to give students a chance to practice consultation and clinical skills and gain feedback.

5.5 Student wellbeing and concerns

Students should engage with teaching, and we would be grateful if you could let us know as soon as possible if you have concerns about a student's engagement or wellbeing.

If you have a concern about a student's performance (for example they seem quiet in a session), please address the issue(s) with the student on a one-to-one basis initially.

Information on how to respond to a concern about a student of their wellbeing can be found on the Wellbeing pages of the CAPC website. Please follow this advice, to look after our students and offer them the best support from the right person at the right time, and to protect you and the university. Remember, in this role you are their tutor not their clinician. Please encourage students to get support from the University or Academy teams and if necessary, see their own GP.

Please see here for student support training and here for a clear flowchart for how to support students in these circumstances.

There is detailed information about the support available for students at: http://www.bristol.ac.uk/students/wellbeing/services/

Wellbeing Access is not intended to be a route for students to access emergency/crisis support. Students in crisis should continue to be directed towards the appropriate emergency services. If you are you concerned about a student's health and/or wellbeing, please recommend that the student contacts the student advisors as above or advise them to see their own GP/Student Health Service.

If you have an immediate safety or fitness to practice concern, act according to local policy and then discussed with the GP2 lead. This might lead to your filling in a Student Referral form (information is at https://www.bristol.ac.uk/health-sciences/student-fitness-to-practise/) but please discuss with the year lead first.

6. Appendices

Appendix 1: Teaching Dates and Topics 2024-25

Session	Stream 2A ("Purple")	Topic	Stream 2B ("Green")	Topic
1	31/10/24	Skin	14/11/24	Body defence
2	28/11/24	Pharmacology	12/12/24	Anaemia, blood and clotting
3	23/1/25	Chest pain	6/2/25	Breathlessness
4	20/2/25	Abdominal symptoms	6/3/25	Urinary & thirst
5	20/3/25	Joint pain	No session	See below*
6	8/5/25	Headache	22/5/25	Collapse

* Students are not with you this fortnight, as they visit a secondary care psychiatry setting.

Appendix 2: Additional teaching resources

These ideas and teaching resources can support your teaching, or plug gaps in the event of patient "no shows" or other last-minute problems:

- Role playing a simulated patient
- Showing students clinical skills e.g. taking a blood pressure and getting them to 'direct' you to do it correctly. There is a Bristol Medical School You Tube play list of clinical skills. You may find it helpful to see how we teach specific skills/use it as a resource for teaching yourself.
- Discussing recent cases you've seen relevant to their learning (and supplement with Speaking Clinically). Log in at https://speakingclinically.co.uk/accounts/login/. Use email as phc-teaching@bristol.ac.uk. Password: primcareGP1GP2
- Discussing significant events that have occurred recently at the surgery

Other useful links to help you facilitate the placement.

Improving gender inclusivity for medical students in primary care placements – a guide for staff (clinical and nonclinical) – online training - takes 15 mins and can be shared with all staff in your GP surgery

Student standards (professionalism, confidentiality, mandatory training and dress code)

Medical Student Understanding – see Appendix 5

Appendix 3: Frequently Asked Questions

Can more than one GP deliver the teaching? Yes, although we would prefer no more than two regular teachers per block.

Can I change the timings of the day? Yes, with agreement with your students and as long as it doesn't clash with other teaching, and morning sessions finish by 12 pm, and afternoon sessions finish by 5 pm.

If I have a GP trainee, can they help? Yes, we welcome involvement from GP trainees and would encourage you to involve them in training as it is an important part of the RCGP curriculum.

Will we still get emailed in advance of the session like last year? Yes, we will aim to email you two weeks in advance of each session with a session plan for that day. The session plans will also be available on our website in advance of the session.

When do we get paid? Payment is retrospective – half-way through the year and again after the final session of the year. After the final session of the year, we also send out a Payment form which we ask you to complete, to confirm that you have taught each session. We will pay the practice by BACS transfer. This is the same as our teaching in all other years.

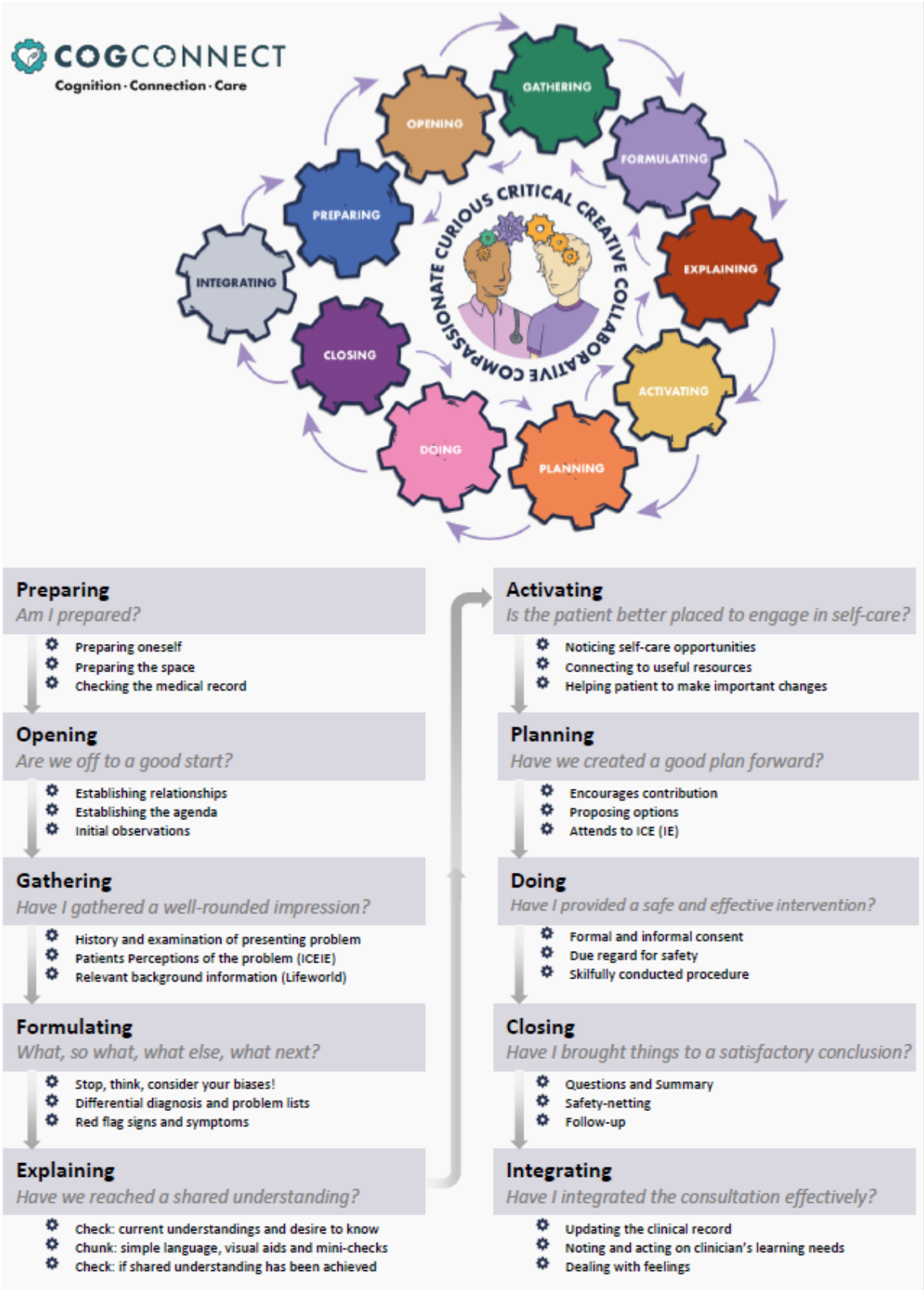
Are the students DBS checked? Yes, the year 2 students have all been DBS checked.

Have the students had information governance training? Yes, the students have had training on the importance of confidentiality and the management of patient identifiable data (PID). They have also completed a confidentiality agreement (copy available on request).

How should I consent patients for student consultations? We would expect you to obtain verbal consent from the patient.

What should I do if I am unable to teach for any reason? We expect you to arrange for a colleague to deliver the session on your behalf. If this is not possible then we ask that you rearrange the day of the teaching at a time that is agreeable to your students. They cannot opt out of any other scheduled teaching to attend GP sessions.

Appendix 4: COG Connect



Consultation Observation Guide

Use this form to provide feedback for a Consulter. Not all aspects will apply, depending on the nature of the consultation.

Chief Complaint of Patient:	**Score** 0=not done; 1=some done poorly; 2=some done well; 3=most done well				Date: Start time: End time:
Preparing and opening the session	0	1	2	3	Points of strength & Points for improvement
Prepares self and consultation space and accesses medical record prior to direct patient contact. Introduces self, checks correct patient, builds rapport. Identifies the patient's main reason(s) for attending and negotiates this agenda as appropriate.	O	O	O	O	
Gathering a well-rounded impression	0	1	2	3	Points of strength & Points for improvement
Obtains **biomedical perspective:** presenting problem and relevant medical history including red flags, PC, HPC, PMH, RoS, DH & allergies *as appropriate to presentation*.	O	O	O	O	
Elicits the **patient's perspective:** ideas, concerns, expectations, impact and emotions (ICEIE).	O	O	O	O	
Elicits **relevant background information:** work and family situation, lifestyle factors (eg sleep, diet, physical activity, smoking, drugs and alcohol) and emotional life/state.	O	O	O	O	
Conducts a **focused examination** of the patient. Gains consent, cleans hands, examines courteously and sensitively. Explains examination findings.	O	O	O	O	
Formulating	0	1	2	3	Points of strength & Points for improvement
Summarises the information gathered so far. Shows evidence of understanding current problems/issues and differential diagnoses with reference to predisposing, precipitating and perpetuating causes. Makes judicious choices regarding investigations, treatments and human factors (eg dealing sensitively with patient concerns).	O	O	O	O	
Explaining	0	1	2	3	Points of strength & Points for improvement
Explains appropriately, taking account of the patient's current understanding and wishes (ICEIE). Provides information in jargon-free language, in suitable amounts and using visual aids and metaphors as appropriate. Checks that the patient understands.	O	O	O	O	Any examples of chunking, checking, clarifying?
Activating	0	1	2	3	Points of strength & Points for improvement
Affirms the patient's current self-care. Enables the patient's active part in improving and sustaining health through, for instance, smoking cessation, healthier eating, physical activity, better sleep and emotional wellbeing. Enables the patient to consider self-care, using skills of motivational interviewing, where appropriate.	O	O	O	O	
Planning	0	1	2	3	
Develops a clear management plan with the patient. Shares decision-making appropriately.	O	O	O	O	
Closing and housekeeping	0	1	2	3	Points of strength & Points for improvement
Brings consultation to a timely conclusion, offers succinct summary and checks the patient understands.	O	O	O	O	

Gives patient opportunity to gain clarity via questions.					
Arranges follow-up and 'safety-nets' the patient with clear instructions for what to do if things do not go as expected.	O	O	O	O	
Integrating	0	1	2	3	Points of strength & Points for improvement
Writes appropriate consultation notes, referrals, etc. Identifies any personal learning needs. Identifies any personal emotional impact of the consultation.	O	O	O	O	
Generic Consulting Skills	0	1	2	3	Points of strength & Points for improvement
Posture. *Voice:* pitch, rate, volume. *Listening skills:* silence, active listening, questioning techniques. *Counselling skills:* **O**pen questions, **A**ffirmations, **R**eflections (simple and advanced) and **S**ummaries. *Advanced skills:* picking up on cues, scan and zoom, giving space to the patient, conveying hope and confidence.	O	O	O	O	
Organisation and efficiency	0	1	2	3	Points of strength & Points for improvement
Fluency, coherence, signposting the stages of the consultation. Keeping to time.	O	O	O	O	

The skills of effective consulting are best learned through trying them out and getting feedback on our efforts. Because lots of stuff is going on, even in simple scenarios, it can be difficult for observers to recall their observations. CC-COG has been designed to help observers to structure and communicate their feedback to consulters. COG Connect is a codification of what already happens in practice – so its contents will come as no surprise.

Preparation

1. The observer needs a copy of this form and something to lean on – a clipboard is ideal
2. Observer and consulter can share in advance any areas they might like to focus on *
3. The observer should read over CC-COG in advance of observing (not necessary for the consulter to do this)

During the Consultation

4. Observer pays attention to generic skills and skills specific to particular phases of the consultation
5. Observer should write down snippets of what is said to trigger recall when giving feedback [content]
6. Observer makes evaluative notes as the consultation proceeds [comment]
7. Scoring by the observer [0-3] is optional and more often used when doing OSCE preparation
8. To distinguish "comment" from "content" it may help to use highlighters or different pen colours

After the Consultation

9. The observer should take a minute or so to check over their observations, rather than speaking immediately
10. Observer seeks to identify up to x3 things to affirm, notes any definite errors or omissions and notes up to x3 things that might have improved the consult

When Sharing Observations

11. Ask the consulter's perspective to start – e.g. "how do did that one go?" or "what really struck you about that consultation?" or "what were the challenges for you in that consult?"
12. Affirm the skills that the learner has displayed (there will be many)
13. Correct any factual or procedural errors and omissions (learners really value this)
14. Share up to x3 "hypotheses as questions" eg "The young girl was very quiet, and mum did all the talking. I wondered what would have happened if you had got more input from the child?"

After Sharing

15. Observer gives the consulter the Observation Guide with their notes

* CC-COG is based on the 10 phases of COGConnect. One consultation will not cover all of these and in the same sequence. Often, particularly in the simulation context, the learner may focus her efforts on one particular skill, such as explaining. In real consultations planning such a focus might not be practical for the *consulter*, but the *observer* can choose to focus on a particular aspect – such as body language or the use of open questions.

In group settings, group members can share out the observational roles and feedback giving. So one learner could focus on gathering, another on generic consultation skills etc.

Appendix 5: Medical Student Understanding

University of BRISTOL
Centre for Academic Primary Care

Bristol Medical School
First Floor, 5 Tyndall Avenue, BRISTOL, BS8 1UD phc-teaching@bristol.ac.uk
http://www.bristol.ac.uk/primaryhealthcare/

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 here in the GMC's Good Medical Practice.

In addition, Bristol medical students should adhere to the MBChB rules which they can access via SharePoint.

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.

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 are bound by the principle of confidentiality of patient records and patient data. Students should not, under any circumstances, copy or capture personal identifiable data (PID) (such as name date of birth and address), in any form other than in the patient's medical notes.

Outside of the GP practice, it may be appropriate to discuss cases in general terms. However this should only be in confidential University teaching sessions, for learning or improvement of patient care, and must be **anonymised.** Any personal notes for your learning you make, including on OneNote, must be anonymised.

Only disclose identifiable information if this is a Uni course requirement e.g. part of a University assignment, and you **must** ensure and document explicit consent from a patient.

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

You should not allow personal views about a person's age, race, disability, lifestyle choices, beliefs, 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:**