

THE PATIENT AND DOCTOR COURSE

TUTOR HANDBOOK

YEARS 1 & 2



Notes For Tutors

Thank you for teaching on the *Patient and Doctor 1* Course for 2019/2020. We hope you will have a very enjoyable year.

This brief introductory section is for **tutors only**. The rest of the handbook is for both tutors and students.

Overall Aim of the *Patient and Doctor* Course

We know that students greatly value and enjoy their *Patient and Doctor* experience. The aim of this course is to provide a motivating introduction to seeing patients and hearing their stories. It should generate thoughtfulness and curiosity about clinical medicine and broaden ideas about being a doctor.

In the words of one *Patient and Doctor* tutor:

“This course is about relating to, and talking to, people. Being curious. Being a detective. A taste of the 40-odd years to come!”

Initial Thoughts For Tutors

It is very important that you have flexibility and freedom to teach the course in your own way. At the same time, we need to ensure a reasonable degree of consistency for the students. There are just a few principles which we would like all tutors to stick to:

- Each teaching afternoon should be a dedicated session of your time and last the appropriate length of time (i.e. approximately three hours).
- When interviewing patients, students should be in groups of no more than three (and ideally in pairs). We have consistent feedback from students that larger groups are less satisfactory for all involved.
- As far as possible, videos should not be used *instead* of interviewing real patients. In the past, we know that there have been difficulties in finding appropriate patients for certain sessions. We hope that the new handbook notes give broader options and ideas, but we will keep this under review and always greatly appreciate your feedback.

Ideas from Tutor Survey 2019

Thank you to everyone who participated in the 2019 tutor questionnaire. Your responses were extremely helpful and gave insight into the broad range of fantastic teaching techniques used by tutors on this course.

Below are ideas which some tutors include in their sessions. Whilst following the handbook as a guide, we encourage you to consider incorporating any of these if you would feel they would add value to your sessions:

- Visiting patients at home
- Teaching basic examination techniques, such as taking a pulse or blood pressure (this might fit in nicely with the Cardiovascular or Consent sessions, for example)
- Involving members of your practice MDT (for example, specialist nurses or GP trainees).
- Asking your students to do some brief preparatory work for the session (they are already asked to read the session notes in advance).

New Updates For 2019/2020

Based on your questionnaire responses and student focus group feedback, we have updated the handbook. The important points are as follows:

- The handbook is now **online only**. Students will access it through *Canvas* (the new virtual learning environment that is replacing *Weblearn*). Tutors can find the handbook on the Nuffield Department of Primary Care website (www.phc.ox.ac.uk/tutorinfo) and will also be emailed a copy by Emma Wiley.
- For this academic year, the session topics remain the same. However, the notes for every session have been reviewed and updated.
- The film clips for Session One have been updated. These have been sent to you at your practice on a memory stick. Please only use these for teaching purposes. There are notes to accompany each clip below.
- You will see that there are five colour-coded themes which run through handbook. **Please see the student introduction for full explanation.** We anticipate that these define and give structure to the sort of material you are already teaching, but will hopefully also provide more detail and stimulate ideas. The themes are:

1. Communication skills
2. Biomedical relevance
3. The Patient-doctor relationship
4. The Clinical History
5. Reflective Practice

- The biomedical science notes have been removed from the student handbook. The general consensus from students was that they were unnecessary given the detail and extent of their scientific learning elsewhere. Instead, each session has been cross-referenced to their **First BM Curriculum** and you will be sent a copy of this for information.

The science notes have been retained for tutors (below) after agreement that this would be helpful at this year's Away Day.

- Students are now expected to complete **one reflective written task per year**, to be read and commented on by you. This should be submitted two weeks prior to the final session of each academic year. Details are in the handbook. This replaces any onus on the students to give written responses to the end-of-session questions, or for you to mark them. The questions have been retained to stimulate reflection and discussion during the sessions.

We will have a *Patient and Doctor* tutor update session at some point during the first two terms of the academic year, in addition to our annual Tutors' Conference at St Anne's College. We will be in touch about this in due course. In the meantime, if you have any questions or feedback, then please do email alison.convey@phc.ox.ac.uk.

Primary Care Teaching Team, October 2019

Session Notes

Please find below brief, **tutor-specific** notes for individual sessions. **These should be read in conjunction with the student handbook.**

You will notice there are not additional notes for every session, only where we felt extra detail for tutors would be helpful. With the exception of Session One, the notes are on

the background science. Please remember you are not expected to teach them their physiology and pharmacology! However, the feedback from you was that you would like to retain the science notes for information.

Session One

Film Clips

The film clips have been updated and sent to you on a memory stick. The aim is to increase variety, both in terms of the type of material and the length of the clips. Please choose those which you feel best illustrate the learning points you wish to get across.

All the clips are valuable from the perspective of discussing the *Duties of a Doctor*.

General considerations and questions for students:

- What expectations of professional behaviour do you have for doctors and other health professionals?
- To what extent does the conduct of the professionals in the video match your expectations?
- Which communication strategies helped or hindered relationships between the patient and the health professionals?

House (*length of clip 10 min 01*)

An American TV drama, filmed over eight series between 2004 and 2012. It stars Hugh Laurie as the central character, Dr Gregory House. A leading “diagnostician”, Dr House is portrayed as a misanthrope with a brilliant mind. The clip here shows various interactions with patients in the hospital’s walk-in clinic. It is a good springboard for discussing the Duties of a Doctor (what would the GMC have to say about House?!) and communication skills. Is it fair to say House is paternalistic and “God-like”? Does he do anything well?

This clip is 10 minutes long, but can be shortened easily.

50:50 (*length of clip 7 min 25 secs*)

A 2011 film about a young man called Adam, who has a new diagnosis of a neurofibrosarcoma. You have three brief scenes, the first with an oncologist, the second with a psychologist and the third showing his family waiting for news of his surgery. Though perhaps not subtle, they are interesting to compare in terms of communication styles. The scene with the young psychologist is also useful for students to think about how they deal with questions about their age and experience (though you may have to

explain the “Doogie Howser” reference to our now post-millennial students: https://en.wikipedia.org/wiki/Doogie_Howser,_M.D.).

The Theory of Everything (*length of clip 2 min 36*)

A 2014 film depicting the early life of scientist Professor Stephen Hawking, who developed Motor Neuron Disease at the age of 21. This brief clip shows the doctor telling Stephen about his diagnosis. It’s a good starting point for talking about breaking bad news, in terms of choice of environment and communication skills. Does the doctor do anything well?

The King’s Speech (*length of clip 9 min 39*)

A 2010 film recounting the relationship between King George VI and his speech therapist, Lionel Logue. This clip shows their first encounter, when the then Duke of York has been pushed by his wife to find treatment for his lifelong stammer. Lionel Logue is not strictly a doctor and obviously most patients are not in line to the throne! However, the clip is valuable for discussing rapport-building, the varying dynamics of a consultation and whether it matters “who” the patient is. It is worth noting that, although this consultation concludes badly, the Duke of York later listens to the recording of his voice and ends up seeing Logue regularly. They apparently became lifelong friends.

The Diving Bell and the Butterfly (*length of clip 4 min 11*)

A beautiful 2007 film based on the autobiography of Jean-Dominques Bauby, who was the editor of *Elle* magazine in Paris and suffered a massive stroke aged 43. It left him with “locked-in syndrome”, only able to move his left eyelid. He “blinked” out his book using a special alphabet-system designed by his therapists. This clip is quite difficult to watch initially because the camera angle is all from his perspective as the patient. It is particularly interesting because the audience can hear his internal reactions to what the doctor is saying. It is in French with subtitles.

Wit (*length of clip 12 min 34*)

A 2001 film, based on a Pulitzer-Prize winning play by Margaret Edson. It tells the story of an English professor with ovarian cancer and her unsatisfactory interactions with the medical profession. The three clips are: her oncologist breaking bad news, an excruciating interview with a junior doctor and an inpatient “Grand Round”.

Session Two

Science notes – Cardiovascular Disease

Nature of cardiac pain

Pain commonly referred to left arm. This follows the dermatomal rule - pain is usually referred to a structure that developed from the same embryonic dermatome as the structure in which the pain originates (heart and arm have same dermatomal origin).

Cardiac anatomy

Heart supplied by two main coronary arteries, right and left, which divides into left anterior descending and circumflex branches.

Physiology

1. Cardiac output

Cardiac output: depends on cardiac rate and stroke volume. The cardiac rate is controlled primarily by cardiac innervation, sympathetic stimulation increasing the rate and parasympathetic decreasing it (chronotropic effects). Sympathetic stimuli also increase stroke volume by increasing the force of contraction of myocardial muscle fibres (inotropic effects). The force of contraction of cardiac muscle also depends on its pre-loading and after-loading. The pre-load is the degree to which the myocardium is stretched before it contracts and mainly depends on venous return to the heart (Starling's law). After-load is determined by arterial pressure. Exercise leads to increased oxygen demand in skeletal muscle and hence increased cardiac output. This in turn leads to increased demand for oxygen in the myocardium, leading to hypoxic pain if coronary blood flow is limited by fixed stenoses.

2. Cardiac blood flow

Angina results from stenosis in one or more of these arteries. At rest, the heart extracts 70-80% of the oxygen from each unit of blood delivered to it. Oxygen consumption can be increased only by increasing blood flow. When the arteries are stenotic, blood flow is usually normal at rest, but there is limited ability to increase it during exercise. When the patient exercises, the myocardium becomes hypoxic and angina pectoris develops. When stenosis reaches above about 85%, there is in addition a fall in normal blood flow and thrombi can form in the narrowed area causing myocardial infarction.

Pharmacology

Nitrates

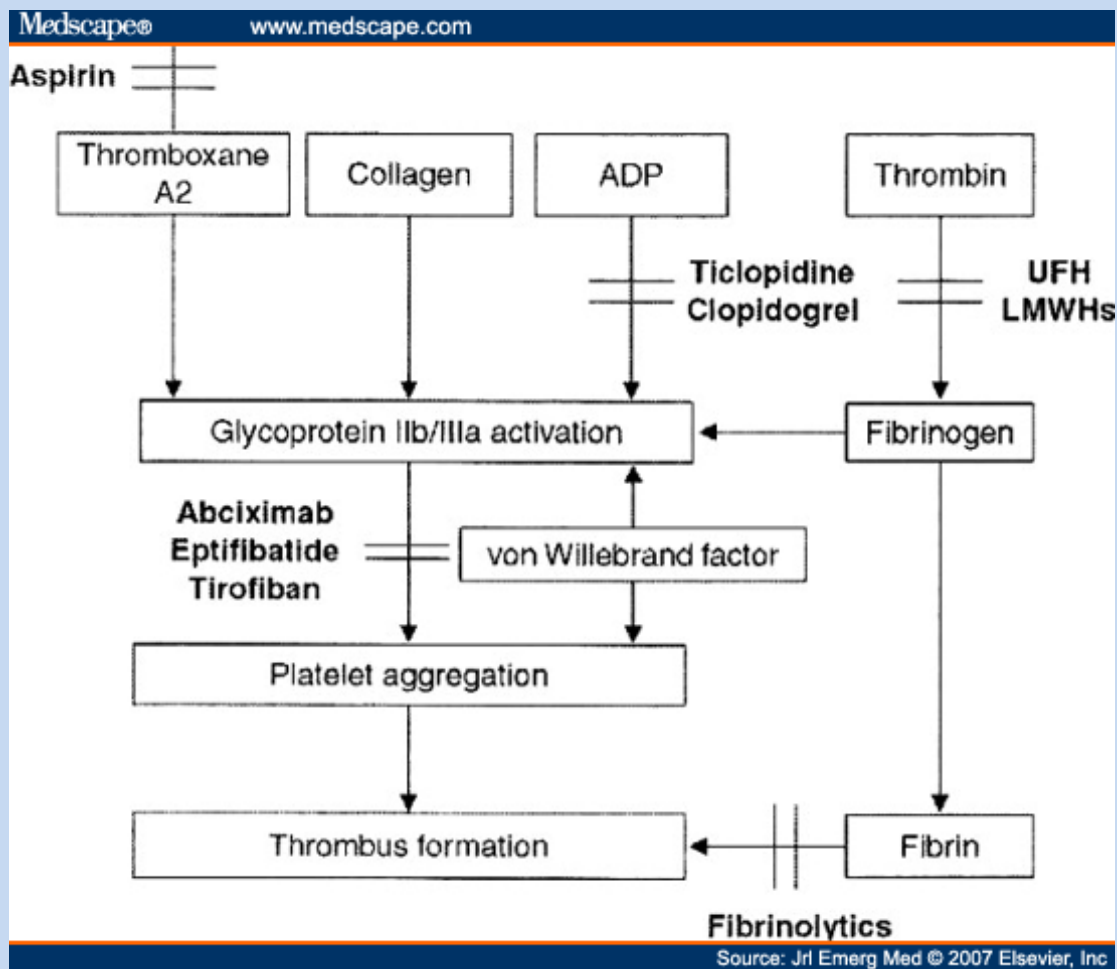
Nitrates generate nitric oxide in endothelial cells and dilate normal arterial vessels (hence headache). However nitric oxide production is defective in atherosclerotic vessels. So the main effect of nitrates is to dilate peripheral vessels. This reduces venous return to the heart, reduces stroke volume and consequently myocardial oxygen consumption.

Beta blockers

Stimulation of adrenergic beta-one receptors leads to increased heart rate and force of contraction. Beta blockade decreases myocardial oxygen consumption by decreasing force and rate (get students to feel the beta blocked pulse).

Aspirin

Aspirin has an antiplatelet effect by inhibiting the production of thromboxane, which under normal circumstances binds platelets together to create a patch over damaged walls of blood vessels.



Session Three

Science notes - Diabetes

The cause of diabetes is deficiency of insulin at tissue level, but the deficiency may be relative.

Type 1 diabetes (about 10%) is due to insulin deficiency caused by autoimmune destruction of the beta cells in the pancreatic islets. It usually develops before the age of 40. Patients are not obese. Untreated the disease leads to ketosis and acidosis.

Type 2 diabetes (90%) is not associated with total loss of insulin secretion. There is insulin resistance and impaired insulin secretion. Patients with type 2 diabetes are often overweight, and glucose tolerance improves if they lose weight. They are not at risk of ketosis and acidosis.

Symptoms of diabetes

1. Increased passing of urine (polyuria), increased thirst, blurring of vision.

High levels of blood glucose cause cell dehydration. Increased osmotic pressure in extracellular fluids leads to the osmotic transfer of water out of cells; and, the osmotic effect of glucose in the renal tubules decreases tubular re-absorption, causing an overall effect of loss of fluid in the urine. This leads to dehydration of extracellular fluid and compensatory dehydration of intracellular fluid. High glucose levels can draw fluid from the lens of the eye causing blurring of vision.

2. Fatigue and/ or weight loss

Insulin deficiency leads to high extracellular glucose levels but intracellular glucose deficiency. Appetite is stimulated, glucose is formed from protein (gluconeogenesis) and energy supplies are maintained by metabolism of proteins and fats. This leads to fatigue and weight loss despite increased appetite.

3. Infections

Uncontrolled diabetes may lead to infections particularly bacterial and yeast infections of the skin and genitalia. This is due partly to effects of impaired glucose metabolism on white blood cell function.

Complications of diabetes

Acute

In type 1 diabetes, fat catabolism is increased and fat synthesis inhibited. This leads to an excess of acetyl -CoA which is converted to organic acids called ketone bodies. They

accumulate causing metabolic acidosis. Together with dehydration the acidosis may lead to coma and death. Treatment involves giving insulin and correcting losses of fluid, sodium and potassium.

Treatment of diabetes with insulin may lead to hypoglycaemic symptoms and coma: treatment is to give glucose or an injection of glucagon, an insulin antagonist.

Long-term

There are two main types of complication:

1. Microvascular: diabetic retinopathy, diabetic nephropathy and diabetic neuropathy affecting the autonomic nervous system and peripheral nervous system. These complications can be reduced by lowering blood glucose and by controlling blood pressure. The combination of reduced sensation from neuropathy, poor blood circulation from vascular disease and increased susceptibility to infection means people with diabetes are at risk of ulcers and gangrene in the feet.

2. Macrovascular: people with diabetes have a high risk of ischaemic heart disease and stroke. Diabetes is a complex metabolic abnormality that affects serum lipids as well as glucose. There is usually a high level of LDL cholesterol and triglycerides. Many people with diabetes also have hypertension. Controlling blood glucose seems to have little effect on risk of macrovascular disease. It is therefore important to control blood pressure, avoid smoking and treat lipid abnormalities.

Session 7

Science notes – Pharmacology of antidepressant drugs

The main classes include: Selective Serotonin Reuptake Inhibitors (SSRIs), Tricyclics, Serotonin and Noradrenaline Reuptake Inhibitors (SNRIs), Selective Noradrenaline Reuptake Inhibitors (NRIs), Monoamine oxidase inhibitors, St Johns Wort.

Noradrenaline and serotonin (5-hydroxytryptamine) are monoamine neurotransmitters concerned in the aetiology of depressive illness.

In depression the following occur:

- Low levels of monoamine transmitters
- Upregulation (increase) of postsynaptic monoamine receptors
- Upregulation of presynaptic auto-receptors (negative feedback control for monoamine release)

Actions of antidepressants:

- Enhancement of monoamine levels - synaptic concentrations of monoamines rapidly increase after starting treatment, although clinical improvement is delayed
- Pre and Postsynaptic blockade of monoamine receptors – this normalises the upregulation of receptors that has occurred in depression. The downregulation of receptors takes time to emerge, partly explaining the delay in onset of clinical action
- Inhibition of monoamine oxidase – by inhibiting their breakdown by this enzyme, monoamine levels increase

Selective serotonin reuptake inhibitors (SSRIs) e.g. fluoxetine, paroxetine, citalopram, sertraline

Mechanism: inhibition of the reuptake of serotonin, but no effect on noradrenaline reuptake. Down-regulation of pre and postsynaptic serotonin receptors occurs.

Side Effects: Generally cause more tolerable side effects than the tricyclics as have few antimuscarinic and antihistaminergic effects. Not cardiotoxic in overdose.

- Nausea, abdominal pain or diarrhoea
- Insomnia, anxiety, agitation
- Anorexia and weight loss
- Sexual dysfunction
- Tremor

Anxiolytic drugs: Beta Blockers e.g. propranolol, atenolol

Mechanism: These drugs block beta-adrenoreceptors, so they are competitive antagonists of catecholamines. Anxiety provokes the release of adrenaline as part of the 'fight or flight' response. Some of the physical effects of anxiety are mediated by adrenaline and B-blockers will block this. The occurrence of physical sensations make many patients feel increasingly anxious (see anxiety circle) and reduction of these sensations can be very helpful. They are also useful for 'performance anxiety'. They are well tolerated and non-addictive (c.f. benzodiazepines). Their side effects are widespread and occur where there are beta-adrenoreceptors e.g. bronchi, heart, CNS, vascular smooth muscle.

Side effects:

- Bronchospasm
- Peripheral vasoconstriction
- Nightmares, sleep disturbance (if cross blood-brain barrier)
- Fatigue
- Bradycardia, heart failure, hypotension

Contraindications and cautions:

- Asthma, COAD
- Heart failure, heart block, hypotension
- Raynauds, intermittent claudication

Tricyclic antidepressants e.g. amitriptyline, imipramine, lofepramine

Mechanism: Inhibition of the reuptake of noradrenaline and serotonin into the presynaptic cleft

Side effects: This is due to the blocking of other postsynaptic receptors: histamine H1, muscarinic and alpha 1 adrenoreceptors

- Sedation: antihistamine effect
- Dry mouth, blurred vision, constipation, urinary retention: antimuscarinic effect
- Postural hypotension: due to blocking alpha 1 adrenoreceptors in peripheral vascular smooth muscle
- Cardiotoxicity: due to both anticholinergic and noradrenergic effects. Tachcardia and severe arrhythmias can occur, especially in overdose
- Other side effects include: convulsions, weight gain, sweating, tremor, hyponatraemia

Benzodiazepines e.g. Diazepam, Temazepam

Benzodiazepines enhance the effect of the neurotransmitter gamma-aminobutyric acid

(GABA) at the GABAA receptor. This reduces the communication between neurones and, therefore, has a calming effect on many of the functions of the brain. One advantage of benzodiazepines is that they alleviate the anxiety symptoms much faster than antidepressants, and therefore may be preferred in patients for whom rapid symptom control is critical. NICE do not recommend use of benzodiazepines beyond two to four weeks, as tolerance and physical dependence develop rapidly, with withdrawal symptoms, including rebound anxiety, occurring after six weeks or more of use.



THE ADDITIONAL TUTOR NOTES
END HERE

THE REST OF THE HANDBOOK IS
FOR TUTORS AND STUDENTS

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Contacts in the Primary Care Department

If you have any questions about the timetable or the logistics of your GP placements, please contact:

Patient & Doctor Course Administrators:

- Jacqui Belcher
Email: jacqueline.belcher@phc.ox.ac.uk

- Maria-Jose Luque Arrabal
Email: maria.luque@phc.ox.ac.uk

If you have queries about the content of the course or handbook, please get in touch with:

- **Patient & Doctor Course Co-ordinator:**

Dr Alison Convey

Alison.convey@phc.ox.ac.uk

WELCOME!

Welcome to Oxford, welcome to the *Patient & Doctor 1* course, and welcome to the medical profession. This is where you will start learning to be a doctor.

On this course you will see patients, listen to their stories and think about how their illnesses impact on their lives. You will start to relate your scientific learning to the diagnosis and management of disease.

As a particularly wise Regius Professor of Medicine once said:

“He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all”. (William Osler, 1849-1919)



Many doctors never forget the first patients they spoke to as medical students. That patients share their concerns, hopes and worries with us is an amazing privilege, not to mention an invaluable opportunity to learn. We hope this course will provide you with memorable experiences, which will inform and motivate your future studies.

You have chosen one of the most fulfilling, exciting and stimulating careers possible. Time to get started.

What are the aims of the *Patient Doctor 1* Course?

On this course you will:

- Begin to experience what it is like to be a doctor
- Develop your curiosity for patients and their stories
- Consider the physical, social and psychological impact of a patient's illness
- Start your career as a reflective professional, by regularly learning from your patients
- Link biomedical scientific learning to your future clinical practice
- Start learning about the professional and ethical principles which guide and govern medical practice
- Begin to develop your clinical communication skills

What is the structure of the course?

The *Patient & Doctor 1* Course is led by the Primary Care Teaching Team and is taught exclusively by GP tutors. This is a great place to start, since GPs are the doctors who see everything and everyone. However, the skills you will gain are important and highly relevant to being a doctor in any setting.

Each college has a dedicated GP tutor (or sometimes two), who will supervise the student group over Years 1 and 2. With your tutor, you will take part in the following afternoon sessions (a timetable of dates will be sent to you separately):

Sessions in Year One

Michaelmas Term

- *“Trust Me, I’m a Doctor”*: Group Seminar on the Duties of a Doctor
- *“I Told You I Was Ill”*: Shadowing a Clinician

Hilary Term

- *“The Heart of the Matter”*: Cardiovascular Disease
- *“Life is Sweet”*: Diabetes Mellitus

Trinity Term

- *“Who Do You Think You Are?”*: The Family in Health & Illness

Sessions in Year Two

Michaelmas Term

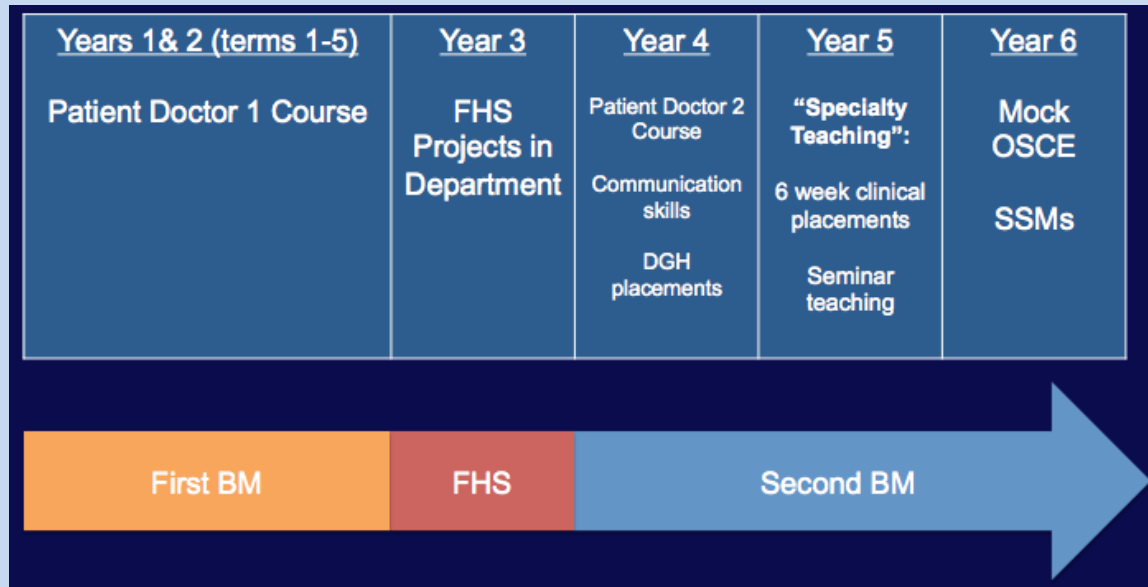
- *“Do You Hear What I’m Saying?”*: Treatment and Consent

Hilary Term

- *“Story of the Blues”*: Psychological Problems – Depression and Anxiety
- *“The Big C”*: Talking to a Patient with Cancer

How does this course fit in to my degree?

You will build on your *Patient & Doctor 1* experiences when you arrive at the clinical school in your fourth year. As well as teaching from our hospital colleagues, you will continue to learn from GP tutors right up until your final year. The diagram below explains how the **Primary Care Team** contributes to your six-year degree:



As you can see, the second part of the *Patient & Doctor* course takes place in Year Four. This is an introduction to clinical medicine and includes a whole week placement at a GP practice. It builds on your early experiences seeing patients during your first and second years as part of the *Patient & Doctor One* course.

In Year Three, you will undertake a project for the *Final Honours School* part of your degree. You will decide on your research topic during Year Two, so if you interested in working with one of the highly rated research groups in the Nuffield Department of Primary Care Health Sciences, please contact Dr Alison Convey (Alison.convey@phc.ox.ac.uk) during Year 2.

How do I get the most out of the course?

The most important way to learn on this course is to be enthusiastic about seeing patients and to listen attentively to their stories.

You will get more out of the sessions if you prepare in advance. There is a “**preparation**” section at the start of each chapter in the handbook. It asks you simply to read the notes and check you have understood what has been covered in previous sessions. Your tutor may discuss doing other preparatory work with you.

You will see that each teaching session has its own individual notes in the handbook. There are themes running through the whole course to guide your learning (see below).

Course Themes

A number of themes run through the course, with varying emphasis given to each in any one session. Taken together, these themes should help you to unite your scientific learning with the practicalities of patient-based medical practice, and begin your lifelong professional development as a doctor. These themes are:

Communication skills

Biomedical relevance

The patient-doctor relationship

The Clinical History

Reflective Practice

They are colour-coded throughout this handbook.

Communication Skills:

You probably already possess most, if not all, of the skills you need to communicate effectively with patients. A clinical encounter is ultimately just a conversation.

By observing doctors at work, and hearing from patients about their past experiences, you should gain insight into which skills are of greatest value in the context of a medical consultation. The course encourages you to analyse why particular techniques are useful in specific situations and to use them in your own conversations with patients.

Medical communication skills are categorised in different ways, in various theoretical “models” of the consultation. You may hear about these later in your degree, but for now experiencing clinical communication in real-life settings is much more valuable. For ease of discussion, sometimes we group skills into the various “stages” of the consultation:

1. Skills for developing rapport
2. Active listening skills

3. Facilitative skills
4. Skills for effective explanation
5. Skills for dealing with emotion

Look out for these areas during your upcoming sessions.

Biomedical Relevance:

Most of the sessions in the course are themed in part around a clinical topic, e.g. cardiovascular disease, diabetes, etc. You should find that these themes tie in with the theoretical scientific learning you have gained recently from your wider First BM teaching. **The biomedical theme for each session will be cross-referenced in this handbook to the relevant section of the First BM syllabus.** This should help to reinforce the relevance of your theoretical learning to your future as a clinician.

The Patient-Doctor Relationship:

The relationship that doctors form with their patients is absolutely fundamental. Without building rapport, understanding and trust it would be impossible for doctors to offer effective advice and treatment.

Again, many different models have been proposed to better understand the interaction between patients and doctors. What all these have in common is their recognition of the separate *agendas* of patient and doctor, and the need to marry these together to create a successful outcome to the clinical encounter.

The patient's agenda refers to the *ideas, concerns, and expectations* that the patient brings to the encounter.

The doctor's agenda refers to their need to obtain and interpret specific information to allow a diagnosis to be established and a treatment plan to be made.

This course aims to help you understand these concepts and start to develop the communication skills you need to bring these agendas together within a clinical encounter.

The Clinical History:

The process of interviewing a patient about their medical problems in order to make a diagnosis is usually referred to as *taking the history*. It is a method used by doctors to ensure that they remember to ask the important questions and to record the answers in a streamlined way. Because all doctors tend to use the same structure, it also acts as a helpful shortcut or “language” for them to communicate with each other about patients they have seen, both verbally and in writing. However, it should never interfere with having free-flowing, empathetic conversations with patients. It is not a script of questions to ask, but more of an *aide memoire* for the information needed by the end of a consultation.

You will learn a lot more about “history-taking” from your 4th year onwards. In order to familiarise you to the structure of the medical history, we mention it in this course and your tutors may want to explore its relevance in individual sessions.

The traditional standard framework is as follows:

- Presenting complaint (PC)
- History of presenting complaint (HPC)
- Past medical history (PMH)
- Drug/ treatment/ allergy history (DH)
- Family history (FH)
- Social history (SH)
- Systematic enquiry (SE)

This will be discussed in more detail in individual sessions.

Reflective Practice:

Reflective practice is about learning from your patients and your encounters with them.

It can be defined as “*the process whereby an individual thinks analytically about anything relating to their professional practice with the intention of gaining insight and using the lessons learned to maintain good practice or make improvements where possible*” (Academy of Medical Royal Colleges and COPMeD).

This can often be challenging at the beginning, but many students and doctors find it the most rewarding way to learn. Furthermore, it is actually a requirement for UK doctors to think and write in a reflective way. Once you qualify, you will be required to complete an annual appraisal in order to maintain registration with the General Medical Council

(GMC). For this, you must demonstrate reflective practice. It's therefore important to get familiar with the principles right from the start!

Assessment

The most important assessment criterion for this course is participation. We hope that you will very much enjoy meeting patients and discussing what you have learned with your GP tutors and student colleagues. At the end of each year, your tutor is required to complete a report form commenting on your attendance, engagement and professionalism. The form is included in this handbook and is on Canvas.

You will also be expected to submit a short piece of written work in both Years 1 and 2, reflecting on a particular patient interaction. This should be handed in to your tutor **two weeks prior to your last session of the academic year.**

Two important notes before you start...

1) Look after yourselves

As doctors and medical students, we sometimes need to have conversations with patients which we find particularly challenging due to events going on in our own lives, or circumstances affecting our families. If you feel that a particular session may be difficult for you in any way then please do discuss this in advance with your GP tutor.

2) The GMC and Medical Training

The regulatory body for the medical profession in the United Kingdom is the General Medical Council. As a medical student, you are already a member of that profession, and, as such, already subject to the regulation and protection afforded by the GMC.

In the very first session, we think about the GMC's *Duties of a Doctor* and throughout the whole course we consider what it means to behave *professionally*.

Professional Dress:

One of the most immediately obvious markers of professional behaviour is what we wear to work. During this course, it is important that you **dress appropriately** for meeting patients. This should be either trousers (not jeans), or a skirt of an appropriate length, with a smart shirt/ top. Ties are not necessary.

Session 1:

“Trust Me, I’m a Doctor...”

In this session, you will consider the duties of a doctor and start to identify principles of effective medical interviewing.

Learning objectives:

By the end of Session 1 you should be:

- Familiar with the GMC description of the essential duties of a doctor.
- Able to apply these duties to the patient-doctor consultation and to your role as a doctor in training, who will soon be meeting patients.

Preparation before you attend the session:

Please make sure that you have read and understood the introduction to this handbook, including the Course Themes section. Please also read the information below.

Themes covered during the session:

Theme	Area Covered Today
The Patient-Doctor Relationship	Trust
Communication Skills	Open questions
Reflective Practice	Discussion with tutor and colleagues

The Patient-Doctor Relationship: Trust

The GMC’s document “Good Medical Practice” sets out the essential duties of a doctor.

<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/duties-of-a-doctor>

It describes the ethical principles to which all doctors in the UK should subscribe:

“Patients must be able to trust doctors with their lives and health. To justify that trust, you must show respect for human life and make sure your practice meets the standards expected of you in four domains:”

1) Knowledge, Skills and Performance

- *Make the care of your patient your first concern.*
- *Provide a good standard of practice and care.*
- *Keep your professional knowledge and skills up to date.*
- *Recognise and work within the limits of your competence.*

2) Safety and quality:

- *Take prompt action if you think that patient safety, dignity or comfort is being compromised.*
- *Protect and promote the health of patients and the public.*

3) Communication, partnership and teamwork:

- *Treat patients as individuals and respect their dignity.*
- *Treat patients politely and considerately.*
- *Respect patients' right to confidentiality.*
- *Work in partnership with patients:*
 - *Listen to, and respond to, their concerns and preferences.*
 - *Give patients the information they want or need in a way they can understand.*
 - *Respect patients' right to reach decisions with you about their treatment and care.*
 - *Support patients in caring for themselves to improve and maintain their health.*
- *Work with colleagues in the ways that best serve patients' interests.*

4) Maintaining trust:

- *Be honest and open and act with integrity.*
- *Never discriminate unfairly against patients or colleagues.*
- *Never abuse your patients' trust in you or the public's trust in the profession.*

“You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.”

Just like Hippocrates...?



These principles can be thought of as the 21st Century UK equivalent of the famous Hippocratic oath, which historically doctors were required to swear on entry into the profession.

Looking at these example statements from the oath, you can see certain parallels with the GMC Guidance:

I will abstain from all intentional wrongdoing and harm.

Whatsoever I shall see or hear in the course of my profession...I will never divulge.

I will not be ashamed to say "I know not", nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery

(There are multiple versions of the Hippocratic oath online, all of which have slightly different wording).

Nowadays you are not required to swear an oath, but you are required to accept and adhere to the GMC principles above. Failure to do so may not only put you at risk of being struck off the medical register, but is likely to mean that your patients will not trust you. Without trust they are unlikely to follow the advice you give them and if this happens then there is little point in being a doctor.

Tasks:

During the first session you will meet as a group with your clinical tutor who will select some of the activities listed below:

Task 1

1. “Brainstorm” session around the group: what attributes make a good doctor? Think about your experience of doctors in the past, as a patient yourself or during work experience. What sort of doctor do you aspire to be? Do you agree with the GMC’s principles in “Good Medical Practice”?

Task 2

2. Students and clinical tutor should pair off. In each pair, one of you should spend five minutes finding out basic information about your partner to share with the group later. The aim is to get information that will help the group know and understand the person you are interviewing.

One of the main skills you will be learning in the Patient-Doctor course is to use open-ended questions. Practise this with your partner. See what responses you receive to a question like “Can you tell me about yourself?”. In follow-up, the interviewer may choose to enquire further about topics he or she feels appropriate for the introduction, for example: biographical data, interests, reasons for choosing to study medicine, work experience.

After 5 minutes, stop interviewing your partner. Make a few notes if you wish so that you will be able to introduce your fellow student to the group a little later.

Switch roles and repeat the interviews.

Go around the room having each person introduce his or her partner. Present whichever data you believe are relevant to a brief introduction on the first day of a course. After the introduction, the group may wish to ask questions of the interviewer or interviewee.

Task 3

Your clinical tutor may show you excerpts from a film or TV show depicting patient-doctor interactions. As you watch these, think about what the doctor does well and what could be done better. You may find it helpful to take notes as you watch the film. Ask yourself these questions:

- What expectations of professional behaviour do you have for doctors and other health professionals? To what extent does the conduct of the professionals in the video match your expectations?
- Which communication strategies helped or hindered relationships between the patient and the health professionals?

Your clinical tutor will ask you to discuss your reactions with the group. Try to use this opportunity to think about how you wish to relate to patients as a medical student and, in the future, as a doctor. What skills do you think you need to learn to help you achieve this?

Your tutor may choose clips from the following films or TV shows:

1) ***House***, an American TV drama, portrays the career of leading diagnostician, Dr Gregory House. What are his strengths and flaws?



2) ***The Theory of Everything*** (2014) depicts the early life of scientist Professor Stephen Hawking, who developed Motor Neuron Disease at the age of 21.



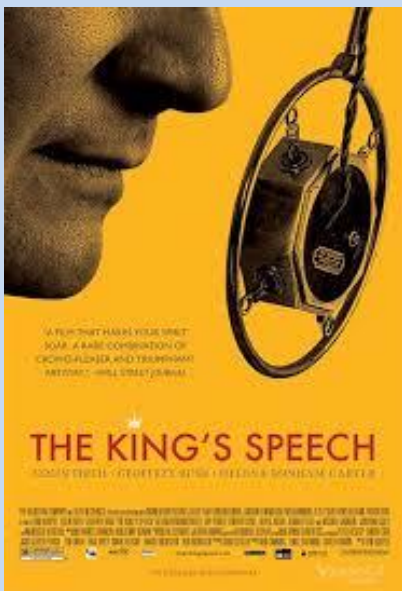
3) *Wit* (2001) is based on a Pulitzer-Prize winning play by Margaret Edson. It tells the story of an English professor with ovarian cancer and her interactions with the medical profession.



4) *50:50*, is a 2011 film about a young man with a cancer diagnosis.



5) **The King's Speech** (2010), recounts the relationship between King George VI and his speech therapist, Lionel Logue.



6) **The Diving Bell and the Butterfly**, 2007 film based on the autobiography of Jean-Dominques Bauby, who was the editor of *Elle* magazine in Paris and suffered a massive stroke aged 43. It left him with “locked-in syndrome”, only able to move his left eyelid.

Reflective Practice - End of session questions

(Your tutor may base the end-of-session discussion around these questions. This is to help you reflect on what you have learnt.)

- Did anything surprise you about the GMC's *Duties of a Doctor*?
- Select one of the *Duties of a Doctor*. Can you think of an example of a situation where there may be some conflict in fulfilling this duty?

With reference to the film excerpts you have watched:

- Give one example of good communication that you observed. What interviewing skills did you identify in this example?
- Can you list two examples of poor communication that you observed? What was unsatisfactory about them? How could they have been improved?
- Give an example of where a doctor in the film clips fulfilled one of the GMC *Duties of a Doctor*.
- Give at least one example of where a doctor in the film clips did not fulfil one of the GMC *Duties of a Doctor*.

Session 2:

“ I Told You I was Ill” – Shadowing a Clinician

In this session, you will have the chance to shadow one of the doctors in the surgery whilst they are consulting with patients. It is a valuable opportunity to start to identify principles of effective medical interviewing, as well as further consider the duties of a doctor.

Learning objectives:

By the end of Session 2 you should be able to:

- Discuss the doctor-patient relationship you have witnessed in today’s consultations and define “therapeutic rapport”.
- Understand the communication skills required to build rapport: appropriate greeting and initial use of open questioning.
- Begin to recognise how doctors elicit information from patients, a process known as “history-taking” (particularly “history of presenting complaint”).

Preparation before you attend the session:

Please ensure that you have understood and reflected on the content of Session 1. Please also read through the information below.

Themes covered during the session:

Theme	Area Covered Today
The Patient-Doctor Relationship	Connecting and Therapeutic Rapport
Communication Skills	Developing Rapport
The Clinical History	“History of Presenting Complaint”
Reflective Practice	Discussion with tutor and colleagues

The Patient-Doctor Relationship: Connecting and Therapeutic Rapport

Connecting with the patient entails greeting them and introducing yourself, giving them (and yourself) time to settle into a comfortable position for the interview in a quiet and private location, and initiating the interview with an appropriately “tailored” opening enquiry. This process is the first step towards the generation of *therapeutic rapport*, which is a vital element to the success of the patient-doctor relationship. This concept is sometimes hard to understand until you have seen it in action, but what it means is simply that the interaction of the patient with the doctor can be a form of treatment in itself, and indeed in some cases may even be all that is needed to make the patient better.

Communication Skills: Developing Rapport

A number of “normal” social skills have added importance when you are first meeting a patient, as they are the first steps in connecting and establishing rapport. As mentioned in the course introduction, you will probably already possess these skills, but analysing them in these sessions will help you ensure that you are using them as effectively as possible. The two areas you should focus on in this session are:

1. Appropriate greeting:

You should always *introduce* yourself by name and explain who you are.



This may seem obviously the right thing to do, but one of the commonest complaints that patients make about their medical care is that staff do not introduce themselves. This is one of the factors which can lead to patients feeling “dehumanised” when dealing with health services, particularly if they are in the hospital environment. It is not enough just to wear a name badge (although you should always do so when working in the hospital environment, and some GP practices prefer this too).

Please see <https://www.hellomynameis.org.uk> if you would like to read further about this.

You should also check how the patient wishes to be addressed, rather than assuming that you can use their first name: simply ask “What would you like me to call you?”.

Think about your **body language** whilst you are introducing yourself.

What factors make us come across as warm, welcoming and respectful? Think about smiling, eye contact, standing up.

Shaking hands is often appropriate. This sort of physical contact is an important part of *connecting* and will help to emphasise your caring role. In most medical encounters, a physical examination of some sort is necessary and therefore physical contact is a natural part of the process. Patients can sometimes express disappointment if a doctor does not examine them, partly because they believe this is a necessary part of the diagnostic process, but also because if they have not been touched they do not feel as well cared for.



2. Open questioning:

Always start the interview with an *open question*. This means a question which gives the patient the unconstrained opportunity to say whatever they have come to say. Some examples:

How can I help you?

Why have you come in today?

Please tell me about your problems

Some doctors even simply start in silence with just an enquiring raise of the eyebrows!

Having asked this open first question, it is very important to allow the patient the time and space to answer as fully as they wish *without interruption*. Patients will often have mentally rehearsed what they want to tell you in detail beforehand. Any interruption of their opening monologue can therefore risk a loss of relevant information and a failure to establish rapport.

When doctors can't stop talking...

A well-known piece of research shows that, unfortunately, doctors typically interrupt a patient after an average of only 18 seconds. However, if they are specifically instructed not to interrupt, then their patients will keep talking for an average of 60 seconds. During this time the doctor will be able to elicit much more of the relevant diagnostic information, as well as the patient's ideas, concerns and expectations.

(See <https://www.ncbi.nlm.nih.gov/pubmed/6486600>).

This has led to the concept of the *golden minute*, a “win-win” situation, in which the patient has room to “get things off their chest”, which facilitates rapport, and the doctor is able to obtain most of the required *history of presenting complaint*.



The Clinical History - History of presenting complaint (HPC)

Remember the framework introduced at the beginning of the handbook:

- Presenting complaint (PC)
- History of presenting complaint (HPC)
- Past medical history (PMH)
- Drug/ treatment/ allergy history (DH)
- Family history (FH)
- Social history (SH)
- Systematic enquiry (SE)

The *presenting complaint* means whatever primary concern the patient is coming to see the doctor about. This should generally be recorded in the patient's own (lay) terms rather than in medical jargon, e.g. "chest pain when I walk up the stairs" rather than "angina".

The *history of the presenting complaint* (HPC) is simply the story of what has been going on. We might be interested in when the problem started, how long has it been happening for, whether it is new and what impact it is having. Listening and open questions are invaluable tools here too:



Tasks:

You will have the opportunity to shadow a doctor during clinical care. The aims are for you to consider how to fulfil the duties of a doctor and to practise interviewing skills.

You may have the chance to spend time interviewing a patient yourself. The goals of this interview are to listen to the story of a patient, to try to understand the experience from the patient's perspective, and to learn about the patient's expectations of their doctor.

During the shadowing session you should:

- Observe the physician-patient relationship during at least one patient interview or consultation. As you shadow, observe the doctor's interviewing techniques:
 - How did the doctor begin each interview?

- How did the doctor put patients at ease?
 - How would you describe the relationship between doctor and patient?
 - How did the doctor elicit all the detail needed to understand the presenting complaint?
- Think about the duties of your role as a “student doctor” observing patients who may be sharing personal and intimate concerns and participating in providing their medical care.
 - If possible, talk with one or more patients to discuss their experience of illness. If you have an opportunity to interview during the shadowing session you should practice beginning the interview with some open-ended questions and try to learn about this individual’s experience of illness. The purpose of the interview is to have an open-ended conversation with the patient about their experience.

Some suggested questions:

- “Could you tell me why you came to the surgery?”
- “How did the problem start?”
- “What treatment have you had?”
- “What impact has this had?”

Consider your own reactions:

- What worked well?
- What parts, if any, were difficult or awkward?
- How would you describe the relationship you were able to form with the patient?

Discuss your observations and reactions during a seminar with the whole group.

Reflective Practice - End of Session Questions

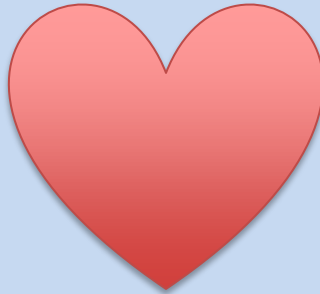
*(Your tutor may base the end-of-session discussion around these questions. This is to help you **reflect** on what you have learnt).*

Thinking about the consultations you have observed:

- How did the doctor build rapport (thinking about verbal and non-verbal techniques)?
- How did the doctor question the patient about their symptoms? What communication skills were used?
- How do you think the patient felt about the consultation?
- How would you describe the patient-doctor relationship in this consultation?
- How did you feel as a student doctor taking on an observational role? How do you think medical students can make the most of these sorts of opportunities?

Session 3:

“The Heart of the Matter”



Unless your clinical tutor tells you otherwise, this session will focus on patients with **cardiovascular disease**. You will develop skills for finding out about the patient’s current and past medical problems.

Learning Objectives:

By the end of Session 3 you should be able to:

- Understand and demonstrate the skills needed for active listening
- Elicit the history of the presenting complaint and relevant past medical history
- Describe symptoms associated with heart disease and relate these to your knowledge of physiology and anatomy
- Describe the effect of illness on the patient’s life
- Understand the importance of lifestyle in the management of heart disease

Preparation before you attend the session:

Please ensure that you have understood and reflected on the content of Sessions 1 & 2, and that you have read through the information below. You may also find it useful to revise what you have recently learned about **cardiovascular physiology and pharmacology**.

Syllabus References

Please see First BM syllabus sections: 8.6.1, 8.6.2, 8.6.3, 8.6.4, 8.6.7, & 8.6.8.

Themes covered during the session:

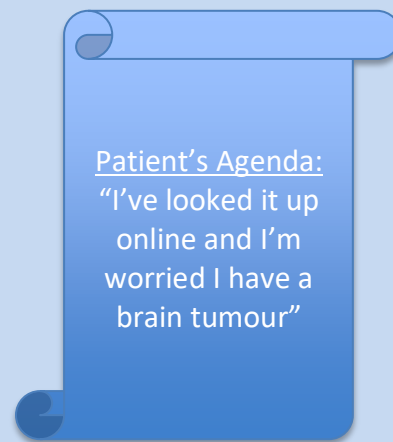
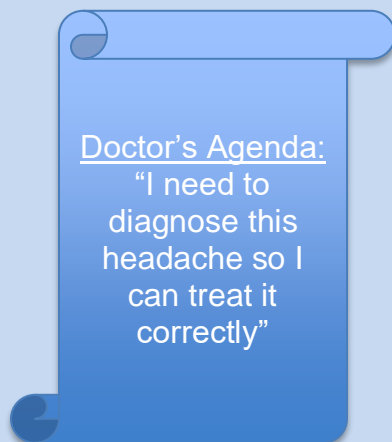
Theme	Areas Covered Today
The Patient-Doctor Relationship	Exploring and Understanding
Communication Skills	Active Listening
The Clinical History	Past Medical History
Biomedical Relevance	Cardiovascular Disease
Reflective Practice	Discussion with tutor and colleagues

Exploring and Understanding:

Once you have connected with the patient and established rapport, as discussed in Session 2, the next task is to explore the patient's problem. This is in order to understand what the clinical diagnosis might be. Equally importantly, it enables the doctor to investigate the patient's *ideas, concerns and expectations*. In other words:

- What does the patient think might be causing the problem?
- Are they worried about it?
- What do they think might need to be done about it?

The conversation needs to encompass both the doctor and patient's "agendas" in this way, otherwise there can be misunderstanding, which damages the doctor-patient relationship and can result in incorrect treatment.



Communication Skills: Active Listening

During a conversation with a patient, you should not only make sure you are listening carefully, but also attempt to demonstrate that you are doing so. The skills needed for this are, once again, ones which you probably already possess from normal social interaction, but active awareness and deliberate usage during a medical interview can further enhance rapport and encourage the patient to reveal more details of their concerns. These skills can be categorised as follows:

1. Verbal response:

If it comes naturally to you, it is okay to interject with brief phrases like “I see”, “Uh-huh”, “Yes”, “Go on”, etc.

2. Non-verbal skills:



You should aim to use *open body language*.

Think about leaning forwards with arms uncrossed, maintaining eye contact (but not too intensely), and nodding.

Also consider *using silence* effectively. Try not to rush to say something to fill what seems like an awkward pause - this may in fact be useful thinking time for the patient.

3. Responding to cues:

A *cue*, in this context, is a verbal or non-verbal signal given by the patient. It may indicate something that is particularly bothering or worrying them. If you pick up such a cue, you should try to acknowledge it to the patient and allow them to expand. For example:

Picking up non-verbal cue:

“You look very anxious this morning. Is there anything you’d like to talk to me about?”

Picking up verbal cue:

“You mentioned you were worried about the rash. Can you tell me more...”

4. Summarising

When you sense that the patient has said everything for the time being, a way to show you have been listening is to summarise their story. This demonstrates that you have been paying attention.


It can also have other benefits:

- It helps you as the doctor to remember all the important details.
- It may prompt the patient to see what has happened more clearly, for example to understand events from a less highly charged emotional perspective.

The Clinical History - Past Medical History (PMH):

- Presenting complaint (PC)
- History of presenting complaint (HPC)
- **Past medical history (PMH)**
- Drug/ treatment/ allergy history (DH)
- Family history (FH)
- Social history (SH)
- Systematic enquiry (SE)

The *past medical history* means the story of all significant medical problems which the patient has suffered in the past. For many purposes, a simple open question may yield sufficient information. These sorts of questions are also helpful:



Have you had any serious illnesses before?

Have you ever been admitted to hospital for anything?

Do you take pills for anything?

There may be specific illnesses which you need to know about in the light of the presenting complaint, in which case closed questions can be used. For example, if a patient has symptoms of ischaemic heart disease you will want to know if they have a history of high blood pressure or high cholesterol.

Tasks:

Your clinical tutor will introduce you to a patient with **heart disease**. Prior to this they will help to orient you by discussing some of the common symptoms you should find out about, e.g. chest pain, shortness of breath, palpitations, and loss of consciousness.

You should interview the patient to find out about the history of their illness and about relevant *past medical history*. As discussed in Session 2, you should begin with *open questions*:

- Can you tell me about your health problems?
- What kinds of treatment have you had?
- How has your illness affected your life?

Allow the patient plenty of time to respond, using *active listening skills* as outlined above. It may then be necessary to focus on details of interest with more specific questions. Remember that it can be useful to demonstrate to the patient that you have been listening by *summarising* what you have heard from them so far.

Lifestyle Factors

Some past medical problems (high blood pressure, diabetes, high cholesterol) are risk

factors for heart disease.

You should also think about risk factors associated with **lifestyle**, such as smoking, fatty diet and physical inactivity. Try to find out from the patient about their diet, exercise and smoking habits. You will need to ask tactfully as this can prove a delicate area. For example, an open question might be: “Do you think there was anything you could have done to prevent yourself from becoming ill?”



After the interview, you will have the opportunity to discuss and compare notes on what you have heard from the patient with the rest of your group and your clinical tutor.

Reflective Practice - End of Session Questions

*(Your tutor may base the end-of-session discussion around these questions. This is to help you **reflect** on what you have learnt.)*

- What skills did you (or your colleagues) use to show that you were listening to the patient?
- How did it feel to gather information about your patient's illness and past medical history? What went well? What might you do differently next time?
- What symptoms of heart disease did your patient have?
- How did your patient feel about their medical condition? What impact is it having on their life?
- What aspects of your patient's lifestyle may have contributed to their cardiovascular disease?

Session 4:
“Life is Sweet”



In this session, you will again meet a patient living with a chronic illness. You will be able to practise the history-taking skills learnt in the earlier sessions. Unless your clinical tutor informs you otherwise, you will meet a patient with **Diabetes Mellitus**. A particular focus of this session is on finding out about the patient’s social situation and how it interacts with their health problems.

Learning Objectives:

By the end of Session 4 you should be able to:

- Describe the main differences between Type 1 and Type 2 Diabetes
- Explain the use of transitional statements and other facilitative communication skills
- Elicit the social history
- Understand the importance of lifestyle in the management of Diabetes ^[1]_[5EP]
- Describe the complications of diabetes
- Discuss the influence of social and cultural factors on the diagnosis and management of Diabetes

Preparation before you attend the session:

Please ensure that you have understood and reflected on the content of the previous sessions, and that you have read through the information below. You may also find it useful to revise what have recently learned regarding the **physiology and pharmacology**

of Diabetes.

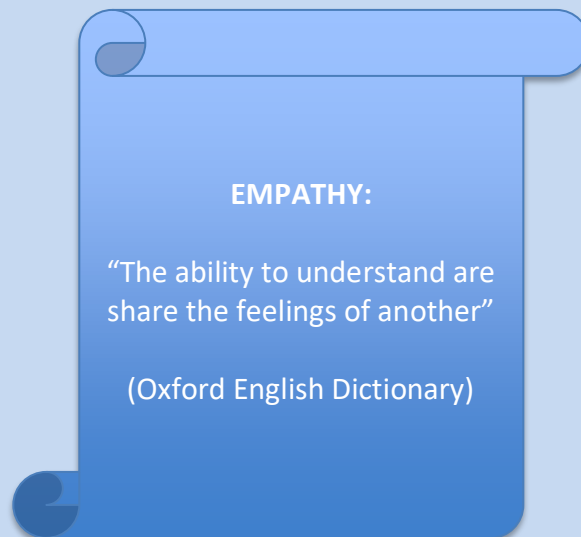
Syllabus References:

Please see First BM Syllabus **section 10.2.**

Themes covered during the session:

Theme	Area Covered Today
The Patient-Doctor Relationship	Empathy
Communication Skills	Facilitative Techniques
The Clinical History	The Social History
Biomedical Relevance	Diabetes Mellitus
Reflective Practice	Discussion with tutor and colleagues

The Patient-Doctor Relationship: Empathy



In a consultation, demonstration of empathy by the doctor is a key element in the establishment of trust. This, in turn, leads to a more effective therapeutic relationship with the patient.

A lot of people are naturally empathic. Those who chose to enter a caring profession, such as medicine, are likely to have a well-tuned sensitivity to the feelings of others. The challenge for medical students, and indeed doctors at all stages of their careers, lies in knowing how and when to demonstrate empathy in order to treat the patient effectively. Doctors need to consider the balance between showing compassion and humanity, whilst retaining the appropriate professional boundaries.

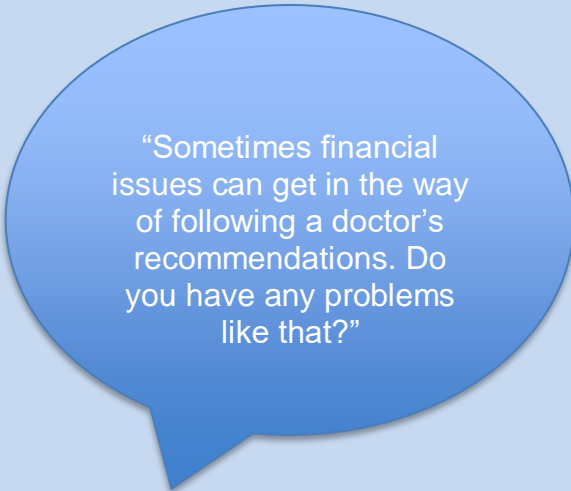
Can doctors truly show empathy for patient's situation they may never experienced themselves? What do you think?

Communication Skills: Facilitative Techniques

Once the patient has told you why they have come to the consultation, they may need some prompting. This offers them the opportunity to share further their ideas, concerns and expectations, plus it gives you more information about the clinical details you require in to make a diagnosis. This process can be facilitated by a number of communication skills:

1. **Open questioning:** as discussed in Session 2
2. **Active listening:** as discussed in Session 3
3. **Transitional statements:**

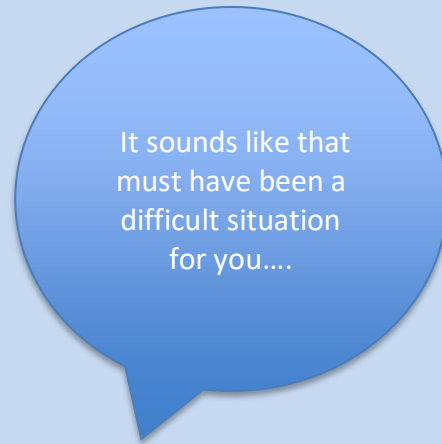
It is important to orient the patient to what you are about to ask about, especially if the questions are quite personal and less directly “biomedical”. You may find it helpful to explain briefly why you are asking something by making a *transitional statement*. For example:



“Sometimes financial issues can get in the way of following a doctor’s recommendations. Do you have any problems like that?”

4. Demonstration of empathy:

Reflective comments may be useful in encouraging the patient to continue. They can also serve to demonstrate that you understand and empathise with their situation.



The Clinical History: Social History (SH)

- Presenting complaint (PC)
- History of presenting complaint (HPC)
- Past medical history (PMH)
- Drug/ treatment/ allergy history (DH)
- Family history (FH)
- **Social history (SH)**
- Systematic enquiry (SE)

The *social history* is a record of the patient's life background. It is the hugely important part of the medical interview in which the doctor learns more about the patient as a person. It is a time to assess ways in which the social, cultural, economic, employment and leisure-related aspects of the patient's life interact with his or her health. These factors have implications for diagnosis, treatment and the ultimate outlook of the patient's illness.

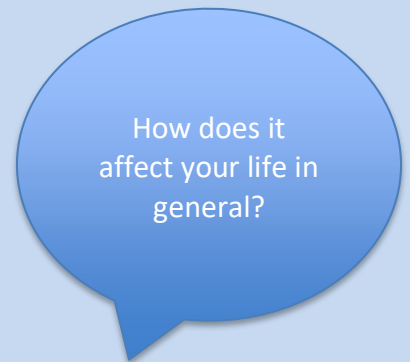
There are numerous pieces of information which might need to be obtained as part of the social history. There are therefore many different questions which you might ask, depending on the circumstances. You should aim to make these clearly relevant to the patient's health problems. When talking to a patient with **Diabetes**, you may want to consider:

Social Consideration	Relevance to Diabetes
<p>Social Support</p> <ul style="list-style-type: none"> • What kind of social (and emotional) support does the patient have? 	<ul style="list-style-type: none"> • <i>Social isolation can lead to self-neglect and non-adherence to treatment in chronic illness such as diabetes.</i>
<p>Living/ Housing Situation</p> <ul style="list-style-type: none"> • With whom do they co-habit? • What kind of housing does the patient have? 	<ul style="list-style-type: none"> • <i>A diabetic with visual impairment may need assistance administering insulin.</i> • <i>A diabetic amputee might not be able to manage stairs.</i>
<ul style="list-style-type: none"> • Do they have children? 	<ul style="list-style-type: none"> • <i>Drugs and needles must be stored out of reach.</i>
<p>Religious/Cultural Beliefs</p> <ul style="list-style-type: none"> • Are there cultural/religious beliefs or practices that affect the patient's healthcare? 	<ul style="list-style-type: none"> • <i>For example, the implications of Ramadan for diet and sugar-control.</i>
<p>Finances</p> <ul style="list-style-type: none"> • Does the patient have enough money to buy what they need for good health? 	<ul style="list-style-type: none"> • <i>Essential for diabetics to have healthy balanced diet.</i>
<p>Occupation</p>	<ul style="list-style-type: none"> • <i>Shift work can make adherence to</i>

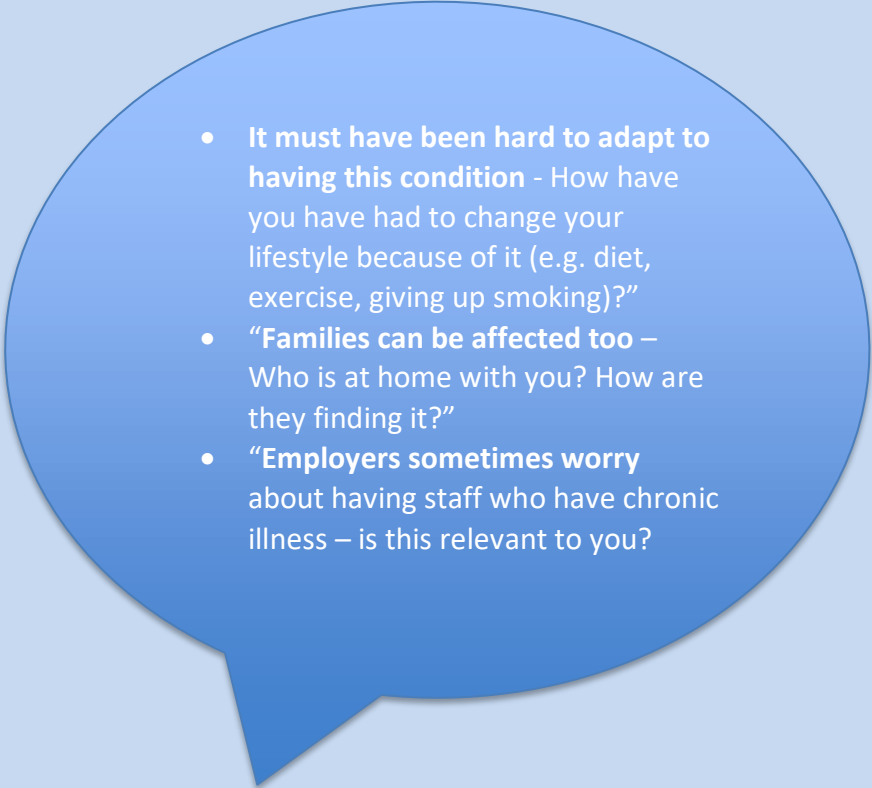
<ul style="list-style-type: none"> • What is their occupation? 	<i>treatment regime difficult in chronic illness such as diabetes.</i>
<p>Driving</p> <p>Do they drive?</p>	<ul style="list-style-type: none"> • <i>Those diabetics at risk of hypoglycaemia must inform DVLA</i>
<p>Smoking</p> <ul style="list-style-type: none"> • Do they smoke? If so how much? 	<ul style="list-style-type: none"> • <i>Greater risk of vascular complications in diabetes)</i>
<p>Alcohol</p> <ul style="list-style-type: none"> • Do they drink alcohol? If so how much? 	<ul style="list-style-type: none"> • <i>Can lead to erratic control of blood sugar levels in diabetes.</i>

Tasks:

In this session, you will meet and interview a patient with **Diabetes Mellitus**. During the interview, you should find out about the patient's experience of this condition, exploring the clinical presentation (HPC), and also the *social impact* (SH) of the condition. As in previous sessions you should start with **open questions**, for example:



As well as opening discussion about the nature of the clinical condition, these questions invite the patient to expand on their own ideas, concerns and expectations. You can subsequently clarify the details of what they have mentioned by using a more focused questioning style, but try where possible to use **transitional and empathic statements** to introduce such questions, for example:

- 
- **It must have been hard to adapt to having this condition** - How have you had to change your lifestyle because of it (e.g. diet, exercise, giving up smoking)?”
 - **“Families can be affected too** – Who is at home with you? How are they finding it?”
 - **“Employers sometimes worry** about having staff who have chronic illness – is this relevant to you?

After the interview you will have the opportunity to discuss and compare notes on what you have heard from the patient with the rest of your group and your clinical tutor.

Reflective Practice - End of Session Questions

(Your tutor may base the end-of-session discussion around these questions. This is to help you reflect on what you have learnt).

- What sort of diabetes does your patient have and how did their diabetes present? How else might diabetes present?
- Does your patient have any complications of diabetes? What is the impact of these?
- Which aspects of your patient's lifestyle are important in the management of their diabetes? What is their attitude to making lifestyle adaptations?
- Describe the relevant social and cultural background of your patient and how this affects their diabetes.
- Did you use any new communication techniques today? How did they work for you?

Reflective Writing Task – Year 1

This is a short written task which will be read by your GP tutor. Its purpose is to consolidate the reflective discussions you have had during your Patient Doctor sessions this year. It will allow you to share your thoughts and learning with your tutor and will provide them with the opportunity to give you feedback to help you in the future.

It should be handed in to your GP tutor two weeks before session 5. It should be no longer than 400 words in length.

Please think of a patient who you have interviewed this year and write under the following headings. You must be careful to avoid using personal details that might identify the patient (i.e. name, address etc.)

Outline the case (max 100 words)

Briefly outline the case, including the history of the patient's condition, relevant past medical history and any treatment you know about.

Discuss the impact of the illness on the patient (max 100 words)

Think about how the patient's illness affects their life, considering work, close relationships, hobbies, housing, finances and cultural/religious beliefs.

Reflect on the doctor's role (max 100 words)

What are likely to be the doctor's priorities when seeing this patient? Do they match those of the patient? Did the patient comment on their experience of healthcare services? Which of the GMC's *Duties of a Doctor* are particularly relevant to this case?

Comment on the skills you have learnt (max 100 words)

What consultation skills did you learn from talking to this patient? Please do consider other patient conversations you have had this year as well, if helpful. How do you feel in general about learning from patient interactions? What would you like to think about more in next year's Patient Doctor Course?

Session 5:

“Who Do You Think You Are?”



In this session, you will learn to take and record a formal family history and consider how the family is important in health and illness in terms of both heredity and environment. You will link this to your studies of genetics.

Learning objectives:

By the end of Session 5 you should be able to:

- Interview a patient to obtain a medical, social and family history
- Present a family history that characterises family dynamics and the medical history of family members (a family tree might be used for this)
- Consider the interaction between genes and the environment in illness and health
- Consider the ethics of genetic testing

Preparation before you attend the session:

Please ensure that you have understood and reflected on the content of the previous sessions, and that you have read through the information below. You may also find it useful to revise what you have recently learned regarding **medical genetics**.

Syllabus References:

Please see First BM syllabus **sections 3.2, 3.4, 3.6, 3.7, & 3.8.**

Themes covered during the session:

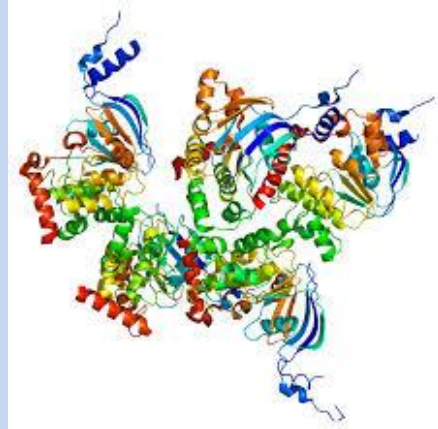
Theme	Areas Covered Today
The Clinical History	Family History
Biomedical Relevance	Medical Genetics
Reflective Practice	Discussion with tutor and colleagues

The Clinical History: Family History

- Presenting complaint (PC)
- History of presenting complaint (HPC)
- Past medical history (PMH)
- Drug/ treatment/ allergy history (DH)
- Family history (FH)
- Social history (SH)
- Systematic enquiry (SE)

A full **family history** details the make-up of the patient's current family, including the age and gender of parents, siblings, children and extended family as relevant. It should include details of state of the health of all these family members, as well as the age at death and cause of death of any deceased first-degree relatives (sometimes also other deceased family members if relevant). These details are sometimes recorded in the form of a diagrammatic family tree.

Genetic Disorders



A detailed family history such as this can be used to assess the risk of single gene disorders such as **cystic fibrosis** or **muscular dystrophy**. A formally recorded family pedigree can help to identify, and sometimes quantify, the risk faced by a patient who is concerned about the possibility of a disorder with a recessive or dominant inheritance.

For a clear description of how to construct a family tree (or “pedigree”) please see this guidance from Health Education England:

<https://www.genomicseducation.hee.nhs.uk/taking-and-drawing-a-family-history/>

Other consultations

In practice, a family history as detailed this is seldom needed, unless the suspected diagnosis has a very clear hereditary basis. Most clinical interviews will involve enquiry into **whether anything runs in the patient’s family**, but will only involve as much detail as above if the reply is in the affirmative and if it seems likely to be relevant to the diagnosis.

Value of the Family History

The family history assists in the **assessment of risk** for diseases that may have both genetic and environmental causes. For example, the risk of ischaemic heart disease is

increased by environmental factors such as smoking and high-fat diets, but also genetic factors which may be indicated by a strong family history of heart problems. The risk is greater when there are both genetic and environmental factors present.

Remember that family history is not only important to the doctor. Think about the patient who comes in with a persistent cough a few years after their father has died of lung cancer. How might this history be impacting on their **ideas and fears** about their symptoms? It is important for the doctor to understand their viewpoint in order to fully manage their concerns.

The family history also **overlaps with the social history** (discussed in Session 4) in assisting understanding of the social and cultural aspects of a patient's presenting problem. For example, a patient caring for a disabled relative may become depressed.

Tasks:

Your clinical tutor will introduce you to a patient.

This may be one of the following:

- A patient with a hereditary condition
- A pregnant woman
- A situation where there are medical problems in a patient's family which are impacting on the patient (i.e. being a carer)

Using the techniques you have learnt in the earlier sessions, you should find out about the patient's medical and social history. In addition, you should find out about their detailed family history:

- Ask about the presence of any illness, the same or possibly related to that of the patient, in first-degree relatives (parents, siblings, children), and if this leads to a pattern suggestive of a hereditary tendency. Then ask about second-degree relatives (grandparents, cousins, grandchildren) and wider if necessary.
- If it seems relevant, ask about consanguinity (marriage between second cousins or closer relatives).
- If it seems relevant, ask (sensitively) about children who have died, physically/mentally disabled relatives, adoptions, miscarriages, still-births, half-siblings.
- If it seems relevant, ask about aspects of the family history related to the social history and family dynamics, for example: who lives together; marriages, divorces; profession; educational level; financial inter-dependence; other relevant information, e.g. problems at school, social services involvement with the family, etc. [SEP]

Your clinical tutor may ask you to record this using a family tree to summarise the

information if relevant.

After the interview, you will have the opportunity to discuss and compare notes on what you have heard from the patient with the rest of your group and your clinical tutor.

A Note on Genetic Testing....

Whilst genetic testing is carried out in all sorts of situations, in general practice it commonly comes into discussions with certain pregnant women. It is worthwhile knowing about the types of antenatal screening routinely offered in the UK. If the patient you see is pregnant, you should ask her views and feelings about this.

For more information, please see: <https://patient.info/doctor/prenatal-diagnosis#nav-1>

Reflective Practice - End of Session Questions

(Your tutor may base the end-of-session discussion around these questions. This is to help you reflect on what you have learnt).

- If relevant, discuss the genetic inheritance of the patient's condition. What is the patient's understanding of this and how do they feel about it?
- How does the patient's family history affect them socially and emotionally? Consider this particularly if your patient is a carer.
- How does knowing a patient's family history help the doctor caring for them?
- What interview techniques did you use today and which were particularly effective?
- During your interview, did you experience any difficulties in asking about the patient's family history? If not, can you describe any circumstances where it might be difficult?

WELL DONE ON COMPLETING THE FIRST YEAR OF YOUR PATIENT DOCTOR COURSE!

We hope you have enjoyed the course and gained a great deal from it. Whilst you're away over the summer, you may find it interesting to look at some of these accounts of being a doctor. Have a think about what is portrayed and how you feel about it. You can always discuss things with colleagues on your return to Oxford.

Have a very relaxing summer (and don't forget to fill in your feedback on the course so far)!



Suggested Titles

- *Trust Me, I'm a (Junior) Doctor*, Max Pemberton
- *A Country Doctor's Notebook*, Bulgakov
- *When Breath Becomes Air*, Paul Kalinithi
- *Do No Harm*, Henry Marsh
- *The House of God*, Samuel Shem

The Patient & Doctor Course Tutor Report Year 1

Student Name	College.....
Tutor Name	Tutor Email Address.....

(1) Tutor's Review of Professionalism

Please make an assessment of the student's **professional behaviours** over the past year, considering the areas below. Please circle one box in each row:

	Satisfactory	Possible concern	Definite concern
Attendance	Consistently reliable and punctual Apologises for any absences in a timely fashion	Late more than once Single unauthorised absence	Repeated lateness or unauthorised absence
Engagement	Motivated, engaged with learning, conscientious	Variable participation in teaching. Does not always complete tasks assigned	Does not engage with teaching. Fails to complete tasks. Poor response to feedback
Interactions with patients	Respectful of patients. Maintains appropriate boundaries Communicates and interacts well with patients	Single episode of - Disrespectful behaviour - Inappropriate communication	Repeated disrespectful behaviour or failures to communicate appropriately

Tutor's assessment of ATTENDANCE:

<p style="text-align: center;">Overall Assessment</p> <p style="text-align: center;"> SATISFACTORY POSSIBLE CONCERN DEFINITE CONCERN </p>	<p style="text-align: center;">(circle one)</p>
<p>Additional comments about ATTENDANCE (optional):</p>	

Tutor's assessment of ENGAGEMENT:

<p style="text-align: center;">Overall Assessment</p> <p style="text-align: center;"> SATISFACTORY POSSIBLE CONCERN DEFINITE CONCERN </p>	<p style="text-align: center;">(circle one)</p>
<p>Additional comments about ENGAGEMENT (optional):</p>	

Tutor's assessment of interaction with PATIENTS:

Overall Assessment	(circle one)	
SATISFACTORY	POSSIBLE CONCERN	DEFINITE CONCERN
Additional comments about PATIENTS (optional):		

(2) Tutor's Overall Assessment

Please make a **global** assessment of the student's performance over the past year:

Overall Assessment	(circle one)	
SATISFACTORY	POSSIBLE CONCERN	DEFINITE CONCERN

Did the student complete and submit the written assignment?

YES

NO

Comments about overall performance/written assignment:

Please submit this form to: Jacqueline.belcher@phc.ox.ac.uk

YEAR 1 STUDENT EVALUTATION FORM
Patient and Doctor Course 2019/2020

Your GP Tutor's Name:

Your College:

Please take some time to fill in this questionnaire during the final session of the academic year. We would like to assure you that all your feedback will be anonymous. We greatly value your comments, as your input will help us develop the course in future.

Here is a reminder of the Patient and Doctor Course Aims.

On this course you will:

- Begin to experience what it is like to be a doctor
- Develop your curiosity for patients and their stories
- Consider the physical, social and psychological impact of a patient's illness
- Start your career as a reflective professional, by regularly learning from your patients
- Link biomedical scientific learning to your future clinical practice
- Start learning about the professional and ethical principles which guide and govern medical practice
- Begin to develop your clinical communication skills

Please rate the following aspects of the course, using the scale:

A = excellent, B = Good, C = satisfactory, D = unsatisfactory E = poor

1. Overall Impression	A	B	C	D	E
2. Insight given into the role of the doctor	A	B	C	D	E
3. Opportunities to meet and interview patients	A	B	C	D	E
4. Opportunities to explore the physical, social and psychological impact of a patient's illness	A	B	C	D	E
5. Opportunities to link scientific learning to clinical practice	A	B	C	D	E

6. Opportunities to practise and develop your own communication skills

A B C D E

7. Quality of teaching from your GP tutor

A B C D E

8. Feedback on your performance during the course

A B C D E

9. Course organisation

A B C D E

Please comment about things that went well:

Please comment about things that you feel need to be changed:

Many thanks for taking the time to complete this form. Please email it to:
Jacqueline.belcher@phc.ox.ac.uk

YEAR 2

WELCOME BACK TO THE PATIENT AND DOCTOR COURSE

Session 6:

“Do You Hear What I Am Saying?”



In this session, you will interview a patient to discuss their clinical problems and undertake a detailed review of their medication. In addition, you will consider whether your patient has given *informed consent* to their treatment, and explore the ethical and communication issues that are involved in this.

Learning Objectives:

By the end of Session 6 you should be able to:

- Take a drug history
- Relate your understanding of pharmacology to the patient’s medication
- Reflect on the ethical and communication issues surrounding informed consent from the perspective of patient and doctor ^[1]_[SEP]

Preparation before you attend the session:

Please ensure that you have understood and reflected on the content of the previous sessions, and that you have read through the information below. You may also find it

useful to revise what you have recently learned regarding aspects of **clinical pharmacology**.

Syllabus References:

There are a number of relevant sections in the First BM syllabus, e.g. **52.4, 54.1**.

Themes covered during the session:

Theme	Area Covered Today
The Patient-Doctor Relationship	Sharing Understanding and Consent
Communication Skills	Explanation Skills
The Clinical History	Drug/Treatment/Allergy History
Biomedical Relevance	Clinical Pharmacology
Reflective Practice	Discussion with tutor and colleagues

The Patient-Doctor Relationship: Sharing Understanding and Consent

Once the doctor has understood and interpreted the patient's story, it allows them to establish a diagnosis and decide what treatment to recommend. The patient must then decide whether they want to accept this advice, or in other words **consent** to treatment. If the doctor has taken care to share his understanding of the clinical presentation and how it relates to the patient's ideas, concerns and expectations, then it is more likely that the patient will trust the doctor sufficiently to give this consent.



Informed consent:

This means consent which is given by the patient after they have received information from the doctor about the pros and cons of the treatment on offer. This is not only necessary for major clinical procedures such as surgical operations, but is important for all forms of medical treatment, such as the taking of prescribed antibiotics. In the case of surgery, patients must give their consent in writing. In contrast, where the treatment is less elaborate or invasive, such consent can be *implicit*, e.g. the doctor can assume that consent has been given because the patient has accepted the prescription. Even here, though, the doctor has a duty to ensure the patient has enough information to make a rational decision.

The GMC gives very helpful guidance on all aspects of consent:

http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

Communication Skills: Explanation Skills

Giving an effective explanation relies on numerous skills which you will learn at a later stage in your medical school career. However, it is important to be familiar with some of the concepts involved. For example:



- **Assessing the patient's starting point** – establishing their level of understanding and desire for more information
- **“Signposting”** – categorising and labelling the information then moving explicitly from one point to the next
- **“Chunking and checking”** – giving information in manageable amounts at a time, and checking that it is understood each time
- **Incorporating the patient's perspective** – relating the explanation to the patient's own ideas, concerns, and expectations

The Clinical History: Drug History (DH)

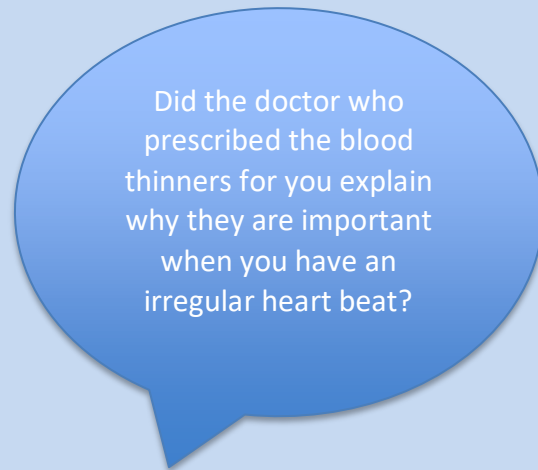
- Presenting complaint (PC)
- History of presenting complaint (HPC)
- Past medical history (PMH)
- **Drug/ treatment/ allergy history (DH)**
- Family history (FH)
- Social history (SH)
- Systematic enquiry (SE)

The DH is really the **drug/ treatment/ allergy history**. It should include details of all medications the patient is currently taking (including dosage), any recent changes to their medication, other recent treatments they may have had (e.g. operations or procedures), and other medications they have had in the past to which they were allergic or had other adverse reactions.

In patients on long-term medication, especially those taking several drugs simultaneously, it can sometimes be difficult to know whether new symptoms are due to an underlying medical condition or are secondary to side-effects of the medication (called *iatrogenic* symptoms). This why precise knowledge of the drugs they are taking is of key importance,

as is knowing the major side-effects and interactions of these medications.

Many patients understand less than we might expect about their medical condition, but can be embarrassed to ask too many questions of their doctor. Exploration of the patient's knowledge of their current drug treatment is a useful way of gauging their overall level of understanding:



Adherence

It is also useful to check exactly when and how (e.g. with/ before/ after food) they are taking the medication that has been prescribed for them, to ensure that they are adhering to the recommended dosage schedule and instructions.

What might be the consequences if patients are not taking their medication as prescribed? What if this is not recognised by doctors?

Note: some doctors will include alcohol consumption and recreational drug use within the DH, although more often this is covered in the social history, as discussed in Session 4.

Tasks:

Your clinical tutor will introduce you to a patient. Using all the skills that you have acquired in the first year of the Patient- Doctor course (rapport-building, active listening and facilitation), interview the patient and find out about their main clinical problems, focusing particularly on *treatment*:

- Identify what medication they are taking, both now and in the recent past, in detail.
- Assess the patient's understanding of the action and potential side effects of their medication.

- How much information have they received about this? Would they have wanted more/less/the same?
- Were there any alternative forms of medication/treatment? If yes, was the patient aware of them and how did they decide which to choose?
- How was the decision-making shared between the patient and doctor? Do they feel the balance was about right for them?
- How much information, in general, they would like to be given about both diagnosis and treatment?

Consider, in the light of your discussion with them, whether you feel the patient has given *informed consent* to the treatment. If so, what *explanation skills* did the prescribing doctor seem to have used to ensure this was the case?

After the interview, you will have the opportunity to discuss and compare notes on what you have heard from the patient with the rest of your group and your clinical tutor.

Reflective Practice - End of Session Questions

(Your tutor may base the end-of-session discussion around these questions. This is to help you reflect on what you have learnt).

- What treatment is your patient getting?
- Is your patient experiencing any side-effects from their treatment?
- Does your patient take their medication as it is prescribed? If not, why not? What factors may lead a patient to not adhere to treatment?
- Do you think your patient gave informed consent to their treatment? Is there anything which the doctor could have done to improve the patient's knowledge and understanding of their treatment?
- What communication techniques are particularly important when explaining treatments and having discussions about consent?

Session 7:
“Story of the Blues”



In this session, you will meet a patient who has experienced **depression and/or anxiety**. You will develop your history-taking skills to find out about the patient’s psychological problems, considering how these affect their life, family and social interactions.

As doctors and medical students, we sometimes need to have conversations with patients which we find particularly challenging due to events going on in our own lives, or circumstances affecting our families. If you feel that this session may be difficult for you in any way then please do discuss this in advance with your GP tutor.

Learning Objectives:

By the end of Session 7 you should be able to:

- Interview a patient sensitively about their psychological and emotional state
- Describe symptoms that are associated with depression and/or anxiety
- Outline the main approaches to management and treatment of depression and/or anxiety
- Describe what treatment your patient has had for their mental health problems

Preparation before you attend the session:

Please ensure that you have understood and reflected on the content of the previous sessions, and that you have read through the information below. You may also find it useful to revise what you have recently learned regarding **the psychology, neuro-physiology and pharmacology of anxiety and mood disorders**.

Syllabus References:

Please see First BM syllabus sections **25.1, 26.8, 26.9.**

Themes covered during the session:

Theme	Area Covered Today
Communication Skills	Dealing with emotions
The Clinical History	The psychiatric history
Biomedical Relevance	Anxiety and depression
Reflective Practice	Discussion with tutor and colleagues

Anxiety and Depression:

In addition to what you have learned so far in lectures, here are some brief notes about the symptoms of anxiety and depression.

What is Anxiety?

Anxiety is a universal and generally adaptive response to a threat, but in certain circumstances it can become maladaptive.

Characteristics that distinguish abnormal from adaptive anxiety include:

- Anxiety out of proportion to the level of threat
- Persistence or deterioration without intervention (> 3 weeks)
- Unacceptable symptoms including: recurrent panic attacks, severe physical symptoms, thoughts of sudden death
- Disruption of usual functioning

Effects of anxiety:

Psychological

- Feeling tense, can't relax, restless
- Excessive or inappropriate worrying
- Fear of 'going mad', losing control
- Derealisation
- Irritability
- Poor concentration
- Difficulty getting to sleep, 'tossing and turning'

Physical

- Palpitations, feeling faint, chest pain
- Breathing problems
- Appetite change, weight change
- Sweating, shaking, dry mouth, feeling hot or cold
- Churning or 'empty' stomach, nausea, frequent urination, diarrhoea, abdominal pain
- Headaches, neck and/or back pain
- Tingling, numbness, lump in throat
- Panic attacks

Social

- Avoidance of usual social situations
- Can involve time off work or poor performance at work

What is Depression?

Depression is characterised by sadness, loss of interest in activities, and decreased energy. Other symptoms may include loss of confidence and self-esteem, thoughts of death and suicide, poor concentration and disturbance of sleep and appetite.

Effects of depression: Psychological

- Low mood, feeling sad
- Loss of interest/pleasure in things
- Feeling Restless/ agitated
- Low energy, feeling slowed down
- Poor motivation
- Finding it difficult to make decisions
- Low self esteem
- Helpless and hopeless
- Inappropriate guilt about things

- Poor concentration
- Thoughts about suicide or self-harm

Effects of depression: Physical

- Weight loss or gain, with changes in appetite
- Sleep disturbance (for example, finding it difficult to fall asleep at night or waking up very early in the morning)
- Tiredness
- Constipation
- Unexplained aches and pains
- Moving or speaking more slowly than usual

Social

- Reduction in social activity, avoiding contact with friends
- Time off work, or poor performance at work
- Loss of interest in hobbies
- Difficulties in home and family life

Treatment of Anxiety and Depression

The patient you see today is likely to have undergone treatment for their anxiety and/or depression. This usually falls broadly into two categories: psychological therapy and drug treatment. The extent to which either of these approaches are used, and at what stage of the patient's illness, is highly individual to the particular patient.

For more information about **psychological therapies**, have a look at Oxford's self-referral service website, Talking Space:


<https://www.oxfordhealth.nhs.uk/talkingspaceplus>

In terms of **medication**, you may want to revise what you have learned about selective serotonin Reuptake inhibitors (SSRIs). Other drugs are also used in the context of anxiety and depression, such as tricyclics and beta-blockers. Your tutors will discuss these with you if appropriate.

Communication Skills – Dealing with emotions

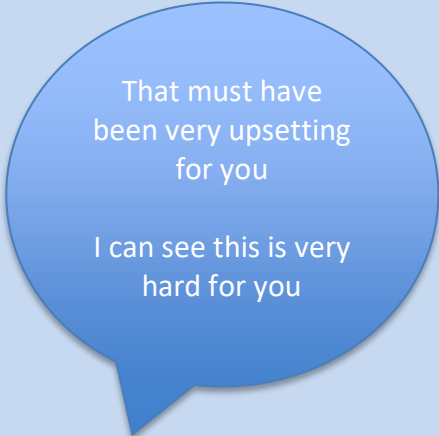
Assessing many patients, especially those with mental illness, inevitably involves exploring their emotions. Look back at the notes for Session 4 of the course: it dealt in part with the role of **empathy**, and the importance of achieving an appropriate balance between compassionate emotional involvement and professional distance. There is a certain set of skills which can be useful to draw on in circumstances such as this, for instance:

- Asking the patient's **permission** to explore their emotions:



Would it be alright if I ask how you feel about....?


- Use non-verbal skills to **demonstrate empathy** – a tilt of the head, offer a tissue. Or verbal statements which **acknowledge** their emotional state, such as:



That must have been very upsetting for you

I can see this is very hard for you

- Use **silence** – Allow space for the patient to calm down and gather their thoughts.
- **Summarise** the patient's story to clearly demonstrate that you have been listening.
- Show your **appreciation**:



Thank you so
much for sharing
this with me

The Clinical History - Psychiatric History:

The elements of the *psychiatric history* are essentially the same as you have learned about for any other full medical history (i.e. HPC, PMH, DH, FH, SH), but will also usually include what is known as a *personal history*. Some elements of this overlap with the family and social history, but these are supplemented with other details to build up a picture of the individual's development and background. These might include any or all of the following, depending on the relevance to the patient's presenting complaint:

- Circumstances related to childhood: mother's pregnancy and patient's birth; early childhood development; childhood separations and emotional problems; childhood illness.
- Education, including level achieved
- Occupations
- Sexual relationships
- Marriage/ partnerships
- Children
- Social circumstances
- Forensic history (i.e. criminal record)
- Pre-morbid personality (referring to the prevailing mood, character attitudes and standards that the patient typically displayed before becoming ill).

Tasks

Your tutor will introduce you to a patient with a history of mental health problems. Using the above information and the communication skills you have worked on in previous sessions, you should interview the patient to obtain the story of their condition. This should include:

- The patient's *personal history* and the background factors which may have contributed to the development of their condition.
- The *treatment* they have received (pharmacological, psychological, social

intervention).

- The overall impact of the illness on their life (behaviour, physical health, family relationships, work, leisure activity).

Try to ascertain:

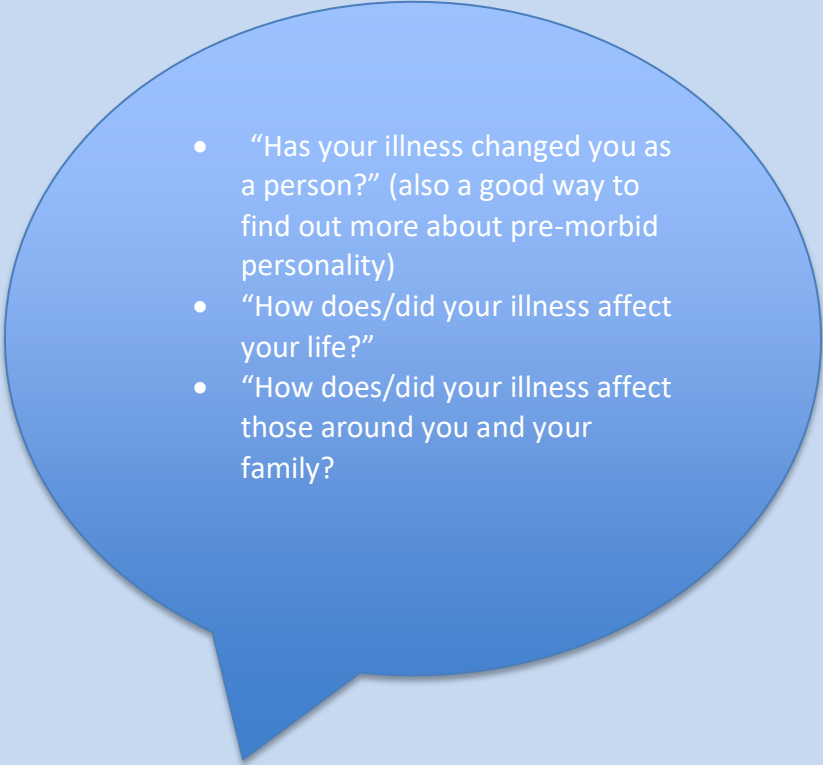
- How the diagnosis was made
- How it was subsequently managed
- What sort of treatment the patient has had and whether there are any side effects

In exploring the emotional impact of the illness, you may find it helpful, as ever, to ask **open questions** such as the following:

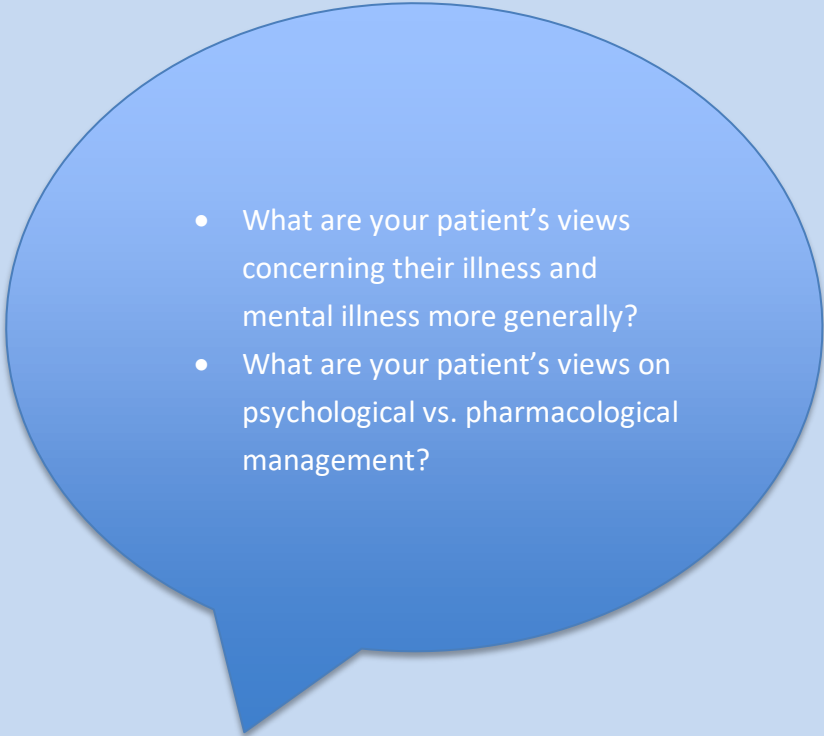


Subsequent focused enquiry should include questions about *biological* symptoms detailed above. Always also enquire about alcohol, smoking and self-medication (including recreational drug use).

To learn more about the **impact of the illness** you might ask:

- 
- “Has your illness changed you as a person?” (also a good way to find out more about pre-morbid personality)
 - “How does/did your illness affect your life?”
 - “How does/did your illness affect those around you and your family?”

Remember to explore the *patient’s perspective*:

- 
- What are your patient’s views concerning their illness and mental illness more generally?
 - What are your patient’s views on psychological vs. pharmacological management?

After the interview, you will have the opportunity to discuss and compare notes on what you have heard from the patient with the rest of your group and your clinical tutor.

Reflective Practice - End of Session Questions

*(Your tutor may base the end-of-session discussion around these questions. This is to help you **reflect** on what you have learnt).*

- What symptoms of depression/anxiety has your patient experienced? What is the impact of their illness on themselves and others?
- How has your patient's depression/anxiety been managed? Has this treatment been successful? Were there any side-effects?
- What are your patient's views on their treatment?
- How did you find interviewing a patient about their mental health? Was anything challenging?
- Give examples of questions or statements you used which worked well.
- How did the encounter make you feel? In general, what can doctors do to look after themselves after emotional conversations with patients.

Reflective Writing Task – Year 2

This is a short written task which will be read by your GP tutor. Its purpose is to consolidate the reflective discussions you have had during your Patient Doctor sessions this year. It will allow you to share your thoughts and learning with your tutor and will provide them with the opportunity to give you feedback to help you in the future.

It should be handed in to your GP tutor two weeks before session 8. It should be no longer than 400 words in length.

Please think of a patient who you have interviewed this year and write under the following headings. You must be careful to avoid using personal details that might identify the patient (i.e. name, address etc.)

Outline the case (max 100 words)

Briefly outline the case, including the history of the patient's condition, relevant past medical history and any treatment you know about.

Discuss the skills you have learnt (max 100 words)

What consultation skills did you learn from talking to this patient? In general, what have you learned about consulting over the past two terms?

Comment on how you felt about the consultation and what you have learnt about yourself (max 100 words)

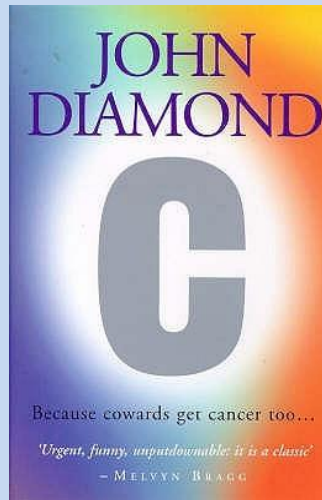
Did this conversation have any emotional impact on you? What have you learnt about yourself from this conversation? You might write about positive personal attributes, or those you would like to work on in future (e.g. "I am good listener" or "I feel uncomfortable when asking patients about personal things").

Make an action plan for your further learning (max 100 words)

What skills will be your priority areas to work on when you reach clinical school in Year 4?

Session 8:

“The Big ‘C’”: Talking to a patient with cancer



In this session, you will take a full history from a patient with cancer and find out about their diagnosis, management and treatment. You should focus on how the patient feels about the care they have received and try, if possible, to explore how they view their future.

As doctors and medical students, we sometimes need to have conversations with patients which we find particularly challenging due to events going on in our own lives, or circumstances affecting our families. If you feel that this session may be difficult for you in any way then please do discuss this in advance with your GP tutor.

Learning Objectives:

By the end of Session 8 you should be able to:

- Describe the outline plan of a full medical history
- Relate scientific knowledge of neoplasia to the patient's clinical presentation
- Identify risk factors in a patient's family history, lifestyle or environment
- Comment on the strengths and weaknesses of the care your patient

- received from the health service
- Establish *therapeutic rapport* sufficiently to allow you to ask delicate questions, such as how a cancer patient perceives their future

Preparation before you attend the session:

Please ensure that you have understood and reflected on the content of the previous sessions, and that you have read through the information below. You may also find it useful to revise what you have recently learned regarding the **pathology and pharmacology of cancer**.

Syllabus References:

Please see First BM syllabus sections **43.1, 43.3, 43.4**.

Themes covered during the session:

Theme	Area Covered Today
Biomedical	Cancer
The Patient-Doctor Relationship	Continuity and Sustaining the relationship
Communication Skills	Putting it all together!
The Clinical History	Full Medical History
Reflective Practice	Discussion with tutor and colleagues

Communication Skills: Putting it all together

Please have a look back at all previous sessions.

The Clinical History : Full Medical History

- Presenting complaint (PC)
- History of presenting complaint (HPC)
- Past medical history (PMH)
- Drug/ treatment/ allergy history (DH)
- Family history (FH)
- Social history (SH)
- Systematic enquiry (SE)

Please see the handbook introduction and all previous sessions.

The Patient-Doctor Relationship: Continuity and Sustaining the Relationship

The processes of connecting, exploring, understanding, sharing and agreeing all act together in *sustaining* the patient-doctor relationship over time. The generation of rapport, empathy, trust and consent serve to ensure that the patient will feel comfortable returning to see the same doctor repeatedly, therefore allowing that doctor to provide *continuity* of care. This is important in many fields of medicine, not just general practice. It can be particularly helpful for patients suffering from severe or chronic illness, who may be feeling anxious or vulnerable. It can be invaluable for them to deal with someone they know well and trust.

Tasks:

Your clinical tutor will introduce you to a patient with a history of cancer. Putting together all the communication skills you have learnt throughout the course, you should interview them sensitively to establish the story of their illness, its impact on their life, their perception of the quality of the medical treatment they have received and how they view the future. During the interview with your patient, try to establish:

- What were the initial and subsequent symptoms, physical signs, and results of investigations (e.g. blood tests, scans or X-rays, biopsy). Consider the local effects of the tumour and the possibility of metastases.
- What treatment has your patient had, both initially and subsequently? What were the side effects?
- How did your patient cope? Who helped them and how? (e.g. family,

friends, health professionals)

- What follow-up care is your patient receiving?
- What has been good about the care received and what could have been improved? Consider speed of diagnosis, investigation and treatment; provision of information; *continuity of care*; effectiveness and availability of treatment; degree of support.
- What risk factors may have been relevant? Ask about family history (draw family tree if appropriate), lifestyle (e.g. smoker?), employment history (e.g. builder – asbestos), environmental risks (e.g. radiation exposure).
- What do you understand of the patient's perspective about their illness and treatment? How do they view the future?
- **What is your view of the care they have received?**

After the interview, you will have the opportunity to discuss and compare notes on what you have heard from the patient with the rest of your group and your clinical tutor.

Useful online resources:

www.cancerresearchuk.org

www.macmillan.org.uk

www.cancer.gov (detailed American site)

<http://www.healthtalk.org/peoples-experiences/cancer> (for first-hand patient accounts)

Reflective Practice - End of Session Questions

*(Your tutor may base the end-of-session discussion around these questions. This is to help you **reflect** on what you have learnt).*

- Tell your colleagues about your patient's story, using the structure of a medical history.
- Did your patient have any risk factors for developing the disease?
- What treatments has your patient received? How do they feel about the treatment? Were there any adverse side-effects?
- What are the most significant ways in which your patient and their family have been affected by their cancer?
- How did your patient feel overall about the medical care they have received? Were there any problems and how might these have been overcome?
- How did your patient perceive the future?
- Which communication techniques were particularly helpful today?
- How did you feel talking about this subject with a patient? *In general, how can doctors do to look after themselves after emotional conversations with patients?*

Congratulations on completing the Patient and Doctor Course!

Please don't forget to fill in your Year 2 student evaluation form.

We hope you have enjoyed speaking to patients and learning from them. The Primary Care Teaching Team looks forward to seeing you again in your Fourth Year, which starts with the *Patient and Doctor Two Course*.

The Patient & Doctor Course Tutor Report Year 2

Student Name	College.....
Tutor Name	Tutor Email Address.....

(1) Tutor's Review of Professionalism

Please make an assessment of the student's **professional behaviours** over the past year, considering the areas below. Please circle one box in each row:

	Satisfactory	Possible concern	Definite concern
Attendance	Consistently reliable and punctual Apologises for any absences in a timely fashion	Late more than once Single unauthorised absence	Repeated lateness or unauthorised absence
Engagement	Motivated, engaged with learning, conscientious	Variable participation in teaching. Does not always complete tasks assigned	Does not engage with teaching. Fails to complete tasks. Poor response to feedback
Interactions with patients	Respectful of patients. Maintains appropriate boundaries Communicates and interacts well with patients	Single episode of - Disrespectful behaviour - Inappropriate communication	Repeated disrespectful behaviour or failures to communicate appropriately

Tutor's assessment of ATTENDANCE:

<p style="text-align: center;">Overall Assessment</p> <p style="text-align: center;"> SATISFACTORY POSSIBLE CONCERN DEFINITE CONCERN </p>	<p>(circle one)</p>
<p>Additional comments about ATTENDANCE (optional):</p>	

Tutor's assessment of ENGAGEMENT:

<p style="text-align: center;">Overall Assessment</p> <p style="text-align: center;"> SATISFACTORY POSSIBLE CONCERN DEFINITE CONCERN </p>	<p>(circle one)</p>
<p>Additional comments about ENGAGEMENT (optional):</p>	

Tutor's assessment of interaction with PATIENTS:

Overall Assessment	(circle one)	
SATISFACTORY	POSSIBLE CONCERN	DEFINITE CONCERN
Additional comments about PATIENTS (optional):		

(2) Tutor's Overall Assessment

Please make a **global** assessment of the student's performance over the past year:

Overall Assessment	(circle one)	
SATISFACTORY	POSSIBLE CONCERN	DEFINITE CONCERN

Did the student complete and submit the written assignment?

YES

NO

Comments about overall performance/written assignment:

Please submit this form to: Jacqueline.belcher@phc.ox.ac.uk

YEAR 2 STUDENT EVALUTATION FORM
Patient and Doctor Course 2019/2020

Your GP Tutor's Name:

Your College:

Please take some time to fill in this questionnaire during the final session of the academic year. We would like to assure you that all your feedback will be anonymous. We greatly value your comments, as your input will help us develop the course in future.

Here is a reminder of the Patient and Doctor Course Aims.

On this course you will:

- Begin to experience what it is like to be a doctor
- Develop your curiosity for patients and their stories
- Consider the physical, social and psychological impact of a patient's illness
- Start your career as a reflective professional, by regularly learning from your patients
- Link biomedical scientific learning to your future clinical practice
- Start learning about the professional and ethical principles which guide and govern medical practice
- Begin to develop your clinical communication skills

Please rate the following aspects of the course, using the scale:

A = excellent, B = Good, C = satisfactory, D = unsatisfactory E = poor

1. Overall Impression	A	B	C	D	E
2. Insight given into the role of the doctor	A	B	C	D	E
3. Opportunities to meet and interview patients	A	B	C	D	E
4. Opportunities to explore the physical, social and psychological impact of a patient's illness	A	B	C	D	E
5. Opportunities to link scientific learning to clinical practice	A	B	C	D	E

6. Opportunities to practise and develop your own communication skills

A B C D E

7. Quality of teaching from your GP tutor

A B C D E

8. Feedback on your performance during the course

A B C D E

9. Course organisation

A B C D E

Please comment about things that went well:

Please comment about things that you feel need to be changed:

Many thanks for taking the time to complete this form. Please email it to:

Jacqueline.belcher@phc.ox.ac.uk