

WHAT THE STUDENTS ALREADY KNOW ABOUT CONSULTATION AND COMMUNICATION

Medical students in Aberdeen have Consultation and Communication Skills training from the beginning of their course. Here is an outline of what students have already had in their Course before they reach Phase III. (New curriculum changes were introduced in 2009 and this has involved changes to the clinical communication teaching. This will not filter through to Phase III students until 2012/13 and we will revise this section accordingly at the next edit).

The aims and objectives of the Medical Interviewing and Communication Skills course, which runs through Phase I and Phase II, are based on: The Scottish Doctor (Scottish Deans Medical Curriculum Group, 2002) and Tomorrow's Doctors (GMC, 2002). The general objectives are to increase student awareness of the following:

- The basic research evidence for the importance of communication skills in medicine.
- The skills needed to successfully develop and maintain successful professional relationships with patients.
- The importance of communicating effectively and sensitively with patients, no matter the patient's lifestyle, culture, beliefs, race, gender, age, etc.
- Be able to take a structured, patient-centered history using good communication skills.
- Recognize the role of psychosocial factors in precipitating and perpetuating illness.
- Understand how to take account of patients' own views and beliefs when suggesting treatment and management, and respect patients' right to be fully involved in their own care.
- The role of teamwork in caring for the patient.

Phase I

One lecture and two 2-hour tutorials focusing on the basics of doctor-patient communication (e.g., "what do patients look for in a doctor" and team working skills). Both tutorials are interactive with students talking to volunteer patients in the former, working on a team building exercise, and reflecting on the process and outcome of this, in the latter tutorial.

Phase II, 2M

Phase II teaching is integrated across 2M and 3M. This teaching is based on the Calgary Cambridge model of medical consultation skills. 2M teaching (1 lecture, 4 small group tutorials and one technical (video) session) focused on identifying and addressing student fears re talking to patients in the wards, and helping them brainstorm how to manage this situation effectively. The Calgary Cambridge model is introduced, and the history taking phase of the consultation is worked through. This covers opening the interview, creating a rapport/building a professional relationship, questioning and collecting information.

The emphasis is basically on taking patient-centered history using good communication skills, such as open questions, active listening, and organizing your time effectively. Students role play taking a patient-centered history with each other, with actors and simulated patients. They receive feedback on specific skills and behaviours in tutorials, and via video analysis.

Phase II, 3M

In 3M (1 lecture, 5 small group tutorials and one technical (video) session), the focus is on using the above information to give information and diagnosis to the patient. This is usually trickier for the students as they do not have experience of either doing this, or seeing it done. Teaching focuses on giving them the skills and practice to find out what the patient knows already, giving a "warning shot" if it is bad news, answering questions honestly (and admitting when they do not know the answers), negotiating priorities, a treatment plan and follow-up with the patient. As before (2M), students role play carrying out a full consultation with each other, with actors and simulated patients. They receive feedback on specific skills and behaviours in tutorials, and via video analysis.

Phase II integrated teaching

The communication skills teaching described above is "stand alone". However, communication skills' teaching is also integrated with clinical teaching at various points throughout the MBChB. Most of this integrated teaching occurs in P3 and P4 but two sessions run in P2. These are: Medicine in a Multi-cultural Society – one lecture, 2M, and Smoking cessation and health behaviour change – one lecture, Respiratory Block 2M

Conclusion

In short, by the time they reach you in Phase III or Phase IV, every student has received 30 hours of communication skills teaching. They have been taught the theory and practice of communicating with patients; they have received feedback on their own performance. If they claim not to know anything about above, please feel free to direct them towards their Medical Interviewing and Communication P2 Handbooks. These provide an enormous amount of information as to how to effectively communicate with patients.

GENERAL PRACTICALITIES OF STUDENT CONSULTING

(Please also see current Phase III & Phase IV GP Course handbooks as details may change from year to year)

General

We appreciate that practices nowadays are often very tight for space and greatly appreciate the ingenuity of tutors as they enable time and space for student consulting in their practices. You will need to make time in consulting for students sitting in - even if it's just one or two appointments blocked off per surgery. Students consulting alone need longer appointment times (20+ minutes). Students value the mixture of both having their consultations observed with feedback afterwards, and consulting in parallel.

Patients' consent will be needed for student consulting. MDDUS do recommend written consent but in reality many practices will have notified patients when booking appointments, re established verbal consent when they present to reception and again when called in for their consultation.

Phase III

Tutors are required to observe and give constructive feedback on a minimum of 12 student consultations in each block. It is also hoped that they will get a lot more experience observed or tandem consulting during the 4 weeks they are with you. Tandem or in parallel surgeries can be arranged if you have the space so that you as GP see 1 or 2 patients whilst the student sees a patient and then you have every 3rd or 4th appointment blocked off to debrief with student and patient leaves.

Phase IV

Students will need to have a minimum of 3 student led surgeries per week – these can be run as described above with GP consulting in parallel. Students will be filling in their log diary and will be expected to reflect as they go along. They should be encouraged to reflect on all consultations, whether included in the log diary or not.

PRACTICAL TIPS FOR TEACHING IN GENERAL PRACTICE

- Acknowledge, "It is all right to be wrong" and that "Now is a safe time to have a go at using your instinct and having a guess!"
- Involve the student as much as possible in your consulting when they are sitting in - vary the learning /teaching strategies - see below for some ideas from Anne Stephenson's text book and also a sheet used in Queens Road Medical Group during 2 days of consulting
- Involve students in any practice educational events, SEA meetings, PLT sessions etc – Students can present their Case studies (Phase III) to the Practice.
- When a student is going out with e.g. a district nurse, give them a few learning objectives, maybe written down and get them to feedback. This helps focus learning.

- When a student spends time with colleagues during their placement make sure you get feedback from them as part of formative assessment.
- Plan some interviews with interesting patients by specifically asking them in to see the student.
- Consider the continuity of the patient journey - e.g. accompanying to out patients or when admitted.
- Telephone technique can be observed using a loudspeaker or double headset on your phone.
- Student can help with audit or do one of own (Phase IV).
- Discuss drugs being used and general issues as doing repeat prescribing.
- Get student to write referral letters - (make sure, however, you check and sign them though!)
- Make a collection of medical educational CDs or list of useful websites for students when you are doing the admin, e.g. The PEP CD - or there are some useful CDs on taking smears and taking a blood pressure.
- Good teaching and learning strategies: A textbook of General Practice" by Ann Stephenson 2004, 2nd edition
- Give student a copy of 1-3 consultation models and whilst they are observing /sitting in on consultations map what actually happens against a model. Discussion then focuses on what is actually going on in consultation rather than content of consultation. Can be done using a video of a consultation so can run it back.
- Refer to A textbook of General Practice" by Ann Stephenson for more excellent examples of teaching and learning strategies.

WHAT TO LOOK FOR WHEN WATCHING STUDENT CONSULTATIONS

- Do they adequately prepare themselves for the consultation?
- Do they use appropriate skills to build a rapport with the patient?
- How long is it before they interrupt the flow of information?
- Are they aware of the patient's presenting emotional state?
- Do they encourage the patient to continue?
- Do they screen for other problems before moving on down the first line of enquiry?
- Have they discovered the reason(s) for the patient consulting them?
- Do they finish or complete taking a history before they examine or start planning care or giving advice?
- Does the medical history explore enough information to consider important and serious conditions?
- Do they explore the patient's problem by using an open to closed style of questioning that encourages accurate clinical reasoning?
- Do they structure and check the accuracy and interpretation of the information they hear by summarising?
- Do they use appropriate closed questions to complete important information about the relevant function of body systems, past medical, family & social history
- Do they discover the patient's perspective sufficiently enough to understand the meaning of their symptoms to them as well as help you plan management?

- Do they respond to patient ideas and concerns in an empathetic and non-judgmental way?
- Do they give information/advice prematurely?
- Do they try to discover the patient's starting point and tailor information to the needs of the patient?
- Can they give information clearly at a pace the patient can understand?
- Do they involve the patient during the process of giving information?
- Do they involve the patient in possible management by making suggestions and offering options?
- Is there an attempt to get reactions and feelings to what is discussed?
- Is there an attempt to discuss and manage uncertainty? (Where relevant)
- Is the plan or management logical and reasonable in light of evidence-based care?

(From: Kurtz S, Silverman J, Draper J. *Teaching and Learning Communication Skills in Medicine* Radcliffe Medical Press, 1988)

GIVING FEEDBACK TO STUDENTS

The following links provide comprehensive information on giving feedback to undergraduate students:

<http://www.skillscascade.com/handouts.htm>. Has information on feedback method e.g. ALOBA (agenda led, outcome based analysis), SET-GO (what I Saw, what Else did you see, what do you Think, can we clarify what Goal we would like to achieve, any Offers of how we should get there)

<http://www.abdn.ac.uk>. Search under 'feedback' for current advice from our own institution

<http://www.asme.org.uk>. The Association for the Study of Medical Education has useful inexpensive guides on medical education topics as well as access to their journals 'Medical Education' and 'The Clinical Teacher'

TIPS ON HOW TO INTRODUCE PUBLIC HEALTH AND OEM THEMES IN THE CONSULTING ROOM

(Also see page 56 of Phase III handbook 2010/2011)

Topic	Common GP Scenario	Discussion
Time pressure	Running late with a full waiting room	Rationing of GP time
Medicalisation of Life	Fatigue, insomnia, stress, aches & pains	'A pill for every ill' (SSRIs, Benzos NSAIDs)
Diagnostic Uncertainty	Headaches (brain tumour or benign?)	In GP: high probability 'benign' & low risk 'tumour'
Outcome Common Disorders	Cough; Conjunctivitis; Acute low back pain (LBP)	Natural history of recovery ('self-limiting disorders')
Treatments that do work	Low dose aspirin for CHD / PVD / TIA / Stroke	Research evidence / RCTs / SIGN guidelines

Treatments that don't work	Antibiotics for sore throats (+ 'patient expectations')	Mostly viral (but similar clinical features as strep. throat)
Duty to the Patient or Society	Sickness certification (e.g. non-specific illnesses)	Deserved & undeserved sick notes.
Lay Health Beliefs	Chronic medication adherence (averages 50%)	Drugs unnatural / harmful / additive / develop tolerance
Registered Population	GP workload	Children (frequent consulters) ; Elderly (home visits)
Screening (breast / cervical)	Borderline test result requiring investigation	False positive results & patient anxiety
Childhood Immunisation	Individual patient unlikely to benefit from intervention	Population benefit ('herd immunity' to infection)
Media scares	Patient anxiety and increased GP workload	Evidence of risk from MMR/HRT
Guidelines and protocols	Individual patient care and vs. cookbook medicine	Patient characteristic differences in primary care VS RCT (e.gco-morbidities)

PHASE IV DAY RELEASE IDEAS AND ACTIVITIES

Please see Phase IV GP attachment hand book for some straight forward ideas to use in this time.

The following is a list from tutors of some of the topics/themes of the Day Release Programme. Please feel free to do something different

- Balancing work and lifestyle including hobbies
- Business of General Practice
- CAM
- Clinical problems e.g. diabetes, epilepsy, back pain, chest pain, dermatology
- Communication skills as applicable in General Practice
- Community hospital x-ray session
- Confidentiality e.g. in a small community, having to meet patients who you also know socially. GMC scenarios.
- Difficult patients/fat folder and describe the pros and cons of difficult patients.
- Emergency medicine in rural practice

- General Practice and the pharmaceutical industry (drug reps and medical advertising)
- How primary care works – NHS management – could arrange a chat with a CHP manager or similar
- Interesting cases
- Introduction to theoretical major incident management with simple written exercise
- Minor injuries management
- New contract “quiz”
- Observation and multi-disciplinary team clinical meeting
- Palliative care issues e.g. logistics of immediate care in a rural community
- Patient Participation Groups
- Patient to come to surgery e.g. recently out of hospital/surgery and are interviewed by student and then their group
- Practical examination skills e.g. ophthalmoscope use
- Pre-hospital arrhythmia management – ECGs
- Pre-hospital emergency care and trauma management including working as a team and with a standard first aid kit.
- Prescribing in General Practice e.g. dispensing practice, community pharmacist
- Professional development in avoiding burnout
- Random case analysis
- Resuscitation
- Rural GP/Community Hospital
- Rural vs. Urban practice
- Sandpiper bag/ rescue equipment. BASICS
- Secondary prevention in General Practice
- Sexual health issues & patient scenarios
- Smoking cessation – quiz/scenario/role play
- Stitching/A&E work
- Team working including team member profile analysis