Primary Health Care Teaching Office
Centre for Academic Primary Care
phc-teaching@bristol.ac.uk
http://www.bristol.ac.uk/primaryhealthcare/

University of BRISTOL

Report

2014 COMP2 GP Teacher Workshop

Contributors

- Prof. Chris Salisbury
- Prof. Gordon Stirrat
- Prof. Karen Forbes
- Dr. Phil Boreham
- The MISFITS THEATRE COMPANY
- Dr. Bernard Newmarch
- Dr Andrew Blythe
- Dr. Lucy Jenkins

'One of the best study days I have been on, thought provoking and made me look at my own practice differently around communication skills. Disability workshops and Misfits theatre group were very powerful and good messages delivered.'

Organisers Jessica Buchan and Barbara Laue

Programme

Tuesday 18th March 2014, Engineers House, Clifton, Bristol

9am	**Registration & coffee**				Mel Butler
9.20-09.30	Intro to the day				Jess Buchan
9.30-10.05	"How do we fit it all in?" Multi-morbidity in primary care and teaching in the consultation				Chris Salisbury
10.05-10.25	How to go beyond "feeling". An approach to common ethical dilemmas in the GP consultation.				Prof. Gordon Stirrat
10.30-11.00	A Disability	B Ethics	C Breaking bad news	D Cardiac causes of SOB	Prof. Gordon Stirrat Prof. Karen Forbes Dr Phil Boreham Jess Buchan
11.00-11.30	A Cardiac causes of SOB	B Disability	C Ethics	D Breaking bad news	
11.30-11.50	**Coffee**				
11.50 -12.20	A Breaking bad news	B Cardiac causes of SOB	C Disability	D Ethics	
12.20-12.50	A Ethics	B Breaking bad news	C Cardiac causes of SOB	D Disability	
12.50-13.50	**Lunch**				
13.50-14.15	COMP2 update				Jess Buchan
14.15-14.45	THE MISFITS theatre company				A Blythe
14.45-15.00	Teaching on the run—pearls of wisdom from a clinical teacher				Bernard Newmarch
15.00-15.20	**Tea**				
15.20-16.00	**3 parallel sessions (choose 1)** New teacher session Assessing learning needs and supporting students in difficulty How to prepare your nursing team to teach medical students				 Jess Buchan Andrew Blythe Barbara Laue
16.00-16.15	Summary, questions & feedback				Jess Buchan & Andrew Blythe
16.15	**Finish**				

COMP2 update

Jess Buchan updated the delegates on the Primary Care course in year 4. Primary Care is part of the “COMP2” unit (Community Orientated Medical Practice) which also includes placements in Medicine for Older People and Dermatology teaching and clinics. This is one of four units in year 4 that students rotate through. Each block is nine weeks long and comprises of central teaching (lectures and seminars) and placements in Primary Care (4 weeks) and Medicine for Older People (4 weeks) with dermatology clinics scattered throughout the block.

The central teaching occurs over two days at the start of the block, and the students return for three days of central teaching at the end of the bloc.

Week 1

- Introduction lecture
- Effective consultation skills workshop—covers migraine, UTI, STIs and emergency contraception, domestic violence and raised PSA

Week 9

- Multi-morbidity
- CVS risk
- Domestic Violence
- Minor Illness
- Disability workshop
- OSCE revision—Covers backpain and GORD

The Primary Care course curriculum is based around 16 core clinical topics. The topics and the Aims and objectives of the course can be found in the Year 4 GP teacher handbook. This and the students “Lecture notes and study guide” as well as contact and other information can be found on our website:

- http://www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/year/four/

On placement the students do the majority of learning through observing their GP consult and then moving to participating and running their own supervised consultations with patients.

Concern about your students and absences

We do not need feedback from you about your student's performance unless there was a problem. Please do contact the element lead or GP academy lead if you wish to discuss any students. If needed, we may encourage you to fill out a "student concern form" which can be found on our website.

The university also needs to be informed of absences. There are clear rules about absences. You should expect your student to inform you of any unplanned absence on the day. If your student wishes to take planned absence then they need permission from the unit lead. If you are unsure please contact the teaching office for advice.

Changes

- Jess Buchan is emigrating to New Zealand and handing over the role of element lead to Lucy Jenkins (see below for contacts)
- This year we welcome two new GP academy leads: Andy Eaton in Yeovil, and John Salter in Gloucester.
- There has been debate about getting written consent for your students to see patients. This is not feasible but please follow good practice as outlined here
  - Alert patients at the time of booking that a student will be present and offer choice
  - Place a notice next to the arrival touch screen which doctor has a student and
  - information on what the patient should do if they don't wish to have a student present
  - Keep a written information sign in reception about students being present in consultations
  - Brief reception staff about students being present in consultations, including what to say to patients.
- The assessments for year 4 are changing. From 2015 students will only sit their OSCE in the summer rather than half the year sitting a COMP2 OSCE in January and half the year sitting it in June.
- From academic year 2015/16 Psychiatry will be taught in year 4 rather than year 3. This will replace pathology teaching which will be taught in year 3.

Contacts

The new Year 4 Primary Care lead can be contacted at lucy.jenkins@bristol.ac.uk .

Lucy would be happy to discuss any teaching or student issues arising from Year 4 teaching.

For all administration matters please contact phc-teaching@bristol.ac.uk

Multimorbidity Chris Salisbury

Impact of multimorbidity: Health care system

- High consultation rates
- Frequent referrals and hospital admissions
- Duplication of effort and inefficiency
- Complex management
- Poor co-ordination of care
- Increased health care costs

Priorities for students to learn

- Multimorbidity is the norm
- These people are the biggest users of general practice
- Guidelines don't replace judgement
- Listen to the patient's priorities. Shared decision making
- Think about quality of life not just disease
- Be aware of depression
- Strategies for dealing with multiple problems in consultations

Tips for students

- Identify the list early
- What are the patient's priorities?
- Negotiate what can be achieved today, balancing GP and patient agenda
- Think of depression
- Simplify medication, ask about adherence
- No need to don't do everything yourself or everything today
- But take personal responsibility
- Recap and share the plan

‘Teaching scripts’ – Disability, Ethics, BBN, SOB

Disability seminar Mike Holroyd Jo Stevens Jessica Buchan

Our guest speakers were Mr. Mike Holroyd from Action for Blind People and Ms. Jo Stevens who is hearing impaired. Both teach our 4th year students about consulting with patients with a disability.

Patients with visual impairment

Mike started the session by talking about guiding and top tips on consulting with a patient with a visual impairment. We practiced guiding and then practiced explaining to Mike how we wanted him to use a peak flow meter.

- Do not focus on the disability. It is unlikely to be the reason the patient is consulting
- Ask about the disability on a need to know basis. Function is more important than the underlying condition. Can the patient perform the task you need them to rather than what is their general level of impairment e.g. can the patient sign the form you need them ***not:*** “How much sight do you have?”
- If you are not sure if someone needs help ask, but offer options: “Would you like me to help you to my room or would you prefer to make your own way?”
- Get to know your patient. Be curious about what would help them in your surgery. Are there any ways you can make things easier for them?

<u>How to guide people with sight problems</u>

- Ask them if they want to hold your arm/shoulder. To get through narrow gaps fold your arm behind your back so the person falls in behind you
- If they have a guide dog approach them from side opposite the dog
- Doorways: say which way door opens; make sure they are on hinge side and open the door with your guiding arm. Unless the person is frail being visually impaired doesn’t impede their ability to hold a door open
- Seating: never back them into a seat; guide them to a seat, then describe it; ask them to let go of your guiding arm and place their hand on back of the seat
- Don’t leave the room without telling them you are going
- We also talked about steps. Do say if the steps are going up or down and when they are approaching the first and last steps. Don’t count steps as everyone has a different way of counting

‘The sections on disability - it opened my eyes to some things that I do not do well (and therefore will not be teaching my students well).’

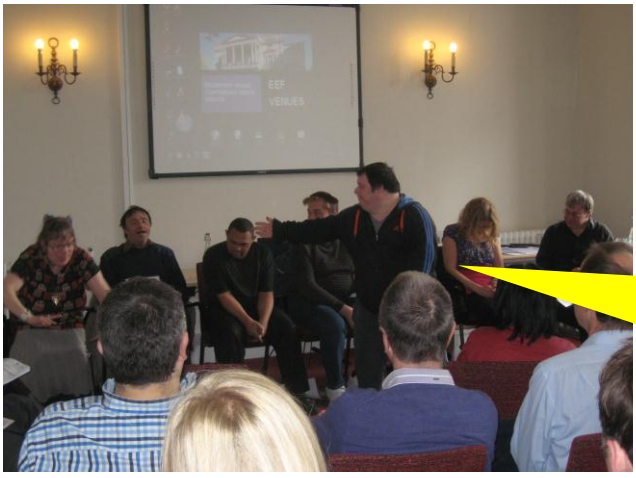
<u>Top tips for guiding are</u>

- Introduce yourself
- Make sure you’re talking to the right person
- Make sure they know you’re talking to them
- Explain in detail what is going to happen next
- When examining tell them what you are going to do. Let them feel any equipment you plan to use unless it is hazardous to do so
- Point out any potential hazards and ask if they would like help “Do you need any help?”

How to consult with patients with hearing problems

Jo then pretended to be a patient with a chest infection. We practiced consulting with her as if we were GPs. We gathered the following top tips.

- Calling in from a busy waiting room can be difficult for patient and doctor. Jo tends to alert the reception in her practice. We discussed using a sign with her name written on it, this can be helpful if you don't know the patient but has the potential to embarrass if not done sensitively
- Find a suitable place to talk, with good lighting and away from noise and distractions. Check your face is not in shadow if the patient lip reads
- Establish how the patient wishes to communicate (e.g. using hearing aid, lip reading, interpreter)
- If using a hearing aid, check it is functioning adequately, or whether they would benefit from using an induction loop
- Even if someone is wearing a hearing aid it doesn't mean they can hear you. Ask if they need to lip-read
- If you are using communication support, talk directly to the person you are communicating with, not the interpreter
- Have face-to-face or eye-to-eye contact with the person you are talking to. We discovered this was tricky when examining someone, especially their back! It helps to explain each aspect of the examination before you do it
- Remember not to turn your face away from a deaf person, particularly when using a computer
- Speak clearly but not too slowly, and don't exaggerate your lip movements
- Don't shout. It's uncomfortable for a hearing aid user and it looks aggressive
- If someone doesn't understand what you've said, try saying it in a different way instead of repetition
- Keep pen and paper handy in case needed and supplement the consultation with written material/patient information sheets if possible. But be aware of associated reading difficulties
- Check that the person you're talking to can follow you. Be patient.
- Use plain language – avoid jargon



'I really enjoyed the Misfits and found it thought provoking and quite emotional. I think all GPs should see them'

Medical Ethics Workshop Gordon Stirrat Andrew Blythe

Please also read Prof. Stirrat's document on page 27

This session was led by Professor Gordon Stirrat, Emeritus Professor of Obstetrics & Gynaecology and Research Fellow in Ethics in Medicine at the University of Bristol. Professor Stirrat was the Dean of the Faculty of Medicine and Dentistry at the University of Bristol and is Honorary Vice-President of the Institute of Medical Ethics.

Participants of this workshop were invited to describe real cases from their clinical experience which presented ethical problems. These included:

- A patient who did not want to reveal to his GP the details of treatment that he was receiving from a consultant and who did not want his diagnosis to be revealed to his family
- A patient in a coma who had expressed wishes previously that he did not want to have active treatment in the event of a severe debilitating illness
- A patient receiving terminal care who could no longer be looked after by the district nursing team because of the confrontational manner of a family member
- A child from a family of Jehovah's Witnesses who needed a life saving operation but did not want a transfusion

Professor Stirrat encouraged each group to consider one of these cases using the strategy outlined in his document "How to approach ethical issues – a brief guide". Each group defined a problem and analysed its components. In each case there were several different parties who had to be considered. The four principles (beneficence, do no harm, autonomy and justice) were discussed. Professor Stirrat facilitated the discussion and demonstrated how the complexity of each case could be analysed. Members of the group brought different perspectives and some solutions evolved. We all learned more about medical ethics as a result of working through these real life case studies.

Breaking Bad News (BBN) workshop Karen Forbes Lucy Jenkins

We discussed the importance of teaching BBN in year 4 as it is now examined in the Year 4 OSCE. It was felt that the one-to-one teaching made Year 4 GP a good place and safe environment to discuss and practice BBN. Also that it may well be an appropriate year for students to be involved in such consultations, or even give the news if the patient has consented and the GP is there and the student has all the information. In those circumstances, it is essential that the GP teacher agrees with the student beforehand with regard to a signal/phrase that either can use to hand/take-over the consult if necessary. It was also suggested that routine consultations can be an opportunity to ask patients how news has been broken to them (well and badly) and any tips they have for the students with regard to this.

We discussed

- Important things to be aware of were student personal or past experiences which may make discussion about BBN difficult and require GP teacher support
- Students often seem to have preconceptions as to what constitutes BBN i.e. NIDDM is bad news to someone who supported a spouse after an amputation, broken finger to concert pianist etc. DNACPR and Advance Care planning are new areas where BBN may occur
- Various methods of BBN including **SPIKES** six step model – summarised here with points from the workshop discussed added.
    - **S** – **Setting** up the interview. Privacy. Involve others. Ensure adequate time. Look attentive and calm
    - **P** – Assessing the patients **Perception**. Ask before you tell. Find out what the patient knows. Always remember ICE
    - **I** – Obtaining the patients **Invitation**. While a majority of patients express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not. Find out how much information would the patient like to know and avoid making an incorrect assumption about this
    - **K** – Giving **Knowledge**. Warning shot first. Avoid jargon. Small chunks. Allow time for emotions Use of silence
    - **E** – Addressing **Emotions.** Showing **Empathy.** Recognise. Listen for and identify the emotion. Show the patient you have done this
    - **S** – **Strategy** and **Summary**. Understanding reduces fear. Summarise the discussion. Strategy for future care. Schedule next meeting. Allow time for questions

<u>Professor Forbes model</u> as taught in year 5:

Students are encouraged to see the breaking bad news as a path they walk the patient along arm in arm. The beginning of the path is where the patient is not aware of the news and the end is where they are fully aware.

- SPIKES principles may support this
- Patients will take different amounts of time and variable support along the way
- This breaking the news can be similar to a bereavement so patient may experience denial, anger, bargaining, depression, acceptance - we should be prepared for and accept these
- Some patients will need more 'pushing' along the path than others The challenge is identifying what the patient wants to know and ensuring they understand the info they have to know
- We discussed the need for care in emphasising any positives – hope tempered with realism 'hoping for the best, preparing for the worst'
- We discussed how breaking bad news involves accepting some degree of uncertainty students often struggle with

<u>NB</u> Professor Forbes model of teaching consultation skills is as follows:

Split the whole group (even if big e.g. 80 students) into threes. One is the patient, one the doctor and one an observer. The scenario runs three times so each person takes each role and the time given will vary. Her feedback tool is **PQRS** - Praise, Question, Review and Summarise

The aim of this is to enable everyone to consult (?more equitable) but without the pressure of more peers observing.

Cardiac causes of SOB Phil Boreham Barbara Laue

We had asked Phil to share with us his pathways and processes for diagnosing cardiac causes of SOB and highlight the predictive value of symptoms and signs. The following is a brief summary of the clear and simple frameworks for classifying symptoms and signs of SOB and some 'rules of thumb' which will all be very useful for our student teaching.

Broad classification of causes of SOB

- Heart
- Lungs
- Heart and lungs
- Brain (Anaemia, acidosis, hyperventilation etc)

'Great structured approach to teaching and clinically informative too!'

Approach to diagnosis

- History
- History of risk factors
- Examination
- Investigation initial
- Investigations secondary

Predictive value of symptoms – the following are not good for distinguishing between heart and lung problems

- Orthopnoea and disturbed sleep
- Ankle oedema
- Chest pain

Predictive value of risk factors

	Risk Factors	
	Heart Failure	Pulmonary disease
PMH of system Disease:-	PMH of Cardiac Disease, eg: Mi CABG, stents, valve, AFib	PMH of pneumonia/chest infections,
The usual risk factors:	Tobacco:- low relevance	Tobacco:- high relevance
Tobacco	HT, DM – high relevance	HT, DM – low relevance
HT & DM	Alcohol excess relevant	Alcohol excess – low relevance
Age	Age: not useful (beware young pts) Recent onset viral Myocarditis)	Age: not useful

Predictive value of examination findings

Examination		
	Heart Failure	Pulmonary disease
Heart Rhythm	AFib common & Cause SoB	AFib uncommon
Murmurs	Heart sounds audible, Murmurs more common	Heart sounds quiet, murmurs uncommon
Unilateral or Bilateral resp signs	Chest is clear in CCF, in acute LVF bilateral basal creps of pulm oedema	Usually there are bilateral signs in COPD, unilateral in pneumonia

	Heart Failure	Pulmonary disease
Crepitations orCrackles	Acute LVF bilat fine inspiratory crepitations	Pulm fibrosis-medium end-insp crackles Infection/COPD-, coarse localised crackles

Predictive value of investigations

Investigations in Primary Care		
	Cardiac	Respiratory
ECG	ECG – usually abnormal (a normal ECG excludes Heart failure)	ECG – usually normal, may have signs of Right Heart strain - cor pulmonale in severe chronic Resp disease
Pulse oximetry	In normal range in CCF, Maybe hypocix in acute LVF	Usually in low range of normal or below after exertion
Peak Expiratory Flow	PEFR normal	PEFR abnormal

Secondary investigations

The role of ECG

If ECG abnormal or previous MI or murmur present, request

- Echocardiogram
- Direct access community Heart Failure service

If ECG equivocal and no prev. MI, request

- BNP venous sample in gold top container for NTproBNP
- CXR usually unhelpful for early COPD or CCF, but will pick up malignancies and pleural disease

ECG abnormalities in heart failure

- Any!
- Ischaemic – chronic/acute, LBBB, Rhythm abnormalities, LVH

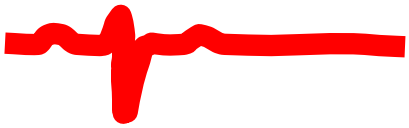
BNP in the differential diagnosis

- BNP can help assess patients – with both COPD and LVF to give an indication of which system is predominant
    - If pt is SOB and BNP levels are low 100- 400, COPD is more likely than LVF
    - If pt is SOB and BNP is raised 400 – 2000 LVF is not adequately treated
- BNP levels can gauge effectiveness of Rx for Heart Failure (high levels ↓ with Rx)
- If BNP raised →ECHO
- If BNP normal and still suspecting heart failure check whether there is a reason for BNP being reduced i.e. medication

What students don't tend to know

- Pulmonary oedema is an acute event and clears when the body compensates
- It is important to take in the 'bigger picture' of risk factors to gauge prior probabilities
- Patients with low output cardiac failure don't go into heart failure with crackles because the output is too low

Take home messages and teaching points for students



- It is ok to use Beta blockers in COPD
- LBBB is always pathological
- RBBB is physiological
- Elderly don't cope well with fast AF and go into acute LVF (due to stiff vessels)
- Always ask yourself
    - Why is there LVF
    - Why are the lungs so bad?
- Normal ECG – It is not heart failure!
- Wheeze doesn't happen in heart failure! 'Cardiac asthma' does not exist
- Acute emergency presentation – act, don't take more history
- Beware of age – young people can have PE, autoimmune fibrosis, viral cardiomyopathy
- Chest is clear in CCF, pulmonary oedema is acute
- History taking
    - Don't start with risk factors
    - Keep an open mind, don't squeeze stuff into a straight jacket that doesn't fit

Pearls of wisdom Bernard Newmarch, Victoria Gate Surgery, Taunton

Student Experience - action

- **Encouraging** diagnosis and management
- **Challenging** knowledge and interpretation
- Purpose and technique of examination and need for investigations
- Use of language with patients, ways of explaining and pitfalls in understanding
  Expectations of patient's behaviour and response to consultation
  Worsening advice.
- Seeing the student as a patient

Patient explanations

- Fever – symptoms and their interpretation
- Use and value of antibiotics
- **Changing** understanding of illness and expectations of treatment. Cultural and language influences
- Mental Health problems and influence in all consultations
- Anxiety and depression – task focused management – problem and "smile" lists

Summary

- **Never underestimate** their need to practice both examination and technical skills as well as the use of practice clinical equipment
- Remain **ready to talk** and explain
- **Be sensitive** to their logistic and pastoral issues. They are trying get to know the staff, practice systems and to quickly absorb and make sense of these new experiences
- **Positive feedback** as well as areas to improve
- **Be friendly**!

New Teachers workshop Jessica Buchan

We were a group of new teachers, returning teachers who wanted a refresher and experienced teachers, some of whom were new to Year 4 in Bristol.

We discussed what we were looking forward to

- Enthusing students for general practice
- Enthusing us as GPs
- Mutual learning, and learning/revising by teaching
- Patients usually liking having students present.

We discussed some of the challenges

Staying up to date with the course when you've moved area/not taught for a while/tend to teach post graduates. Not knowing the course/structure.

- This is the point of workshops and most of the information you need is in the GP teachers handbook at http://www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/year/four
- Do also **ASK** if you are not sure!

Time constraints

- Do timetable in breaks for you to catch up with admin
- Sessions do not have to be timetabled in half day slots
- The student could spend one to two hours with you in surgery and then spend time with the nurse or HCA while you catch up

Consent and confidentiality

- Do talk to your student about professionalism and expectations
- Remind them not to talk about patients they have seen, particularly where they can be overheard and safely dispose of any written notes

Answers to more teaching questions

Can students take time off?

- Planned absence needs permission from the Unit lead. There are clear rules on absence so if approached by your student for time off do check with phc-teaching@bristol.ac.uk
- The students have 30 (out of a possible 40) sessions to spend with you. This leaves 10 sessions for their pre timetabled dermatology teaching (you should get a copy of this timetable 4-6 weeks before your student arrives) and private study time.
- The student does not choose when they have their private study time unless you are able to accommodate requests. Usually their study sessions are dictated by your schedule.

What are the tutorial requirements?

- A minimum is 2 tutorials in a 4 week block.
- These should be 1-2 hours and protected time.
- Try and use the students learning needs to guide the topic.
- Students should know the topic and do home work before the tutorial.
- Additional tutorials are fine but shouldn't distract from time for the student to consult.

How to organise a surgery?

- We discussed a rule of thumb that surgeries should be reduced by ¼.
- Payments are intended to cover a locum for this level of reduction in appointments.
- We discussed how to build in time for the students to consult. One option is to have joint surgeries for the morning and afternoon but to schedule in an hour at the beginning of the afternoon (or end of the morning) where students have 2-3 patients booked for half hour slots: 20 minutes to see them alone with 10 minutes at the end to consult with you.

How to get the rest of the team on board*?*

- We discussed informing your reception and admin team before the students arrive
- Discuss expectations – students are not doctors

Giving and getting feedback

We ran out of time before discussing feedback to students. We did discuss that they need to fill in our feedback on line about the course (please make a computer available for them to do this). Please gather your own personal feedback for teacher development as well. There is a reflective template and feedback form on our website for your use.

Students like and need to know how they are doing. Please see the following for good feedback giving.

<u>Giving constructive feedback on consultation skills</u>

GPs and students should use the Calgary-Cambridge Guide to identify and record strengths and weaknesses. This serves several purposes:

- Students, and GPs become familiar with the Guide
- Students learn to assess their own and each other's performance
- Students learn to give useful feedback

Feedback should be **'SMART'**
S: Specific, significant, stretching
M: Measurable, meaningful, motivational
A: Agreed upon, attainable, achievable, acceptable, action-oriented
R: Realistic, reliable
T: Time-based, timely, tangible, trackable

Feedback giving process – different methods

In terms of the process of how this information is given and received, there are two broad approaches - Pendleton rules and ALOBA, see below. You may wish to mix and match the processes.

Before beginning feedback

- ensure the consulting student has a chance to “recover” and clarify any matters of fact first
- Always remember to ask the actor for their opinion

We are lucky in Bristol to have an experienced group of simulated patients, who can uniquely offer the patient.

Pendleton rules

These provide a safe if somewhat formulaic way of delivering and discussing feedback. Particularly useful for students new to learning consultation skills in a group setting.

- Clarify matters of fact
- The doctor consulting says what **went well** and how
- The observers identify other things that **went well** and how
- The doctor consulting says **what could be done differently** and how
- The observers add to this, **what could be done differently**
- The pair or group agree areas for development

However, there are some acknowledged limitations to this approach and in later years, students and tutors are being encouraged to adopt an Agenda-Led Outcome Based Analysis (ALOBA) approach.

Agenda-Led Outcome Based Analysis (ALOBA)

ALOBA is a ‘maturer’ approach, whereby:

- The student is asked before the scenario what problems they have experienced before and what help they would like from the feedback
- After the consultation, the learner gets to comment first, which may lead them to review or refine their “learning agenda”, and may focus immediately on problem areas rather than strengths
- To assist this process, the teacher describes what they saw (not provide solutions) so the student can reflect on what happened.
- Both teacher and student are involved in problem solving, allowing the student to go first, so that they are working to help themselves in the future.
- Rehearse suggestions: this takes the analysis and feedback to a deeper level of understanding by practicing specific skills

Assessing the student's learning needs Andrew Blythe

It is useful to start every attachment with a learning needs analysis. This will help you to plan your teaching and tailor it to the learner.

What should you do in a learning needs analysis with your student?

Assessing Knowledge & Skills

Ask about past performance in assessments
Ask them about their performance in previous assessments. Have they done really well in all of their exams so far? Have they failed some exams or had to repeat a year? Did they intercalate?

Reflection

- How do their think their studies are going? Do they think that they are keeping on top of their studies?
- What have others said (teachers, peers & patients)?

Review of planned learning objectives (Gap analysis)
Look at learning objectives of the course (including the 16 core problems). Have they seen patients with these problems before? How confident do they feel about these topics? You are trying to identify the gaps between what they know and what they are expected to know/understand at the end of the course.
You may need to revise your analysis after a few days on the basis of observing the student.

One danger of conducting a learning needs analysis is that you narrow the student's horizons too much. Much of the learning in primary care is unexpected and is not captured by the published learning objectives.

Making a holistic assessment of the student
The student will be with you for 4 weeks. There may be all sorts of things in their life that may have an impact on their learning. The situation you want to avoid is only finding out at the end of a difficult attachment that the student is going through bereavement or has a severe chronic illness. The student may not want to divulge too much at the start of the attachment but if you make clear you are asking them in order to be supportive then they will usually be very open. There is no one at the Medical School who will automatically alert you to a student's personal difficulties at the start of the attachment. Students have a right to confidentiality and are often reticent to give their permission for information about them to be shared. Here are two questions you can try asking:

- How do you feel about starting this attachment?
- Do you need any time off to attend appointments?

- Finally ask them if there is there anything in particular that you want to get out of this attachment?

Students in Difficulty Andrew Blythe

Studying medicine is arduous and at time stressful. It is also expensive. So it is not surprising that students often get into difficulty.

What sort of difficulty?

- Academic – failing exams
- Financial
- Personal
- Health – mental/physical

All of these things often overlap. For example if the student is having to work 20 hours a week in order to pay their fees and have enough to live on, then they have less time to study and are more likely to struggle academically. Also working long hours may have an effect on their mental health.

Exams and the national ranking system for application to the Foundation Programme are potent sources of stress. The number of exams escalates in the final 18 months of the course. Table 1 (page 26) shows some of the major events in the medical school timetable that are a source of stress. There is a lot of evidence to show that nationally medical students are more likely to suffer from depression, anxiety and other mental health problems than the general population.

The doctors at Bristol University's Student Health Service tell us that mental health problems often come to light in Year 4 of the medical course. We are trying to address this issue by reducing the burden of assessment in year 4.

The GMC recognises that the mental health of medical students is a cause of concern. Last year it published a document "Supporting Medical Students with Mental Health Conditions" http://www.gmc-uk.org/Supporting_medical_students_with_mental_health_conditions___July_13.pdf_52834713.pdf
At Bristol we are responding to this document in number of ways:

- We are planning training events to inform our teachers about the mental health problems faced by our medical students
- We are promoting good health and want to start a series of Health and Wellbeing Days in the Academies
- We are giving all students in Year 2 a taster session in " Mindfulness"

How can you help?

- Be on the lookout for signs of difficulty
- Facilitate the student's access to support e.g. give them time off to attend appointments (CBT or GP appointments)
- Do not try to act as their GP
- Encourage them to seek help from the Faculty Student Advisor, Emma Teakle, emma.teakle@bristol.ac.uk, or the Director of Student Affairs, Revd Dr Nigel Rawlinson, nigel.rawlinson@bristol.ac.uk

How to prepare your nursing team to teach medical students

Barbara Laue

Our discussion showed that practices involved practice nurses and other health professionals to a varying degree in medical student teaching. This depended on a number of factors

- The size of the practice
  - This has an effect on the skills mix and therefore opportunities for students to spend time with other health professionals
- Nurses' preparedness to teach
  - Some nurses refuse
  - Some nurses feel intimidated and are not happy with students asking questions
  - Nurses seem to feel more challenged when they perceive it as disease or topic teaching
- Student attitude
  - Students might not think they can learn from nurses
- Problem with the language used
  - 'Sitting in' suggests passivity and may put students off because they prefer to be actively doing something

Current range of teaching by other health professionals

- Practical skills
  - Blood tests, Injections, testing urine etc
- Observation - Sitting in on
  - Chronic disease management clinic
  - Baby clinics
  - Minor illness clinics
  - Contraception clinics
- Spending time with health visitors, CNOP nurse, community matron etc

Top tips

- Create a positive 'teaching philosophy' in your practice – everybody working in the practice is expected to teach
- 'Push' nurses into more active teaching
- Need to ensure that the nurses can teach
- Don't give your students a choice – they should be prepared to learn from everyone in the team
- Email students with timetable and stress that they will be taught by all members of the team – guide expectations
- Block slots for teaching
- Lead GP should take responsibility for organising sessions with nurses and other team members
  - If only observing, make it just 1-1 ½ hours
  - Shorter sessions can work well with managing GP workload
  - If students is going to do some active tasks – make it a whole session
  - It is our responsibility to make sure that the student has a useful time

Good practice

In one practice the GP teacher holds a 'mini teaching workshop' every two to three months and goes over

- How we teach, What students are expecting, How to be involved

From the Teaching workshop for Practice Nurses Sept. 2013

The following shows some discussion points and suggestions from practice nurses who attended our teaching workshop for practice nurses last September.

Background

The roles and responsibilities of GPs and practice nurses have shifted substantially over the last few years. In most practices the nurses now manage most of the consultation for chronic diseases, including using specialised skills such as insulin conversion. This means that GPs have become relatively deskilled in these areas. Medical students also need to acquire competencies in a number of practical skills as described in the CAPS logbook. In General Practice most of these activities are carried out by Practice Nurses. This means that we should explore and develop the role of Practice Nurses in medical student teaching.

Discussion

Our discussion showed how much Practice Nurses can contribute to teaching medical students in General Practice. At present this tends to happen in an ad hoc fashion and often Practice Nurses don't have enough information and not enough time to be fully effective. Teaching students is an opportunity to promote nurse roles.

Challenges

- Often you don't have enough information about the student(s)
    - Year
    - Learning needs
    - Student and practice expectations
- Lack of time
    - No time at the start of your surgery to get to know the student and find out what they want to learn
    - No space for teaching

Small changes needed to support Practice Nurse teaching of medical students

The following small changes would help to enhance Practice Nurse teaching

- Student's timetable
- Time at the start of surgery to get to know the student, their learning needs, their expectations
- Some appointments blocked out for teaching
- Information about the CAPS logbook
    - How to teach and sign off the competencies
- Slot at the end of surgery for questions and review of learning needs, planning for further session(s)

Key elements for engaging and supporting nurses in student teaching

- Information about the student and the curriculum
- Allow some time (block appointments)
  - Get to know student and their needs
  - Set learning objectives
  - Revisit learning objectives
- Disseminate and share teaching skills and knowledge
  - Make teacher guidebooks available (in paper/electronic/website)
  - CAPS logbook sign off
  - Making teaching active
- Ideally put student teaching on the agenda for some practice team meetings

'One of the best study days I have been on, thought provoking and made me look at my own practice differently around communication skills. Disability workshops and Misfits theatre group were very powerful and good messages delivered.'

Workshop evaluation

1. Which Academy is your practice attached to?			
Bath:		12.5%	4
Gloucester:		28.1%	9
North Bristol:		15.6%	5
South Bristol:		12.5%	4
North Somerset:		6.2%	2
Somerset:		25.0%	8
Swindon:		0.0%	0

2. Which year do you teach in?			
I am teaching 4th year students in this academic year:		n/a	27
I plan to teach 4th years in 2014-15:		n/a	5
Other *(please specify)*:		n/a	3

3. "How do we fit it all in?" Multi-morbidity in primary care and teaching in the consultation - Prof Chris Salisbury			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		43.8%	14
Excellent:		56.2%	18
Did not attend:		0.0%	0

4. How to go beyond "feeling". An approach to common ethical dilemmas in the GP consultation - Prof Gordon Stirrat			
Poor:		0.0%	0
Below average:		3.1%	1
Satisfactory:		12.5%	4
Good:		50.0%	16
Excellent:		34.4%	11
Did not attend:		0.0%	0

5. Small group session - Disability			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		3.1%	1
Good:		34.4%	11
Excellent:		62.5%	20
Did not attend:		0.0%	0

6. Small group session - Ethics			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		6.2%	2
Good:		62.5%	20
Excellent:		31.2%	10
Did not attend:		0.0%	0

7. Small group session - Breaking bad news			
Poor:		0.0%	0
Below average:		3.1%	1
Satisfactory:		18.8%	6
Good:		56.2%	18
Excellent:		21.9%	7
Did not attend:		0.0%	

8. Small group session - Cardiac causes of SOB			
Poor:		3.1%	1
Below average:		0.0%	0
Satisfactory:		18.8%	6
Good:		43.8%	14
Excellent:		34.4%	11
Did not attend:		0.0%	0

9. THE MISFITS Theatre Company			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		18.8%	6
Excellent:		78.1%	25
Did not attend:		3.1%	1

10. Teaching on the run: Pearls of wisdom from a clinical teacher - Dr Bernard Newmarch			
Poor:		0.0%	0
Below average:		3.1%	1
Satisfactory:		21.9%	7
Good:		37.5%	12
Excellent:		31.2%	10
Did not attend:		6.2%	2

11. Please indicate which of the three parallel sessions you attended			
New teacher session - Dr Jess Buchan:		25.0%	8
Assessing learning needs and supporting students in difficulty - Dr Andrew Blythe:		46.9%	15
How to prepare your nursing team to teach medical students - Dr Barbara Laue:		21.9%	7
Did not attend any:		6.2%	2

11.a. Now please rate the session you attended:			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		71.9%	23
Excellent:		21.9%	7
Did not attend:		6.2%	2

12. Please rate the workshop overall			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		50.0%	16
Excellent:		50.0%	16

Thanks for enjoyable day. Great to meet up with old friends. As usual inspired to teach, but also to take back learning to the practice.

'Meeting other GP s who train, being enthused by excellent academic GPs, a chance to reflect & draw breath, and the sheer joy of the Misfits!'

'Learnt some new ideas as how to involve nurses more in teaching med students, looking at their sessions when teaching, may need to be slightly shorter with some time for student feedback etc'

Table 1: Major events during the 5 year MB ChB Programme that might be a source of stress

	Sept	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*June*	*July*	*Aug*
Year 1					Exams				Exams			
Year 2					Exams			Exams				
Year 3					Exams					Written Exams	Project (SSC)	
Year 4					OSCE					Written exams + OSCE	Project (SSC)	
Year 5	Apply for Foundation Programme (ranked in deciles)		1st Long Case	Written Finals (MCQ & DOSCE)	Situational Judgement Test	2nd Long Case Prescribing Safety Assessment (PSA)	3rd Long Case Find out about Foundation Programme	Elective			Graduation Ceremony	

How to approach ethical issues – a brief guide

Gordon M. Stirrat, Emeritus Professor of Obstetrics & Gynaecology and Research Fellow in Ethics in Medicine, University of Bristol, Hon. Vice-President Institute of Medical Ethics

g.m.stirrat@bristol.ac.uk

Caring for patients cannot be isolated from ethical judgements. These judgements must take full account of all the circumstances of the case and be based on sound principles. Decisions must be consistent, free from contradiction and clinically relevant. Some of the principles are outlined here and a guide is provided to facilitate the translation of ethical analysis into moral action. The purpose of this brief outline is to assist in the development of consistent, critical and reflective attitudes to ethical decision-making.

Background

Ethical problems can be complex and may involve true dilemmas where the choices are between equally undesirable alternatives. Unfortunately ready-made answers cannot be found in textbooks, because the situations in which problems arise and the stories of people involved are all different. The desired goals may also differ. For example, the prevention of disease and health promotion tends to raise different issues and require alternative solutions to the relief of symptoms, pain and suffering or the cure of a disease.

The basis for ethics

Since at least the time of Socrates people have asked questions like 'How do we know what is good?' 'How should I live?' 'How can we know which decision is right?' and 'What is justice?' Ethics, or moral philosophy, addresses these fundamental questions in order to establish a basis for moral judgements. Morals are the specific judgements, codes or beliefs of particular groups or societies and the actions that follow from these.

Summary of some essentials of ethics

- Ethics is for something and must be translatable into moral action. (It has to work in real life.)
- Each one of us is required to think ethically and act morally (i.e. we are all 'moral agents'). This is not an optional extra.
- Ethics is about individuals living and working in community. It is not just about 'me' and 'mine'.
- Individuals not only have rights but also duties/obligations towards others.
- The fundamental principles underpinning medical ethics are (or should be) those of society in general
- We as healthcare practitioners have special obligations or duties to our patients that are clearly laid down by our regulatory bodies (e.g. GMC or NMC).
- Clinical medicine, ethical analysis and moral action cannot be practiced in isolation from one another. (Ethics is a necessary part of good clinical practice.)

Diversity of moral theory

One characteristic of homo sapiens is the need to make sense out of uncertainty by classification and codification of what we think we know. We need frameworks as reference points to allow us to progress through our lives as individuals in society. One result of this is the development of a multiplicity of theoretical approaches in Ethics. Only the briefest and necessarily incomplete overview is possible here. For fuller discussion and further reading refer to the reference list. The two main theories are described below.

Deontology (or 'duties in action')

The best example is found in the writing of the philosopher Immanuel Kant in the 18th century. The essence of Kant's ethics is:

- Each of us has a set of duties to our fellow men and women. One of the most important duty is to 'act so that you treat humanity, whether in your own person or in that of any other, always as an end, and never as a means only'.
- Certain kinds of acts are intrinsically right and others intrinsically wrong, determined by a set of rules.
- The rules must be universally applicable, coherent (i.e. not contradictory) within 'a rational system of nature' and capable of being freely adopted by 'a community of rational beings'.
- Among the rules are 'do not kill, cause pain, disable, deprive of freedom or pleasure'; and 'do not deceive, break promises, cheat, break laws or neglect one's duty'.
- An action should not be judged to have been right or wrong by its consequences in individual situations.

The main problems with this theory are defining the meaning of 'rational' and agreeing on universally applicable rules.

Consequentialism

In the 19th century Jeremy Bentham and John Stuart Mill developed a system in which the 'rightness' or 'wrongness' of an action were based solely on consequences. This is called Consequentialism (or Utilitarianism) in which the maximisation of pleasure or happiness is what make acts right. This is summarised as "The greatest happiness of the greatest number". Consequentialist theories can be further divided into 'act consequentialism' (the right action is the one that produces the most good): and 'rule consequentialism' (does an action accord with a set of rules whose general acceptance would result in the most good?). In each case 'good' is determined solely by the beneficial consequences.

The problem with consequentialism is that although consequences are undoubtedly important in moral judgements and actions, happiness is highly subjective and what is good (let alone the 'greatest good') is not always easy to determine. Moreover, benefiting the majority could result in ignoring vulnerable minorities. Where do the seriously disadvantaged in our society such as the severely disabled child, the terminally ill or the elderly with dementia fit with this philosophy? A rule to protect the vulnerable could be set aside if it did not promote general happiness.

Clearly these theories are not sufficient for real life and several other views have been developed to try to deal with their inherent problems. The 'Four Principle Approach' was first formulated by Beauchamp and Childress in 1979 [See Ashcroft et al in further reading] as a basis for working out practical solutions for problems in Medical Ethics.

The Four-Principle Approach

Principle:	The obligation
Beneficence:	To do what is in the patient's best interests
Non-maleficence:	Not to cause harm and, indeed, to seek to prevent it
Autonomy ('self-rule'):	To respect the right of the individual to make choices about his or her own life in the context of equal respect for everyone else involved
Justice:	To treat all patients fairly and without unfair discrimination

Problems with the Four Principles:

They can be used as a ‘Instant Coffee Ethics: i.e. people use them simplistically and uncritically and think that they can find the solution to ethical problems as easily as one produces a cup of coffee by pouring water on the freeze dried granules. They also tend to be used as a checklist without an underlying theory; are often in conflict with one another (with no internal resolution); and do not deal with emotional aspects or relationships.

In particular the concept of autonomy is widely misunderstood. It does not necessarily mean doing what someone requests or demands at one point in time. It implies a settled view of the individual reached by deliberation as to what is in his or her own long-term best interests. It is also to be balanced with the autonomy of others, including, in this context, healthcare staff. If, however, one recognises their shortcomings and incorporates some other insights such as those discussed below, the 'Four Principles' can provide a useful framework for analysing ethical problems.

Other useful ethical perspectives

Feminist approaches to ethics

One form of feminist ethics attempts to balance the dominant masculine ethos of traditional ethics with a more feminine perspective. The ethics is one of caring for individuals and, although caring resolutions may be different in their outcomes, they are linked by personal regard and respect given to individuals. Personal relationships are emphasised. A second form focuses on justice and on unfair discrimination against women, whether as patients or practitioners.

The feminist philosopher, Susan Sherwin considers that different theoretical perspectives should be viewed as providing alternative frameworks or templates for different sorts of approaches to problems. She suggests that we use competing theories as a set of lenses through which we can get a clearer view of complex moral problems. Some lenses will provide clearer understanding than others.

Narrative ethics

Narrative ethics takes account of the patient's and the practitioner's context, emotions and relationships. Indeed, whatever the approach, the patient’s story must be part of the ethical relationship and one's own feelings are relevant to the moral choices.

Virtue ethics

Instead of asking "How should I act?’ virtue ethics asks 'How should I live?’ ‘This system tried to define 'excellences' of character or behaviour to which individuals or groups should aspire. One

aspect is caring about someone rather than just caring for them and it can provide a useful perspective in, for example, those faced with chronic and/or serious illness or disability.

Making ethical judgements

There are two main ways in which ethical issues arise. The first, and the aspect on which this summary concentrates, occurs while dealing with patients and their clinical problems. The second arises when faced with an issue in abstract (e.g. 'what do you think of cloning?'). In my experience dealing with the former informs my approach to the latter and, incidentally, provides valuable insights not given to the non-clinician. How then do we go about making ethical judgements in the clinical context? Some of the points to emphasise are shown below.

The nature of ethical judgements

- Ethical judgements are integral to the caring/clinical process. Indeed you have been making ethical decisions every day since you qualified perhaps without recognising it!
- Whatever method we use it must suit the realities of the problem you are facing
- It should go without saying that the process must be carried out sincerely and honestly 'making the care of your patient your first concern'
- There is no 'magic' formula (beware those who suggest that there is) and each case is different from any other
- Indeed, there is seldom an absolutely 'right' or 'wrong' decision. One is often trying to balance the greater good or the lesser evil!
- This does not mean that ethical decision making is arbitrary
- Although some decisions must be reached quickly, the decision-making process should be no less rigorous
- Do not express your personal beliefs (including political (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress [Good Medical Practice, 2013]

There are several approaches that can be used. Whatever method is used it must at least identify all the ethical conflicts, be consistent and free of contradiction within and among cases and produce answers that are both comprehensive and clinically relevant.

My own approach involves the answering (usually subconsciously) of a series of questions under five task-orientated headings as outlined below.

Making Ethical Judgements – 1. Analysis

Define the problem(s)

Analyse the problem(s)

- What are its elements? – e.g. medical, ethical, legal etc
- What parties are involved? – the patient, her family, statutory authorities (e.g. social workers, police), health care professionals etc.
- How do their perspectives fit together or conflict and, if the latter, what are the appropriate mechanisms for resolution?
- What is its context? – e.g. social, economic (within this may be issues about 'rationing')

Consider the underlying principles involved

- It may be useful to start with the 'Four Principles' (beneficence, 'do no harm', autonomy and justice).
    - What is in the patient's best interests?
    - How can I balance this with the avoidance of harm?
    - Is the patient competent? If so:
        - Is she expressing her 'settled' view on what she wants?
        - Am I respecting her right to make choices about her own life?
        - Does this conflict with the autonomy of others and, if so, how is this to be resolved?
    - If she is not competent (e.g. a minor or an unconscious adult) or if this is open to question (e.g. a child aged 12-13) how is this to be dealt with?
    - Are there any issues of justice? e.g.
        - Is the patient being unfairly discriminated against?
        - Is there any conflict between what I consider to be in the patient's best interest and what can be provided in the NHS?
- What other perspectives could assist in resolution?
    - Have the patient's social context, emotions and relationships been adequately considered?
    - Am I sure that I am treating the patient as a person?
    - Are we both 'caring for' and 'caring about' the patient?

Making Ethical Judgements – 2. Action

Move towards recommending actions that best meet the above criteria

- What are the proposed objectives? e.g. cure, relief of symptoms (e.g. pain and suffering) or prevention of disease?
- Which objectives are essential and which desirable?
- What alternatives are available (including doing nothing)?
- What are the risks of acting (or failing to act) and what is their probability and severity?
- Do the expected benefits outweigh the potential risks?
- Has the patient been properly informed of the available options?
- Is she competent to give consent?
- If so, has the consent being obtained properly?
- **If yes, put chosen option into effect**
  If she is not competent who, if anyone, can legally give consent?

Dealing with potential or actual conflict:

This difficult area cannot be dealt with comprehensively here but examples include

- The patient (or family in the case of a minor) refuses to accept the recommended interventions
    - If competent, she has the right to do so even if it leads to harm of herself. Do not coerce her.
- There is disagreement between parents of a child
- Among the things to do are:
    - If junior, inform more senior colleagues: if senior, seek advice through clinical governance channels.
    - Make sure that full contemporaneous notes are made.
- She (or her family) requests intervention that informed medical opinion suggests is not justified or in her best interests.
    - You are not bound to do as they ask particularly if it is contrary to your principles.
    - Offer referral for another opinion or, if needs be, transfer care to another team.
- Another party tries to intervene inappropriately e.g.
    - The family or another third party asks for confidential information.
    - The presumption is that confidentiality must be kept.
    - Any breach can only be justified in 'exceptional circumstances'
        - It is preferable that this be with the knowledge of the patient
        - However, if, for example, it is judged that the patient would be seriously harmed by knowing that her illness is terminal but that it would be in her best interests that a close relative should know about it, information may be divulged without consent.
- The family asks that the patient be not told the truth of her illness.
    - The assumption (possibly rebuttable with good grounds –see example above) must be to tell the truth at all times.
    - Not to do so can have regrettable consequences e.g. who is she to trust when she discovers any deception?
    - Remember that your primary duty of care is to your patient and not her family.

    Good communication skills in general and knowing how to impart bad news in particular are central to good care

Review the outcome

- Ethical issues do not lend themselves easily to audit but it may be useful to record and review major cases from time to time
- In individual cases remember that a good or bad outcome does not necessarily mean that the intervention was 'right' or 'wrong'.

Some of the ethical issues we face can be dealt with relatively straightforwardly. Others are highly complex and may be intractable. The establishment of clinical ethics committees by some NHS trusts has helped both in dealing with particularly difficult problems (e.g. end of life decisions) and the development of guidelines for good practice in dealing with them.

References

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3. General Medical Council. Good Medical Practice; 2012 [www.gmc-uk.org/standards/].
4. British Medical Association: Medical Ethics Today, 3rd edn. Wiley-Blackwell: 2012

COMP2 GP Teacher Workshop		
Date/Venue/Hours	18th March 2014, Engineers' House, Clifton, Bristol	**6 hours**
Description		
Reflection and Feedback		
What have I learned? What did I enjoy?		
Forward Planning		
How I will use the learning and ideas from this workshop as a GP teacher and in my GP work		
Key points to remember		
Name, date, signature		