101 THINGS TO DO WHEN NOT SEEING PATIENTS IN GENERAL PRACTICE

A TEACHER AND STUDENT GUIDE

December 2012

TEACHING & LEARNING MATERIALS FOR STUDENTS IN THE COMMUNITY

These materials have been put together to help improve the experience of students on GP placements. Many practices already have some excellent resources of their own and their own way of ensuring students gain a good learning experience. These are designed to supplement, not replace what you already do. Their use is not compulsory, but we hope that you will find something useful in them. Although primarily aimed at fifth year students, we are happy for you to adapt and use them in earlier years too.

GP supervisors

Most of the materials are in the format of worksheets, designed to promote reflection; to get students thinking and questioning what they see going on in practice. You may wish to

- suggest your student reads through the relevant section before taking part in a particular activity
- work through the questions with your student over coffee
- or simply keep them handy for the student to work through when there is a quiet moment (but be prepared for questions – they are meant to provoke active discussion).

Students

You should find plenty of material in these worksheets that will help you to:

- start a discussion with your GP supervisor or other members of the community team, so that you can learn more about different aspects of their work
- prompt you to read around a topic and build up your background knowledge
- write a reflective entry into their portfolio.

Feedback and suggestions for improvements are always welcome, and if you have materials of your own to contribute we are more than happy to receive them. Contact me, Pip Fisher, the CBME fifth year clinical lead, at pip.fisher@manchester.ac.uk

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The practice population

During your undergraduate training, you should experience of a number of different GP surgeries. With luck you will have a chance to see different populations and communities and to reflect on how this affects the work of the GP.

ACTION: Think about the population of your practice. What is the age sex profile? Ethnicity? Social class? Geographical distribution? Talk to the staff about how this affects the practice workload. Ask the GPs in your practice how much they considered the practice population when they chose to work there. Which population do they find easiest to work with and why?

If you are thinking about your future career, it is worth looking at the range of populations that you might serve as a GP. The highlands and islands of Scotland have a special training programme for GPs who may be a long way from secondary care.

See http://www.nes.scot.nhs.uk/media/570062/general_practice_rural_track_2012.pdf

Other GPs may prefer to find their challenges working with populations in inner city areas of high deprivations; working with people with drug and alcohol problems; caring for a large number of elderly patients in nursing homes in a retirement area; for students (lots of sports injuries, sexual health and stress); or for patients of a particular ethnicity to use their language skills.

The variety that is available within general practice means that there is room for allsorts of different personalities and doctors, and even within a practice patients may choose to consult a particular doctor because they like their “style” of consulting.

ACTION: Try to sit in with different doctors and consider which type of patients are attracted to them and why. Think about the style you are aiming for, whether or not your ultimate goal is to enter general practice.

General practice business and finances – in brief

At the moment there is a huge variety in the structure of practices in the UK. They range from:

All of the doctors are business partners

Most of the doctors are business partners

Just a small number of the doctors are business partners, most are salaried employees

All the doctors are salaried employees to a much larger organisation

Some of the doctors and some of the nurses and managers are business partners

Everyone is part of a social enterprise or community interest company so no-one is a business owner as such

ACTION: Ask the staff in the practice you work in which model applies most closely.

What do they think are the relative advantages and disadvantages of their model?

How are big decisions made about the running of the practice? For example, who made the decision to teach medical students in the practice? Are decisions made by majority vote or do they use powers of veto? Who attends the practice meetings?

Another way to look at relationships within a practice is to look at how the various staff interact with one another. An interesting spotlight on this might be something simple such as the tea and coffee.

Who makes it?

Who pays for it?

And who washes up?

It seems like a very small thing but each practice is different and sometimes it is the small things that show the differences.

Now ask about practice finances. A big difference between working in hospitals and working in General Practice is that GPs tend to be much more aware of the finances. This is NOT because they are more focused on money than their consultant colleagues, it is about how the organisations are structured. Hospitals are similar to the types of practices where everyone is salaried to a big over-arching (and often seemingly distant) employing organisation. As an employee it is easy to complain about management imposing budgetary constraints. If you are a business partner, you are the one making the decisions, so you will see the rationale (and the pain) behind saying “Yes, we can afford to do that” or “No, we can’t”.

ACTION: Ask the partners or practice manager how the practice makes its income. What proportion comes from:

- Hitting targets (QOF, DES, LES, QUIPP, National Patient Survey.... find out what each of these means)
- Simply registering more patients
- Offering more consultations in the day
- Offering consultations in the evenings or at weekends
- Taking medical students (and what does the practice give up in order to do this)
- Private medical reports and solicitors letters
- Other activities (and what are these)?

Remember that you will be making your own careers choices in the near future, so although it should not be the only factor influencing your decision, now is your chance to find out.

ACTION: Be diplomatic when you ask your questions and be aware that not everyone will be happy to talk figures.

What is the take home pay of a partner in this practice?

What is the take home pay of a salaried GP here?

How does this compare to the average GP income across the country?

How does it compare with the newspaper headline figures of £250,000? Why do you think the media pick up these figures?

Of course, pay is only relevant if you also know the working hours, so ask about these too.

ACTION: Be sure to ask the actual hours worked (including additional paperwork and reading at home), not just the surgery opening hours which may be very much less.

Start time

Finish time

Any work at home?

Any out of hours?

Any days off or half days?

Any lunch breaks or are these taken up by paperwork and meetings?

ACTION: Find out about the pay scales for hospital doctors too, again taking into account actual hours worked and additional sources of income from merit awards and private practice.

http://www.hospitaldr.co.uk/features/hospital-doctors-pay-scales-for-20092010

You might want to compare the earnings and hours of a doctor in your practice with those of

A nurse?

A nurse practitioner?

A receptionist?

It used to be said that nurses always complained about their hours (but work fewer than doctors) and doctors always complained about their pay (but earn much more than nurses).... You can decide for yourself whether this still holds true. To some extent your perspective on income depends on your expectations and who you compare yourself to. We all tend to assume that our own background is the norm. We expect to earn at least that much. Anything less than our parental income may feel too little, more may feel great. It is worth looking up the average income for the UK, as a comparator http://news.bbc.co.uk/1/hi/8151355.stm

A final point on practice income and students, which is worth thinking about because of all the rumours that circulate... Practices get paid for having students because they give their time to provide suitable supervision, tutorials, administration, assessments and the like. You can see the payment rates on t he CBME website

http://www.medicine.manchester.ac.uk/cbme/feeguideandinvoicing/financepolicy.pdf

The payments may seem large when you are living on a student budget, BUT ask your practice how much they would have to pay for a locum to cover a 2.5 hour surgery. Now consider how many hours of contact time you have in surgery, adding up all the ten minute discussions of cases (which slows down the rate at which the GP can see patients), induction, tutorials, reading of reports (on SSCs and project options) etc. Time spent with other practice staff, such as the nurse, the manager, the phlebotomist, also has to be paid for. You can decide whether or not the University is adequately re-numerating the practice for the time they spend away from patients, helping you learn. You will probably come to the conclusion that the best practices teach for the love of teaching, not because it pays more than seeing patients.

Looking at the appointment system – time in reception

It is easy to think as a medical student and as a doctor that your sole focus should always be on the patient and their presenting problem, BUT think about your own experiences as a patient or as a patient's relative. What has been done well and what has gone wrong? Very often we hear, "The doctors and nurses were great, but …

I had to wait ages to be seen

my results were missing

I was told I would be sent a follow up appointment, but it never came."

And many more complaints about how the health care system works.

Is this your problem? Well, if you are thinking of becoming a GP partner, it will be, as the practice is your business. You need to keep both patients and staff happy and the practice running efficiently. Even if you are not planning on being a partner, surely you have some duty to speak out if you see the system is not working for patients?[1]. Spending time in reception is just one way in which you can begin to look at how the system works; whether the service is easy to access and staff and patients are happy. In addition to observing in reception, it is worth talking to the reception staff and to the GPs and nurses too, to hear their views.

ACTION: Here are a few questions you may wish to ponder, whilst observing the workings of the appointment system:

What time do patients have to phone in order to get an appointment the same day?

What happens if the patient phones with an urgent problem, but there are no appointments left that day?

Who decides what is urgent?

What clinical training does that person have?

Do you think the appointment system has enough slots available to cope with demand?

What happens if the patient has a complex problem, communication difficulties or several problems to discuss? Do they get the same length consultation?

Do all the GPs run to the same appointment times?

Do all the GPs run on time?

Is the patient demand for all the GPs the same? Which type of patient chooses which type of doctor?

How do colleagues cope with having different consulting patterns and remain on amicable terms?

What strategies might you suggest to help cope with demand?

A few strategies that have been devised to overcome the ever increasing demand for appointments in general practice are listed below.

ACTION: Take some time to think about the pros and cons of the suggestions below and see if you can come up with something new.

- Short "emergency" appointments to deal with immediate book on the day problems. But can you be confident that the patient will not have a hidden agenda?
- Longer appointments to try to deal with more of the patient's problems without requiring return appointments. But longer appointments means fewer appointments available in a given time.
- Telephone appointments to try to deal with those issues that do not need face to face consultations. Are you confident to consult on the phone?
- The doctor phones the patient back before booking the appointment with the appropriate person. What if the patient does not have English as a first language? Or if they have no credit on their mobile?
- Use of different cadres of staff (e.g nurse practitioners, pharmacists, phlebotomists) to reduce demand for doctor time (which is the most expensive). What does this do to continuity for the patient? What does it do to the responses patients give on the national patient survey (which asks about how easy it is to get an appointment with the doctor of your choice)?

Finally it is worth looking at the appointment system from the point of view of the reception staff.

ACTION: Observe the interactions between the reception staff and the patients.

How well do the receptionists know the regulars?

How often do they have to face hostility? How do they handle that? Do they feel supported by their doctors?

What they would like to change if they could.

1 GMC Good Medical Practice Raising & acting on concerns about patient safety (2012) http://www.gmcuk.org/Raising_and_acting_on_concerns_about_patient_safety_FINAL.pdf_47223556.pdf

Consider the hidden potential of the consultation

As you learn and practice your consultation skills, you are likely to be focussing on exploring and managing the patient's presenting complaint. But if you are watching the GPs in your surgeries consult, you will soon realise that they seem to be doing much more than this. The patient, who comes in complaining of a cough, may be advised on home management of a self limiting condition, asked about their marriage problems and gently reminded to have their thyroid function checked. So far in your training you may have concentrated on the Calgary Cambridge model of the consultation, but there are others. One such was described by Stott and Davis, who considered the potential of the consultation in four aspects:

Management of the presenting complaint	**Care of ongoing chronic problems**
Management of care seeking behaviour	**Health education**

Of course the GP has the advantage that they probably know much of the patient's past history already, so it is easier for them to draw other aspects of care into the conversation, but you can use the records to help you in this too – hence the importance of well summarised notes with a clear and easily accessible list of key problems.

ACTION: Observe the GPs in your practice and notice how they manage to juggle between the different aspects of the consultation. Then try using the Stott and Davis model in your own consultations. Considering the care of the patient's ongoing chronic problems is probably a good place to start.

Ask if the patient knows what all their medicines are for.

How often do they have a check up for their blood pressure? Asthma? Arthritis? Depression?

Are they up to date with the blood tests they need?

What has the doctor (or nurse) told them about their condition?

Do they know what to do, or when to seek care, if things seem to be changing (for example their peak flows are dropping or they develop green sputum)?

Using the time you have with the patient in this way is a good method to:

- Revise your own knowledge of prescribing
- Gain an insight into patients' beliefs and level of understanding
- Help educate the patient

ACTION: Look up other models of the consultation and discuss with your supervisor or with any GP STs in the practice which they find useful and why.

Write a template

Many practices now use “templates” or proformas in their chronic disease management. These are reminders to clinicians to ensure that all the key points of explanation to the patient and management of the condition are adequately covered. For example, every time a doctor types in a read code for depo-provera injections for contraception, the computer might ask if they wish to use the template that reminds them to put in a recall due date and to make sure they have discussed all the risks and benefits.

ACTION: If you have not seen any templates in use, or are not sure what they are, ask any of the clinicians in your surgery to show you, the doctors, the nurses or the health care assistants may be using them. Which templates are available in your surgery? Who uses which one most often? Were they written by the surgery or has the practice adopted “off the shelf” versions from elsewhere?

ACTION: Discuss with the staff the pros and cons of using templates. What advantages and disadvantages can you think of? HINT: Which bit of the consultation is missing?

ACTION: Before you explore all the templates available in your surgery, try to write down what you would include in one for some of the more common topics, say management of hypertension, or prescribing the oral contraceptive pill. This is an excellent way to revise your knowledge of a subject. It forces you to pick out what is really important (bio-medically and medico-legally) when giving an explanation to a patient or ensuring adequate follow up and safety netting.

ACTION: Ask the practice team if there are any templates that they think might be useful but have not had time to write yet. Perhaps you could have a go?

If you have done an audit and found an area that the practice needs to improve, writing a template around the management of the issue in question is a good way to help the practice team change their habits, especially if you can set up the computer so that the clinician is reminded to use the template every time they make a read coded entry on that issue.

Repeat Prescribing – thinking about safe systems

Signing repeat prescriptions is something that GPs do every day. We have systems in place to try to reduce the risks.

What are the risks?

Some of the risks of repeat prescribing are common to all prescribing. They include the patient receiving drugs that:

- They are allergic to
- Interact with other drugs they are on
- Give them side effects
- Don't work as well as they might (because the dose is wrong, the dosing regime is wrong or there are better drugs available)
- Aren't taken
- Are no longer needed

Repeat prescribing is possibly even more risky than acute prescribing because it may involve medicines the patient takes for a long time, even for life. The chances of problems may creep up over many years.

ACTION: To make sure you understand a little about the repeat prescribing system in your practice, make sure you can answer the following questions:

How does a patient in this practice ask for repeat prescriptions?

How much medication is given at a time on repeats?

What are the pros and cons of repeat prescriptions that allow the patient to collect their medicines:

Weekly?

Monthly?

Three monthly?

When might the different options be used?

How long can a patient go on collecting repeat prescriptions without being seen by a clinician?

How is this time limit enforced?

Are there any medicines that the practice has special policies to deal with? – hint – think of drugs whose effects need extra careful monitoring or have rare but extremely dangerous side effects.

How can clinicians within the practice recognise if the patient is NOT collecting medicines that they should be taken?

What safety nets would be in place if the doctor prescribed a medicine in a dose that was clearly incorrect?

E.g. Penicillamine instead of penicillin?

Or paracetamol 500mg two tablets qds to a two year old?

Significant Event Analysis around prescribing issues

ACTION: If you have not already learned about significant event analysis (also called critical incident reporting), this would be a good time to do so. Ask the clinicians in your practice to tell you about significant events around prescribing that they have been involved in. What did they learn, and how did it change their practice?

Building up a formulary for prescribing

ACTION: Use the time set aside for repeat prescribing, to build up your own formulary of drugs you are familiar with. Learn about common drugs that are prescribed every day, by picking up one or two repeat prescriptions every day and testing yourself. You should be able to answer the following questions on common drugs:

What class of drug does it belong to?
How does it work (in brief)?
What is it used to treat (indications)?
When should it NOT be used (contraindications and drug interactions)?
What side effects might you be on the look out for as a doctor? And which would you warn the patient about?
When should it be taken? Any special instructions?
What monitoring is needed if it is given long term?

Tip – Ask a practising clinician to help you pick out the IMPORTANT side effects and interactions. The BNF lists so many side effects of most drugs, that it is difficult to see the wood for the trees.

ACTION: Learn more about prescribing by working through modules on these excellent websites:
https://www.medischonderwijs.nl/LRS.Net/login.aspx This is a Dutch site – in English – with lots of learning resources. You will need to create an account using your university email address.

http://www.npc.co.uk/elearning.php This is the national prescribing centre website. It has lots of e-learning modules on specific aspects of prescribing (e.g. prescribing for atrial fibrillation, or on more general issues such as improving concordance with treatment and using patient decision aids).

Drug name and class	Mechanism of Action	What is it prescribed for? (indication)	Contra-indications	Side effects	Any special monitoring needed?	Anything special to tell the patient (e.g. take it at night, report any indigestion…)?

Medication Reviews

As part of repeat prescribing, GPs will undertake regular medication reviews. You will already have thought about the risks and benefits of repeat prescribing.

ACTION: Look at some repeat prescriptions. Think through the processes that the doctor will consider when performing a medication review. You should include some of the following:

- What steps does the GP take to monitor and improve concordance/ adherence?
- What practical steps could be taken for patients whose adherence is poor due to disabilities both physical and cognitive?
- Has all the necessary monitoring been done for the medication prescribed and the conditions being treated?
- How can the practice make collecting the medicines easier for the patient?
- What are the advantages and disadvantages of the local pharmacy taking over medication ordering on behalf of the patient?

ACTION: Think about who else might be involved in a medication review with a patient apart from the GP.

- Find out about the role of the Medicine Management Team
- Think about where the community pharmacist (that is the local chemist) fits in. What are Medication Use Reviews (MURs)?
  See http://www.pcc.nhs.uk/uploads/Pharmacy/january_08/murs_faqs_dec_2007_v1.1.pdf

ACTION: Ask if you can see a few patients and perform a full medication review before they see the GP, then present this to your tutor with the patient present. Contrast this by conducting a medication review without the patient present.

Think about where and how medication reviews could be performed and the advantages and disadvantages of each:

In clinic without the patient present

In clinic with the patient present, either planned or opportunistically

With a third party present eg a family member or nursing staff

In the patients home

In the pharmacy

Acting on Test Results

Dealing with test results is one of the everyday activities in general practice that often seems to go on “behind the scenes”, in that time before the medical students arrive for the day, or when they have been sent away for a long lunch. But it is worth getting involved in, as there is a lot to learn.

ACTION: Sit with your GP tutor as they look at the results. See if you can decide whether the patient needs:

- simple reassurance
- advice
- tablets
- to increase or decrease medication
- more tests in the next few weeks
- repeat tests in a year or longer

At first when you are looking at results you may have some difficulty knowing what to do with all the abnormal. What do you do about a raised monocyte count? What if the potassium is 0.1 above the normal range? How low do neutrophils have to be before we start to worry (and what is it that we worry about?)? Try to predict how y our GP will action the results. And, if you are not sure why a certain decision has been taken, ask.

Notice how even normal results may alter the manner in which a patient is treated. For example, a patient with a normal U&E result who has just started ramipril may need to have the dose increased and the test repeated in a couple of weeks. This means the doctor seeing the results must know *why* the test was taken. It is not enough just to look at the bald figures.

MAKING SURE FOLLOW UP HAPPENS

One big difference between working in a hospital and working in the community is how you ensure follow up of results. For in-patients this is not a problem. You see the results, do the ward round, request more tests or different treatment and the change is made. In the community, there are many more steps involved, because the patient is not there in front of you.

ACTION: Imagine designing a system for testing in the community from scratch.

- How would you arrange for the patient to receive the results?

- Would you rely on the patient to call for the results themselves? It is certainly the cheapest and least time consuming option, but what if they don't call and the result is important, then what happens? Whose responsibility is that? Doctor or patient? Can all patients be relied on to call for their results? What about the elderly? The confused? Or the simply chaotic?
- Could you phone the patient with every test result? What if they are not in? Can you leave an answer-phone message and be sure of confidentiality?
- Would writing to the patient be better? What about the cost to the practice? And can you reassure the patient in the same way in writing as by discussing the result over the phone? Should the letter be personalised to address the concerns of each patient, or standard and therefore quite impersonal (but much quicker to generate)?

Fitness for work notes

During your GP attachment it is almost certain that you will see GPs issuing fitness to work notes , so even though you may have had some teaching in year three on this, now is a good time to revise what you know and to think about how you will handle this in future.

First you need to know the rules around fitness to work notes.

ACTION: Find out who can issue notes and under what circumstances. Useful guides can be found on the Department of Work and Pensions website:

http://www.dwp.gov.uk/docs/fitnote-gp-guide.pdf

http://www.dwp.gov.uk/docs/fitnote-hospital-guide.pdf

It can be quite difficult to estimate how long a patient will take to recover from a particular health problem. It is worth looking at the guidance for post-operative recovery times as when you are a Foundation Doctor you may be asked by patients when they can expect to return to work.

See http://www.rcseng.ac.uk/patient_information/get-well-soon and also

http://www.workingfit.com/Surgery/FitnessSurgery.html

Recovery times for mental health problems, back pain and many medical problems can be very varied so discussions with patient will be much more difficult. Think about how you will negotiate the more tricky situations. What will you say if you think a patient is fit for work, but they think that they are not? Some doctors take the view that if a patient says they are not fit, then they are not fit. Others take a more firm view that work is good for health (as research has shown), so encouraging people to do some work related activity is part of the doctor's role. This approach is closer to that recommended by the DWP, but can generate an uncomfortable consultation.

ACTION: Watch different doctors in practice. Do you see a difference between the approaches used? Notice how long different doctors give off work for different problems. Ask them the reasoning behind their decision. Is it better to give a long sick note so that the patient does not keep on rebooking appointments? Or is it preferable offer only a short sick note and review often approach to give the message that you do expect the patient to be making a speedy recovery?

ACTION: Ask GPs in your surgery for their views on signing patients off sick due to alcohol dependency or drug dependency.

Some patients with addiction problems, chaotic lifestyles or personality disorders would genuinely struggle to stay in paid employment, but you may hear moves by politicians to try to remove benefits from those who politicians think should be able to motivate themselves to change. What do you think would be the consequences of removing benefits from such individuals?

Because the fitness to work note allows doctors to restrict duties, rather than simply signing a patient as totally unfit for any work, you should think about the times when you might use this option.

ACTION: Think about the restrictions you might place on the work of a patient with

- back pain
- epilepsy
- angina
- recent acute coronary syndrome
- insulin dependent diabetes
- recent stress related time off

It is important to take into account the type of work and the workplace conditions for the patient. The DVLA fitness to drive guide might be relevant for those whose job involves driving, for example. Check that you are aware of the rules around epilepsy and acute coronary syndrome in particular as these are the most frequently encountered, but be prepared to look up other cases:
http://www.dft.gov.uk/dvla/medical/ataglance.aspx

Telephone consultations and telephone triage

Many practices now offer patients the chance to talk to the doctor on the telephone. This may be

- as an alternative to a face to face consultation, where advice alone is sufficient without seeing the patient
- prior to a face to face consultation, in order that the GP can decide who in the team is most appropriate for the patient to see

Telephone triage and telephone consultations can be an effective and efficient tool, saving time for both patient and doctor. However, there are some disadvantages too. If the GP ends up seeing the majority of the patients after a telephone discussion, then no time may have been saved, indeed extra time may have been spent duplicating part of the consultation. Use of telephone consultations may be easier for some patient groups than others. Some patients may feel that they are being "fobbed off" if they are offered a telephone rather than a face to face consultation. And the use of the telephone may alter the GPs ability to pick up on the patient's hidden agenda – many problems in general practice are not raised as the initial presenting complaint but are only brought into the discussion once the patient feels at ease. They are raised "whilst I am here doctor" but may actually be a key reason for the consultation. Will telephone consultations pick up on these?

ACTION: Make sure you spend time with one of the GPs in your practice, undertaking telephone triage and consultations. This is easy to achieve on telephone systems that have a speaker phone function. Both you and the GP can listen in and talk to the patient.

ACTION: Keep a brief log of the patients for whom you undertake telephone consultations during your first week in general practice, then return to their records later, to see what the final outcome of the consultation was.

ACTION: Write a short reflective piece for your portfolio about the experience. You might like to think about the following points:

- What type of problems was most easily dealt with over the phone?
- Which proved difficult to sort out without a face to face consultation?
- How did it feel doing telephone consultations?
- Did you feel as safe clinically? If not, how did you compensate for this (i.e. what safety nets did you put in place?)

- Can you think of any groups of patients for whom telephone consultations might prove difficult and telephone triage may not be possible?
- What other forms of media might you find yourself using to consult in ten years time? Again think if this will disadvantage any patient groups in terms of access?
- How does the practice deal with issues of confidentiality when using electronic communications with patients?

Referral letters

As a medical student you receive a lot of training in communication skills, but most of the focus tends to be on verbal communication. Considering that much of the communication between primary and secondary care is written, it is worth spending time now considering how to write a good referral letter whether this be from general practice to a hospital specialist or from one specialty to another.

ACTION: Think about what you would like to know about a patient who is attending out-patients for the first time. Write down a list of all the things you feel should be included.

A referral letter should include much of the information you would ask in taking a full history for the first time, not just the presenting complaint. You may think that the specialist can take the history again, so there is little reason to include all the details, but it is surprising how many patients forget to mention issues the doctor might consider important, or are too embarrassed to speak out in the consultation. For example, it is good to give not only a list of current medication, but also an outline of the treatments already tried for the condition. Otherwise the specialist may suggest medication that has already been rejected for one reason or another, and the patient will be no further on.

Social history is important., A fit 27 year old with a supportive family would be expected to manage bowel preparation for a colonoscopy at home, but could a forgetful, frail 78 year old? Or a 43 year old alcoholic? The hospital needs to know if special circumstances should be taken into account.

Don't forget to include relevant past medical history. For example, a patient with acne referred to a dermatologist would not be suitable for isotretinoin treatment if they have a history of depression.

There are also some important differences between a simple history and a referral letter:

Think about including the reason for referral, instead of starting simply "thank you very much for seeing". Do you need to exclude a diagnosis such as cancer? Have you made a diagnosis and now need specialist help to begin treatment, such as when initiating disease modifying drugs for rheumatoid arthritis? Do you think the patient needs assessed for

surgery? Or have you tried (and failed) to reassure the patient and now need a second opinion (but would really like the specialist to back up what you have already said)? You need to be clear in your letter exactly what help you are requesting.

Also remember the importance of letting the specialist know what has been said to the patient? This is particularly important for a two week wait cancer referral, where you may already have begun a difficult discussion with the patient.

Some parts of a patient's history may be automatically included in your referral letter by the practice computer system. This highlights the importance of having a good summary within patients' electronic records, as the computer can only pickup key points if the data is entered correctly in the first place. Ask the GPs you are attached to what the computer template puts into the letter automatically.

ACTION: Look at the referral letters in the records of patients you have seen. Critique them against the standard you consider acceptable. How could they be improved?

ACTION: If you see a patient who has to be referred, have a go at drafting a referral letter and then discuss it with your GP supervisor. How long did it take you?

ACTION: When you return to a hospital placement, you can continue learning about referral letters by looking again at the letters of patients being admitted or being seen in clinic. There is always room for improvement, so try to think how you would have written the letter to be clearer and more complete, whilst still being concise.

What happens to discharge letters?

Once you are a junior doctor you will be asked to write discharge summaries and will progress on to write more detailed discharge letters, or letters from out-patient clinics. Have you ever thought about what happens to those letters? Are they read and then thrown away? Are they filed somewhere for ever? Is just reading the letter enough, or does the GP have to take any actions once they have read the contents?

ACTION: Find out about what happened to in-coming post within the practice.

- How much is received electronically and how much is still on paper?
- If paper, what happens to that paper? Is it saved or scanned and shredded?
- Who in the practice reads the letter? Is it the patient's "own" GP, the referring doctor, the doctor on post duty that day or someone else? What are the advantages and disadvantages of each system?
- How are medication changes made in hospital followed through to make sure that the appropriate change is made on the practice prescribing system?
- How does the practice ensure that new diagnoses are added to the patient's electronic summary or problem list (to ensure that the doctors seeing that patient in future are aware of significant past medical problems, without having to take a full history again)?

ACTION: Look at a few discharge summaries and clinic letters.

- Do they contain all the information you would like to know about that hospital encounter?
- Are handwritten forms legible?
- Are you confident that the hospital doctor was aware of all the medication that the patient was already being prescribed and took that into account in making any changes?
- How long after the hospital encounter did the letter take to arrive at the practice?

Poor communication between primary and secondary care can be a significant risk to patient safety, and is not uncommon. Try to learn from what you see and decide how you will make sure that your communication is good in the future – don't simply copy what you see, aim to be better that the doctors who precede you.

ACTION: Speak to the doctors in the practice and ask them how they think an ideal system for communication between hospitals and practices should work.

Talking to colleagues on the telephone

There will be many times in your career when you need to talk about a patient to a colleague on the telephone. This may be a telephone referral or a request from a senior for advice. In both instances you will want to be able to present your information clearly, in a manner that is easily understood by a colleague who does not have the advantage of seeing the patient themselves. This can be quite a difficult skill to acquire and is one that many FY1 doctors wish they had spent more time practising. During your course you will be taught to use the SBAR model for telephone discussions.

ACTION: If you have not yet been taught SBAR or are feeling in need of a refresher, look it up on the web. Here is a particularly useful site: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html

ACTION: Now think about how you have been presenting your cases to your GP supervisor. Did you use a similar process? Would it have improved your presentations? Try going over each of the patients you saw today and composing a three or four sentence summary that you might have used in a phone call for advice.

ACTION: If you really want to practice asking for telephone advice, ask your supervisor if they would be happy for you to call them over the internal phone system before they come into the room to review your patient.

ACTION: If you or your GP do see a patient who you feel you needs an urgent referral, or who you might manage with advice from a specialist, ask your GP if you can make the call with the phone on speaker phone. You might want to rehearse the conversation with your supervisor first.

ACTION: Find out how long a telephone referral or advice call from general practice takes? How easy is this to fit into a busy surgery or between home visits and lunchtime meetings? Can you think of any ways that primary and secondary care could change how they work to make rapid two way communication easier? Remember that one day you may be managing a practice or a department. Anything you can do to make communication smoother must be beneficial to patients in the long run.

TALKING TO RELATIVES

You are taught a lot during your medical course about talking to the patient, but perhaps not so much about talking to relatives. However in your every day practice, form the moment you begin your foundation jobs, you will find that speaking to families can form a big part of your work load.

ACTION: Think about how talking to relatives differs from talking to the patient themselves. You might want to look at the GMC guidance on confidentiality.

www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp#t2

Because we teach the importance of confidentiality it is easy to think that you simply say nothing in response to families' questions until you have sought the consent of the patient to share the information. But is it always that easy? What about the confused patient? The young teenager? The wife who says her husband asked her to find out...? How will you actually handle the situation in practice? What will you say?

ACTION: Observe the GPs in your practice in action. Notice how often they have to talk to relatives on home visits and how they manage the situation. Do you think they always get it right? Or are there instances when you feel they may be breaching confidentiality? How far does their knowledge of the family situation over the years make a difference to how readily they share information? Ask about times when they know there is a split in the family. How do they deal with information sharing in such instances?

Sometimes the GP may have to agree to take information from a relative, but explain that they cannot give out any information without consent. This happens sometimes when a relative is worried about their family member's mental health and comes to alert the doctor to the problem for example. It can be very frightening for relatives not to know what is going on for a loved one. Often the doctor will try to arrange a joint consultation, for the relative to bring the patient in or to be present during a home visit, but this is not always possible.

ACTION: Discuss with the GPs in your surgery how they feel about these consultations and how they handle them. How acceptable do you think it is for the doctor to talk in hypotheticals? Is it Ok to say " If a patient were to be expressing those thoughts then it might fit with a diagnosis of x....."? Or, in cases where a patient were found to be suffering from x, what we would usually do would be...." ?

ACTION: If your surgery has a population of mixed ethnicity, see if you can notice any differences in the patients' expectations of confidentiality. In some cultures families expect to be told bad news even before, or instead of, the patient. This may not fit with a Western idea of individual autonomy, but would be defended within those communities on the basis that "wisdom comes with age", the family knows the best interest of the patient and too much bad news might depress the patient and make them lose hope. It could be argued that the Western individualised model has come about because of a loss of trust in family and leaves us more isolated in our difficult times. What do you think?

Palliative Care

Over a third of deaths in the UK occur in the patient's own home (if deaths in old people's homes and nursing homes are included). A proportion of these may be sudden and unexpected, but many are planned in accordance with the patient's own wishes. To illustrate this, the number of people dying from cancer in their own home, (30,920 per year on average) exceeds the number dying in hospices (22,228), even when nursing (8,472) and old people's homes (4,430) are excluded. (See http://www.endoflifecare-intelligence.org.uk/resources/publications/variations_in_place_of_death.aspx). This gives the GP a key role in care at the end of life and you should try to use your GP attachment to gain first hand experience of palliative care in the community.

ACTION: If possible try and accompany one of the doctors of nurse on a visit to a palliative care patient. Talk to the health care professionals about what preparations they may have made with a palliative patient, even if the patient is not expected to die in the next few days. If a palliative care meeting is scheduled during your attachment, try to attend with a member of the team.

ACTION: Think about the practical issues that might be faced by a patient, their family and the services providing care when the patient is known to be terminally ill. It is tempting to focus on symptom control such as pain relief, anti-emetics and other drug management, but this alone is not sufficient. Consider aspects such as

- Who discusses where the patient would like to die? Is this documented clearly? What happens if the patient takes a turn for the worse and a doctor is called in the night?
- Does the practice have a record of the next of kin (especially important if the patient lives alone)?
- Do they have a record of who the patient is happy to share information with? And who should be consulted if the patient loses capacity?
- Are adaptations or aids needed in the home?
- Is there any financial assistance available to cover costs such as taxis to hospital appointments (without the delay that slows down receipt of most DSS benefits)?
- Do the family or carers know who to call if and when the patient dies? If this happens in the middle of the night, who will come then? Legally when can the body be removed from the home and to where?
- Who will issue the death certificate (and what will happen if the usual GP is on holiday or off sick)?

ACTION: The practice should have a palliative care register. Find out what is contained in this register and how often the practice updates it. Are all the patients cancer patients?
See http://www.goldstandardsframework.org.uk/GSFOtherSettings/SpecialistPalliativeCare and http://www.mcpcil.org.uk/liverpool-care-pathway/ for guidelines.

ACTION: Have a look at a copy of the form that is sent to the out of hours provider about patients nearing the end of life and consider why this information is shared. Does this raise any issues about confidentiality?

ACTION: Find out what a DS1500 form is, and ask your GP how the topic of filling in this form is broached with the patient.

Dealing with Deaths in General Practice

35 per cent of people die at home or in a care home in the community (National Audit Office, 2008). So your general practice attachment provides you with a good opportunity to learn about completing a Death Certificate.

ACTION: Ask to accompany the GP if a death occurs whilst you are attached to the practice (provided the GP feels this would be appropriate for the relatives of the deceased).

The GP may:

- Go out to the home to confirm death (although this may be done by nursing staff in a nursing home, or by paramedics if they are called)
- Visit the family to offer support and condolences
- Complete the Medical Cause of Death Certificate, which the family then take to the Registry Office.
- View the body at the undertaker's if a cremation form is to be completed

Note that the "Medical Cause of Death Certificate" is not the confirmation of death, rather a judgement of the cause. If you cannot be certain of the cause, or if there is a likelihood that there will be legal questions asked in future, then you cannot sign the death certificate without discussion with the coroner.

ACTION: Read up on the rules around death certification:

http://student.bmj.com/student/view-article.html?id=sbmj.b1570

And learn more about the work of the coroner:

http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/corbur/coron02.htm

You may be surprised to learn that you do not have to see the the body to sign the death certificate.

ACTION: Ask if you can see the practice's book of death certificates. This is a tear out book with a stub that allows the GP to keep a brief copy of what is written. What is the commonest cause of death certified in the community? Why do you think this is? Do the GPs in your practice ever put smoking as a cause of death? What are their views on this?

The time after a death has occurred in a family can be a very busy and a very stressful one. Friends and distant family members have to be informed; perhaps a note in the paper; the funeral

arrangements have to be made; the death certificate has to be taken to the registry office; the will has to be read and the financial affairs of the deceased person dealt with, including closing bank accounts and informing pensions and welfare benefits providers. And all of this occurs in a time when those bereaved are feeling low themselves. There is good evidence that the surviving partner has a higher chance of dying in the first year after bereavement[1] therefore the GP may try to provide extra support.

ACTION: Ask how your practice records the death of a close family member in the patient's records.

1 P Martikainen and T Valkonen (1996) Mortality after the death of a spouse: rates and causes of death in a large Finnish cohort. Am J Public Health 86(8 Pt 1): 1087–1093.

Cremation forms

Different cultures prefer different methods of dealing with the deceased's body. Currently around 70% of bodies in the UK are cremated, but this may change with societal trends.

ACTION: It is worth talking to people of different backgrounds to find out their views on what should happen to their body when they die. These do not have to be patients, ask your classmates or ask the staff in the practice at coffee break.

The rules around cremation are quite strict to try to prevent a body being burned if there may be legal questions asked about the cause of death later on.

Two doctors (from different practices) must see the body and they must talk to either someone who has nursed the patient in the last illness, or someone who was present at the time of death.

In addition, they must assure themselves that there is no pacemaker fitted. This is because a pacemaker may contain radioactive material that would be harmful if released during cremation.

Prosthetic implants, such as artificial hips, do not have to be removed before cremation. They do not burn to ashes but are removed by a large magnet before the burned remains are pulverised further into the fine ash that relatives may choose to collect after the cremation.

Doctors receive extra payment for signing cremation forms (as it is considered to be outside their normal NHS work. They do not receive extra payment for completing death certificates as this is a legal obligation.

ACTION: Read through the frequently asked questions on

http://www.salford.gov.uk/cremation.htm

to learn more about the actual practice of cremation.

Ethics in practice

You have probably learned the biomedical ethical framework for considering ethical dilemmas, in which you have to weigh up the tensions between:

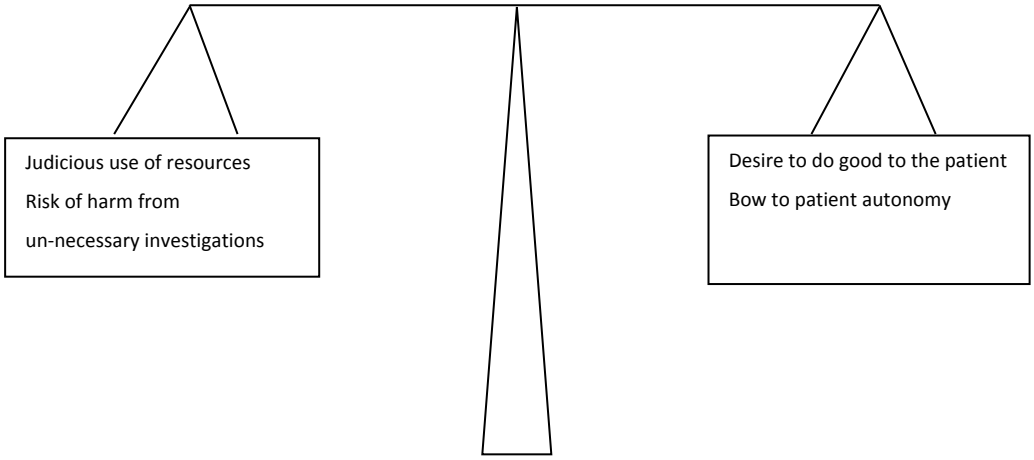
Patient autonomy

Beneficence (doing good)

Non-maleficence (doing no harm)

Justice (thinking of the greater public good).

But sometimes there is danger that our teaching of ethics makes it seem dry and unrelated to every day practice. That is a shame because in the real world even apparently simple consultations often incorporate ethical dilemmas and you are probably seeing and dealing with them every day.



"I wondered if I should have a scan doctor…"

The scales here illustrate the dilemmas involved in deciding on whether or not to send the patient for the test they are requesting. Of course, how much weight you give to each pan in the scale depends on how likely you think it is the scan will find anything that will change your management, any risks you perceive (such as due to repeated exposure to radiation, or the probability of finding a co-incidental abnormality that worries the patient) and even how much the scan costs. How would your decision change if you were working in a fee for service system in which the patient pays to see the doctor and pays for the scan? Even if you would not profit from the scan itself, might sending the patient for a test make you amore popular doctor?

ACTION: Try making a list of all the ethical issues you see in one surgery. Ask your GP supervisor to do the same and then compare lists. You can use the lists as a basis for discussion.

ACTION: There are a number of important medico-legal areas that you must have some familiarity with. Tick off the issues as you learn about them from the list below, then write a brief reflective piece on one or two, outlining your learning points for your portfolio. You could use the key questions that you have been asked to consider during small group teaching sessions as a guide to this. Here they are again as a reminder:

First consider: What do my instincts tell me? What do I feel is right? What am I inclined to do? What am I aware that I might have to do?

Then consider the following questions:

- What are the ethical/legal components of this case?
- Consider the patient, the doctor, the family and society
- What ethical/legal KNOWLEDGE is required?
- What sources of information are needed to resolve this case? Eg support from a clinician, reference to relevant documentation
- What is the currently accepted 'right' answer in the UK?

	Read about it	**Talked about it**	**Seen a case**
Advanced directives			
Deprivation of liberty act			
Lasting powers of attorney			
DVLA rules around driving			
Rationing of treatment on the NHS			
Confidentiality issues			
Gillick/ Fraser competence			
Assessment of capacity and refusal of treatment			
Termination of pregnancy			
Genetic counselling			
Third party in consultation			
Medical errors/ admitting fault			

Professional dilemmas and the GMC

All doctors in Britain have to follow the guidance of the General Medical Council, Good Medical Practice, when faced with decisions that may create a professional or ethical dilemma. The GMC guidance can be found on their website:

http://www.gmc-uk.org/guidance/good_medical_practice.asp

You should know the basics of Good Medical Practice before you begin work as a doctor, and understanding it may help you in achieving a good score in the **situational judgement test** for the Foundation Programme application.

You may find reading through the guidance quite dry, but it is more interesting if you have a particular case that you are trying to deal with and relate it to the situation in front of you.

ACTION: Try doing the interactive case studies on the GMC website.

http://www.gmc-uk.org/guidance/case_studies.asp

These cases bring the guidance to life and outline real situations that you may meet in your own professional life.

Cases that deal with end of life decisions are also available at

http://www.gmc-uk.org/guidance/9166.asp

ACTION: Think about where else you would turn for advice if you had to handle a professional dilemma. Ask your GP supervisor who they ask if they are uncertain of the right thing to do.

ACTION: Some of the free GP papers, such as GP or Pulse, have weekly columns in which different people say what they would do in tricky situations. See if your practice has copies of these papers that you can look at.

Significant event analysis

What is significant event analysis?

Put simply significant event analysis (SEA), sometimes also known as critical incident reporting, means learning from our mistakes. It makes sense that, when something goes wrong, we should look at what happened and see how we could avoid that outcome in future. It helps to improve the service and the evidence shows that, when combined with a swift apology, an assurance that lessons will be learned is often enough to halt complaints from patients.

How do we do it in practice?

Because looking at ourselves critically and admitting our mistakes can be painful, there have to be certain rules around how we manage a significant event analysis in the work-place. The number one rule is that the approach should be "no blame", that is to say we are looking at how the system can be improved, not looking for one individual to point the finger at. For example, if a tired Foundation Year Doctor makes a prescribing mistake whilst trying to juggle several tasks - looking at the bleep, speaking to the radiology department on the phone and writing out the TTOs - it would be easy to blame the doctor. We are all responsible for our own prescribing after all. However, a less accusatory approach might reveal the problem to be one of workload and organisation. If a task requires full concentration, then the doctor needs to be given a quiet workplace and time to achieve the task in hand. Perhaps protected time for TTOs for an hour every morning, during which the Foundation Year doctor is able to sit quietly at a computer station away from the general mele of the ward activities, would reduce the number of prescribing mistakes? Changing the system rather than blaming the individual is likely to achieve a greater improvement overall.

Once we have grasped this approach, doing a significant event analysis simply becomes a question of looking at

- What happened?
- What went well? (this is the Pendleton bit to make us feel comfortable!)
- What went badly? And why did this happen?
- What could be changed to prevent this event happening again?
- Finally, how can the lessons learned be disseminated, so that others can also learn from our mistakes (rather than repeating them).

Ideally the SEA should be done as a team effort, with each different team member able to contribute. In practice often one individual will undertake the SEA then present their findings for

discussion at a team meeting. It takes diplomacy to manage this in a non-confrontational manner that allows everyone to speak and feel comfortable with facing the flaws in the system.

What kind of events would justify a significant event analysis?

The most obvious events to look at are those where a patient (or a staff member) has come to harm. But we should not limit ourselves to only learning from those incidents. There are times when there is almost a calamity – we have a "near miss" and disaster is just avoided. These also offer us a chance to look at how we are working. Don't just breathe out with a sigh of relief. Maybe next time it won't be a near miss it will be a full blown disaster, so think about how you can prevent a recurrence or worse.

A few incidents that you might want to consider for an SEA could include:

- A patient complaint
- An unexpected death – could it have been predicted or avoided?
- A new cancer diagnosis - could it have been diagnosed earlier?
- A suicide or suicide attempt
- A drug error that has been recognised
- A diagnosis delay
- A staffing shortage
- Appointment mix ups
- An in-house accident (such as a slip or injury)

A bigger root cause analysis might look at why a practice has a high DNA (did not attend) rate for a particular clinic. Perhaps the clinic times need changing, patients need reminding closer to the date or the service is not wanted.... This is not a single event but the concept of no blame enquiry is very similar.

ACTION: Speak to the practice you are attached to. Ask them to tell you about recent significant events they have looked into. What types of events do they SEA? What have they learned and what changes have they made recently as a result?

ACTION: Ask if you can look through the records of a patient who may have had a significant event (such as those suggested above) to try and conduct your own mini- SEA and present it back to

the practice. Be careful – you must be aware that the process could potentially be quite threatening to those providing care, so you need to be very diplomatic.

Remember, when you are working as a junior doctor if you see, or are involved in a near miss or a critical incident that almost caused harm, you should use the local SEA protocol to ensure that lessons are learned.

Complaints

It is inevitable that in your working lifetime you will receive a number of complaints. These may be verbal or written, with the latter feeling much more threatening.

Every organisation in the NHS must have in place a policy for handling complaints. There are two aims to any such policy:

1. Firstly, to try and satisfy the complainant by dealing with the complaint locally, and so prevent the additional stress and expense that occurs when complaints go outside the organisation.
2. To try and learn from the complaint to prevent future harm or stress to others.

ACTION: Find out about the practice complaints procedure. What targets do they have in terms of replying to a complainant and investigating a complaint?

ACTION: Ask your GP supervisor or the practice manager if they are willing to discuss the kind of complaints that they have received in the past. How were they dealt with and what was the outcome? Be aware that talking about some complaints can provoke strong emotional reactions, so not everyone will be happy to talk about such issues. In addition the practice will still have a duty of confidentiality to the patient even after the complaint is dealt with.

ACTION: Consider how you will feel after your first complaint? If you have made a serious error you may feel like giving up medicine, but is this a realistic view of your career achievements? If you think the complaint is not justified, how will you feel about continuing to treat the patient who complained?

You might be surprised to hear that you cannot ask a patient to leave the practice list just because that patient has made a complaint against you, but clearly allowing such removals might make patients afraid to put in a legitimate complaint. Continuing to offer high quality care in the face of ongoing complaints can be a considerable challenge to your professionalism.

All doctors should reflect on any complaints received and document them in their annual appraisal folder (akin to your portfolio). If you don't document any complaints year on year, your appraiser may start to disbelieve you. Perhaps you have had no complaints because you don't see enough patients?

Consultations with non-native English speakers

Almost one in eight of us in Britain were not born in this country[1], and this figure is even higher in the North-West. That means that you need to develop your skills in consulting with non-native English speakers. You will need to learn how to use interpreting services, whether they be face to face or over the telephone. And if you already speak a second language fluently perhaps you want to practice consulting in that language? You may well find that at first you feel you are outside your comfort zone.

ACTION: Think about why professional interpreters are important.

What can go wrong if you do not have an interpreter? What problems might you foresee using family or friends to interpret?

ACTION: Read the articles on the following links

You will need to be a member of the BMA to access this one – if you are not a member, you could ask your GP to log in and print it out for you:
https://web.bma.org.uk/nrezine.nsf/wd/ESML-85CED2?OpenDocument&Login&C=15+May+2010

Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. BJOG 2011;118(Suppl. 1):1–203.
Look especially at pages 10 & 11 recommendation number 2:
Available at http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02847.x/pdf

ACTION: Find out the views of the GPs in your surgery on how an interpreter changes the consultation.

How does using an interpreter affect the consultation? Are there situations in which the GP does not use an interpreter? Why? Do you think this is justifiable?

Does your surgery offer telephone consultations with patients who don't speak English (via an interpreter)?

ACTION: Find out how interpreters are booked at your surgery.

Does the surgery use face to face or telephone interpreters or a mixture of the two? Who pays for the service? What advanced notice is required? What happens for telephone consultations?

ACTION: If there are frequent consultations using interpreters in your surgery, ask if you can try taking a history through an interpreter. Alternatively if your GP supervisor speaks a second language with patients ask if they will act as interpreter for you – but be aware it is very difficult to be a neutral interpreter if you have not been trained to do so.Find out how interpreters are booked at your surgery.

Reference

1 Focus on people and migration. Office for National Statistics. 2005 edition. Palgrave Macmillan, Hampshire.

Patients with challenging behaviour

People come in all shapes and sizes. Some are polite, others are less so. When they are stressed or frightened, or if they have had past bad experiences of dealing with services and authority figures, some people can become excessively demanding hostile, confrontational, or down right aggressive.

Disruptive behaviour may include more than simple rudeness or aggression. The patient who repeatedly makes appointments then fails to attend, or turns up very late, may well be issued with a letter regarding their behaviour, as this can upset the smooth running of the surgery. Other patients may make more subtle demands on the practice, such as insisting on un-necessary referrals, or particular (expensive) medications. These can be much harder to confront, as we may worry about the very small chance of missing a rare diagnosis or be afraid to provoke a complaint against the practice.

ACTION: Ask the practice staff which patients they find most difficult to manage and why?

ACTION: If you see a consultation in which the doctor patient relationship seems to go wrong, write a reflection on what happened and how it might have been handled differently.

In handling aggressive or rude patients there is a need to balance:

- The professional and moral obligation to provide care to a stressed patient
- And the need to avoid risk to staff (or other patients) within the practice

It is always important to assess why a patient is behaving as they are. Some medical conditions might provoke abnormal behaviours, for example

- Hypoglycaemia
- Head injury
- Infection in the elderly
- Dementia
- Psychosis

We tend to be less sympathetic to patient with alcohol or drug problems who may become abusive when they are withdrawing or when they are intoxicated, but it is worth remembering that they too may be ill and needing our help

Practices do have the right to ask for a patient to be removed from their list if they feel that the relationship has broken down irretrievably, but (unless there is a high risk of violence or the police have been involved) they must give the patient a reason for removal, and should have issued a

warning to the patient in the last year. Some people with very chaotic lifestyles (often those with substance misuse problems and/or mental health problems) may find themselves repeatedly removed from the lists of different practices. This has been shown to correlate with very poor health outcomes. In some areas one particular practice may agree to take the patients with more challenging behaviour, and may negotiate a higher staffing ratio to allow for this, but often the opening hours of such services are not as good as mainstream practice and the patient may have to travel further.

ACTION: Ask within your practice about removing patients from the list. Who has been removed in the last year or two and why?

ACTION: If you think this is just an issue in the community take a look at the following article as a salutary lesson on why we need to look for the cause of the behaviour, not just at the behaviour itself: http://www.bbc.co.uk/news/uk-england-london-18814487

The frequent attender

When you began to study medicine you may have assumed that all the patients you would see would have a serious physical illness, or diagnosable mental health problem. It often seems that way in PBL, when the vast majority of cases you learn about generate a clear final diagnosis. However, as you progress through the course, and are exposed to the real world, you should begin to realise that life is not so black and white. Some people resist going to the doctor even when they are seriously unwell, others attend so often that they become labelled as "frequent attenders". Frequent attenders may have genuine illnesses (physical or psychological) but be struggling to cope. They may have a high level of anxiety about health related symptoms, or they may be going through a difficult time in their life and need to know there is someone they can turn to for support. GPs are estimated to spend 80% of their clinical time on 20% of their patients (1).

Some frequent attenders do not appear to have diagnosable problems, rather they present with "medically unexplained symptoms". Studies suggest that medically unexplained physical symptoms are present in 19 - 35 % of general practice consultations (2) *and* around half of new out-patient referrals (3). It is important to be alert to psychological problems, and, of course, a very small proportion of people with unexplained symptoms may turn out eventually to have a diagnosable rare condition, but many will escape such definition. We may be doing patients a disservice by continuing to investigate and refer onwards, when the probability of finding a definite pathology is very low as medical investigation and treatment is not without hazard. So it is important to develop skills for caring for people who present with medically unexplained symptoms, in order to protect the patient, the services and yourself.

ACTION: Ask the GPs in your practice about the strategies they use to cope with frequent attenders. How do they balance the risk of missing a significant diagnosis against the need to prevent over-investigation? How do they manage their own responses (both emotional and professional)?

ACTION: Look at the patient's views on reasons for frequent attendance at the doctor.

Hodgson P et al (2005). *Stories from Frequent Attenders: A Qualitative Study in Primary Care*. Ann Fam Med vol. 3 no. 4 318-323. Available at http://annfammed.org/content/3/4/318.full

And read about some ways of helping the patient in Guthrie E (2008) *Medically unexplained symptoms in primary care.* Advances in Psychiatric Treatment vol. 14, 432–440 Availabel at http://apt.rcpsych.org/content/14/6/432.full.pdf

ACTION: Spend some more time reading around this topic on

http://www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh/medicallyunexplainedsymptoms.aspx

References

1) Neal RD et al (1998): Frequency of patients' consulting in general practice and workload generated by frequent attenders: comparisons between practices. *Br J Gen Pract*, 48:895-898.
2) Peveler R et al (1997) 'Medically unexplained physical symptoms in primary care: A comparison of self-report screening questionnaires and clinical opinion', Journal of Psychosomatic Research Volume 42, Issue 3; 245-252
3) Nimnuan C et al (2001) 'Medically Unexplained Symptoms; an epidemiological study in seven specialities', Journal of Psychosomatic Research Vol. 51; 361-7

Intramuscular Injections

The vast majority of IM injections (in the UK at least) are given by nurses, but you may be called on to give them when:

- the nurse is busy
- the patient is in a hurry
- you are working alone in the African bush

So use your time in General Practice to make sure you know how to give them safely.

If you have given an IM injection it is worth logging in your portfolio

- What you gave
- The site you used
- The anatomical landmarks you looked for to be sure you avoided causing damage to important structures nearby
- The important structures you were avoiding
- The gauge of needle you used, and why
- Which length needle you used, and why

Ask the nurse about the rationale for making these choices, for that particular injection.

What other IM injections are given within the practice?

ACTION: Check you know why some injections are given in the buttocks, some in the arm and some in the thigh, and fill in the table below.

Medication			
Site	**Deltoid**	**Lateral thigh**	**Buttock**
Landmarks			
Structures to avoid			
Gauge of needle			
Length of needle			

Skin Complaint Bingo

OBJECTIVES

By playing skin complaint bingo, the student will be able to:

- See, and learn to treat, a wide variety of skin complaints that commonly present in general practice
- Involve the whole clinical team in the learning and teaching of students
- Have a chance to win a small prize

HOW TO PLAY.

Familiarise yourself and the clinical staff in your practice with the table of skin complaints below. Ask them to call you to see any skin lesions or rashes that present whilst you are in the practice. Seeing a rash in real life is much better than reading about it. When you have seen a rash or a lesion, you should

- Make sure you know how to discuss with the patient what it is and how it can be managed
- Also ask the doctor or nurse supervising you to sign and date across the rash or lesion seen.

In each block in year five there will be a prize for the first student to complete a line of five squares. You can claim the prize by scanning in your signed card and e-mailing it to me at pip.fisher@manchester.ac.uk . A line may be vertical, horizontal or diagonal but it must be five squares long.

A larger prize is available to any student completing a FULL HOUSE during their fifth year GP placement – all rashes and lesions on the card signed off.

Even if you do not see all of the lesions on the card, remember to look them up during your placement and learn about how to recognise and how to manage them.

Chickenpox (varicella zoster)	Acne rosacea	Eczema	Impetigo	Lipoma
Psoriasis	Pityriasis versicolor	Viral wart	Abscess	Ring worm (tinea corporis)
Pityriasis rosea	Acne vulgaris	Scabies	Hand, foot and mouth disease	Basal cell carcinoma
Mongolian blue spot	Vitiligo	Athlete's foot (tinea pedis)	Sebaceous cyst	Shingles (herpes zoster)
Leg ulcer	Spider naevi	Slapped cheek disease	Cold sore (herpes simplex)	Fungal toe nails (onychomycosis)

How to do an audit

1. **Choose a topic.**

For your first few audits this may be suggested by your supervisor. Later you may develop your own ideas.

2. **Find out about the topic.**

Read relevant guidelines. Ask about local policy. Discuss with colleagues. Consider what is possible within your workplace.

If you are auditing HIV screening, for example, you need to read the British HIV Association guidelines and also speak to the GPs about what their practice policy for offering HIV testing is. You may decide to rethink your topic if the staff in the practice tell you that they never implement HIV testing guidelines, unless your audit is meant to be a trigger to change and to provide them with a baseline figure. Or perhaps HIV testing is only done by the midwives? In that case you need to find out if you can access the results of blood tests taken by the midwives through the practice computer (this is usually possible but may require additional admin support).

If the practice is offering HIV testing, you will need to know how they record it in the patient's notes. Do they code the offer of a test, or only record a result of tests done? This will affect what you can find out, since you will not know whether people without a test result were not offered a test, or were offered one but declined to be tested. It is important to be clear about this distinction when you discuss your results.

3. **Set your audit criteria.**

You might like to think of this as a question.

Is the practice screening all the at risk population for HIV?

Or more precisely

Do practice records show an offer of HIV testing has been made to all the at risk population?

Note the difference between the two questions. In the second you are being clear that you can only measure a record of a test, it is possible that an offer of testing was made but not recorded – you cannot know this. Also note that setting a suitable question relies on you knowing (from your reading) who the" at risk" population is, and (from your discussions) that you can pick out this population in a computer search.

You should try to narrow your question down to make it easier. Thus instead of saying "all the at risk population" (which would include men who have sex with men, drug users, those from Sub-Saharan Africa, and adults from areas where the prevalence is greater than 2/1000) you might want to focus

on just one group, but you must make sure that your target group are identifiable on the computer. Few practices record and code reliably a patient's sexual preferences for example. One possibility would be

Do practice records show an offer of HIV testing has been made to all patients who have been born in Sub-Saharan Africa?

This question relies on the practice recording country of origin. If that information is not available you may need to think laterally and search on ethnicity, then check the individual records to exclude those born in this country (Black British/ those born to Black African parents). In this instance, children born here are unlikely to be unknowingly infected with HIV as mothers are tested for HIV antenatally in the UK, but children born overseas may be infected by mothers who are unaware that they are HIV positive.

Do practice records show an offer of HIV testing has been made to all Black Africans not born in the UK?

4. **Decide on a suitable standard/target.**

What percentage of patients do you, or the guidelines, think should be achievable? Now you can turn your question into a statement:

The records of 85% of all Black Africans (not born in the UK) should show an offer of an HIV test has been made

Remember that if the practice has not yet done much work on the topic of your audit, it may be more realistic (and kinder) to set a lower audit standard.

5. **Now think about your sample.**

Do you want to go through the records of all the patients born in Sub-Saharan Africa? If this will be a very big population, you may want to sample every third patient, or only look at those registered in the last two years, for example. Now you can be really focused:

The records of 85% of all Black Africans (not born in the UK), who registered with the practice in the last two years, should show an offer of an HIV test has been made

6. **Develop a data table.**

Be sure to collect all the information you will need. Remember that if the audit standards are not being met you will want to think about why not. This may involve asking if different age groups are not being targeted, different sexes, patients attending different members of staff … so you may wish to record the factors you think relevant.

Have your supervisor look at your data collection table before you start as it is easy to do badly and good to be advised by someone with experience.

Although you should try to anticipate the data you want to record there is often something you realise once you have started the audit. A pilot on just a few sets of records is useful. Another good tip is to allow a good sized other comments column in your table. This will allow you to scribble down points you think relevant, for example patient moved away before having a new patient check, or patient already known to be HIV positive…

7. **Collect your data**

You will soon find that different clinicians use the records in slightly different ways with the result that data can be "hidden" indifferent parts of the record or coded in slightly different ways. In the example we have used:

- An HIV test taken in the practice should be found in the microbiology (serology) results
- Patients found to be HIV positive when tested elsewhere are likely to have a code of HIV positive in the problems list or summary

This gives you two places to look, but remember, you want to find out who has been tested, not just who has been found to be positive, so you might also want to:

- Run a search of the journal section of the records to find the term "HIV" in case any negative results from elsewhere have been free texted, and to pick up offers of testing where the patient has declined the test. Ask in the practice if other terms might be useful to search on too, such as "blood-borne virus".
- Find out if you can access blood test results taken in hospital or antenatal clinic via the practice records system (in some areas this is possible).

8. **Analyse your data**

Once you have collected all your data, you can decide whether or not the practice is meeting the target or audit standard. But there is more to analysis than a simple yes or no, remember to look at any trends that might tell you who is being screened and who is often missed. It will be important to consider this in your report as it will influence your recommendations. When looking at HIV testing in our example, you might notice that more women than men have been tested. Think about why this might be.

9. **Make recommendations to improve services in the future.**

Try to be more specific than simply suggesting more education for the team, or the importance of remembering to check in future. How could the system be changed to ensure that patients are not missed in future? Are there alerts or recall systems that could be used? Could you create a template that can be used whenever seeing patients about a particular topic? A template acts like a checklist to remind the clinician to cover all the necessary areas. If you have ideas for change be sure to

discuss the practicalities with your GP supervisor or the practice manager, as they will know what is feasible.

10. Present your work.

You must try to present your audit to the team, so that it can be discussed and your recommendations considered. Audits should not simply be put on the shelf and no action taken to improve the practice.

A good set of headings to use in your presentation (and written report) might be

- Background including literature review – this section tells the audience why the audit was needed – why the topic is important in general and especially so in your practice. Finish this section with your audit criteria and standard.
- Methods – this can be short. Tell the audience about the computerised searches that you ran (which records you looked at and any you excluded).
- Results – try to present data in graphical format not just tables, as this often catches the eye and is more readily understood.
- Discussion – this should contain your analysis of the results. Discuss why you think the standards are not being met (which is usually the case). It is good to also include a brief outline of the weaknesses of your study. If you criticise yourself first, then others might not do so.
- Finally give recommendations for how the practice can change but try to be specific. Just suggesting more education is needed is easy but not necessarily going to change people's habits. Can you make change easier by writing a computer template that could be used? Making a leaflet to give to patients? Suggesting a pop-up that can be added to records to remind clinicians?

It is important to remember your audience when you present your work. Make the presentation relevant to the people you are speaking to. Also remember the importance of diplomacy when you are suggesting a need for improvement and change. It is a good idea to rehearse your presentation with your supervisor before giving it to the practice as a whole so that any wrinkles can be smoothed out beforehand.

11. Close the audit cycle

This step is difficult, especially for students who may only be in the practice for a short time. Ideally, sometime later, the team should repeat the audit that you have carried out to see if your recommended changes have been implemented and made a difference. If not, then they need to think again.

12. Think about submitting your work for presentation at a regional or national level.

If your work carries a message that could be useful to a wider audience,, then perhaps you could submit an abstract to present a poster at a conference?

Turn your audit or project into an abstract for submission

(and gain a point on your Foundation Programme application)

Many practices encourage students to undertake a small audit or piece of project work. You may be able to do this during those "long lunch breaks", or you may do one during a community SSC or PEP. Your project should be something that interests you and is useful to the practice. You might also want to think about whether there is a message that other practices could learn from. If there is, then you have the basis for a presentation at a conference.

Presentations at national or international conferences

- Are good experience for you
- Showcase your work
- Spread the message wider
- Look good on your CV
- Gain you a point on your Foundation Programme application.

Presenting at a conference is not as difficult or daunting as it might sound at first. A poster presentation may in some cases mean you do not even have to stand up and speak formally, or you may speak for just five to ten minutes to an interested audience of 10 – 20 people (who are mostly also presenting their work).

If you are not sure what might be accepted look on the internet for the programme of abstracts for conferences from previous years for ideas, but don't simply repeat what has been done before. There needs to be an element of originality.

Your supervisor may have a good idea of the conferences that might be related to your topic. Check out the rules around which conferences count on the Foundation Programme application before you submit (see the Foundation Programme applicants' handbook). The Royal College of General Practitioner's Annual Conference is often a good one to try. It is held in the early autumn each year, with submissions accepted from around the end of March. You usually hear from the RCGP if your submission has been accepted by the end of August (in time to include in an FP application that year). International conferences overseas may sound attractive but do remember the cost of getting there and consider if you can afford the time away from your course..

How to write an abstract

Watch the word count – write down what you would like to say, then edit, edit, edit to cut out excess words.

Use simple headings such as Background, Methods, Results and Discussion to help structure your piece.

Think about your audience – remember most of your audience do not just want to know how one practice in Greater Manchester is doing – they are more interested in knowing if what you have done would be important in improving their practice

Look out for rules for particular conferences – the RCGP for example ask that the practice and town are not mentioned in the abstract, so that the work can be judged "blind".

Make sure your supervisor checks your abstract before you submit it. Your supervisor should also be a joint author, as they have helped you shape the project and allowed you access to the patients and records.

When submitting your abstract you may be asked which institutions you are affiliated to. You are part of the University of Manchester Medical School, and your supervisor is either part of the University too or part of their GP surgery.

How to design a poster

You don't need to design your poster until you have been advised that your abstract has been accepted. And a good abstract is half way to being a poster already.

Make it eye catching – use pictures or diagrams and avoid big blocks of text. Wordy posters make passers-by keep on walking. You may want to take a photograph yourself to avoid copyright issues.

You MUST state that you are a medical students at the University of Manchester Medical School – remember if you were not part of the medical school you would not have been able to achieve your project. Include a University logo in the top left hand corner of the poster too.

If you would prefer to use a template, contact the department of Community Based Medical Education for the University one which automatically inserts the logo and University colours.

Your supervisor should check your poster before you send it for printing.

A0 portrait is usually the biggest size that can comfortably fit onto a poster board. Landscape posters may have to be slightly smaller, but check with your conference.

Printing the poster in material makes it easy to roll or fold up for carrying and you can iron it (on the reverse, cool setting) if need be to get rid of creases.

The department of Community Based Medical Education can often help with printing, but you need to contact them in two to three weeks in advance to check on this and printing may take up to a week. So get in touch early. Contact them at cbmeposters@manchester.ac.uk

You will need A4 sized copies of your poster as handouts and a clear plastic jacket for them, to stick on the poster board.

It is always a good idea to take a bit of sticky Velcro of your own as some conferences do not provide enough to keep your poster happily on the board (especially if it has been rolled up and curls).

Don't forget

You will need to have permission from your base hospital Dean to attend a conference and will be expected to minimise the time away from your normal activities, so once your abstract is accepted make sure you ask for permission.

Check on the Foundation Programme application website to see if the conference you plan to submit to is likely to gain you a point. Then be sure to follow the guidance on the Foundation Programme application form to the letter. Students have missed points in the past because the evidence they submitted omitted details such as the name of the conference. It is a good idea to save the letter or e-mail that you receive when your abstract is accepted, as you may need to use it as evidence. More guidance is available on Medlea under Academic Achievements and Foundation Applications.

Help with costs

To help you with the costs of attending a conference

- The department of Community Based Medical Education may be able to help you with the printing (but make contact early – your imminent deadline is not our crisis!)
- You may be able to get a £50 bursary towards the cost of attending a conference. More information is available under project option and ssc guidelines on medlea.

For more support and advice on writing and submitting your abstract, contact cbmeposters@manchester.ac.uk

Good luck.