



UNIVERSITY
OF ABERDEEN

School of Medicine and Dentistry
College of Life Sciences and Medicine

PHASE IV MBChB

General Practice and Community Attachment

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INTRODUCTION

Welcome to your Phase IV General Practice and Community attachment.

You will spend one week working with your fellow students studying a wide range of conditions that are common to both General Practice and Mental Health. The rest of your attachment will be spent in a General Practice or Community setting.

Primary care in the UK is still the gate keeper for health care. Illnesses range from minor and self limiting to major and life threatening; patient ages range from months to one hundred years; the range of knowledge required is from psychology to surgery, or cardiology to immunopathology.

General Practitioners are the true generalists in health care. We enjoy what we do and are proud of the quality of care we provide. Our tutors are keen to share their enthusiasm for medical care in the community with you.

We hope your time in General Practice and Community is enjoyable, but if you have any problems, please contact:

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1. AIMS AND OBJECTIVES FOR PHASE IV

To prepare for the competent, safe, effective and professional practice of medicine as a doctor in the foundation training programme by:

- **Developing and integrating practical and clinical skills through the supervised application including making recommendations for the prescription of drugs and monitoring of progress of patients in hospital and in the community.**
- **Developing organisational skills through the shadowing of junior medical staff during hospital and community attachments.**
- **Ensuring competence in the management of acutely ill patients under supervision.**
- **Consolidating and extending knowledge of illness and its management through attendance at teaching ward rounds, clinics, GP surgeries and tutorials. Ensuring a clear appreciation of the core material relating to the broad range of professional practice presented in the Phase IV curriculum.**
- **To extend personal and professional development through the design and performance of a project in any field of medicine at an approved institutions in the elective course.**
- **To foster the development and maintenance of attitudes and conduct appropriate to professional practice.**
- **To assure patient well being and safety in all aspects of your practice.**

These are the overall Phase IV aims - the GP and Community attachment contributes to all these, apart from the one relating to your elective.

The following are the Phase III aims and objectives for the General Practice attachment. In the Phase IV General Practice and Community attachment, we expect you to achieve these objectives at a higher level of understanding than for Phase III.

Aims

- To enable the student to understand how illness presents in Primary Care and to learn about the management of common conditions encountered.
- To develop the student's interpersonal skills and to encourage a reflective approach to the student's learning.
- To understand the importance of communication skills in the doctor-patient relationship and to be able to receive training and feedback on this.

Objectives

At the end of the attachment each student should be capable of the following, which are consistent with Outcomes for Graduates in Tomorrow's Doctors (GMC, 2009).

1. **Describe the context of Primary Care in the Community**
2. **Describe the presentation and management of common problems encountered in general practice**
3. **Carry out a patient-centred consultation, demonstrating appropriate medical interviewing skills, shared decision making and eliciting the patient's ideas, concerns and expectations**
4. **Demonstrate a reflective approach to his/her experiences, utilising this to identify personal learning needs and consequently acting on these.**

2. THE GENERAL PRACTICE AND COMMUNITY SETTING

2.1 ETIQUETTE

In Phase IV, you will be attached to a general practitioner on a one to one basis. You will also have close contacts with other members of the primary health care team. It is essential that you are aware of and observe certain basic rules.

- Always tell patients you are a medical student as well as telling them your name.
- Always ask the patient's permission to interview/examine them and thank them when you have finished.
- Always observe the guidelines concerning patient confidentiality.
- On meeting the new members of the primary health care team, always identify yourself.
- Always wear your ID badge.
- Be neatly, tidily and professionally dressed, appropriate to the setting in which you are working.
- Make sure you always carry with you any basic medical equipment that you might need (e.g. stethoscope).
- Always arrive on time for arranged sessions, or give as much notice as possible if unable to attend for any reason.

2.2 ETHICAL CODE

- Treat every patient politely and considerately.
- Treat colleagues with professional courtesy and respect.
- Respect patients' privacy and dignity.
- Listen to patients and respect their views.
- Do not give patients information or an opinion that you are unqualified to give.
- Develop and practice the use of medical skills and knowledge to the best of your ability.
- Recognise the limits of your medical competence.
- Be honest and trustworthy.
- Respect and protect confidential information.
- Make sure that personal beliefs do not prejudice dealings with patients.
- Avoid abusing your position as a medical student.
- In addition, we expect you to adopt professional behavior in relation to the use of social networking sites.

2.3 EXPECTATIONS OF BEHAVIOUR IN ATTACHED ACCOMMODATION

If you are away from Aberdeen the minimum provided is a room in local community hospital, self catering flat or bed and breakfast. Meals are not included however, in the B&B establishments we have negotiated breakfast and in most cases dinner as well. This should be considered a bonus, as if you were in your own accommodation you would be buying all your own meals. We do not pay any subsistence to students.

We expect a high standard of behaviour and professionalism from students in this accommodation as you are representatives of the University while you are there. Please refer to the Code of Conduct for all accommodation provided by the University of Aberdeen or used whilst on University business.

This is found on the Medi-CAL Resource Centre and you should have signed a copy.

2.4 GUIDANCE FOR STUDENT ACCESS TO GP PRACTICE IT SYSTEM

The following procedure should be followed to allow student access to the practice IT system:

- Students use their own network username and password, as for the Suttie Centre and Foresterhill site.
- Practice IT administrator contacts IT Help desk on 54444 or emails the IT service desk on grampian.servicedesk@nhs.net and gives them the details, who will allow access for the period of time that the student is on their attachment.
- Practice IT administrator sets up the student for Vision and Docman as they would for any new member of staff and issues the student a username and password for this.
- Practice IT administrator should disable the student access when the student leaves the practice.
- Also good practice for the IT administrator to notify the IT dept when the student has completed their attachment to disable access their end.

3. ILLNESS IN PRIMARY CARE

3.1 SEVERITY OF ILLNESS

The general practitioner deals with the whole gamut of disease from the very major to the very minor. Most **acute** serious diseases will be dealt with in hospital, at some stage, but the general practitioner is still responsible for the initial differentiation and after-care. Many (but by no means all) less acute but still serious illnesses are dealt with in hospital at some stage, but the bulk of the care of most of these illnesses (e.g. asthma, chronic bronchitis, angina, cardiac failure, hypertension, peptic ulceration, CVA, rheumatoid arthritis, etc) takes place in the community and many of these diseases are, because of demographic and social changes, on the increase. The long term, continuing care of much serious illness therefore lies with the general practitioner. The availability of increasingly safe but potent therapies, and the advancement of team care, enhances the scope for management out with the hospital of more and more of these serious conditions.

Nevertheless, much of the illness presenting to the general practitioner is **minor** in terms of threat to life or physical disability; but these minor diseases cannot be dismissed as unimportant. Firstly, the patient is not necessarily able to know whether his symptom is minor or major in terms of possible **outcome**; a major part of the general practitioner's job is to give an expert opinion on this (which may be all that is required). Secondly, illness is not necessarily minor in its effects simply because it is self-limiting; considerable (if temporary) personal discomfort, inconvenience and disruption of domestic routines may result and, nationally, these minor diseases are responsible for much greater loss of working time and productivity than other causes, such as industrial disputes. Thirdly, a consultation, even for the most obviously minor illness, is rarely a complete waste of time. It adds to the general practitioner's store of knowledge about the patient's background and reaction to symptoms and this information may be of major importance at a later date. Also many general practitioners use the opportunity to educate the patient to make more appropriate use of medical services or to adopt more responsibility for self-care; to 'case-find' by measuring blood pressure or weight, or asking about smoking/alcohol habits; and to give the patient general advice on a healthy lifestyle, whether or not related to the presenting complaint. A fourth, and final reason why such consultations should never be dismissed as unimportant is that this is often the way (ticket of admission) in which patients present a psychological or social problem of much greater potential significance (e.g. occupational stress, marital discord, alcoholism), and apparent disinterest or annoyance on the part of the doctor may close the door to these more sensitive and important areas.

A useful distinction can be made between **new** and **old** (pre-existing) problems, both of which may of course be present in the same patient at the same time. The major difference is that consultations which deal predominantly with **old** problems (i.e. review consultations) usually contain less of a diagnostic component and are mainly concerned with management (although diagnostic review may be required from time to time). Apart from the obvious need for review of **management** over time, another important concept is that of **diagnosis** over time because, in the UK at least (as opposed to, say the USA), having categorised new problems as either 'urgent' or 'non-urgent', the general practitioner will attempt to solve the more complex non-urgent problems in a series of small bites over time, rather than immediately. The USA system of payment encourages the 'one big bite' principle, but the UK system allows the evolution or resolution of symptoms over time to be taken into account in clinical diagnosis, thereby avoiding the inconvenience, danger and expense of initial intensive investigation, such as the USA system promotes.

3.2 NON-HOSPITAL ILLNESSES

For a want of a better name, this is used to categorise the types and stages of illness which the student is very likely to see in general practice and very unlikely to see in hospital. This is an important part of your learning, because it completes your general clinical experience.

As stated earlier in this handbook; conditions which are common in hospital practice (appendicitis, cancer, acute myocardial infarction, etc) are relatively rare in general practice and you may not see any such cases in the whole seven weeks. A medical student in the hospital wards might see more new cases of cancer, appendicitis and so on in a week than a general practitioner sees in a year and although this is very valuable, concentrated experience, the danger is that medical students may gain a much distorted impression of the incidence of these diseases. In one year, an individual general practitioner might see about ten new episodes (not necessarily new patients) of myocardial infarction, six new episodes of stroke, three new cancers and four or five abdominal emergencies of all types. A general practitioner will probably not see a new case of rheumatic heart disease in the whole of their lifetime, but they might see a new case of significant congenital heart disease every few years.

The general practitioner's day will be filled by acute infections of all sorts (predominantly upper respiratory), skin disorders, psycho-emotional complaints, minor accidents, intestinal and rheumatic complaints and symptomatic illnesses which often remain uncertain in origin. General practitioners deal with many patients with established chronic complaints - hypertension, ischaemic heart disease in all of its manifestations, arthritis, diabetes, asthma, bronchitis, thyroid disorders, epilepsy and so on.

This section is intended only as an introduction, because the disease content of general practice is very well described in existing textbooks. Please note that our clinical assessment procedure may include the questions about the primary presentation, differential diagnosis and general management of any of the common diseases, which we expect you to see.

3.3 PRESCRIBING IN GENERAL PRACTICE

The great physician Sir William Osler only half-humorously defined medicine taking as the one factor that clearly distinguished man from animals. At anyone time about 66% of the population is consuming medicine of some kind, of which only one half or less (depending on the country and its medical system) is prescribed by doctors.

General practitioner prescriptions make up 60% of NHS primary care costs. Over the years since 1949 general practice drug costs have occupied a constant proportion of about 10% of the total NHS budget, but in real terms (even allowing for inflation) the cost of general practice prescriptions has risen considerably in recent years. You may have an opportunity to discuss the possible reasons for this during your attachment.

On average, about ten prescriptions are issued per registered patient per year. Most of these (80%) are for regular repeat medications, issued to a minority of patients who may individually require anything from twenty to forty or more prescriptions per year for often less than three separate preparations, and sometimes more. Work out, for example, how many monthly prescriptions per year an elderly person with angina, obstructive airway disease and occasional dyspepsia might require.

Internationally, the volume of prescriptions varies from, say, twenty-one per person per year in Italy, to about five per person per year in the Netherlands, so that UK is towards the lower end of the scale. The most commonly prescribed therapeutic groups in Scotland in the year to March 2007 were:

By volume and by cost:

1. Cardiovascular System
2. Central Nervous System
3. Gastro-intestinal System
4. Endocrine System
5. Respiratory System

There is much argument about how much of general practice prescribing is inessential - certainly the very great variations between general practitioners in the volume and nature of drugs prescribed suggest that some general practitioners may prescribe more efficiently and economically than others. The open-ended fiscal commitment, the ease of access to detailed information and the ambivalence of public attitudes to the pharmaceutical industry are some of the factors which make general practice prescribing an attractive, although controversial, area for politicians.

4. MEDICO-LEGAL ADVICE FOR SENIOR MEDICAL STUDENTS

(By Dr Bill Mathewson, MDDUS)

An important part of our role at the MDDUS is education and this article will help you practice medicine more safely, thus avoiding complaints and claims alleging medical negligence.

There is no doubt that medical litigation is increasing steadily. It is often prolonged, stressful, and can be damaging to your career.

In the last decade medical litigation has emerged from near obscurity to the high profile social phenomenon of today. Patients' expectations have increased. Their willingness to accept complications has decreased. These factors combined with easier access to legal advice, an increasing desire to participate in health care decision making and patient advocacy and self help groups have led to the increasing level of litigation.

I would like to deal with three topics of **particular** medico-legal importance.

4.1 CONFIDENTIALITY

Medical confidentiality is keeping secret all information passing between the patient and the doctor in the course of the professional relationship. It is the fundamental principle of medical ethics and is one of the corner stones of effective medical care. Medical confidentiality is an ethical concept, not a legal principle, and carries no statutory duty.

Confidentiality has no rigid rules and in many areas there is much scope for differences of opinion, both in and out of the medical profession. It can, on occasions, bring doctors into conflict with other professional groups (e.g. the legal profession and the police). The General Medical Council booklet entitled 'Confidentiality: Protecting and Providing Information' should be your guiding text.

Doctors, if in doubt, should consult their medical defence organisation. The areas which prove most difficult in practice are those of the public interest and disclosure to the police. Where there has been a serious crime committed (e.g. murder, rape) and the police seek information regarding a patient whom they have strong suspicions of involvement, then careful consideration should be given to disclosure. It is better in these circumstances to discuss the matter with your defence organisation, prior to making a decision. Doctors should be wary however, of the casual enquiry from a police officer going about his professional duties and seeking help from medical information. Information should not be disclosed in these circumstances and to do so could result in the doctor being reported to the General Medical Council.

Doctors regularly receive requests from solicitors asking for record disclosure. The practitioner should ask that these requests be in writing. They should also ascertain for whom is the solicitor acting, why he is seeking information and exactly what information he requires. Disclosure should take place only with the written informed consent of the patient, which should be provided by the solicitor.

The doctor has a duty of confidentiality, even after the death of his patient and information should not be disclosed to any source without the consent of the next of kin or the executors. All non-medical staff should be very conscious of their duty of confidentiality when they become aware of secret information in the course of their everyday duties. In general practice, the particular areas of difficulty are telephone discussions, reception area confidentiality and mail opening. Procedures should be carefully laid down, adhered to rigidly and reviewed regularly.

An area of particular difficulty is the multi-disciplinary case conference. The doctor should, at all times, be acutely aware of his duty to preserve confidentiality. Each case must be judged on its own merits and, if any doubt, the doctor should not disclose confidential information. At all times the doctor should act in the best interests of his patient.

A doctor's duty of confidentiality may be in conflict with the public interest where a patient's fitness to drive is in question. If a doctor has an epileptic patient whose condition is such that he should not drive, the doctor should make his patient aware of this and ask him to contact the DVLA. If the patient refuses, the doctor should inform the patient that if he continues to do so then the doctor must break confidentiality and inform DVLA personally by writing preferably to a medical officer.

The problems of medical confidentiality are seldom clear cut and easy. In general, it is much better to err on the side of safety. Doctors should not hesitate to discuss these matters with their defence organisation.

4.2 RECORDS

Medical records should be legible, dated and signed with the name, and status. However strongly you are tempted, do not write funny, sarcastic or derogatory remarks in the records. Whatever seems amusing at the time will not have the same effect on the judge if you have to read these entries aloud in the Court before going on to explain exactly what you meant!

It is best to avoid abbreviations where possible especially those, which are not generally accepted.

Negative finds (e.g. 'urine - no sugar' or 'no neck stiffness') can be of greater significance in some cases than positive findings. It is therefore important to be aware of the value of making these records. Records should be written up at the time of the examination or ward round when the facts are fresh and clear. Obviously records of actions in an emergency cannot be written at the time but should be entered as soon as practical thereafter.

Do not alter records after a complaint or claim has been made. If you wish to make further comment at this time the addition should be clearly dated and signed.

4.3 COMMUNICATION

Lack of courteous, effective communication between patient and doctor is at the root of many medico-legal complaints and claims. As a senior medical student, you may at times be close to the patient and are most likely to be asked questions. Be kind, courteous and empathic. Patients will forgive many accidents and mistakes, but will not forgive being misled or having requests for information ignored. Beware of automatically telling relatives medical details. Do check with your patient first lest you breach confidentiality.

Good communication with your fellow doctors is very important, especially at hand over and stand-in times. These are danger times and mistakes are often made in identifying patients and passing on information. This, when notes are not subsequently checked, can lead to very serious errors. Take special care at these times. Effective communication with your senior colleagues is equally important. Do not hesitate to seek advice. When in doubt find out. Do not undertake a task you do not feel competent to do, even when asked by a senior colleague. It is far better to explain your misgivings or lack of confidence than make serious mistakes. Do not delegate any of your duties to other students. Equally important is effective courteous communication with your colleagues in other health care professions.

4.4 REQUESTS FOR INVESTIGATIONS

These can be of great medico-legal significance. Clearly it is important to write sufficient clinical details to allow the laboratory doctor or radiologist to make the appropriate examination and report (e.g. if you suspect a foreign body, especially glass, you should state this on the request form). If you are in doubt regarding specimens for the laboratory or appropriate views for x-rays, etc, the relevant consultant's advice should be sought.

In summary, clear legible requests with sufficient clinical details and precise investigations required should prevent subsequent problems.

4.5 PRESCRIBING

This is an area in which you may be involved. Careful legible writing is vital. Decimal points should be avoided, as should abbreviations. Amounts should be written in full (e.g. micrograms, milligrams).

Special care should be taken with calculating and administering paediatric and geriatric doses and generic terms should be used.

4.6 A FEW DOS and DON'TS

- Do realise you are responsible for your acts of omission and commission.
- Do be careful.
- Do be courteous.
- Do seek help.
- Do not always accept others' diagnoses.
- Do not rely on your memory.
- Do not accept tasks beyond your competence or training.
- Do talk to your patients.
- Do phone your defence organisation if problems arise.

5. THE ATTACHMENT

The course is delivered as four eight-week blocks. The teaching consists of one week core teaching jointly with Mental Health, which is held in Aberdeen. Thereafter, students have a seven-week practice attachment, which will be either General Practice or Mental Health.

The attachment in Orkney will be divided between General Practice and the local hospital.

Teaching Dates (Core Week)	Date of Practice Attachment
29/08/11 - 02/09/11	05/09/11 - 21/10/11
24/10/11 - 28/10/11	31/10/11 - 16/12/11
09/01/12 - 13/01/12	16/01/12 - 02/03/12
05/03/12 - 09/03/12	12/03/12 - 27/04/12

It is anticipated that in every block, approximately two thirds of students will specialise in General Practice and one third in Mental Health.

5.1 COURSE CORE TEACHING - WEEK 1

All students will spend the first week of the course involved in core teaching. Eight half-day sessions will be delivered by tutors from both general practice and mental health. The programme is designed to address core issues relevant to both specialities in the remaining seven weeks of the community attachment.

Clinical issues will be explored in a series of five clinical vignettes, each lasting a half-day. For these, the students will be divided into five small groups, each led by a tutor from the relevant disciplines. Students will follow an individual case over time, and will have the opportunity to take part in role-play exercises and group discussion.

Topics for clinical vignettes:

1. Addiction
2. Adolescent eating disorder
3. Somatisation
4. Life crisis / anxiety / depression
5. Dementia

Other sessions:

1. Dealing with aggression and violent patients
2. Occupational health and stress
3. Careers session

Proposed Time-Table for Core Week (this may change)

	Monday	Tuesday	Wednesday	Thursday	Friday
9.30am - 1230pm	Introduction Management of Aggression	Occupational Stress	Careers Session	Clinical Vignette	Clinical Vignette
1.30pm - 4.30pm	Breakaways training sessions 1-3pm & 3.30-5.30pm	Clinical Vignette	Clinical Vignette	Clinical Vignette	Breakaways training sessions 1-3pm & 3.30-5.30pm

Students should use the time in the core week to meet the other students in their geographically related group (Cell group), discuss transport arrangements to the attachment and begin to agree any issues they will want to discuss in their Day Release sessions.

5.2 GENERAL PRACTICE / COMMUNITY ATTACHMENT - WEEKS 2 - 8

5.2.1 CONSULTING

Students should consult in parallel with the tutor, although other arrangements are possible. We would recommend that consultations are at 20 minute intervals for a maximum of 1 hour 40 minutes, plus feedback time (i.e., the student will see five patients during one consulting period). This does not include time to undertake home visits as appropriate. We expect that students will have three or four solo consulting periods per week.

5.2.2 STUDENT SELECTED PRIMARY CARE BASED ACTIVITIES

The aim of this is to enhance the clinical apprenticeship element of Phase IV and all students have one session per week set aside i.e. 7 in total for this part of the curriculum. It is not intended you should try to do everything on the list but aim for seven different activities over the time of your attachment to the Practice or Community.

The following list is not proscriptive although availability to do some of the activities will vary depending on local practice circumstances but equally some practices may be able to offer opportunities out with the list below. Where possible you should be trying to get “hands-on experience” (under supervision!), not just observing one of these professionals at work.

All these activities require planning so it is essential that when you make contact with the practice during your core week in Aberdeen to introduce yourself and find out the arrangements for starting, you discuss this part of the course with your tutor.

These primary care activities could include:

- Community Nurse: Doing a dressing of a leg ulcer/ setting up a syringe driver.
- Health Visitor: Doing a Child Development Assessment.
- Occupational Therapist: Possible topic options might include “washing and dressing practice”, kitchen assessment, transfers, home visits from hospital, making hand splints, wheelchair assessment etc.

- Physiotherapist: Assessment of and instructing a patient in a rehabilitation programme after hip/ knee surgery or injury.
- CMHT: Attendance at Substance abuse clinic/assessment session following a GP referral.
- School Nurse: Health education session in a local school.
- Practice Nurse: Near patient testing e.g. Warfarin Clinic (under very close supervision!)
- Home Care: Helping home care assistant for morning/afternoon or even evening.
- Session with local (health related) voluntary group.
- Community Hospital: Attend MDT meeting (plus any clinical opportunities).
- Nursing Home: Lifting and handling patients, dementia assessment.
- Working with Paramedic crew.
- Community Pharmacist- Making up weekly 'Dosset' boxes, supervision of daily methadone/drug dispensing.

Those students who are based within commuting distance of Aberdeen will be offered a session at the GMED out of hours service. You are expected to attend this session. Students based in more remote and rural practices should be able to attend an out of hours session with their tutor or with one of the other GPs in the practice.

5.2.3 DAY RELEASE

Aims

To provide a supportive environment for students to discuss issues that have been raised in the previous week.

The students will meet weekly with one GP tutor from a geographically related group of up to six students per group (Cell group). One GP tutor in each Cell group will be responsible for coordinating the Day Release programme in their cell. Day Release sessions will take place once per week in Weeks 3 - 7; i.e. five Day Release sessions in one block. There will be no Day Release in the first and last weeks of the GP attachment.

The GP tutor should be the facilitator of these sessions; not the teacher. Students must take responsibility for the content and delivery of these sessions.

To discuss:

1. Random case analysis (RCA)
2. Problem case analysis (PCA)
3. Practice experience
4. Specific prepared topics (which students will be asked to prepare in advance)

Suggested Topics:

There may be others, which are peculiar to a geographical area or practice. Students should organise who will present the topics amongst themselves.

1. Rural GP / community hospitals
2. Prescribing
3. Pre-hospital care

4. Palliative care
5. Evidence based practice
6. Interfaces in healthcare
7. The future of primary care
8. Specific clinical topics such as Abdominal Pain, The Unwell Child, Headache, Tired All The Time, 30 Off His/Her Legs, Low Back Pain, Women's Health Problems, Chest Pain, Addiction, Psychological Problems, Respiratory Illness, Social Problems, Cases With No Apparent Diagnosis.

Proposed time-table for day release

10.00am - 12.30pm	RCA/PCA / practice experiences
12.30pm - 1.30pm	Lunch with group
1.30pm - 4.00pm	Topic discussion

If the student has to travel more than 80 miles from their attachment practice to the Day Release practice they will be entitled to claim overnight accommodation up to a cost of £35 per night.

5.2.4 STUDENT ASSISTANTSHIP IN GENERAL PRACTICE

A new requirement for final year students is a Student Assistantship. Details of this can be found in the GMC document 'Clinical Placements for medical students' pages 12-16 at <http://www.gmc-uk.org/education/undergraduate/8837.asp>

This document is one of four supplementary guidance papers following on from Tomorrow's Doctors (2009).

The purpose of the Assistantship is to help prepare students for practice. As part of the Assistantship students should be fully integrated with clinical team and have a defined role with defined responsibilities.

Students should participate in activities similar to a newly qualified doctor, where possible. Tasks include: clerking, practical procedures, managing acute patients, prioritising, working shifts and OOH, patient paperwork, recommendations for prescribing.

Learning outcomes include:

- complex communication skills, for example breaking bad news
- prioritising a complex workload
- understanding and applying legal and ethical considerations
- understanding the operation of the NHS
- knowledge of prescribing.

In the Phase IV Medical and Surgical attachments the Student Assistantship will be arranged as a formal week, with students carrying a pager and being part of the ward team.

In the General Practice attachment there is no benefit to artificially having a separate week which is badged as the 'Student Assistantship' week. As a Phase IV student you are part of the primary healthcare team for the full seven weeks of your GP attachment and you should record relevant evidence of having achieved Student Assistantship outcomes as part of your Log Diary.

5.2.5 STRUCTURED REFLECTIVE LOG DIARY

All remaining time should be spent by the student on their log diaries and on self-directed learning.

5.2.6 HALF DAY

All students are entitled to one half day per week, which can be agreed to suit both the student and the practice.

5.3 ASSESSMENT

5.3.1 ASSESSMENT REQUIREMENTS

Structured Reflective Log Diary of patient contacts during attachment. The log diary should be completed by 5pm on the last Friday of the attachment. The Diary is located on the MRC site under your timetable. Your diary will be assessed and the CAS mark and feedback given on the MRC site. Late completion, without prior approval, will result in the loss of a full CAS band. Failure to complete the diary on time may also result in your class certificate being withheld. You will receive guidance on the SRLD at the Introductory session in your core week.

Tutors Formative Assessment:

- a) Interim assessment Week 4
- b) Final assessment

The forms for these assessments are included in the Phase IV Assessment booklet.

Both formative assessments should be signed off by the tutor and student.

At the end of your attachment please submit hard copies of these assessment forms to Mrs Ann Christie at the Division of General Practice and Community Medical Education, West Block, Polwarth Building, Aberdeen. You may wish to use recorded delivery and keep a copy for your records.

At least two mini-CEX assessments.

Guidance and forms for the mini-CEX assessments are provided in the Phase IV Assessment booklet. These forms should be returned to Ms Fiona Petrie in the Medical School Office.

If you have any problems with your assessments you must contact Mrs Christie on 01224-437264.

5.3.2 INSTRUCTIONS FOR COMPLETION OF REFLECTIVE LOG DIARY

This is a structured reflective log diary to help you record and learn from your clinical attachment in the General Practice and Community blocks.

There is an introductory section to allow you to identify your learning needs from your attachment. These should then be discussed with your tutor to help identify opportunities to meet your needs.

There is a review section at the end of the log diary to allow you to assess what you have learned from your attachment.

You have to complete **all** sections of the log diary. You can include patients seen with your tutor and do **note** that that one patient may be suitable for inclusion in more than one clinical area. Students who are on a Community placement in Orkney can record cases from either their General Practice or Hospital attachment.

Over your seven week attachment you will see far more than the required number of cases in general practice and/or the community. It is up to you which of these cases you select for inclusion in this log diary.

There is a section for you to outline the practicalities of undertaking an audit in primary care by working through the steps of the Audit Cycle. The topic may be one you are interested in or one your tutor would like carried out. It would be good practice for you to present the results of your audit to your tutor. Your tutor may wish to comment on your audit in your end of block formative assessment. Two example audits can be found at <http://www.abdn.ac.uk/capc/teaching/index.hti> under the Phase IV heading.

There is also a page where you can record evidence of having achieved Student Assistantship outcomes.

These include;

- **CONSULTATION**
Record the number of solo surgeries undertaken; date and number of patients per surgery.
- **PRACTICAL PROCEDURES**
List the procedures undertaken with date.
- **MANAGEMENT OF ACUTE PATIENTS**
Record the types of acute presentations you managed under supervision.
- **PRIORITISING PATIENTS AND TASKS**
Give examples of prioritisations of patients or tasks you undertook under supervision.
- **WORKING OUT OF HOURS AND EXTENDED HOURS**
Record the out of hours sessions and extended hours surgeries you have attended, with dates.
- **PATIENT PAPERWORK**
Give examples of the patient paperwork you undertook under supervision.
- **DRUG PRESCRIBING**
Record details of the prescribing you undertook under supervision.

The purpose of the structured reflective log diary is to help you learn as much as possible from the cases you see. Reflection helps you develop as a clinician, to use knowledge and skills that you have gained to help you when next in a similar circumstance.

True reflection is about what you have personally learned from your clinical contacts with patients. As such, there may be no right or wrong answers but we expect you to demonstrate a deeper understanding and exploration of the issues.

By becoming a reflective learner, you will have the basics for true life-long learning, demonstrating that you can learn from every clinical contact.

As a foundation doctor you must maintain a personal record of educational achievement to describe and record your experiences and to identify strengths and weaknesses. This portfolio should include summaries of feedback from your educational supervisor and significant achievements or difficulties, reflections of educational activity as well as the results of the foundation programme assessments. It will help you as a foundation doctor to demonstrate progression during your foundation training.

Making the most of the log diary during your Phase IV GP/Community attachment will help you develop skills that will be required in developing and maintaining this personal record in your Foundation years.

5.3.3 REFLECTIVE LOG MARKING SCHEDULE

A student will be allocated a CAS mark for their diary based on the following criteria. To be awarded a CAS mark within an individual CAS banding will require that at least two of the descriptors under a particular heading are met.

Outstanding - CAS mark 18-20

1. The log diary consistently demonstrates a level of reflection well beyond that of peers.
2. The diary demonstrates an excellent level of understanding of the complexity of the presentation and management of illness in general practice and the community.
3. The diary has been used as an effective learning tool in all sections.
4. All sections are completed to a very high standard.

Very good - CAS mark 15-17

1. The log diary demonstrates a consistently high level of reflection.
2. The diary demonstrates a very good level of understanding of the complexity of the presentation and management of illness in general practice and the community.
3. The log diary has been used as an effective learning tool most of the time.
4. Most sections are completed to a high standard.

Good - CAS mark 12-14

1. The log diary demonstrates a good level of reflection but not of a consistent standard.
2. The diary demonstrates a reasonable understanding of the complexity of the presentation and management of illness in general practice and the community.
3. The log diary has been used as a learning tool in several sections.
4. Most sections are completed to a reasonable standard.

Poor - CAS mark 9-11

1. The log diary demonstrates some reasonable level of reflection but not of a consistent standard.
2. The diary demonstrates a poor understanding of the complexity of the presentation and management of illness in general practice and the community.
3. The log diary has been used as a learning tool only occasionally.
4. Most sections are completed to a poor standard.

Fail - CAS mark 6-8

1. The log diary demonstrates appropriate reflection very occasionally.
2. The diary demonstrates little understanding of the complexity of the presentation and management of illness in general practice and the community.
3. There is little evidence that the log diary has been used as learning tool.
4. One or two sections are incompletely answered.

Clear Fail - CAS mark 5 or less

1. The log diary demonstrates little or no reflection.
2. The diary demonstrates little or no understanding of the complexity of the presentation and management of illness in general practice and the community.
3. There is no evidence that the log diary has been used as a learning tool.
4. Several sections are incompletely answered.
5. Token submission or no submission at all.

5.4 ATTENDANCE

Full attendance is required at all timetable sessions, in week one and all clinical and day-release sessions in weeks 2 - 8. Unexplained absence may result in the refusal of your class certificate. Consent is required from your tutor and either Dr Foster or Dr Miller whom you should contact in the first instance. Planned absence also requires written authorisation from the Phase IV Co-ordinator. Please contact the Phase IV secretary Miss Fiona Petrie (f.petrie@abdn.ac.uk).

5.5 STUDENT FEEDBACK

We will ask you to submit feedback on your attachment on the final page of your log diary. Feedback is important as it allows us to monitor the quality of the student experience and allows us to address any problems at an early stage.

The feedback we get is taken very seriously and we share this feedback with your tutors. We also give them, in confidence, your provisional CAS marks. This allows them to develop their own assessment skills.

If you have any objections to the sharing of this information with your tutor, please let us know.

If you have any feedback that you do not want shared with your tutor, please contact either Dr Foster or Dr Miller in confidence.

5.6 GENERAL PRACTICE/COMMUNITY PRIZES

Sheila M McLennan Prize

This prize was established in 1995 by a generous endowment from Dr William M McLennan, formerly a general practitioner in Fraserburgh, in memory of his wife Sheila M McLennan. It is awarded to the most distinguished student in the General Practice attachment in Phase III.

Richardson Prize

This prize is named the Richardson Prize after Professor Ian M Richardson, who retired in 1984 and was the founder of the Department of General Practice in 1970. The prize is funded from an endowment bestowed upon the University by the subscription of his friends and colleagues. It is awarded to the best student in clinical General Practice.

Eligibility

Eligibility for these Departmental Prizes is dependent on successful fulfilment of three criteria:

1. For the Sheila M McLennan Prize students will be required to gain an overall Excellent in the Global Assessment rating (Equivalent to a CAS mark of 18 - 20) in their Phase III Community Attachment (General Practice, Public Health and Occupational Medicine) Formative Assessment. If there are two or more students meeting the criteria for this award and whose assessments are equal, those students will be invited to participate in a fifteen-minute oral examination at the end of the relevant academic year.
2. For the Richardson Prize three marks will be considered when allocating the prize. These are:
 - the mark from Phase III Community attachment (General Practice, Public Health and Occupational Medicine) Formative Assessment (20% of the total)
 - the mark from the Phase IV General Practice and Community attachment Structured Reflective Log Diary (40% of the total)
 - the mark from the Mini-CEX assessments during the Phase IV General Practice and Community attachment (40%) of the total.

Students will be required to have undertaken both Phase III Community Block and Phase IV attachments in General Practice/Community in consecutive years.

The top three students according to these criteria will be invited to participate in a fifteen-minute oral examination at the end of the relevant academic year.

These Prizes will then be awarded according to the criteria described for each.

5.7 EXPENSES CLAIMS POLICY FOR CLINICAL ATTACHMENTS - PHASE IV

The policy for student travel and accommodation expenses is published on the Medi-CAL Resource Centre site. Any claims must be in line with this policy.

5.8 STUDENT SUPPORT

Student Support Services is managed by the Head of Student Support Services, Dr Lucy Foley, and consists of two areas specialising in non-academic support for students:

- the University Counselling Service,
- the Student Advice & Support Office

Dr Lucy Foley and her PA, Mrs Brenda Mackie, are located in The Hub, Elphinstone Road, Aberdeen.
Tel: +44 (0)1224-274434 (or +44 (0)1224-273935)
E-mail headofstudent.support@abdn.ac.uk

6. THE PSYCHIATRIC HISTORY AND MENTAL EXAMINATION

Presenting complaints

Distinguish between symptoms (subjective awareness of an altered feeling state that conveys harmful implications for an individual's sense of well being) and signs (objective recognition of changes in an individual's mental or bodily functions that indicate the likely presence of disease).

History of presenting complaints

Determine if the present episode is a new episode, a recurrence of a previous episode, a relapse of a recent episode or, it is not possible to date its onset precisely. Record factors that may have explanatory value, for example recent experience of adversity, physical illness, or dislocation from or disruption of social relationships.

Determine the duration of symptoms, the extent to which these impair activities of daily living (work, sleep, recreation, and social relationships) and factors that relieve or exacerbate their effects.

Social History

Describe fully the current employment status, living group, financial issues, marital status, children etc; drug and alcohol use; smoking.

Current Medication

Dosage, duration, side effects, compliance; prescribed, non-prescribed and illicit

Previous medical history

Record systematically all illnesses that have required medical attention.

Previous psychiatric history

As above, record especially previous psychiatric treatments (drug and non-drug) their duration, extent and effectiveness.

Personal History

a) Family structure

All first-degree relatives (alive or dead) by current age or age at death. Siblings (including deceased) listed by given name, age and relevant medical or psychiatric illnesses. Note educational and occupational attainments of family members.

(b) Childhood

Educational attainments, stability of family life; experience of loss, deprivation, discord and disharmony. Identify overprotective parenting and the presence of neurotic traits in childhood (e.g. bed wetting, stealing only at home, night terrors, school refusal).

(c) Occupational history

List work by dates and reasons for leaving each employment, identify loss of work associated with symptoms or signs of mental illness/impairment or personality disorder.

(d) Psycho-sexual history

Describe current relationship(s) and estimate stability and satisfaction. Identify milestones of sexual development, define sexual preferences, current sexual adjustment and relate these, if appropriate, to current symptoms suggestive of mental illness. Determine family structure and note the extent and value of relationships between family members.

(e) Forensic and financial issues

Determine the extent of involvement with the police, previous convictions and enquire specifically about dangerous behaviours. Be circumspect in the recording of activities that have led to conviction. Estimate current financial burdens.

The Mental State Examination

(a) General health

If indicated identify current symptoms suggestive of impaired physical health.

(b) Disorders of anxiety

Neurotic symptoms.

- **Worries, fears, anxieties**

Distinguish between state and trait anxiety, estimate the comprehensibility of anxiety and the extent to which it appears to limit personal effectiveness.

- **Psychophysiological correlates of anxiety**

Ask about bodily changes when anxious and include blushing, breathlessness, nausea, butterflies, urgency to micturate/defecate, difficulty breathing, palpitations, tremor, paraesthesia, dysphonia, impaired motor co-ordination.

- **Specific phobias**

Identify factors that are likely to provoke anxiety.

- **Panic attacks**

Determine the extent to which attacks of severe anxiety occur and note their precipitants.

(c) Disorders of mood - depression

- **Depression**

Ask about low mood, sadness, pessimistic thinking, low self-esteem and despair. Record depression | as present if these (or related) features are present for more than a few hours.

- **Difficulty in thinking**

Determine the presence of impaired concentration and/or registration.

- **Anergia**

Ask about general level of energy, lack of spontaneity or difficulty initiating action.

- **Libido**

Determine level of interest in sex, frequency of sexual thoughts or activities.

- **Sleep**

Determine time of retirement to bed, delay in falling asleep, time on waking, any episodes of rising from bed. Decide on early morning waking, delayed or broken sleep.

- **Self-blame**

Ask if the patient blames self or others for his/her predicament.

- **View of the future**

Ask appropriately about the future, hopes and plans.

- **Suicidal ideation**
Always ask about feelings of despair, senses that life is not worth living, “better off dead” or thoughts of self-harm.
- **Suicidal intent**
If appropriate, ask about plans to harm oneself, anticipatory actions (writing a note, cancelling newspapers) or actions of deliberate self-harm.
- **Anxiety associated with low mood**
If patient is both depressed and anxious try to establish which began first and the relationship of one to the other.
- **Hypochondriasis**
Ask about bodily sensations and worries about physical health.
- **Reduced appetite**
Ask about interest in the preparation and eating of food.
- **Weight loss**
Try to establish recent history of weight changes and to relate these to changes in appetite.
- **Irritability**
Ask if others find the patient touchy or awkward and seek to relate this to changes in mood.
- **Observed speech**
Record samples of speech and seek to estimate rate and connections between items spoken about. Look for punning, looseness of associations and flight of ideas.
- **Motor behaviour**
Record examples of overactivity, bizarre postures or movements.
- **Judgment**
Question gently to determine the extent to which a depressed patient can correctly judge the relationship between the content of their thoughts and the experience of persistent low mood.

(d) Disorders of mood - elevation

- **Pressure of thought**
Ask if thoughts are ever uncomfortable because they are so fast it is difficult to keep up “as though thinking under pressure”.
- **Grandiose ideation**
Ask about special powers or abilities or even if the patient is ever aware they may be related to someone famous or important.
- **Diminished need to sleep**
- **Overactivity and social intrusiveness**
- **Increased libido and sexual activity**
- **Poor judgment and planning**
Ask about shopping, recent changes of job or investment.

- **Irritability**
Ask if others find the patient touchy or awkward and seek to relate this to changes in mood.
- **Observed speech**
Record samples of speech and seek to estimate rate and connections between items spoken about. Look for punning, looseness of associations and flight of ideas.
- **Motor behaviour**
Record examples of overactivity, bizarre postures or movements.

(e) Disorders of thinking

- **Difficulty in thinking**
Ask if the patient can think clearly or if there is any interference with their thoughts. If positive, explore the explanations offered.
- **Perplexity (delusional mood)**
Ask if things ever seem strange, changed in some special way or even specially arranged. Ask about explanations and determine if unusual or bizarre conclusions have been drawn from otherwise commonplace circumstances.
- **Thought insertion**
Ask if thoughts ever seem strange or unusual and made the patient wonder where they came from. Try not to suggest that such thoughts are placed inside a patient's head by an external agency (thought insertion); instead seek a description of the origin of those thoughts and then ask for an explanation of how this may have arisen. Always try not to suggest a disorder of thinking.
- **Thought broadcasting**
Enquire if it ever seems possible for someone else to be aware of another's thoughts. Ignore suggestions such as "by the expression on my face", but follow up leads like "by telepathy" or descriptions of the sensation that private thoughts are immediately accessible to others. Seek an explanation of how this could arise.
- **Thought withdrawal**
This can be quite difficult to detect and should only be recorded as present if described as the awareness that one's own thoughts are being deliberately removed.
- **Thought blocking**
Although occasionally described clearly "as if there were no thoughts at all" it is so often accompanied by vagueness and uncertainty that it is difficult to record with any certainty.
- **Audible thoughts**
This is different from thought broadcasting but asked about in a similar way. First, determine if thoughts are spoken out aloud inside the patient's head. If so, ask how and when this comes about. If it is immediate and the voice is not recognised as alien, but is so loud and clear that someone standing alongside might hear it, record as present. If the voice occurs some moments after those thoughts, record 'thought echo' as present. These are special types of auditory phenomena and are not auditory hallucinations.

(f) Disturbances of perception

- **Hallucinations (any modality)**

It is essential not to pose leading questioning about hallucinations, especially to suggestible subjects. Initially, ask open-ended questions such as: “do you ever hear or see things that are difficult for you to explain?” If positive ask “can you describe that?” Then, “is that with your eyes (or ears) or is it just in your mind?” When an hallucinatory experience is recalled, record exactly what the patient says, use the patient’s own words and show your reasoning that this is an hallucination and not some other disorder of perception. Lastly, determine the mood state at time of hallucination and judge the likelihood that this experience is ‘mood congruent’ or ‘mood incongruent’.

- **Illusions**

Typically arise in circumstances that allow some perceptual ambiguity. These are clearly located by the patient within his/her own mental processes and not in the external world.

(g) Delusions

These can be various types and are best classified as primary or secondary delusions, or full or partial delusions.

- **Primary delusions**

Can arise in response to a commonplace event that can be shared by others, but from which the patient immediately derives delusional significance. Sometimes termed ‘autochthonous’ delusions. Often it is impossible to identify the source or event that gives rise to a fully formed delusion.

- **Secondary delusions**

Are delusions provided by the patient to support or explain in a logical or quasi-logical manner the origins of their primary delusions or the nature or purpose of hallucinations? These can be systematised.

- **Partial delusions**

Are delusions from which the patients can be temporarily dissuaded by force of argument? To be a full delusion, it must be impossible to talk the patient out of believing it.

- **Asking about delusions**

- **Paranoid delusions**

This is often difficult especially if the patient is suspicious or frightened. Pose open-ended questions such as “are there people about who are not what they seem to be?” “Do you ever feel there are people about who intend to harm you?” “Who do you think would be behind this?” Sometimes it is necessary to prompt an explanation when paranoid ideas are intimated. These usually concern the activities of secret organisations (e.g. Opus Dei, the free masons, communists, terrorist groups) and may involve speculation on secret methods of influence (e.g. telepathy, electronic surveillance).

- **Grandiose delusions**

Usually concern special powers or abilities or ideas of grandiose identity. Sometimes the patient believes entitlement to inheritance or a National Lottery win.

- **Nihilistic delusions**

Are most often congruent with depressed mood. They concern ideas of poverty, disease or guilt.

(h) Cognitive function

- **Orientation**
Test awareness of time, date, day, month, year, place, floor of building, country, region and town.
- **Attention / Concentration**
Recite the months of the year, first forwards and then in reverse.
- **Registration**
Test ability to repeat simple arithmetical calculations, spell five letter words in reverse order.
- **Short-term verbal memory**
Give simple unconnected words to repeat immediately and then after about five minutes distraction.
- **Immediate recall of logical verbal information**
Ask patient to immediately recall your reading of a short (about 100 word) logical account of a related sequence of events containing seven key points.
- **Delayed recall of logical verbal memory**
After five minute distraction, ask patient to relate an account (as in 'immediate recall of logical verbal information' above).
- **Topographical memory**
Ask for a description of a journey between well-known landmarks with which the patient is familiar.
- **Naming of common objects**
- **Praxis: demonstrate use of objects (e.g. scissors, pencil sharpener).**
Follow a three-step sequence of motor commands (e.g. use a piece of paper; address an envelope to oneself). Set simple constructional task with matches.
- **Reasoning**
Test ability to discern differences (e.g. between a desk and a bookcase, river and canal) or similarities (between cabbage and turnip, knife and a razor). Ask patient to describe how to locate a friend (whose address has been lost) in a strange city.
- **Sample of writing**
Ask for a sentence to be written into case record and dated.
- **Memory for designs**
Draw simple figures and ask for a copy first directly and then, after a delay, from memory.

(i) Appearance and behaviour

- **Speech**
Great care should be taken to listen carefully to patients' descriptions of their symptoms. Ask if you can take notes and record samples of speech verbatim. Focus on descriptions of symptoms, always record in a patient's own words any account suggestive of hallucinations or delusions.

- **Motor activity**
Note over or under activity, responses to the interview, interruptions or extraneous events.
- **Self-care**
Record unusual appearance in dress or personal hygiene. Look for evidence of self neglect or injury.

The Physical Examination in Psychiatry

Routine physical examination is commonplace in psychiatry and should be performed on all outpatients with symptoms or signs of physical disease or where any intended therapy may exacerbate pre-existing illness or cause adverse effects (e.g. hypertension). The emphasis in psychiatry is sometimes on the exclusion of certain categories of physical disease (e.g. cerebral disease or hypothyroidism), the stigmata of alcohol or substance abuse, or evidence of self-harm. When a patient is admitted to a psychiatric unit, the physical examination becomes, in addition to the above, an important document of record of the physical condition of the admitted patient.

In this context, it is essential to record precisely the nature, extent and location of any marks (suggestive of injury to the patient) present on admission. Sometimes, it is suggested that injuries arising in hospital were in fact present on admission (or vice versa).

The Differential Diagnosis

A differential diagnosis should always be attempted on completion of psychiatric assessment and development of a formulation. It is probably easiest to consider clinical features within an hierarchical framework and in a stepwise fashion exclude diagnoses in each level beginning with level one, organic conditions, then schizophrenia, paranoid psychoses, manic-depressive illnesses, neurotic illnesses and personality disorders at the lowest level.

The statement of differential diagnosis first excludes a number of higher level diagnoses but cannot readily exclude most lower order diagnoses as these can commonly co-exist with diagnoses from intermediate levels.

Few clinical features in psychiatry are pathognomonic or diagnostic. Most are “suggestive” of a particular diagnosis. Diagnostic statements are made tentatively, subject to the results of further enquiry or follow-up.

The Formulation

When you have completed the psychiatric history and examination of the mental state, you should try to summarise comprehensively what you now know about the patient. The term formulation describes the process of first bringing together a synthesis of main clinical features, secondly, ordering the likely explanations of these features and thirdly indicating the likely course (natural history) of these features if left untreated and, if indicated, their probable response to treatment.

a) The descriptive component

Summarises the main signs and symptoms of mental illness and/or impairment that are of diagnostic importance, the temporal order of their onset and their relationship to social or somatic factors of possible causal significance.

b) The explanatory component

Argues for the best fitting explanation of symptom onset. This includes information about pre-morbid social adjustment and familial factors that convey increased susceptibility to develop symptoms of this type. The results of investigations (diagnostic tests) are included here and support distinctions between diagnostic categories of particular importance when symptoms and/or signs suggestive of organic cerebral disease are present.

c) The prognostic component

Especially when a diagnosis can be confidently reasoned, it is important to indicate the likely course that these clinical features will follow. The effect of various treatments and how these can be combined is relevant here. The risk of continuing psychological disability, diminished attainments and relapses/recurrences of symptoms (re-instatement) and the reduction of these risks should be emphasised. If suicide is a detectable risk this must be mentioned and relevant steps to manage such a risk must be set out.