Imperial College London

School of Medicine

## Year 5 — 2012/13

# General Practice
# Primary Health Care
# Oncology and Palliative Care

## Course Guide


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https://education.med.imperial.ac.uk

# General Practice and Primary Health Care, Oncology and Palliative Care
## Year 5 – Course Guide

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# SOLE Questions

GP attachment

Please answer the questions for the GP Attachment. There is an opportunity to comment on any aspects about which you feel strongly at the end of this section.

*Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree / No Response*

- I have developed an understanding of the roles and responsibilities of the primary health care team.
- I progressed from observing consultations to undertaking consultations alone during the attachment.
- Consultation skills were well taught.
- Examination skills were well taught.
- Teaching was pitched at the right level.
- I received sufficient guidance and feedback.
- I had the opportunity to carry out all the clinical procedures listed on the clinical log sheet.
- Overall I am satisfied with this attachment.

If you wish to make further comments about this attachment, in particular if there are any ways you feel that your experience could have been improved, please use the space below.

## GP Teacher

Please answer the questions for the GP Teacher. There is an opportunity to comment on any aspects about which you feel strongly at the end of this section.

**Overall, I am satisfied with this GP teacher.**

*Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree / No Response*

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## GP Departmental Teaching

Please answer the questions for the GP Departmental Teaching. There is an opportunity to comment on any aspects about which you feel strongly at the end of this section.
*Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree / No Response*

- The introductory session lead was an appropriate preparation for the attachment.
- I received sufficient guidance and feedback in the consultation skills session.
- The facilitated discussion of the significant event analysis was a valuable learning experience.
- Overall, I am satisfied with the departmental teaching sessions.

If you wish to make further comments about the departmental teaching and learning opportunities for this attachment (e.g. Introduction, consultation skills teaching and SEA debrief), please use the space below.

# General Practice and Primary Health Care, Oncology and Palliative Care

## Introduction to the course

As part of the ongoing move towards increasingly patient-centred care it is important that healthcare is designed to care for individual patients rather than just the symptoms related to a single disease process. Whilst a doctor or nurse may meet an individual patient for a only few minutes or hours of their particular journey through the system, that patient will experience many different healthcare professionals.

An ideal integrated healthcare system would see a patient move seamlessly through lifestyle advice, screening, disease detection and treatment through to chronic disease management. Often we fall short of these ideals, usually due to poor communication, lack of relevant information, inadequate training, and ill-defined roles within the care pathway.

Oncology and general practice may seem well defined areas of clinical work, however, in practice the patient journey involves multiple contacts in both primary and secondary care. This attachment has been designed in part to enhance the exposure to integrated healthcare through different specialties and stimulate discussion and debate about how medical students of today will create the integrated care pathways of tomorrow.

As part of this attachment it is hoped that you begin to understand that patients do not exist in silos and we, as health care professionals, need to be smarter at working across boundaries. We can strive to be better at communication, working with patient pathways and systematic medicine, listening, and understanding the wider effects of illness and chronic disease on patients, family and society.

We hope you enjoy this attachment and will find it valuable whatever specialty you finally choose.

## Course structure

You will by now have received your GP allocation and details of this can be found on the intranet. You have also been allocated to a group e.g. A1, B4, please make a note of this as you will need it to check your electronic timetable.

The electronic timetable on the intranet will provide details of all your departmental GP sessions, oncology sessions and dates on which you will be expected at your GP attachment. Once at your placement you will be provided with a plan of your activities in the practice.

We expect you to attend all sessions. In the event of illness or unavoidable absence please inform us immediately. If you are due in your general practice you must inform your GP teacher by telephone as soon as possible.

The attachment will begin with an introductory session given jointly by a general practitioner, an oncologist and a palliative care physician. You will be given assessment forms for GPPHC.

On Monday afternoon you will go to your general practice to meet your GP teacher and members of the practice. You will finalise your activities for general practice with your GP teacher.

You will have an Undergraduate Clinical Supervisor (Oncology) who will support you throughout the course and will meet with you each week to review and sign off your clinical activities. Please contact your Supervisor to arrange the first meeting. All details about oncology and palliative care are on the intranet.

# Timetable

**Group A**

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| **Week 1** | Introduction | GP | Oncology | Oncology | Cons skills 1 |
| | GP | GP | Sport | Oncology | Clinical Reasoning |
| **Week 2** | Oncology | GP | Oncology | GP | Oncology |
| | Oncology | GP | Sport | GP | Oncology |
| **Week 3** | Teaching Skills course | | | | |
| **Week 4** | GP | GP | Oncology | Oncology | Oncology |
| | GP | GP | Sport | Oncology | Oncology |
| **Week 5** | GP | GP | Palliative care | Oncology | GP |
| | GP | GP | Sport | Oncology | GP |
| **Week 6** | GP | Oncology | Cons skills 2 | GP | Debrief and SEA |
| | GP | Oncology | Sport | GP | |

**Group B**

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| **Week 1** | Introduction | Oncology | Oncology | GP | Oncology |
| | GP | Oncology | Sport | GP | Oncology |
| **Week 2** | GP | GP | Oncology | Oncology | Cons skills 1 |
| | GP | GP | Sport | Oncology | Clinical Reasoning |
| **Week 3** | Oncology | GP | Palliative care | GP | Oncology |
| | Oncology | GP | Sport | GP | Oncology |
| **Week 4** | GP | Oncology | Oncology | GP | GP |
| | GP | Oncology | Sport | GP | GP |
| **Week 5** | Oncology | GP | Cons skills 2 | GP | Debrief and SEA |
| | Oncology | GP | Sport | GP | |
| **Week 6** | Teaching Skills course | | | | |

# Learning outcomes

### General Practice

By the end of this attachment the students should be able to:

- Practise your communication and consultation skills with real and simulated patients to develop experience in patient-centred care.
- Practise your skills in taking a focused history, making a working diagnosis and agreeing an appropriate shared management plan with the patient.
- Describe the presentation, assessment and basic management of common acute and chronic diseases in primary care.
- Apply a patient-centred ('bio-psycho-social') approach to illness, integrating the physical, psychological and social factors contributing to presentation, disease and management.
- Describe some of the ways in which family/personal relationships affect the presentation, course and management of illness.
- Identify and critically reflect on the impact of ethical issues and personal experience on patient care, including shared decision making and confidentiality.
- Evaluate the role of the general practitioner's continuing relationship with the patient in managing current and on-going problems
- Identify and discuss the role of health promotion and screening interventions in general practice
- Describe the roles and responsibilities of members of the primary health care team and demonstrate an understanding of the importance of the multi-disciplinary team in the delivery of effective health care.
- Experience the difference between primary and secondary care settings in presentation and management of illness. Describe the interface between them, including referral pathways and communication issues.
- Identify a personally significant event. Develop skills in reflecting, analysing and critically appraising them in discussion with a tutor and your student colleagues.

## Primary and Secondary Care Multidisciplinary Working

### Attitudes

- Understand holistic assessment and care, multidisciplinary team working
- Describe the healthcare team involved in delivering primary care, specialist palliative care and oncology
- Demonstrate awareness of the value of inter-professional working between palliative care, oncology and primary care teams.
- Demonstrate ability to analyse effective and ineffective communication: face to face and written, patient health care professional and inter-health care professional
- Discuss the role of charitable and non-governmental organisations involved in cancer care and research

### Skills

- Formulate and analyse a referral letter from primary care to secondary care
- Formulate and analyse a discharge summary from secondary care to primary care
- Explain the principles of sharing difficult news and practise sharing difficult news
- Analyse face-to-face communication between health care professional and patient

## Oncology

### Knowledge and comprehension

### Cancer screening/detection

- Discuss risk factors for cancer development including: prevention programmes, genetic, environmental
- Discuss current NHS cancer screening programmes
- Describe the diagnostic pathway from presentation in primary care to formal diagnosis; including common signs and symptoms and features of cancer presentation
- Demonstrate and understanding of the holistic impact of a diagnosis of cancer; including physical, psychological, spiritual, financial, social
- Describe the issues around cancer survivorship; including physical, psychological, financial, sexual and life style changes
- Discuss the concept of 5 year survival, including follow up care and variations between cancers

### Undergoing treatment for cancer

- Outline the different modalities used in the treatment of cancer; including definition of terms, common treatments for breast, lung, prostate and colon cancer, modes of radiotherapy and chemotherapy
- Describe the pre treatment assessment; including performance status, aims of treatment and informed consent
- Describe the aims of treatment; curative, palliative and its impact on patient quality of life
- List complications of chemotherapy and radiotherapy treatments; common and uncommon, including short and long term
- Describe the common oncology related emergencies and their management

### Clinical Research and Science

- Describe the scientific basis of new drug development and personalised medicine (including phase I-II trials, principles good clinical research, ethical and legal framework, funding: ward, tutorial and SDL)
- 
- Discuss the role of charitable, governmental and industrial, corporate funding of cancer research

## Specialist Palliative care

### Knowledge and comprehension

- Describe the factors contributing to disease trajectory:  early, advanced and terminal phases
- Describe trigger factors for referral to specialist palliative care
- Illustrate the patient's experience of their journey with cancer
- Use holistic assessment to identify palliative care needs in symptom control, emotional, psychological or social domains
- Discuss the role of charitable and non-governmental organisations involved in cancer care and research

# Useful websites and bibliography

### General practice

Stephenson, A. (ed.) *A Textbook of General Practice*. London: Hodder Arnold, 2004.

Fraser, R C. (ed) *Clinical Method: a General Practice approach*. London: Butterworth Heinemann, 1999.

Silverman J, Kurtz S and Draper J. *Skills for Communicating with Patients*. Oxford: Radcliffe Medical Press, 2004. Very comprehensive and reviews all the supporting research evidence.

Tate, P. *The Doctor's Communication Handbook*. Oxford: Radcliffe Medical Press, 5th edn 2006.

Douglas, G, Nicol, F and Robertson, C (eds.) *Macleod's Clinical Examination*, London: Elsevier, 2005.

Hope, T Savulescu J and Hendrick J *Medical Ethics and Law: the core curriculum*, London: Churchill Livingstone, 2008.

Clinical skills intranet site https://education.med.imperial.ac.uk/Skills/Skills.html

### Oncology and Palliative Care

Oxford Handbook of Oncology

Adjuvant Online – program for patients and health professionals to determine benefits from adjuvant therapy
www.adjuvantonline.com

Macmillan Cancer Care and Support – includes a wealth of patient information sheets about specific cancers and its treatment
www.macmillan.org.uk

National Institute of Health website
http://health.nih.gov/category/Cancers

National **Cancer Survivorship** Initiative www.ncsi.org.uk

Office of National Statistics – UK statistics for cancer incidence and survival
www.statistics.gov.uk

ABC of Palliative Care Ed. Marie Fallon Geoffrey Hanks BMJ Books

Palliative Care Formulary PCF3 Ed. Robert Twycross, Andrew Wilcox Palliative drugs.com 2007

Oxford Textbook of Palliative Medicine Ed. Derek Doyle, Geoffrey hanks, Nathan Cherny, Kenneth Calman Oxford University Press 2005

Symptom Management in Advanced Disease Robert Twycross 3rd Edition Radcliffe Medical Press 2003

Care of the dying John Ellershaw Susie Wilkinson Oxford University Press 2003

The Dying Patient Robert Twycross CMF (available Palliative Care Office St Mary's Hospital)

# Contact details

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# General Practice and Primary Health Care

## 1. Introduction

As you may be aware more clinical teaching is happening in general practice. Many patients traditionally managed in hospital are now managed in the community. This attachment is a good opportunity to meet patients both in the surgery and in their homes and to see aspects of illness or disease that you may not have seen before. You will find that you see a wide range of diseases covering most specialties and see aspects of disease you will not have seen before. You will also get the chance to witness the unique relationship your GP has with their patients and the continuity of care they offer to them.

You will have the benefit of working with an experienced GP tutor on a one to one basis which gives you the opportunity to fill any gaps you may have, identify your own particular learning needs, strengths and weaknesses which you can then plan to address jointly with your tutor.

# 2. Coursework and Assessment

**Formative assessment** is feedback, guidance and advice to help you improve in whatever you are doing. It also includes self-assessment when you reflect on your learning and experiences to help you fill in gaps or plan learning for the future.

To help you plan your learning on the attachment you will be asked to complete:

- Personal learning objectives
  A simple list to fill in whenever you find something that you need to know more about. It is worth taking some time to think about what you hope to gain from the attachment and write it down here.
- Clinical log sheet
  Defines the essential activities you need to undertake in the practice. Discuss this with your GP tutor at your introductory session and look at it frequently to ensure you are doing what is expected.
- Consultations competency assessment
  Breaks down the different components of a consultation and allows your GP tutor to assess your competence in each and to give you feedback.

  **Summative assessment** You will be assessed on the various aspects of the course which together will indicate how you have performed and whether you have passed the attachment.

- GP tutor overall assessment
- Patient Project presentation
- Discussion of your written significant event analysis
- Referral letter (written in General Practice, assessed by Oncology)
- Review of a hospital discharge summary (written in Oncology, assessed in General Practice)
- Participation in the consultation skills sessions
- Confidentiality e-module in Medical Ethics and Law on Blackboard
- Satisfactory attendance

**DOPS (Directly Observed Practical Skills)**
You need to ensure that you have observed and signed off for as many skills as possible.

### PART 5 FINALS EXAMINATION

At the end of the year there will be a Practical Assessment of Clinical Examination Skills (PACES) of six stations. These will include scenarios in a General Practice setting covering Paediatrics, Psychiatry and Obstetrics & Gynaecology.

## The Patient Project

### Aims

The Patient Project aims to increase your understanding of patient-centred care in the context of chronic and complex illness. We are also asking you to analyse the patient's care and make constructive suggestions for change. Your GP tutor will identify a suitable patient for you to interview at the patient's home.

The patient project will also be an opportunity to practise your presentation skills and to gain valuable feedback from the practice team. It will hopefully enhance the care of the patient by exploring unmet needs and the wider issues surrounding care pathways and the primary/secondary care interface.

### Content

You are expected to cover:

**Patient's Narrative and journey**

- Take a detailed history from the patient and gain an understanding of how the patient lives with their condition and how they have adapted to a life with chronic illness.
- Describe the patient's journey from symptoms to diagnosis and ongoing care.

**Management**

- Look at the current management and compare this with established protocols/ guidelines.
- Focus on each of the patient's symptoms and try to relate them to their medical problems, treatments, and/or psychosocial factors.

**Needs Assessment**

- Carry out a needs assessment and describe which members of the primary and secondary healthcare team, and which family members and lay professionals meet the patient's needs.
- Describe how these people communicate to ensure optimal patient care.
- Identify any unmet patient needs or an area of care which you feel could be improved.
- Discuss and evaluate possible improvements in patient care, given the available resources. You could look at current practice or local protocols. Some examples of this could be: blood monitoring of cytotoxic medication, referral to community physio/OT, access to urgent appointments/home visits for palliative care patients/ dissemination of information to out of hours services (OOH)/ availability of syringe driver OOH/ home rescue packs etc.

**Ethics and Personal Reflection**

- Consider whether the patient's care raises any ethical issues (for example confidentiality, autonomy, resource allocation or professional ethics). Provide a balanced discussion of the key dilemmas, and consider your own standpoint.
- Reflect on what you have learned from the patient project and how you might use what you have learned in your future career.

**Presentation skills**

- You will be assessed on your presentation style and use of IT.
- All references should be correctly cited.

### Presentation and assessment

Begin thinking about the project in the first week of the attachment. You will be allocated sessions for visiting the patient and preparing your presentation.

Arrange a date to present your project during the final week of your attachment. You should do this at your first meeting in the practice.

The patient project will be assessed as a formative exercise as a Power point presentation to your GP practice, ideally within a regular practice meeting. It should be 10 minutes long, with 10 minutes for discussion. You are free to use any other aids or props that you think will make your talk more engaging. Your GP tutor will give you written and verbal feedback.

If it is not possible to present your project at a practice meeting you should arrange a meeting with your GP tutor and present it to them.

Please bring a printed copy of your Power point presentation (six slides a page) and the feedback sheet to the department on the final day of your attachment.

### Project Prize

The Project judged by the departmental tutor to be best in the year will be put forward for the annual North-West Thames Provost Prize (£100) awarded by the Royal College of General Practitioners.

## Significant Event Analysis

You are asked to write a description of **one** significant event that occurred in the practice. On the final Friday you will be asked to speak about your SEA in a small group with a GP tutor and this will be assessed by the tutor. No visual aids needed.

### What is an SEA?

A Significant Event is any incident that:

- causes you distress or anxiety
- makes you feel proud of your achievements
- makes you question the situation
- exposes a gap in your understanding
- arouses other important thoughts or feelings

Incidents may arise out of your own consultations with patients. Others out of an interaction with your GP tutor or another member of the primary healthcare team. Choose any event significant to you personally.

#### Why do SEAs?

Educational research has shown that SEAs are a valuable learning tool for both students and doctors.

- SEAs help develop a reflective approach in preparation for graduate practice.
- In the context of the busy working lives of doctors, reflection and analysis are commonly neglected, yet they are essential to our further education and development. All doctors are expected to keep records of their experiences for their annual appraisal. The QOF requires GPs to document SEAs and any change occurring as a result.
- SEAs are an excellent way of reflecting on current practice, identifying learning needs and acting on them.
- Virtually every SEA will have an ethical component. The SEAs provide an opportunity to reflect and develop your ethical viewpoint in the light of your experiences
- New developments in education encourage learners to be active participants in the process of learning. SEAs enhance active learning.

Self-evaluation and reflection can be a safety-valve for releasing stress. Writing down SEAs is important as it *forces* you to think and express yourself.

**Writing up an SEA**
This should include

- Patient details (age, sex, ethnic group, etc.)
- Patient description – how did the patient appear to you?
- An account of the scenario / event.

Describe your thoughts and feelings about this event:

- Why was it significant for you?
- What ethical issues did it raise? Explain how these challenged/reinforced/helped you develop your ethical thinking in this area.
- Personal reflections, summary and learning plan (including what skills, knowledge and attitudes you have learnt from this event to apply in the future).

**Reference**
Rughani, A. *The GP's Guide to Personal Development Plans*, London: Radcliffe, 2001.

## A referral letter of a patient

This should be based on a patient whom you have seen either in the surgery or on a home visit who is to be referred to a hospital. The aim is for a concise letter, stating the question to be answered and providing background details. As with the patient project it should be anonymous.

The letter should include the following:

- Details of your GP teacher, name, address, telephone number (usually on headed paper)
- Patient details; initials, age, sex, ethnic background, NHS number, hospital number ( if has one)
- Reason for referral, what question is being asked of the specialist
- Degree of urgency
- Description of clinical problem
- Summary of presenting complaint and examination findings
- Relevant past, psychological, family and social history
- Relevant investigations (including negatives)
- Medication, drug sensitivities
- Accurate reflection of what took place
- What patient has been told and patient's understanding of the problem
- Language and terms the patient can understand,
- Patient is quoted and where suitable, use 'you' to be specific and be sensitive to issues of confidentiality
- Whether an interpreter is required
- Reason for referral, what question is being asked of the specialist?

You should hand this to your GP Tutor for feedback.

**Reference**
Stephenson, A, *A Textbook of General Practice*, page 101, London: Arnold, 2004.

## Review a discharge summary

The aim of this review is to appreciate the importance of communication of information necessary for high-quality multi-disciplinary discharge management and medicines management.

- Compare the discharge summary of a patient on 4 or more medications with the guidelines set out in Section 3 of the Scottish Intercollegiate Guidelines Document No. 128 (http://www.sign.ac.uk/pdf/sign128.pdf). Then carry out a medication review.

- Interview the patient, if possible, to ascertain their understanding of the medication.
- Compare the medication in the discharge summary, in the patient records and in the patient's mind. Consider the reasons for any difference.
- If there has been a change in medication, discover what the patient has done with medication previously prescribed and no longer necessary. (This medication should normally be returned to the local pharmacy.)
- Write a brief summary (200 words) reflecting what you have learned from the exercise. Submit this with the rest of your coursework at the end of the attachment.

**Further reading**

Elwyn G, Forster A, Freeman G, Mind the gap: the risk of adverse events and errors during patient discharge, saferhealthcare, National Patient Safety Agency, 2005.

http://www.saferhealthcare.org.uk/NR/rdonlyres/0FEA9B5F-0D4C-42EE-B5C4-5522473A0C15/0/shcdischargingpatients.pdf

## Write a prescription

Writing a prescription has always been one of the numerous activities which help you to gain experience in your general practice attachments. We want to ensure that you take the opportunity to develop your prescription writing skills. This is to ensure that you:

- develop this essential skill
- reflect on what makes for safe and effective prescribing
- understand the key principles that allow you to give safe, clear and legible instructions to the dispensing pharmacist (a prescription is an instruction to a pharmacist)

It will feature in some of the other attachments of Year 5. It is one of the skills you may be asked to demonstrate in the end of year examinations.

**Why write a GP prescription?**

This is a good question as you are not allowed to write a prescription on a GP or outpatient prescription form until you are a fully registered doctor. However, the opportunity to develop this skill whilst in a one-to-one situation with your GP tutor will help ensure you get it right. A GP script is a blank sheet so you need to think about all the different components necessary for safe prescribing.

You also need to think about prescribing in the wider context of patient management – something you will see from day to day as part of your attachment, but something it is valuable to focus on specifically.

**How to go about it**

1. Background reading and specific instructions. Read chapter 8 (page 137) of *A Textbook of General Practice* by Anne Stephenson (Hodder Arnold 2004 - **2nd edition only**).
   This book is available in the college libraries and many practices have it in their own

libraries. If you are unable to get it from either of these sources please contact Tom Durley (t.durley@imperial.ac.uk) who can send you a digital version.

2. Discuss with your GP how you will go about this:
   - Write your first prescription as a practice exercise
   - Write your second for a real patient

3. Look at what you have written together and compare it to the advice given in the BNF. See the section "Prescription writing" in the first chapter *Guidance on Prescribing*. (this is also available on the BNF website at http://www.bnf.org/bnf/bnf/current/29420.htm)

**Remember: although you may write a real prescription *it can only be signed by your GP tutor* as it is his/her legal responsibility to prescribe. They will of course also have to agree with what you want to prescribe.**

## Medical Ethics and Law

The primary care rotation is part of the vertical integration programme for medical ethics and law. The aim of this programme is to help you apply and integrate your teaching in ethics and law into clinical practice.

During your GP attachment you will be expected to identify and critically reflect on ethical issues raised by individual cases and to incorporate this analysis into your clinical decision making. This will be assessed as part of your patient project. Your ability to discuss ethical issues in your significant event analysis will also be assessed (see next page).

We have created a series of e-modules to help you refresh yourself on the key areas in ethics and law. The e-modules are in the year 5 Ethics and Law area on Blackboard.
They are based on teaching material in Year 2 and 3, so that the content should be familiar to you. There are 6 e-modules:

1. Consent, Capacity and Refusals in Adults
2. Confidentiality
3. Resource allocation
4. Children and the law
5. Abortion and disability
6. The Mental Capacity Act

The e-modules are designed to be used flexibly. Each module has a self-assessment section for you to review your learning and understanding. By the end of Year 5 you should have completed all six modules. During this attachment the **self-assessment section of the confidentiality e-module** is part of your assessment. Please print off your e-module self assessment report and submit it with the rest of your coursework.

# 3. Departmental Sessions

## Consultation skills

**Learning to take a focused history**
You have learnt the skill of clerking a patient by going through a “shopping list” of standard questions

During this attachment you will gain experience of taking a focused history where you focus on areas and certain questions most likely to be of importance in the history. In this approach you use information gained early on to plan further questions. Having obtained a focused history it will allow you to carry out a focused examination of the relevant system.

When you watch senior doctors taking a history they will almost always use this approach as it is both more economical and more effective than the shopping list method you necessarily learn at the beginning of your career. The skill of doing so grows with practice so you should start early. To work it requires good communications skills, clinical judgement and clinical knowledge. It is therefore something that you continue to develop for some years after qualifying.

**The ethical foundation of good communication**
Good consultation skills can be seen as ethics in action. Our respect for individual autonomy, a duty to protect vulnerable individuals and a concern for welfare are reflected in the way we communicate with patients during a consultation. Slides 15–19 of the autonomy and paternalism e-module discuss how respect for autonomy translates into a patient-centred approach and shared decision making.

There are **two consultations skills sessions** in which you will each play the role of a foundation year doctor. The scenarios are based on real patients seen in general practice and played by actors experienced in working with medical students.

You will role play a complete consultation of ten minutes or less, as if in the general practice setting. You will be able to prescribe, refer and follow-up as you think appropriate. You should have encountered many of the problems presented, so apply and integrate your clinical knowledge to the best of your ability.

It is important that you begin to identify skills and attitudes which will facilitate your consulting process, and to gain awareness of the emotional and ethical issues in the consultation and to achieve greater confidence in dealing with them.

**Aim to:** Develop a **patient-centred approach** to the consultation.

- Use an ***open*** question and allow the patient to talk at the beginning: a minute uninterrupted can often save time and allow you to discover what the patient is actually concerned about (the patient’s agenda): it also gives a picture of that person and his or her life. Keep watching so that you do not miss any clues, verbal or visual. The ‘presenting complaint’ may not be the most important to the patient. If you find this out at the beginning it will save time and misunderstanding.

- Explore the patient's health understanding. Ascertain their ideas, concerns and expectations of their state of health.

Remember that each patient is unique. It is important to adopt a flexible approach to your patients such that the advice and management plan is tailored to his or her own health beliefs, values and concerns as well as his/her social and cultural context.

**Aim to**: Prioritise

- If the patient has several items (a 'shopping list') ask the patient what is the most important, urgent matters she/he wishes to discuss, you may feel that other problems are more important – negotiate!

**Aim to:** Close with all ***relevant*** information

- Use ***closed*** questions. Enquire about other parts of the history.

- **Examine** the patient if necessary. When you wish to do this, tell the patient – s/he (actor) will hand you a slip of paper with the findings. Whilst this is not ideal, you should still think about the timing and focus of the examination, the skills you would need, and how you will discuss your findings with the patient.

- **Formulate a working diagnosis**
  Explain the problem to the patient: aim for a shared understanding of the problem and with the patient agree a shared management plan. Be sensitive to how much he/she wishes to be involved. This improves compliance and enhances patients' responsibility for their health. The 'take home message' can then be reinforced by asking the patient to summarise the agreed plan.

  You will have to use your judgment here. Is this something which can 'be sat on" and reviewed or is urgent referral/action required? Remember that the opportunity to review the patient

**Aim to: Summarise** and **clarify** at the end of the consultation

- Time management: make effective use of the consultation:
  You will be given approximately 10 minutes. Not everything can be achieved in one consultation.

The cases are chosen to stretch you and give you an opportunity to practise your consultations skills in a 'safe space'. Remember that mistakes in these situations are learning opportunities without harmful consequences. The patient, GP tutor and your peers will give you feedback – feedback from the actors is particularly useful.

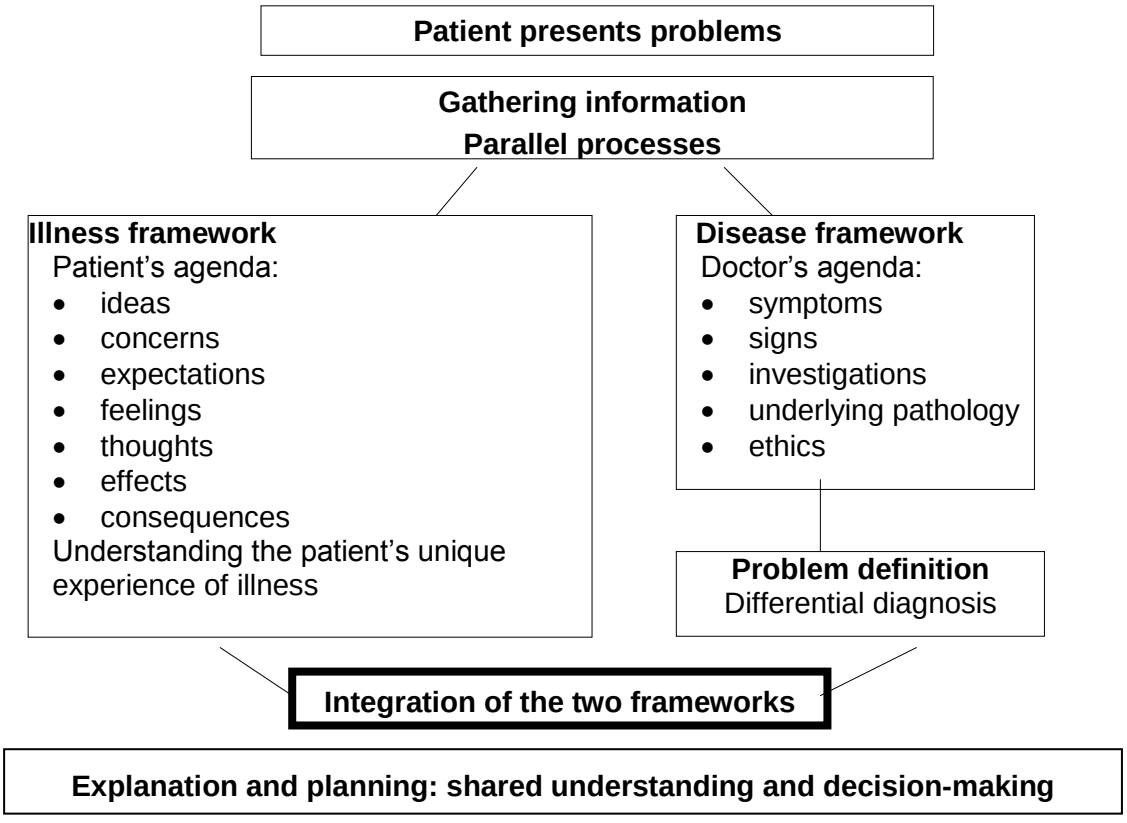


**Figure 1** Patient-Centred Clinical Method: Integrating the medical and patient-specific aspects of the consultation (after Stewart & Roter 1988)

### Giving and receiving feedback

When you return to the room the tutor will ask you to spend a minute reflecting on the consultation in preparation for feedback.

The student who undertook the consultation will have the opportunity to speak first initially concentrating on the positive aspects and then stating any areas of difficulty with which s/he would like specific help.

During the feedback you will have an opportunity to hear the voice of the patient from the actor who will also give constructive suggestions as to how the consultation might have been developed to the benefit of the patient.

The following rules of feedback can help maximise your learning and reduce possible anxiety. Learning to give and receive feedback is important in many other contexts.

### Guidelines for *giving* feedback

1. Start positive there are always good elements!
2. There is no criticism without recommendation: suggest alternative.
3. Be considerate: laughter or other noise can disturb. Remember that you will be having a go too!
4. Be specific and give examples where possible.
5. Keep notes – use the sheets provided (see end of section)
6. Use 'I' and give your experience of what happened'
   (i.e. when you said..., I felt that you were ...', etc.).
7. Ask yourself 'Why am I giving this feedback?' (Is it for you or for the person concerned?)
8. Remember that feedback says a lot about you as well as about the person to whom if is directed.
9. Try to confine negative feedback to things that can be changed, rather than personal attributes.

### Guidelines for *receiving* constructive feedback

1. Listen to it (rather than prepare your response/defence).
2. Ask for it to be repeated if you didn't hear it clearly.
3. Assume it is constructive until proven otherwise; Pause and think before responding.
4. Ask for clarification and examples if statements are unclear or unsupported.
5. Accept it positively (for consideration) rather than dismissively (for self-protection).
6. Ask for suggestions of ways you might modify or change – take opportunities to rehearse.

## Clinical reasoning in general practice

This is on the first (Group A) or second (Group B) Friday afternoon of the attachment. It will be both an informative and stimulating session and focuses on real patient cases. You will deconstruct the diagnostic process and rehearse different techniques.

## Debrief and discussion of significant event analysis

You will be asked to speak about your SEA in a small group with a GP tutor and this will be assessed by the tutor. You do not need to produce any visual aids for this presentation.

## Personal Learning Objectives

| Things I need to learn | What am I going to do about it? | Did I do it?<br>Did it work?<br>Do I need to do anything more? |
|---|---|---|
| | | |
| | | |
| | | |

## Self-rating of knowledge at start of attachment

1 = no knowledge 5 = good knowledge 6 = unable to grade

| Topic | 1 | 2 | 3 | 4 | 5 | | 6 |
|---|---|---|---|---|---|---|---|
| Focused history taking in the consultation | | | | | | | |
| Knowledge of health promotion and screening in primary care: | | | | | | | |
| childhood immunisation | | | | | | | |
| developmental milestones | | | | | | | |
| child abuse and at risk register | | | | | | | |
| cervical cytology screening | | | | | | | |
| lifestyle counseling | | | | | | | |
| STD prevention | | | | | | | |
| smoking cessation | | | | | | | |
| Problems of medication use in the elderly and the issues this raises in communicating between primary and secondary care | | | | | | | |
| Understanding the diagnosis and management of chronic diseases in primary care: | | | | | | | |
| Hypertension | | | | | | | |
| Cardiovascular disease | | | | | | | |
| Diabetes | | | | | | | |
| Asthma | | | | | | | |
| COPD | | | | | | | |
| Knowledge of the roles of the members of the primary health care team | | | | | | | |
| Practice Manager | | | | | | | |
| Receptionist | | | | | | | |
| Nurse Practitioner | | | | | | | |
| Practice nurse | | | | | | | |
| Health care assistant | | | | | | | |
| District nurse | | | | | | | |
| Health visitor | | | | | | | |
| Elderly care link worker | | | | | | | |
| Community midwife | | | | | | | |
| Macmillan nurse | | | | | | | |
| Admiral nurse | | | | | | | |
| CPN | | | | | | | |
| Psychologist | | | | | | | |
| Counsellor | | | | | | | |
| Pharmacist | | | | | | | |
| Social workers | | | | | | | |
| Community care co-ordinator | | | | | | | |
| Home carer | | | | | | | |

## Clinical Log Sheet

It may help to show your GP Teacher this on the first day and during your placement, so that you and your GP teacher can monitor your progress by completing the tick boxes below.
**Please bring to the Department on the final day.**

**Essential practice experience:**

| | |
|---|---|
| Preliminary meeting to set learning objectives/ goals | ❑ |
| Patient identified for project by day 1/2. Arrange one1/2 visits to the patient | ❑ |
| Presentation of the patient project and final debrief (fix the date at the start of the attachment) | ❑ |
| Deciding on an SEA | ❑ |
| Draft a referral letter | ❑ |

**Recommended practice experience:** A range of activities that we hope you will have. What is possible will vary much depending on your needs, your teacher's personal teaching style and practice arrangements

3 surgeries as an observer
8 surgeries involving you consulting:

1–2 student consultations per surgery (observed by teacher). Minimum of 6 during the five weeks

| 1 | 2 | 3 | 4 | 5 | 6+ |
|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

1–2 physical examinations per surgery (observed by teacher). Minimum of 6 during the five weeks

| 1 | 2 | 3 | 4 | 5 | 6+ |
|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Home visits (Minimum of 2)

| 1 | 2 | 3 | 4 | 5 | 6+ |
|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | |
|---|---|
| One session with practice nurse | ❑ |
| One session with health visitor | ❑ |
| One session with district nurse | ❑ |
| Student writing-up time (1-2 sessions) | ❑ |
| Use: | |
| Auroscope | ❑ |
| Ophthalmoscope | ❑ |
| Blood pressures | ❑ |
| Urinalysis | ❑ |

**Additional activities**: These could be used to fill less busy periods

| | |
|---|---|
| Participate in clinics e.g. antenatal, baby, chronic disease (record which below) | ❑ |
| Spend time behind reception and in the waiting room. | ❑ |
| Spend time with computer (with a particular task to complete) | ❑ |
| Visit a pharmacy | ❑ |
| Visit a nursing/residential home | ❑ |
| Attend practice meeting | ❑ |
| Specialist visits e.g. police surgeon, drug dependency unit, domiciliary midwife, undertaker, hospice, school | ❑ |

| | |
|---|---|
| Speak to practice manager | ❑ |
| Attend a PCT meeting | ❑ |
| Attend a postgraduate meeting | ❑ |
| Nurse practitioner | ❑ |
| Skills: | |
| Injections | ❑ |
| Venepuncture | ❑ |
| Using a BM meter to check glucose | ❑ |
| Venesection | ❑ |

## Consultations: competency assessment form

Your GP teacher may find this form useful for giving feedback.

| **Taking a patient-centred history** | |
|---|---|
| • Attempts to elicit the patient's ideas and concerns about the presenting symptoms or illness | Y / N |
| • Explores the patient's presenting problem | Y / N |
| • Determines the patient's expectations of the consultation | Y / N |
| • Evaluates the effect of the illness on the patient's functioning and within the context of their environment (e.g. work, home family and carers) | Y / N |
| • Summarises | Y / N |
| Comment | |

| **Examination** | |
|---|---|
| An examination appropriate for the clinical condition | Y / N |
| Comment | |

| **Defining the clinical problem(s)** (to be assessed by questioning afterwards) | |
|---|---|
| • Makes a credible diagnosis using the information elicited | Y / N |
| • Formulates a three-dimensional diagnosis: | |
| • Physical diagnosis | Y / N |
| • Psychological | Y / N |
| • Social | Y / N |
| Comment | |

| **Management plan** | |
|---|---|
| Student attempts to draw up a shared management plan (according to their stage of learning | Y / N |
| **Comment** | |

What feedback can be given to the student that was good about the consultation?

Overall, how could the consultation be improved?

## Consultations: feedback from patient

Please give this to a patient whom you have seen to gain feedback on your consulting. You may wish to discuss it with your GP teacher.

What did the student do or say that you liked?

Why was that good?

Anything else that worked well?

What else would you have liked from the student?

Why would that have made it better?

Is there anything else you would like to say to the student?

# Directly Observed Procedural Skills (DOPS)

### Skills to be acquired during GPPHC

The following are skills that can best be assessed during your GP attachment. Please ensure that you make time to demonstrate yourself competent in each skill to your GP tutor or a healthcare worker in the practice. Please ask them to use the forms in your DOPS book.

| | |
|---|---|
| **Clinical procedures** | 1. Throat or skin swabs |
| | 2. IM injections |
| | |
| **Therapeutic procedures** | 3. Teach use of MDI |
| | 4. Wound care and dressings |
| | |
| **Near patient testing** | 5. Urinalysis using multistix |
| | 6. Explain how to produce MSU |
| | 7. Perform a dipstick pregnancy test |

# The Multidisciplinary Team

## THE ROLE OF THE GENERAL PRACTITIONER IN PRIMARY HEALTH CARE

The GP is a doctor who provides personal, primary and continuing care to individuals, families and communities in their homes or the surgery, irrespective of age, sex or illness, sometimes over years or decades. He or she will make the initial decision on every problem presented – medical or otherwise

- Around 98% of the population are registered with a GP and there are currently approximately 35,000 GPs in the UK.
- Each GP has an average list of 1,900 patients. There are variations in size due to uneven geographical distribution of doctors, with the largest lists in London, doctors can also exercise choice over list size.
- There is considerable variation between practices in terms of the way they organise themselves, levels of workload, services offered and the nature of the patients who consult them.

Around 700,000 people consult GPs every day, each GP seeing between 25–35 patients.

This means that the GP's work is based on a large number of short consultations. Many of these will be with patients they have seen before, so in some ways it is more accurate to think of consultations in general practice, not so much as isolated episodes, but as single episodes in a continuing relationship.

Although in some areas the population is very mobile around 50% of people have been registered with the same GP for at least 10 years.

## CORE MEMBERS OF THE PHCT – EMPLOYED STAFF

**Practice Manager**
Most practices employ a practice manager to oversee the practice administration including the management of staff, staff recruitment, contracts and appraisal. Managers are usually responsible for the pay and tax and superannuation of all the practice team including the GPs. They oversee the systems in place for the GP Contract & the QOF and liaise with the Primary Care Trust (PCT) and are the first contact for any complaints. They are also responsible for rotas, appointments systems and the care of the premises.

**Receptionist, secretary and clerk**
The receptionists have a challenging task which requires excellent interpersonal skills; they are in the front-line, dealing with a range of queries including; requests for appointments, prescriptions and test results, either face to face or on the phone, with people who may be anxious or unwell. Along with clerks and secretaries they are responsible for looking after the medical records, scanning and filing the enormous amount of correspondence received and keeping paper and computer registers up to date.

**Practice Nurse**
Practice nurses are usually Registered General Nurses who work from the practice treatment room. In larger practices, there may be several Practice Nurses sharing duties and responsibilities.
The employing GP is responsible for the nurses' work and training.

The work of the practice nurse includes: new patient health checks, blood and urine tests, injections, immunisations, dressings, monitoring blood pressure, assisting with minor surgery, syringing ears and sterilising all practice equipment.

With the shift of chronic disease management from secondary to primary care practice nurses are increasingly developing as nurse specialists across a range of chronic diseases and depending on their additional training assist in delivery of care to patients with cardiovascular disease, diabetes and asthma also smoking cessation. Many also undertake family planning and cervical screening clinics.

An increasing number of practices are employing nurse practitioners with training to undertake a broader range of clinical duties which may include diagnosis and management of minor illness. Some nurses are now able to prescribe a small range of medicines from the nurse's formulary.

**Health care assistants**
Many surgeries employ health care assistants (HCAs). They are not trained nurses, but have received some formal training and perform tasks such as venepuncture, dressings, and blood pressure checks, measurement of height & weight and urine testing.

**Elderly care link workers**
Some practices employ "link workers" with responsibility for over 75s screening, they also link old people with services necessary to enable them maintain independent living

**Psychological therapy**
Many practices employ a counsellor to provide psychological support for depressed, anxious and bereaved patients. Although formal qualifications are not required to practise as a counsellor most are trained and all should have regular supervision The British Association of Counselling has recently set up a register for practice counsellors.

Some practices employ clinical psychologists.

**Complementary practitioners**
Other clinical staff may include osteopaths, acupuncturists or chiropractors. These are less likely to be employed by the GP and may sometimes charge.

## ATTACHED STAFF – COMMUNITY NURSES

**District nurse**
District nurses are Registered General Nurses with an additional one year's training. There is approximately one district nurse per 4,000 registered patients. They work predominantly in patients' homes where their tasks include dressing operation sites and ulcers, giving injections and eye drops to the housebound, looking after catheters, pressure sores and syringe drivers etc.

As hospital stays get shorter and chronic serious conditions such as cancer and AIDS are cared for at home the role of the district nurse is expanding, although at least 20% of her time is still spent helping to keep people with leg ulcers comfortable and mobile. District nurses also provide support for carers and may advise other family members on the care an individual needs.

**Health Visitor**
Health Visitors are Registered General Nurses with a one-year specialist training in health education and child development. They have a statutory obligation for visiting all babies on the tenth day after the birth and are responsible for ensuring that s/he

receives regular health supervision and full immunisation as well as undertaking developmental screening. They also offer health education for parents. They see children at home, in the GP surgery or in a Community Child Health Clinic. The health visitor continues to have responsibility for the well being of children until the age of five especially those children considered to be 'at risk'.

**Community midwife**
Midwives are usually General Nurses with least one year's special training. They are involved in ante-natal and post-natal care in patients' homes, community based clinics or the GPs surgery. They have a statutory responsibility to attend all home births (around 1% of all births) and monitor all mothers and babies up till ten days post-partum whether at home or in hospital.

Some areas now have 'domino' schemes for low risk births in special hospital units where Community Midwives provide all the care before, during and after the birth.

**Community Psychiatric Nurse (CPN)**
CPNs are Registered Mental Health Nurses who visit, support and supervise the care of people with mental health problems in the community. These are often patients with psychoses who have been discharged from hospital but they will also take direct referral from GPs to assess patients and provide special support including counselling and behavioural therapy.

They are usually employed by the local psychiatric hospital, Mental Health Trust or Primary Care Trust.

## OTHER ATTACHED MEMBERS OF THE PRIMARY HEALTH CARE TEAM

**Physiotherapist, dieticians, specialist nurses** e.g. diabetic, respiratory, specialist palliative care nurses, Admiral nurses (dementia care) and chiropodists are available to patients in the Community Clinics, the GP surgery or in patient's own home. Access is generally by referral by one of the core members of the PHCT.

**Pharmacist**
The community pharmacist who runs the local dispensing chemist is not strictly speaking a member of the PHCT but s/he provides an enormous amount of primary advice and over-the-counter (OTC) medication as well dispensing the huge quantities of drugs prescribed by doctors.

They will fill dossette boxes for patients to assist with compliance especially helpful for elderly patients. GPs and pharmacists are increasingly seeing the advantages of working closer together for clinical and economic reasons. Some pharmacists perform medication reviews with patients.

**Social Care and Primary Health Care**
Health problems usually impinge on a person's social world – sometimes necessitating specialist advice, support or protection through Social Services.

With increasing numbers of severely mentally ill and elderly people in the community as well as earlier discharges from hospital the demands on social services are high.

**Social Workers** can provide advice, support and counselling for vulnerable people such as the disabled, those with mental health problems and their carers. They also have statutory responsibilities under the Mental Health Act (if a patient requires sectioning) and under the Children Act (if a child is at risk or requires protection).
Occasionally social workers are attached to a GP practice and can make a valuable contribution to the team

**Community Care**: local authority Social Services departments are responsible for assessing the needs of an individual who requires practical support to survive in the community. An assessment for community care can be requested by the patient, the **GP, community nurse or carer**. The assessment must take into account both health and social factors and Social Services must then decide what support is required and whether to provide it directly or invite others in the voluntary, charity or private sector to do so.

**Home Carers** take on domestic responsibilities such as personal care, washing and dressing when for example an elderly person becomes housebound. They can also provide domestic support when a single parent becomes ill. The client is usually required to pay a small contribution.

**Meals-on-wheels and laundry services** are amongst the other support services available to the very needy.

**Voluntary agencies**
A variety of organisations provide help for individuals with specific conditions. For example the British Diabetic Association organises holidays for diabetic children and the Eczema Society awards grants for special clothing. Others, such as Alcoholics Anonymous, Body Positive and the MS Society, focus on self-help groups and mutual support for sufferers and carers. Age concern volunteers support the elderly and in some areas provide a bathing service. The overall contribution of these bodies to health and social care is considerable and growing.

# Oncology and Palliative Care

## 1. Introduction

Oncology is a broad subject and it will not be possible to cover all aspects comprehensively within your 5 week attachment. It is important that you gain exposure to the treatment of some common cancers and an understanding of the patient pathway from presentation to diagnosis and treatment and the holistic impact of being diagnosed with cancer. You should also appreciate the different aims of treatment (radical, adjuvant and palliative) and should directly observe cancer therapies including radiotherapy and chemotherapy. In addition, research is a vital component of oncology and there will be opportunities for you to meet research staff (nurses and trial co-ordinators) and patients involved in trials to gain practical experience of clinical research in practice. You will meet Clinical Oncologists and Medical Oncologists and both give systemic therapy to patients, but only the Clinical Oncologists administer radiotherapy. Medical Oncologists have a strong research base and are involved in clinical trials.

This course guide sets out appropriate learning objectives which you should aim to cover through the programme of taught sessions and self-directed learning. Throughout this attachment, you should complete a minimum of six case studies as detailed below. As part of your analysis of these cases, there are a number of questions to assist reflective learning. There is also a list of required clinical experiences which you should complete and ensure that these are signed off at the time of the activity and the completed Clinical Experience Log Sheet (Oncology) is signed by your Undergraduate Clinical Supervisor.

At the beginning of a course in oncology and palliative care some students are apprehensive and may feel ill equipped to talk to patients, many of whom know they are going to die. Patients may ask difficult questions or recount distressing stories of their experiences. Don't be afraid to admit that you don't know the answer to their questions and take the opportunity to learn from this attachment how professionals do or should deal with emotive situations.

Some of you may have had experience of cancer with a member of your family or a friend, and may find aspects of the course difficult. We would like to help and support you and suggest that you discuss this with your supervisor at the first meeting. Dr Katie Urch is also available for help and support throughout the course.

You should aim to meet with your Undergraduate Clinical Supervisor on a weekly basis to discuss your progress and any issues or concerns that you have. These meetings will also allow you to present and discuss your case studies. It is helpful if you print out your timetable so that your Supervisor knows when they will see you in the clinics or wards and to plan your meetings.

Each student will be assigned to core activities; one common cancer clinic; one uncommon cancer clinic; one multidisciplinary meeting; one radiotherapy session and one chemotherapy session.

The inpatient wards are only at the Charing Cross and Chelsea and Westminster Hospitals. If you do not have a scheduled session, go to the wards to see patients. Introduce yourself to the senior nurse and the junior doctor and ask for the names of patients you could see. At Charing Cross, you can attend the Patient Board Round which is held each day at 0900 hours in the Treatment Room on 6 North and you could also be allocated patients from this meeting.

## Radiotherapy Session

The aim of the radiotherapy session is to observe the journey the patient makes through CT pre-treatment assessment, planning and treatment, and to talk to patients who are undergoing treatment. (Refer to Clinical Case Study 1 in your guide)

It is more comfortable for patients and staff if there is one student only in each area. Students will rotate through the three different areas and spend 45 minutes in each area. Agree this rotation between your group when you arrive and report to the receptionist who will direct you to the different areas. Staff will point you in the direction of the next area and it is your responsibility to move on after 45 minutes.

The Radiotherapy Centre at Charing Cross is located on the ground floor and the main entrance is off St Dunstan's Road. You can also follow the signs from the main corridor in the Laboratory Block.

Morning session 0900 and afternoon session 1400 hours

CT Simulator (AQSim) Ground Floor
Planning First Floor
Linear Accelerator (4 treatment rooms; LA3; LA4; LA5; LA6) Ground Floor

A useful website to access before the visit is: www.nhs.uk/ips
This has been set up to provide information to patients and the Imperial Trust is a Beacon for this initiative.

## Chemotherapy Session

The aim of chemotherapy session is to observe the delivery of chemotherapy and to talk to patients about their experience and pairs of students will have one session at: Charing Cross, St Mary's, Hammersmith or Chelsea and Westminster.

On arrival introduce yourself to the senior nurse and ask if you could be allocated to a patient. There might be an opportunity to talk to a patient or a family member in the waiting room but please be aware of their privacy and confidentiality.

Morning session 0900-1230 and afternoon session 1330-1700 hours

## Multidisciplinary Meetings (MDT)

Each MDT has a co-ordinator who arranges the meetings and takes the notes. We suggest that you introduce yourselves to the co-ordinator who may ask the members to introduce themselves or give you the names of the members.

# 2. Oncology and Palliative Care Learning Objectives

**Knowledge and comprehension**

**1. Cancer screening/detection**

1.1. Discuss risk factors for cancer development including: prevention programmes, genetic, environmental
1.2. Discuss current NHS cancer screening programmes
1.3. Describe the diagnostic pathway from presentation in primary care to formal diagnosis; including common signs and symptoms features of cancer presentation
1.4. Demonstrate and understanding of the holistic impact of a diagnosis of cancer; including physical, psychological, spiritual, financial, social
1.5. Describe the issues around cancer survivorship; including physical, psychological, financial, sexual and life style changes
1.6. Discuss the concept of 5 year survival, including follow up care and variations between cancers

**2. Undergoing treatment for cancer**

2.1. Outline the different modalities used in the treatment of cancer; including definition of terms, common treatments for breast, lung, prostate and colon cancer, modes of radiotherapy and chemotherapy
2.2. Describe the pre treatment assessment; including performance status, aims of treatment and informed consent
2.3. Describe the aims of treatment; curative, palliative and its impact on patient quality of life
2.4. List complications of chemotherapy and radiotherapy treatments; common and uncommon, including short and long term
2.5. Describe the common oncology related emergencies and their management

**3. Clinical Research and Science**

3.1. Describe the scientific basis of new drug development and personalised medicine (including phase I-II trials, principles good clinical research, ethical and legal framework, funding: ward, tutorial and SDL)
3.2. Discuss the role of charitable, governmental and industrial, corporate funding of cancer research

**4. Specialist Palliative care**
**Knowledge and comprehension**

4.1. Describe the factors contributing to disease trajectory: early, advanced and terminal phases
4.2. Describe trigger factors for referral to specialist palliative care
4.3. Illustrate the patient's experience of their journey with cancer
4.4. Use holistic assessment to identify palliative care needs in symptom control, emotional, psychological or social domains
4.5. Discuss the role of charitable and non-governmental organisations involved in palliative care

**5. Primary and Secondary Care Multidisciplinary Working: Attitudes**

5.1. Understand holistic assessment and care, multidisciplinary team working
5.2. Describe the healthcare team involved in delivering primary care, specialist palliative care and oncology
5.3. Demonstrate awareness of the value of inter-professional working between palliative care, oncology and primary care teams.
5.4. Demonstrate ability to analyse effective and ineffective communication: face to face and written, patient health care professional and inter-health care professional

# 3. Clinical Experience Log Sheet (Oncology)

Please ask a member of staff to sign the sheet at the end of each activity/experience and to give their designation. Your Undergraduate Clinical Supervisor will sign at the bottom of the form when you have achieved the experiences. If you have any difficulties please discuss with your UCS who will advise you.

| | **Clinical Experience** | **Date** | **Signature and Designation** |
|---|---|---|---|
| 1 | Oncology Out-patient Clinic<br>(breast or lung or bowel or prostate) | | |
| 2 | Other Oncology Out patient clinics<br>(eg head and neck, skin, GTT, ovarian, HPB etc) | | |
| 3 | MDT attendance | | |
| 4 | Gold Standards Framework (GSF)<br>a: awareness of GSF<br>b: patient visit with district or specialist palliative care nurse | | |
| 5 | Chemotherapy Day Care | | |
| 6 | Radiotherapy Planning Session and Treatment | | |
| 7 | Presentation at teaching sessions | | |
| 8 | Referral letter (from GP) | | |
| 9 | Case Histories:<br>1 Chemo / radiotherapy<br>2 MDT meeting<br>3 Inpatient<br>4 Living with advanced disease<br>5 Survivorship<br>6 Observed communication | | |
| 10 | Hospice/Maggie Centre visit (optional) | | |

## Completion of Activities and Experienced signed by Undergraduate Clinical Supervisor

Signature: Date:

# 4. Clinical Cases

**1: Chemotherapy and radiotherapy** (include impact of diagnosis/referral pathways)

**2: MDT**

### Holistic assessments

**3: Inpatient**

**4: Living with advanced illness** (not necessarily cancer)

**5: Survivorship**

### Holistic Domains

**Physical:** history, diagnosis, current symptoms and signs
If relevant include; FBC, LFTs, U&E, physio /OT, dietician, SALT assessments, symptom control, disease trajectory,

**MDT**: palliative care register, communication issues, symptom control

**Social:** assess family / carer issues, employment, financial, housing, support networks, social care teams / family tree, care packages, AHPs

**MDT** includes social services, discharge team, voluntary organisations

**Spiritual:** metaphysical questioning (why me? why now? what next?), religious needs, legacy of life If relevant include: any advanced care plans, advanced directives, preferred place of care
NB: one area least discussed, but essential to understand how the patient is coping with illness, is how it fits in with their belief of self, medicine, and future.

**MDT** includes chaplaincy / religious organisations, psychology,

**Psychological:** fears, worries concerns for self and others, through to formal anxiety, depression disorders, pre-existing mental health issues, communication issues; HADS or BECKS depression scales, body image and sexual wellbeing

**MDT** includes complementary therapies, counselling, AHP, psychology, psychiatry.

## 4.1 Clinical Case Study 1: Chemotherapy and Radiotherapy Treatment

*Learning Outcomes: 2.1; 2.2; 2.3*

**Questions to aid Reflective Learning**

You will need to engage in self-directed learning to provide considered answers.

- What was the type of cancer and diagnosis?

- What is the intention of the chemotherapy and radiotherapy being given? (radical, neo-adjuvant, adjuvant or palliative)

- If radical or adjuvant therapy, what is the expected survival outcome for this patient? If palliative, what is the expected benefit of therapy?

- What side-effects of chemotherapy or radiotherapy is the patient aware of?

- Other important side-effects?

- Is the consent form reflective of these side-effects?

- If having chemotherapy, is the patient aware of what to do if they develop a fever following chemotherapy? Why is neutropenic sepsis important?

- What written information has the patient been given? Language?

- In addition to the expected physical side-effects of treatment, what other impact has chemotherapy/radiotherapy had on the patient's life (see holistic domains).

## 4.2 Clinical Case Study 2: the MDT meeting

*Learning Outcomes: 1.3; 5.1*

**After attending an MDT please consider the following questions**:

- What was the tumour site being discussed at the MDT?

- MDT members: List as many as you can and their roles

- Now consider one of the patients discussed
    - Provide a summary of the case history as discussed at the meeting.

    - What was the stage of disease and what investigations were used to determine the stage?

    - Who was involved in the discussion of this case?

    - What options for management were discussed?

    - What is the treatment intent for this patient?

    - What is the expected survival for such a patient?

### 4.3 Clinical Case Study 3: Ward Inpatient (see holistic domains)

*Learning Outcomes: 1.1; 1.2; 1.3; 1.4; 1.5*

**Consider the following questions**:

- How did the patient present?
- Read and reflect on the referral letter/ pathway/timeline
- What are DoH targets for Cancer waiting times?
- Is there a screening program for this type of cancer? Limits, benefits and problems with screening
- Describe the patient's QOL throughout their patient journey
- Consider the holistic impact of this patient's cancer diagnosis
- What is this patient's current WHO Performance Status?
- What specialist nurses have the patient been involved with and what support have they provided?

| |
|---|
| **Physical** |
| **Psychological** |
| **Social** |
| **Spiritual** |
| **Personal reflection** |

### 4.4 **Clinical Case Study 4: Living with advanced disease** (not necessarily cancer)

*Learning Outcomes: 4.1; 4.2; 4.3; 4.4*

| |
|---|
| **Physical** |
| **Psychological** |
| **Social** |
| **Spiritual** |
| **Personal reflection** |

## *4.5* **Clinical Case Study 5: Long term survival from cancer**
(this will be in the GP practice) *Learning Outcomes: 1.5; 1.6*

More than 2 million people are living in the UK having had a diagnosis of cancer.
This figure is likely to double in the next 20 years. Many live long and healthy lives. Some suffer short or long term consequences from cancer or its treatment.

**Consider the following questions**:
Does the patient have any information needs?

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| **Physical**<br>What was the diagnosis and stage of the cancer?<br>What type of treatment did the patient receive and how long ago was this treatment?<br>What hospital follow-up is the patient receiving if any? What does this involve?<br>Does the patient have any information needs? |
| **Psychological** (any long term psychological effects of cancer diagnosis and cancer treatment or living with uncertainty (see holistic domains) |
| **Social** (any financial or family consequences of the cancer diagnosis (see holistic domains) |
| **Spiritual** (see holistic domains) |
| **Personal reflection** |

## 4.6 Parallel Communication

*Learning Outcomes: 5.2; 5.3; 5.4*

**Aims:** Parallel note taking is meant to enable you to use the skills of listening, talking and reflecting to increase awareness of communication issues

**Health professional reflection**:

- Their understanding on the interaction,
- The purpose of the discussion
- What they felt they had communicated

**Patient's reflection/understanding of the event (<12 hours):**

- Do they remember the communication episode,
- What did they think was said or meant,
- How did they feel?
- Any specific phrases or comments

**Reflect**:

- Having heard the patient's view do you think the communication was: good, clear, good correlation between what was meant and said, or confusing, poor
- Reflect yourself on the interaction; what was good, what could have been improved, have you learnt anything?

**Analyse the communication**:

- What body language was apparent, did body language alert you to problems or signs of understanding, what verbal skills were used; types of questions, phrases that opened, closed or moved the consultation.
- What aspects of the consultation demonstrated 'good communication skills' – how was this achieved?
- What aspects of the consultation demonstrated 'poor communication' what could have been done differently?
- Ethical dilemmas or issues; collusion, exclusion, autonomy, beneficence, justice

**Parallel Communication continued**

*Learning Outcomes: 5.2; 5.3; 5.4*

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| **Setting (when, place, who present):** |
| **Health Professional Communication –** analyse examples of verbal non –verbal skills, good /bad, turning points / opening / closing |
| **Health Professional Reflection:** what where their aims / good points/ what might have they done differently |
| **Understanding of interaction:** did they feel listened too / understand information/ able to ask questions / |
| **Your reflection /learning points on the event:** |