Central Locomotor Virtual Placements

Tutor Guide

2021-2022

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Tutor Guide

During this extraordinary time we have adapted our structured face-to-face teaching to a virtual model and we will continue to deliver this virtually for a period of time. We thank you in advance for being a part of it and to helping improve our service to the students. We all strive to ensure the students get the most out of these experiences to prepare them for the future.

The aim of the module is to provide clinical knowledge of conditions commonly encountered in primary care but also to provide students with the opportunity to develop and improve their consultation skills.

The Online Unit as a whole consists of Dermatology, Musculoskeletal Medicine, and Health Care of the Elderly. It is usually a twelve-week attachment. Community-Based Medical Education is responsible for two weeks of the module. Ie the "Central" teaching week and their GP placement week.

ENT is also now included in our "Central" teaching on Monday AM. Please see the end of this document to see what has changed.

Student Guide
In order to help students prepare for the scenarios, student guides have been produced. Student learning objectives and instructions are also included in the Tutor guide with references to support learning on the clinical content. Students have been asked to review their guides prior to the session, as well as having them present during teaching.

Assessment

There will be no formal assessment unlike the usual teaching. **Attendance is mandatory but involvement in the role-plays, are not mandatory.**

Contacts
You will meet an academic lead at the beginning and end of each session. We will have a chance to discuss how the session worked and for general feedback. If you have any concerns about a student during the session, please discuss this with the student concerned if possible and/or speak directly to the academic lead.

Otherwise, please email (Year 4 administrator Jim Manzano), who will pass your concerns to the academic lead. Please see above for details.

IT back up – details to be provided to you during introductory briefing.

Simulated Surgeries

The simulated surgeries consist of **THREE** role-plays. **We will have the actors rotating between 3 groups**. The tutor's role is to facilitate the learning process by providing both consultation skills and clinical knowledge of the cases. This guide contains all the cases for the simulated surgeries and some additional tutors' notes relevant to clinical aspects of the scenarios. It is perfectly reasonable to ask students to look things up if they are going off subject or if you feel unable to answer the questions asked.

We will provide the necessary resources in the "shared file folder" within Blackboard.

During session

1. Briefing 1-1.30pm: CHROME or Firefox best.
2. Log in your room at approx 1.30 pm to start for 1.45pm.
    - May wish to discuss details with your Actor. How you wish to communicate with each other (private chat function).
    - How you like to deliver feedback e.g. in or out of role.
    - How you will be a called "into the room"
    - How you will show the photo/relay examination findings
3. 1.45 – 1.50pm: Introduction including Ground rules

    - You will want them all to have videos and mics on to introduce every one.

    - Then ask them to switch off all video/mic during student role-play. This helps with sound quality and connectivity.

NOTE: 10mins for role-play and 15-20mins for feedback – Discuss how you might signal the end of the consultation or interrupt if necessary. E.g. raising your hand. Allocate feedback to the observers. See feedback form below.)

4. 1.50-2.30pm: 1st scenario
5. 2.30- 3.15pm: 2nd scenario
6. 3.15- 3.30 pm: Break
7. 3.30- 4.05 : 3rd scenario
8. 4.05-4.15pm: Close – informal feedback to yourself from the students but also show the **QR code and link**.
9. Return to Virtual room for debrief with fellow tutors.

Introduction (yourself, actor and students) inc Ground Rules

Please take 5-10 mins to explain how the session will run and set agenda

- **MIC and Camera on – warn it is a professionalism issue if a consistent problem and will be escalated to academic lead**. If poor/broken equipment can get support from student office.
- They need a pen and paper to hand
- Student guide should be available to them for reference
- Can always use chat function to ask any questions or raise hand to speak.
- Establish 3 volunteers.

At the beginning of each session please facilitate the group to come up with any other ground rules in order to make this a safe and interactive learning environment. Here are some ideas you might like to contribute, if they have not already been said:

- Mobiles switched off. Please also switch off mic if not speaking.
- **Group confidentiality and sensitivity – imperative to make explicit. There will be no recording by QM but also ensure each student is not recording separately.**

- Respect for each other.
- Follow good feedback practise – offering specific constructive meaningful feedback **RIGHT to the end**
- Ensure students know they can use the chat function on the bottom right to message you individually if something is upsetting or they wish to not do a role-play for personal reasons.

Remote Consulting
It is worth noting with the students that the role-plays have not been changed to reflect they are "video consultations". This was to try and ensure students were learning in their usual environment. It is worth discussing that there will still be possible examination findings to discuss and rashes to describe (if possible.)

OVERALL THEY SHOULD TRY AND ENJOY AND GET AS INVOLVED AS POSSIBLE!

Group Process
Please take time to create a safe environment for the students. It can be challenging and exposing to role-play in front of your peers and these sessions are challenging in that they bring clinical content together with consulting skills. We always have more to learn about consulting and the purpose of these sessions is to have an opportunity to try things out, to make mistakes, to improve through obtaining feedback and through observing others' consultation styles. It is also important to explain to the students the option of taking timeout if they are stuck. In this case they could ask their colleagues in the group how best to proceed. Feel free also yourselves to institute timeout if the role-play is going around in circles or you can see the student struggling.

Please select a volunteer from the group who will role-play the doctor. The student can invite the Simulated Patient (SP) into the room and role-play for 10-15 minutes. Once the student has finished history taking or the time has run out, (you as the tutor will need to act as time keeper, giving a one-minute warning) ask the student and SP to stop and re-join the group.

You can use 2 different feedback models:

Please see feedback proforma attached to help guide the discussion, you may want to allocate certain sections before the role-play begins and a scribe.

Pendleton: student – group – SP – facilitator feedback in this order first, on what went well and then on what could be improved

Agenda led feedback: student – group - SP– facilitator feedback in this order discussing the agenda as the role-playing student sets it out. Instead of having to say what was good or bad, they just say what is on top for them.

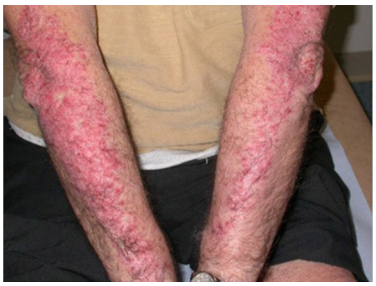
If there is time you can also discuss any questions, clinical issues including any management or ethical issues raised by the case. There are also some "Further Discussion Points" we have added to some scenarios, to allow students to reflect on some wider clinical issues/educational points. The whole case should last 40 minutes.

Close
At the end of the session (the last case of the afternoon) please ask the student to list the things they have learnt and will take away from the session. **QR code then to be shown.**

Debrief

At the end of the session the tutors are asked to gather in a pre-designated virtual room, discuss their afternoon. If there are cases that did not work well then tutors should feedback to the academic lead for the session. The Year 4 team will review all the comments received and amend scenarios accordingly. This is also an opportunity to discuss any issues you may have encountered with students during the session. Please share good and bad practise with each other thus allowing for development as tutors.

Dermatology



Case 2 Dermatology – 40-year-old accountant with a longstanding rash on his/hers elbows and knees (psoriasis)

Student Information

Learning objectives

By the end of this station the student should

- Have attempted to develop a shared management plan with a simulated patient
- Understand the basic principles of negotiating a shared management plan **(See Appendix 2)**

Student Instructions

You are a FY1 Doctor on your GP attachment. Your next patient is a 40-year-old man/women with 2-year history of a rash that seems to be worsening. He/she has recently started propranolol for stress at work and noticed that the rash got worse after starting this medication. Sam Bailey.

Please speak to this patient in order to formulate a diagnosis and negotiate a management plan.

You may want to consider general management:

- Explanation of diagnosis to patient and patient given written information
- Discuss treatment options, benefits and side effects and agree a management plan

Simulated patient instructions

This station aims to allow the student to practice taking a patient centred history, describe a rash and start to formulate a shared management plan**.**

When the student starts asking questions about the rash, please prompt the GP tutor/Student to refer to the guide where there is a photo.

You are a 40-year-old accountant (Sam Bailey) with a rash that seems to be spreading over the past 2 years. It is itchy and you are embarrassed by it. It started on the front of your knees and now it is on the backs of your elbows also. It never seems to go away. You feel embarrassed to wear short-sleeved shirts or show your knees in public, even when the weather is very hot. You did not think it was necessary to see a doctor when it first started because the patches were small. They have been present in one form or other for most of your life. However, since they seem to be expanding you are getting concerned and want a diagnosis.

If the student asks about your social life and you feel comfortable with the student to talk about personal issues, you can explain that you are in a new relationship and are concerned regarding intimate contact with your partner because you do not want her/him to see your rash; you are also concerned it may be contagious. You are hoping to get a tablet to cure the rash once and for all.

If asked and feels appropriate:

- You are not aware of an improvement in sunlight
- The rash is also on your lower back and you have noticed your nails look odd.
- You are fit and well, with no allergies. You are not applying anything on your skin. You are not taking any OTC medication.
- You have no history of skin conditions previously
- You vaguely remember your mother having psoriasis, but you do not remember what it looked like
- PMH: You have had a lot of stress at work recently and had been having palpitations, this symptom has been investigated and you have been diagnosed with anxiety.
- FH: no skin conditions that you can think of.
- Drug history: One month ago, you were prescribed a drug called propranolol; you are not sure how much you are taking but you are using it whenever you feel anxious. Its helping. You are not on any other medication otherwise.
- SH: You do not smoke and you rarely drink alcohol nowadays. 1-2/month – couple of glasses of wine. No recreational drugs.
- You have no children and have never been married.

The student will be asked to develop a management plan with you. If you feel as though they are telling you what to do rather than attempting to come to a shared plan of action then try to encourage the student to explain the plan to you – you might say " I'm sorry but I am not quite sure what you mean, could you explain this?" You could say here "The propranolol had really helped me manage work a lot better and so I would find it difficult to stop this, Dr." Other things you may say depending on the management plan "I know steroids can cause you to gain weight and thin your skin, I hope this does not contain steroids!" "I don't like the idea of having to rub greasy cream on my skin every day".

If they have not elicited your actual concern and expectation then ask them "Will I need to avoid my girlfriend/boyfriend until it is cured?"

If you are happy with their approach then share your concerns with the student in an open manner and so encourage them to provide an explanation to provide reassurance.

Further discussion points

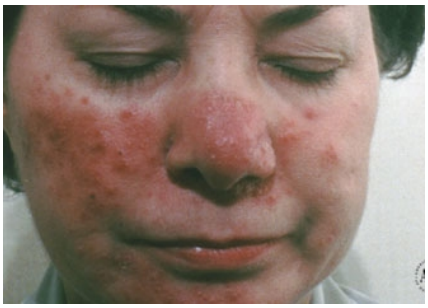
This scenario is a good example of managing complexity and shared decision/risk management.

Case 6 Dermatology – 45-year-old woman/man with severe pustular facial rash (Rosacea)

Student Information

Learning objectives
By the end of this scenario the student should

- Be able to use a patient centred approach to history taking and effectively explore a patient's ideas, concerns and expectations during a consultation
- Feel comfortable using dermatological terms to describe a rash
- Make a diagnosis of the facial rash and draw up a differential diagnosis
- Consider the psychological effect of the facial rash on the patient



Student Instructions

You are a FY1 doctor on your GP attachment. During the morning surgery you are asked to take a history from a 46-year-old man/women with a longstanding severe facial rash, which has worsened recently. Edward/Edwina Rourke.

- Please take a history from the patient.
- Explore the patient's ideas, concerns and expectations regarding the effects of treatment.

Simulated patient instructions

This scenario aims to allow the student to practise taking a dermatological history in particular exploring the psychological effects of having a severe facial rash and also exploring the patient's ideas, concerns and expectations (ICE) in order to address the patient's expectations of improvement with treatment.

You are a 46-year-old cleaner. (Edward/Edwina Rourke.)
You have had a facial rash for five years. This has got progressively worse. You have had a lot of stress recently. Last year your partner lost his job due to low back pain and has not worked since. You were also made redundant six months ago and have only recently started a new job. You also had multiple dental implants, which cost "an arm and a leg". You find that the rash looks worse in the morning and you do not like to look at yourself in the mirror. The rash is making you feel bad about yourself and you have lost confidence. You think that people look at you as if you have been drinking heavily. You are now a cleaning manager and you feel embarrassed in front of your staff. You feel low but would not say that you are depressed.

If asked:
The rash is only on your face mainly across your forehead, over the bridge of your nose, your cheeks and chin. It is very red. It is not itchy. There are several small pustules on your nose and cheeks. You think that the skin on your nose has become thickened. Friends have told you that you really must get something done about it and you realise you have let it go and now do need to do something about it.

You are usually fit and well. You don't smoke and only drink occasionally but this has increased of late. You have been avoiding spicy foods as you think this may make the rash worse. You have been taking medication intermittently usually for a few weeks over the

years for the rash and you are currently taking oxytetracycline 500mg twice daily for the last few months but this has had no effect. You also occasionally use metronidazole gel. Offer the student your picture if they want to examine you or ask to see the rash. Give the student the following information only if they attempt to explore your ICE.

Ideas: You have looked up the rash on the internet and think that you have rosacea. You think you are starting to develop complications and that you need a referral to a skin specialist.
Concerns: You have seen many doctors in the practice over the years about the rash and you are worried that the doctor will not understand the effect that the rash is having on how you feel about yourself and you are worried that you will not be taken seriously or get treatment that will work. You also wonder if it will ever get any better.
Expectations: You do not expect that the skin on your face will be perfect but even a small improvement would make you feel so much better.

If asked:
Have you been feeling low? "you wouldn't say depressed". No thoughts of harming yourself.
PMH: NO other medical issues
FH: You think your mother may have had a similar rash.
DH as above. No known allergies
SH Drinks normally 1 bottle of wine or so over a month. NO recreational drugs. Lives with your partner and have no children.

The students should discuss a possible diagnosis and differential diagnosis with you. They should explain that with treatment you will get some improvement in the rash but that you may still have some redness. They may go on to suggest antibiotics and some creams or referral to a dermatologist. If you feel that the student has taken a good history and explained the diagnosis and treatment to you, you should express relief and gratitude about their understanding. If not, please try to offer clues for the student that they need to explore ICE for example "Do you think I should be referred to a dermatologist?"

Please remember that these students will not have had very much experience of seeing patients with skin conditions and are just starting to learn consultation skills.

Tutor notes

- Please ask the student to describe the rash

Further discussion points

This shows the impact on daily life and moods with skin conditions can have. It is worth discussing the possibility of referral due to distress in itself. And if no referral is made despite repeated request, how this can impact of future relationship/trust with the patient.

Background Information

The onset of rosacea is often preceded by a history of episodic flushing. The features of the rash include:

- Erythema – initially intermittent but becomes more permanent
- Telangiectasia
- Papules and pustules
- **Absence** of open comedones (blackheads), unlike acne vulgaris

- Thickening of the skin can occur when chronic, for example, rhinophyma represents marked thickening of the nasal skin and can cause serious disfigurement

Distribution – central face (forehead, nose, cheeks and chin with sparing of the peril-oral and peril-orbital areas)

Eye involvement
- Occurs in over 50% of patients
- Gritty eyes, conjunctivitis, blepharitis, episcleritis. Keratitis is a more serious complication

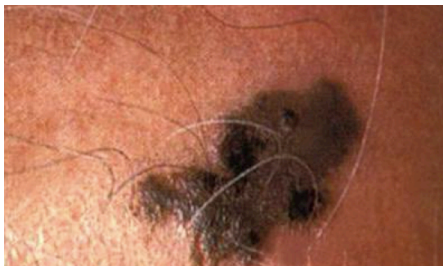
Epidemiology Age – adults and older patients. Bi-modal prevalence of 20 -30 years of age with a larger peak at 40 -50 years. More common in women. More common in patients with fair skin and blue eyes

Aggravating features
- Anything that aggravates flushing including sunlight, caffeine, alcohol, spicy foods
- Drugs that cause vasodilatation
- Topical steroids

Differential Diagnosis
- Acne – younger age group, blackheads, wider distribution and improvement with sunlight
- Seborrhoeic eczema – no pustules and eczematous changes present
- Systemic Lupus Erythematosus – shows light sensitivity, erythema and scarring but no pustules
- Perioral dermatitis – occurs in women with pustules and erythema around the mouth and on the chin

Management
- Provide a patient information leaflet
- Minimise factors that aggravate symptoms
- Emollients
- Papular/pustular lesions: Mild symptoms – topical agents e.g. metronidazole 0.75% gel or cream bd or azaleic acid 15% cream bd as first-line treatment. More severe – or where topical agents have failed, systemic treatment with a tetracycline (doxycycline 100mg is the drug of first choice). Initial treatment should be for at least three months. Severe symptoms that respond poorly to treatment or psychological distress a referral to a dermatologist can be made.
- Flushing/erythema/telangiectasia: If persistent, pulsed-dye laser treatment can be effective though not permanent. Consider camouflage creams –refer to British Red Cross clinics usually associated with hospital dermatology departments
- Rhinophyma: Responds well to CO2 laser ablation). If present, referral should be initiated.

Case 3 Dermatology – 50 year old landscape gardener with a suspicious mole



Student Information

Learning objectives:

By the end of this tutorial the student should:

- Be aware of two validated mole risk assessment tools (Glasgow seven point check list and ABCDE system)
- Have an attempt at discussing the implications of a suspicious mole and the next steps in management. This will involve breaking the news to the patient in a sensitive and tactful manner. (**See Breaking Bad News Framework in Appendix 3)**

Student Instructions:

You are a FY1 doctor on your GP attachment. This 50-year-old (Kelly/Keith Wise) landscape gardener has come to see you today because the mole on his/her back has become itchy and their partner told them to.

- Please take a history from this patient.
- Describe the mole.
- What is the likely diagnosis?
- Please explain the next steps in management

Simulated patient instructions

Background

This station aims to give the student the opportunity to practice discussing a potential cancer diagnosis with a patient.

You have attended today because your partner is concerned about the mole on your back. You are a very jolly 50-year-old landscape gardener of Irish origin with ginger/blond hair and blue eyes. You own a large and successful landscape gardening company. Nowadays you are mainly involved in management and only garden for your own enjoyment. However, you spent 15 years as a landscape gardener in Australia in your twenties and thirties until you and your partner relocated to the UK. You come from a wealthy family and spent most of your summers during your childhood in the south of France.

You remember always burning in the sun and never being able to tan as a child and adolescent no matter how hard you tried; you always ended up looking like a red lobster. Therefore, now you tend to cover up and follow appropriate sun avoidance advice (SPF 30 sunblock, hats, avoiding midday sun). You enjoy gardening even when you are not working and also cricket and tennis.

If asked and feels appropriate

Ideas and concerns: Your father died of skin cancer so this is upper most in your mind as a cause of your itchy mole. You don't really know what to expect. If asked you admit your

partner noticed the mole had been red and inflamed a few months back but healed over so you decided it was ok, thinking you probably scratched it accidentally.

- PMH: You are fit and well with no medical problems.
- DH: You are not taking any medication. No allergies
- SH: You smoke 10 cigarettes a day, but are trying to quit. You drink 2 glasses of red wine most days of the week. Take no recreational drugs.
- You live with your partner Jon/Jan who is 48 in a large detached house. She is a house wife/husband. You have a wonderful marriage and travel to the south of France as often as possible where you have a holiday home. You have 2 children. Jane is 18 and about to start medical school in Manchester and Samuel is 27 and an architect. You are proud of them and happy to share information about them if asked.

The student will be asked to explain that he/she thinks your mole looks suspicious. If the word cancer is avoided then ask, "Do you think its skin cancer doctor?" If you think the news was delivered sensitively then you calmly ask, "What happens now" and once told, thank the doctor for being so helpful.

If you feel the student did not manage the discussion well then tell him or her about your family history and give the student another opportunity to discuss your concerns. Students have not had very much opportunity so far in their training to talk to patients about a potentially life-threatening diagnosis and so you need to encourage them to do so as much as possible but also trying to avoid distress for you and the student.

Tutor notes

- Once the student has finished taking the history please show them a picture of the mole, ask them to describe it and ask then ask for a diagnosis.

- The focus of this station is two-fold. Firstly, to ensure the students understand the red flag characteristics to look for when examining a mole (discuss the Glasgow 7-point check list and ABCDE system) and secondly to instruct them on breaking bad news.

Further discussion points

- Students can often feel this "breaking bad news" scenario is not appropriate for their level. Please encourage them to understand that suspected "bad news" in a consultation occurs frequently and it is worth reviewing the "breaking bad news" framework in the **Appendix 3.** In this scenario the mole is obviously malignant, however the student should not make a diagnosis of malignant melanoma without histology (after all it could just be a very atypical mole).

- Please discuss the challenge of dealing with uncertainty and breaking bad news.

- Please prompt (if time) a discussion about safety netting re: 2ww referral. Perhaps a template can be used. What would you say to a patient to ensure they get the appointment appropriately and timely? It is important they understand this is also the responsibility of the clinician.

- Please also note the use of dermlite and teledermy in primary care. Would this be a suitable management option in this case?

Background information

Malignant Melanoma of the Skin

Epidemiology

1. More common in women than men. 6th most common cancer in females and males
2. Less common than non-melanoma skin cancer (BCC/SCC)
3. Incidence- women: 16.5/100,000. Men 15.9/100,000
4. Lifetime risk of developing melanoma in the UK 1in 61 for men and 1 in 60 for women
5. Amongst white populations the incidence of malignant melanoma of the skin is rising
6. Median age of diagnosis men 62 years of age, women 60 years of age

Distribution

- Men: head and neck (22%), trunk (41%), arm (18%), leg (13%)
- Women: head and neck (14%), trunk (19%), arm (23%), leg (40%)

Subtypes

- Superficial spreading malignant melanoma – most common subtype (70% of all MM. Most commonly presents on the trunks of men and legs of women)
- Others: Nodular malignant melanoma, Lentigo malignant melanoma, Amelanotic malignant melanoma, Acral lentiginous melanoma inc subungual – most common in pigmented skins.

Risk Factors

PMH or FH of MM or DH of immunosuppresants

Naevi are the most powerful predictor of melanoma.

- A person with >100 has a 5-20-fold increased risk of MM
- Sun exposure (short sharp burst of acute exposure in childhood, severe sunburn)
    - Occupation and leisure (gardeners, air crew, cricketers and those involved with outdoor pursuits)
    - Past sunbed use particularly when <30 years of age
- Skin pigmentation (skin type 1 or 2: fair skin, red/blonde hair, blue eyes and freckles)
- Solar keratoses
- Atypical naevi
- Atypical mole syndrome
    - >100 common moles (2mm in diameter)
    - >two atypical naevi (5mm in diameter)
    - Naevi in unusual sites e.g. breast in females, buttocks, scalps, ears, dorsum of feet and hands, irises

Musculoskeletal cases

Case 3 MSK – 29 year old IT Consultant with a painful knee

Student Information

Learning Objectives

- To be able to take a history of a non-traumatic painful knee
- To consider the differential diagnosis of a non-traumatic painful knee
- To understand the immediate management of a non-traumatic painful knee

Student instructions

You are a FY1 in General Practice. This 29 yr old patient was booked as an emergency by your colleague after a telephone call. He/she told your colleague he/she had a very painful knee and really hoped to see someone today. Anthony/Antonia Rogers

- Please take a history from this 29-year-old patient.
- Consider diagnosis and initial investigation and management for this patient.

You will not be expected to examine the patient but the Tutor will discuss the findings at an appropriate point.

Simulated patient instructions

Anthony/Antonia Rogers is a 29-year-old IT Consultant

Presenting Complaint: "My knee has become really painful overnight" **Patient should limp into the room.**

History of Presenting Complaint:

Last night you went to sleep at 10pm and your left knee had a mild ache but nothing that bothered you in particular. You woke in the night at about 3am and your knee was painful. This has never happened before. You got up and had to limp to the medicine cabinet in your bathroom where you took two paracetamol. This has eased the pain a little. You went back to bed and were able to sleep a little.

You woke this morning and your knee felt worse. You are having real pain when walking or even bending it. You feel really tired and unwell. If asked you do feel hot and sweaty, you had thought this was due to the pain and having had a poor night's sleep. You have taken 2 paracetamol tablets and 2 ibuprofen tablets this morning (If asked the paracetamol was 500mg tablets and the ibuprofen was 200mg tablets). This has taken the edge off very slightly.

If asked:

A few years ago, you had a painful right great toe. At the time you were travelling in Indonesia. You went to a local pharmacy and got some strong painkillers and the pain eased over a few days. You never quite knew what caused the pain but it hasn't happened again. You will mention this only if you are asked specifically about previous joint problems. You have not connected that incident with the current problem.

It is currently very painful and you are finding it increasingly difficult to walk on the joint or weight bear. You had to hop the last few yards to the surgery when you got out of the cab that you arranged. You have never arranged a cab to get a GP appointment in your life.

You have Type 1 diabetes and have had this since you were 14 years old. You are well controlled and take your diabetes management seriously. You use a basal bolus regime (insulin) and Short Acting (three/day), which you are confident using. Interestingly this morning your BMs have been running high (12ish – usually 7-8) and you are not sure why. If asked how many exact units. Be vague and adjust according to food and activity levels – it varies. Approx. 12.

You work as an IT consultant and enjoy playing football and you usually play twice a week. You last played on Sunday and don't remember having any particular problems with your knee during the game.

Patient Medical History: Type 1 diabetes

Drug History: Insulin - Levemir (basal regime) and Novorapid (bolus doses 3/day). Ramipril to protect your kidneys. Atorvastatin to reduce cholesterol. You cant remember the doses.

Social History: Non smoker. Episodic binge drinker when out with the team. No recreational drugs. You split up with your girlfriend/boyfriend 6 months ago and have been using tinder to date a variety of women/men. You usually have protected sex. When you were on football tour over 2 months ago you visited Latvia and had unprotected sex. You don't have any symptoms. Last test was 5 months ago. You will not reveal this unless your rapport is very good and the student is particularly good OR you are specifically asked questions about your sex life and your personal life. If they elicit this and if they ask – no you do not have abnormal vaginal/penile discharge currently. All seems normal.

Family History: Your maternal aunt has arthritis; you don't know what sort of arthritis.

Ideas: You really don't know why your knee is so painful. You are quite worried about what it might be.

Concerns: Why is this happening? Have I done anything to make this happen? Football is an important aspect of your life and you really enjoy it, when will you be able to go back to playing?

Expectations: You are hoping the GP will be able to tell you what is going on and give you something to make it better.

Tutor notes

Examination finding to tell the student:

Alert, flushed, temp 38.2C

Left knee, swollen, red, hot and painful on active and passive movement. Significantly reduced range of motion.

Right knee normal.

This is meant to be a case that explores taking a history for a non-traumatic painful knee. Students should consider the variety of differential diagnosis and direct their history to

exclude the possibilities. Asking about how the patient feels and establishing that they do feel unwell and are feverish are important to establishing that the patient is potentially acutely unwell.

He has a number of risk factors that students should be try to elicit in their history taking. Type 1 diabetes is the most important risk factor. The previous acute arthritis of the right great toe is likely to have been an episode of gout. The patient sexual activity puts them at risk of a reactive arthritis.

Further discussion point

This is a good example of dealing with uncertainty and managing accordingly.

From a GP point of view this patient has quite clearly got symptoms of an acute arthritis. The severity of symptoms and fever with no clear previous history of other possible cause mean that we are unable to exclude a septic arthritis. The consequences of not treating a septic arthritis are severe and need to be prioritised over other possible causes.

Immediate referral to a rheumatologist for consideration and further management of a possible septic arthritis is appropriate medical management.

Staph aureus is the most common causative organism for septic arthritis, this includes those over the age of 2 and patients with prostheses. However, gonorrhoea is the most common cause in sexually active population.

Relevance of taking a sexual health history; Students should consider gonorrhoea as a potential cause for this patient's septic arthritis. They may not feel comfortable asking a sexual history and depending on the time of the year students may not have been taught how to take a sexual health history.

Further investigations; it is worth asking the students what further investigations students would like to do to establish the diagnosis. Students should be able to justify their tests and explain what the rationale is for the test.

This would include FBC, CRP, ESR, Synovial fluid examination (gram staining, leukocyte, count, polarising microscopy and culture), sexual health screen should also be considered.

Although this is primarily a clinical diagnosis student should be aware that other types of imaging may be necessary to further investigate the joint if the diagnosis is unclear.

If time discuss SICK day rules.

Background Information

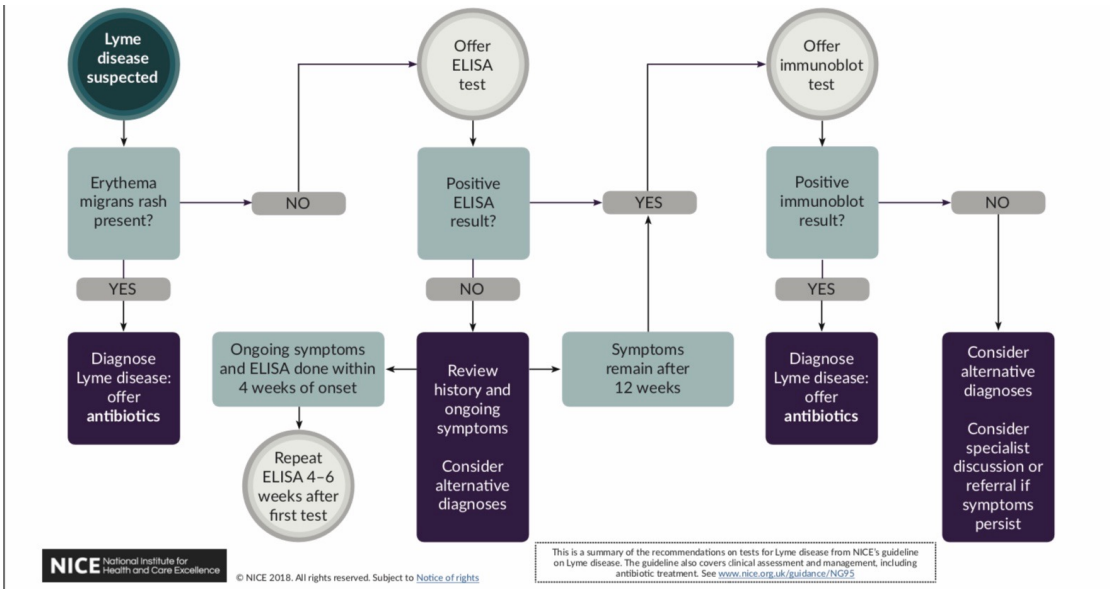
The differential diagnosis includes;

- Primary rheumatological disorders (e.g., rheumatoid arthritis, osteoarthritis), vasculitis, gout and pseudogout
- Drug-induced arthritis.
- Reactive arthritis, post-infectious diarrhoeal syndrome, post-meningococcal and post-gonococcal arthritis, arthritis associated with intrinsic bowel disease.
- Lyme disease.

- Infective endocarditis.
- Viral arthritis.

(Please note below new NICE Guidance on suspected Lyme Disease.)

https://www.nice.org.uk/guidance/qs186/resources/lyme-disease-pdf-75545724732613



Case 4 MSK – 35 year old postman/women with low back pain

Student Information

Learning Objectives

By the end of this tutorial the student should

- Be able to discuss the indications and know how to complete of a "Fit note"
- Know the red flag symptoms of back pain inc cauda equine syndrome.
- Aware of the yellow flags for back pain and the impact this has on management

Student instructions

You are a FY1 doctor working in a busy inner-city general practice that serves a deprived area. A 35-year-old man/women presents to you complaining of back pain. Sam Tweed.

- Please take a history from the patient
- Suggest any further management for him.
- Consider the use of a 'Fit note' in this case.

You will not be asked to examine the patient but will be given findings at an appropriate point by the Tutor.

Simulated Patient instructions

You are a 35-year-old postman/women. Sam Tweed. You have been working at a busy Regional Post Office for the past month. Yesterday, whilst lifting a bag of post, you felt your back go. You had ignored it initially and continued working through the pain. This morning, however, the pain was excruciating and your back was very stiff. You were able to find a nurofen tablet in your bathroom cupboard and braved it into work. During the day your back has gradually seized up and your manager told you to go and get your back checked out. He has advised you get signed off sick but you would rather not.

It is left lower back, occasional in L bum and thigh but no where else. 7/10 severity

You do not feel unwell, you are just in pain.

PMH

You have never had any back or joint problems in the past. Or any other problems.

FH no arthritis or jt problems.

SH

You play football every week with mates in order to keep fit. You smoke 10 cigarettes a day. You drink a couple of pints with the lads if you go to the pub; you have cut down (you used to drink 8-9 pints at least 3-4 times a week). You do not take any recreational drugs.

DH NO allergies. Not on any other medication.

If asked:

You are in a lot of pain, so it should be evident on your face and with every movement you make. Attempt to avoid sitting down for too long. The pain stays in your back and does not move anywhere else. It is aching and constant. It is seems worse in the morning and at the end of the day. You have no weakness or numbness anywhere. You have no problems with your bowel and bladder function. No recent weight loss or night sweats

No pain elsewhere e.g. shoulder or neck.

You have been walking short distances and dressing slow. But trying to stay active. You are worried about this and getting back to work.

The doctor should offer you a sick note. If you feel the doctor has been empathetic and explored your ideas, concerns and expectations satisfactorily, reluctantly accept it and thank him for him/her for their help. If you do not feel the doctor has explored these, then you might insist on stronger painkillers than have been prescribed so you can go to work.

Ideas: You are concerned that you may have slipped something in your back but you are not sure. You are not sure if it will get better.

Concerns: Your partner is 36 weeks pregnant with your first child. You cannot afford not to be working, and you certainly cannot afford to be unwell. You have a lot of work to do in the house in preparation for the baby.

Expectations: You just want some strong painkillers so you can get back to work. You only get statutory sick pay “which isn’t great”. You know that it might be possible for you to go back to work with a medical certificate that allows you to avoid heavy duties and restricts you to light duties. You may suggest this to the doctor if the opportunity presents itself. You are happy to go to a physio if suggested, but not really clear what they do there. You think its just massage.

Tutor notes

- Please show student the fit note before or after the roleplay. Discuss how it is used and filled in.

- Examination to tell the student: pain on flexion and limited movement of lumbar spine in all directions

Further discussion points

Please could you ask the students to consider the use of Fit notes and the possibility of encountering patients who require large amounts of time off work? It would be interesting if you could begin to explore the issues around secondary gain but teaching this in a context of medical safety. This patient does need a Fit note but many others may not. Please explore with the group how Fit notes are managed.

Please also consider exploring responsible prescribing in the patient who wants strong painkillers to return to work, particularly if their work involves driving a vehicle.

Please see **Appendix 2** for some useful points on "Negotiating skills"

Background Information

What's new in the primary care management of low back pain

The STarT (Subgroups for Targeted Treatment) Back Trial (Lancet 2011; 378;1560)

The STarT Back Screening tool (a 9 or 6 point questionnairehttp://www.keele.ac.uk/sbst/downloadthetool/) stratifies patients presenting with low back pain in primary care into low, medium and high risk taking into consideration the psychosocial dimension. Please see

Appendix 4

Of first presentations in primary care:

- 55% low risk of poor outcomes – patients do well irrespective of treatment given and many may be referred unnecessarily for further care
- 33% medium risk
- 12% high risk – includes patients not only emotionally distressed by their back pain but also includes patients with complex pathology and social issues

In the research these three groups were matched to targeted treatment pathways. The research found better outcomes for those in the high-risk group treated with CBT trained physios. Using the STarT approach is the first evidence that taking a stratified approach reduces costs both direct health costs and indirect costs through days lost not working but also improves outcomes for patients. Low risk patients do not receive unnecessary treatments and high-risk patients do not have treatments denied to them.

This tool is in part derived from the idea that there are yellow flags as well as red flags. Please see... https://www.bmj.com/content/326/7388/535

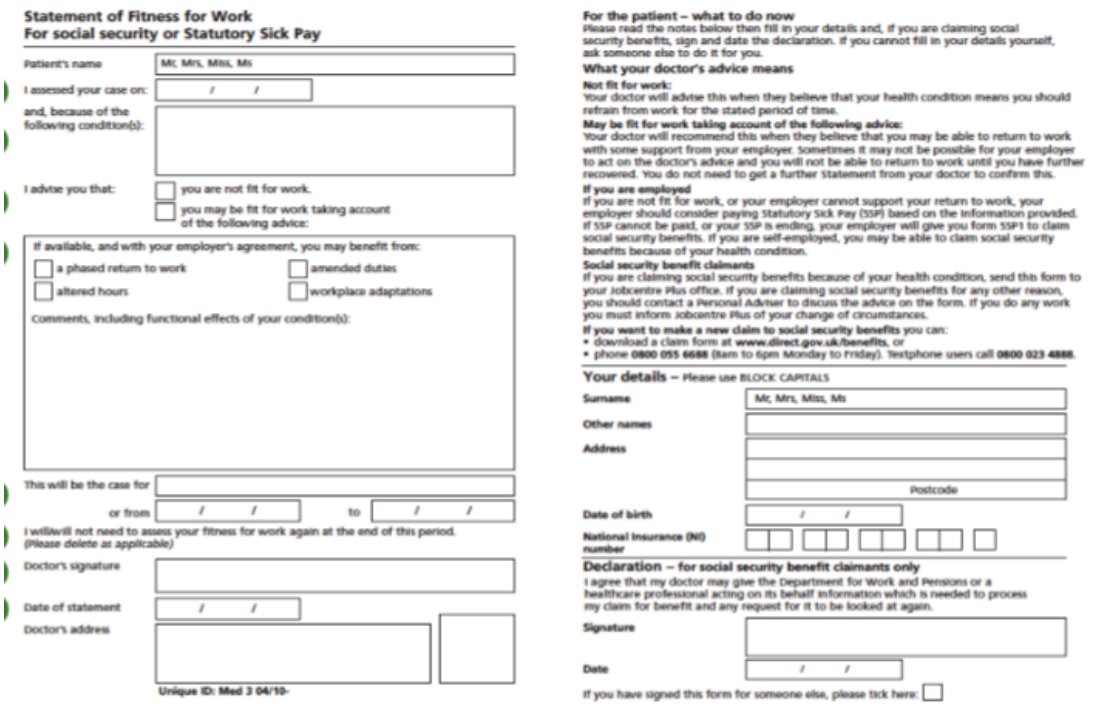
It is very important to discuss cauda equina syndrome and red flags. ANY concern in regards to below would need emergency referral to Hospital Neurosurgeons or an AE Pathway.

NICE March 2018
Red flag symptoms and signs
Serious conditions whose signs and symptoms may overlap with sciatica are listed below.

- Cauda equina syndrome. Red flags include:
    - Bilateral sciatica
    - Severe or progressive bilateral neurological deficit of the legs, such as major motor weakness with knee extension, ankle eversion, or foot dorsiflexion.
    - Difficulty initiating micturition or impaired sensation of urinary flow, if untreated this may lead to irreversible
        - Urinary retention with overflow urinary incontinence
    - Loss of sensation of rectal fullness, if untreated this may lead to irreversible
        - Faecal incontinence
    - Perianal, perineal or genital sensory loss (saddle anaesthesia or paraesthesia).
    - Laxity of the anal sphincter.
- Spinal fracture. Red flags include:
    - Sudden onset of severe central spinal pain.
    - There may be a history of major trauma (such as a road traffic collision or fall from a height), minor trauma, or even just strenuous lifting in people with osteoporosis or those who use corticosteroids.
    - Structural deformity of the spine (such as a step from one vertebra to an adjacent vertebra) may be present.
    - There may be point tenderness over a vertebral body.
- Cancer. Red flags include:
    - The person being 50 years of age or more.
    - Gradual onset of symptoms.
    - Severe unremitting pain that remains when the person is supine, aching night pain that prevents or disturbs sleep, pain aggravated by straining (for example, at stool, or when coughing or sneezing), and thoracic pain.
    - Localised spinal tenderness.

- No symptomatic improvement after four to six weeks of conservative low back pain therapy.
- Unexplained weight loss.
- Past history of cancer — breast, lung, gastrointestinal, prostate, renal, and thyroid cancers are more likely to metastasize to the spine.

- Infection (such as discitis, vertebral osteomyelitis, or spinal epidural abscess). Red flags include:
  - Fever
  - Tuberculosis, or recent urinary tract infection.
  - Diabetes.
  - History of intravenous drug use.
  - HIV infection, use of immunosuppressants, or the person is otherwise immunocompromised.



Statement of Fitness for Work
For social security or Statutory Sick Pay

Patient's name: Mr, Mrs, Miss, Ms

I assessed your case on: / /

and, because of the following condition(s):

I advise you that:
- ☐ you are not fit for work.
- ☐ you may be fit for work taking account of the following advice:

If available, and with your employer's agreement, you may benefit from:
- ☐ a phased return to work
- ☐ amended duties
- ☐ altered hours
- ☐ workplace adaptations

Comments, including functional effects of your condition(s):

This will be the case for

or from / / to / /

I will/will not need to assess your fitness for work again at the end of this period.
(Please delete as applicable)

Doctor's signature

Date of statement / /

Doctor's address

Unique ID: Med 3 04/10-

For the patient – what to do now
Please read the notes below then fill in your details and, if you are claiming social security benefits, sign and date the declaration. If you cannot fill in your details yourself, ask someone else to do it for you.

What your doctor's advice means

Not fit for work:
Your doctor will advise this when they believe that your health condition means you should refrain from work for the stated period of time.

May be fit for work taking account of the following advice:
Your doctor will recommend this when they believe that you may be able to return to work with some support from your employer. Sometimes it may not be possible for your employer to act on the doctor's advice and you will not be able to return to work until you have further recovered. You do not need to get a further Statement from your doctor to confirm this.

If you are employed
If you are not fit for work, or your employer cannot support your return to work, your employer should consider paying Statutory Sick Pay (SSP) based on the information provided. If SSP cannot be paid, or your SSP is ending, your employer will give you form SSP1 to claim social security benefits. If you are self-employed, you may be able to claim social security benefits because of your health condition.

Social security benefit claimants
If you are claiming social security benefits because of your health condition, send this form to your Jobcentre Plus office. If you are claiming social security benefits for any other reason, you should contact a Personal Adviser to discuss the advice on the form. If you do any work you must inform Jobcentre Plus of your change of circumstances.

If you want to make a new claim to social security benefits you can:
- download a claim form at **www.direct.gov.uk/benefits**, or
- phone **0800 055 6688** (8am to 6pm Monday to Friday). Textphone users call **0800 023 4888**.

Your details – Please use BLOCK CAPITALS

Surname Mr, Mrs, Miss, Ms

Other names

Address

Postcode

Date of birth / /

National Insurance (NI) number

Declaration – for social security benefit claimants only
I agree that my doctor may give the Department for Work and Pensions or a healthcare professional acting on its behalf information which is needed to process my claim for benefit and any request for it to be looked at again.

Signature

Date / /

If you have signed this form for someone else, please tick here: ☐

Case 5 MSK – 30 year old shop assistant with aches and pains (Fibromyalgia)

Student Information

Learning objectives

- To be able to take a history from a person with aches and pains
- To learn how to broach the psychological aspects of disease
- To be able to explore a diagnosis of fibromyalgia

Student instructions

You are a FY1 in General practice and have been asked to talk to this 30-year-old patient about his/her pain. (Kelly/ Kevin Scott)

- Please try to discuss likely diagnoses
- What tests you might like to organise.

An important aspect of this case is to think about how to manage this patient's pain.

You will not be expected to examine this patient.

Simulated patient instructions

Kelly/ Kevin Scott is a 30-year-old sales assistant in a department store

For the last three months you have been getting aches and pains all over your body in your muscles but have particular weakness in your legs. If asked to expand, you have been getting very tired and find that you cannot stand for long periods of time. You have been well before and cannot understand what is going on. You have not noticed that any of your joints are swollen and have no other signs of disease. You are a little cross as no one at work seems to believe you and you feel very protective and sensitive about how people relate to you.

Lately you have found that wearing tubigrips on your arms has helped. You have been taking ibuprofen on and off but you do not like taking medication

You are very focused on the pain: some days it is not too bad and others it seems worse. You have kept a diary of all this. You have recently noticed some tingling in your hands and feet.

If asked and rapport present: You are down in mood. If this is explored this does in fact predate the pain but the pain has made it worse. You think that people are judging you as they believe it is all in your head, which is making things worse. You have been missing days at work and this again is affecting your mood.

You are resolutely against this having a psychological cause and can become a little irritated if this is even mentioned. You have a hyper acute awareness of pain so simple movements make you wince and everything feels a little dramatic.

Social History: You live alone in a flat in Bow; you do not smoke and have stopped drinking to see if the pain improved.

Previous Medical History: Nil

Drug History: Nil, **Allergies:** Nil

Family History: Your mother has chronic long-term health problems and has been diagnosed with fibromyalgia- she lives around the corner from you and you are her main carer.
Ideas: You think you may also have Fibromyalgia.
Concerns: You do not want to be in wheelchair like your mum.
Expectations: You want to be taken seriously and listened to. You feel that medical treatment is the only way forward and are not in the mood to discuss psychological treatments
Questions: Do you think I have Fibromyalgia? What tests should I have?

Further Discussion Points

How do you think some patients feel about having a condition with no pathology known, also with a strong link to low mood? Tutor should mention that some patients like having this label (i.e. a name for their condition) and some do not like the association to the label of Fibromyalgia. Knowing this, how could this change your communication in this type of consultation?

How is fibromyalgia diagnosed managed?

Background information

What causes fibromyalgia?
Research shows that there is a direct relationship between the physical, mental and psychological aspects of the illness. This means that the pain you feel is often affected by the way you are feeling and vice versa. Feeling depressed or anxious can make the pain feel worse, which in turn adds to the stress and anxiety, and so on...

Research has also shown that people with fibromyalgia are more sensitive to physical pressure – this means that what would be a relatively minor knock for many people could be extremely painful for someone with fibromyalgia. While this increased sensitivity is not fully understood, we think this could be related to chemical changes in the nervous system. It's also thought that sleep disturbance contributes to this increased sensitivity.

Guidelines for Primary Care

https://www.guidelinesinpractice.co.uk/pain/fibromyalgia-is-a-clinical-diagnosis-for-primary-care/342046.article

Diagnosis

- It is important to take a careful history and to acknowledge the individual's experience and description of pain. Patients with fibromyalgia do not look ill and do not appear clinically weak. Apart from restriction of movement due to pain and the presence of the multiple tender points, physical examination tends to be unremarkable. Blood tests, X-rays, and scans will typically yield a negative result

- Red flags indicating other potential pathology could include:

- involvement of the joints
- systemic malaise, especially with weight loss
- evidence of thyroid dysfunction

The American College of Rheumatology (ACR) chronic widespread pain is common, along with associated symptoms of fatigue and other somatic features. In the 2010 revision, the ACR detailed three key criteria for the diagnosis of fibromyalgia:

- Presentation of widespread pain for more than 3 months
- Assessment of the number of painful body areas
- Assessment of additional symptoms, including cognitive ailments.

Pharmacological management

- Many patients may find available medications either insufficient to control their symptoms, or difficult to tolerate due to a high incidence of adverse effects. Therefore, all medications should be reviewed at regular intervals to monitor their efficacy. Awareness by patients that some adverse effects may resolve in time can encourage continuation with treatment
- General intolerance to medication will dictate the treatment used. Individualised programmes of pharmacological and non-pharmacological therapy may be more effective than drug treatment alone
- Management often involves the use of antidepressants and anticonvulsants. Low dose tricyclic antidepressants (TCAs), such as amitriptyline, are used commonly to reduce pain, and improve sleep and fatigue. However, tolerability and durability of TCAs is poor
- Selective serotonin reuptake inhibitors (SSRIs) can improve the symptoms of pain, fatigue, and depression. SSRIs can cause insomnia and restlessness; therefore, morning administration is recommended. Although better tolerated than TCAs, beneficial effects of SSRIs can be less reliable
- Serotonin and noradrenaline re-uptake inhibitors (SNRIs), e.g. duloxetine and milnacipran, reduce pain and improve physical function and quality of life
- The benefits due to any of the antidepressants are independent of their effect on mood
- Pregabalin and gabapentin also reduce pain and improve sleep quality, fatigue, and quality of life

- Alternatively, tramadol, a centrally acting analgesic with SNRI properties, will reduce the pain; or pramipexole, a dopamine agonist, can improve pain, fatigue, function, and global well-being

- Muscle relaxants, e.g. baclofen or tizanidine, can be helpful if muscle twitching or cramps accompany the pain

- Poor sleep quality is common in fibromyalgia and hypnotics such as zolpidem improve sleep and fatigue, but do not modify pain

- Benzodiazepines can be useful for initially re-establishing a sleep routine, but long-term use may have associated risks

- Irritable bowel syndrome is a common co-morbidity. Use of antispasmodics, e.g. mebeverine or alverine, may reduce the spasm of hypersensitive bowels. Intolerance to wheat and/or dairy products and excess fibre may exacerbate the symptoms. A well-balanced diet is required, especially if complicated by medications causing weight gain

- Symptoms of depression can arise from the fear and isolation of living with chronic pain. Coming to terms with living with fibromyalgia and adopting changes in attitude and lifestyle is often sufficient to deal with depressive symptoms. It is important to tackle any co-existing factors that may be contributing to the depression. In persistent cases antidepressants can prove effective

Non-pharmacological management

- Psychosocial factors play an important part in fibromyalgia and its successful treatment

- Cognitive behavioural therapy.

- **Exercise management: Graded therapy is gold standard and more evidence emerging of the benefits.**

- Fatigue and poor sleep are common adjuncts to fibromyalgia, it can be helpful for the patient to manage activity in a way that uses energy wisely. Prioritising, planning, and pacing activity can make a significant impact on the amount people can do in the long term

- There is limited empirical research to substantiate the use of alternative therapies. However, more focused on-going research is beginning to recognise some physiological and emotional benefits of these interventions:

Health Care of the Elderly Cases

CASE 3 HCOE – 75 year old woman/man present with a fall

Student Information

Learning Objectives

- To be able to take a history from a patient who has recently had a fall
- To discuss the issues that may have led to the fall.
- To review medication as necessary
- To be able to take a focused social history and how it affects on-going care

Student instructions

You are a FY1 on clinical attachment in General Practice and the GP, Dr Ross has asked you to speak to Mrs/Mr Baker at home. She/he has requested a home visit as she/he has had a fall at home in the early hours of the morning, the ambulance was called and suggested going to hospital for some further investigations/monitoring but she/he wanted to stay at home at all costs. They agreed on the basis she would call he GP in the morning. During this phone call, she/he told Dr Ross, that you that Jean (daughter) expressed concern over her/his safety at home and intends to stay with her/him overnight.

- You visit the patient at home. Please take a medical history
- Please explore the patient's perspective about her daughter's worries.

Simulated patient instructions

Name: Mrs/Mr Maureen/Mo Baker,

Age: 75 years old,

Mrs/Mr Baker requested a visit after falling at home at home. She/he has osteoarthritis with severe mobility problems and has recently had several falls at home. Her/his daughter is concerned and has spoken to the GP on a number of occasions about her/his safety at home and is hoping the doctor will talk to Mrs/Mr Baker about their options.

Presenting complaint: "I fell this morning but it is nothing really"

History of presenting complaint: You have asked your GP to come today after you had a fall at home - your left leg "just gave way". When you landed you hit your forehead on the corner of the table. The cut bled quite a lot so you called an ambulance, by the time they arrived it had stopped bleeding and you told them you did not want to go to hospital. The paramedics asked you to see your GP.

The paramedics noticed that your BP was 90/60 mmHg on arrival at the house and your pulse was 102bpm. You were told your heart rate was regular. The trace of your heart was normal, just a bit fast. Your blood sugar was 6.0 and all your observations were normal

Past Medical History: In the past 6 months you have been having minor falls occasionally – this is becoming more frequent. Total of 6 falls, but 3 of them are within the last month.

Although you have suffered minor cuts and bruises after previous falls, this is the first time that your GP has been requested to do a home visit.

You have suffered from osteoarthritis for the last 10 years. It has become worse in the last year and you now have severe mobility problems. You are mainly affected in your hands and hips, suffering from pain and stiffness.

- You have pain in your groin, inner thighs and buttocks from your hips. You walk stiffly, slowly and awkwardly.
- Your fingers joints are painful to move and tender to touch. You find fine motor skills difficult (e.g. Writing) and have had to adapt some activities (e.g. buying an electric can opener and getting audio books from the library as you find it difficult to turn pages).

Apart from osteoarthritis and reflux, you have no other medical conditions and consider yourself very healthy for your age. NO weight loss and eat/drink well.

If asked:

- Not recently unwell with diarrhoea, vomiting, cough/cold or temperature.
- You did hit your head but didn't loose consciousness.
- No symptoms before the fall like chest pain, shortness of breath or palpitations.
- You did not notice any weakness on one side of the body, drooping of the face or slurred speech.
- NO biting of the lip, or loss of water works or bowels after the fall.

Drug history:

You take paracetamol (prescribed - 2 x 500mg 4 times daily) for your osteoarthritis. You take omeprazole (prescribed - 20mg once daily in the morning) and Gaviscon (over the counter - before bed).

A water pill in the morning, Bendroflumethazide 2.5mg

Amlodipine 10mg once daily

You have no drug allergies

Social history: You live in a terraced house in Bow, where you have been for over 50 years. Your partner died 9 years ago of a heart attack, shortly after having bypass surgery. You now live alone, but Jean visits most evenings to bring you some shopping and help you wash and get into bed.

You still cook for yourself, but maybe not as much as previous years. You buy more prepared food than before "there's nothing wrong with pilchards on toast" and have made other adaptations (e.g. buying an electric can opener).

You worked as a music teacher at the local secondary school until retirement. You drink infrequently - a glass of sherry with your friends on special occasions. You have never

smoked or taken recreational drugs. You are a strong-minded woman/man who is determined to stay in your own home.

You feel pressured by Jean to sell your house and move in with her (she lives 10 miles away in Harlow), but you don't want to leave your house and your friends. You are proud and don't consider yourself ill, so why should you have to leave?

Ideas: That this fall is "just one of those things" and that you need to be more careful in future. You are determined to stay in your own home. You wonder if Jean's husband wants to use the money from selling your house to improve theirs. You are religious about taking your medication for osteoarthritis, blood pressure and reflux - you believe that by taking them correctly you can reduce the chances of being "forced" into having the hip replacement. You have a good relationship with your GP but you don't like other people interfering with your personal life.

Concerns: You are worried about losing your independence if you have to move in with Jean. You are slightly worried about the falls you have been having, but won't admit to it easily.

Expectations: That Jean will be around soon and there isn't anything else really needed to be done next.

You are amenable to suggestions of further investigations like bloods or an ultrasound of the heart, as well as a physio/occupational therapist (OT). Please clarify what a physio or OT would do if this isn't explained. This is all fine as long as it means you do not have to go to hospital, the least fuss made and you get to stay living independently.

Tutor notes

This case should reflect the morning session where the students will have been taught about multi disciplinary teams and how to keep patients in the community if at all possible and if that is their wish. Please discuss with them the problems associated with the frail elderly and what options can be offered at home.

Please draw the students' attention to the list of medications. Polypharmacy may cause changes in blood pressure (postural hypotension). It is important that they understand that the falls might be affected by both her pulse and her BP.

In summary, the assessment of falls requires a multifaceted approach with consideration of different possible factors that might be contributing to the falls including vision, blood pressure, feet, neurology, cognitive and environmental factors. It is also important that you clarify the nature of the fall – is it a simple trip, a faint, cardiac related, pain related and so a careful history needs to be taken to establish this and of any previous falls. (See local Basic Falls Clinic Assessment Form attached.)

Further Discussion Points

· How does it feel to deal with uncertainty of a diagnosis and deal with many complex issues?

· How do you manage to work within that? Ensure safety as best you can?

Case 2 HCOE - 68 year old for health review at the practice three months following a CVA

Student Information

Learning objectives for the case:

- To be able to take a history from someone who has had a previous stroke
- To understand and manage the risk factors for CVA
- To address the issues around concordance and why patients do not take medications
- To practise the consultation skills e.g. FRAMES (behaviour change) and negotiation skills needed for this consultation **(See Appendix 2).**

Student instructions:

You are a FY1 doctor in General Practice. You have been asked to review Mr/Mrs Dexter following his/her visit to your practice nurse who found the patient's blood pressure to be 160/98mmhg and their Hba1c was 75mmol/mol (9.0%). The nurse was concerned especially because of this patient's previous stroke, 3 months ago.

- Please take a history
- Discuss the patient's understanding of his/her condition, his/her current medication and future management.

Simulated patient instructions

Name: Mr/Ms Dexter

Age: 68-year-old African-Caribbean chef.

Presenting complaint:

You had a stroke 3 months ago and you came into see the practice nurse for a review and she has now asked you to see the GP.

History of presenting complaint:

You have been asked to come to the practice for review and to check on how things are going.

The nurse that saw you before says your blood pressure and sugars are high.

You confide in the Dr that you have not always been the best at taking your medications.

If the student explores with you why this is you reveal that the amlodipine gives you puffy ankles and the lisinopril makes you cough, plus one of your friends says it doesn't work anyway. The metformin gives you an upset stomach so you stopped taking it after a week but didn't think to tell anyone. You don't like the diabetic nurse so haven't been coming to your diabetic appointments but the optician said your eyes were ok so you thought it wasn't anything to worry about.

HOWEVER, you are worried about having another stroke and now see given your high blood pressure and blood sugar that the medications might be important. You have been feeling guilty for not taking your medication.

Past Medical history: High blood pressure**,** High cholesterol, Type 2 diabetes was diagnosed at the same time as your stroke.

Drug history:

Blood Pressure: lisinopril 5mg, amlodipine 5mg.
Anti cholesterol: simvastatin 20mg.
Anti diabetes: metformin 500mg three times a day
Nil Allergies

Social history:

Have smoked 20 cigarettes a day for the past 38 years.

You like a glass of rum and coke every night. No recreational drugs.

Daughter lives nearby your son lives about 1 hour away. You have 7 grandchildren.

Family History:

Father died of heart attack aged 72. Mother still alive in Trinidad

Ideas: You have fully recovered from the stroke but don't want another one

Concerns: The tablets might have been more important than you realized

Expectations: That you are going to get a telling off by the Dr.

Questions:

Can I take different tablets to the ones I have?

How important is my blood sugar- Should I stop drinking coke?

Can you help me to stop smoking?

Further Discussion Points

This is a complex case that may need your guidance. The student needs to be sympathetic and non- judgmental with the non-compliance and this is something worth exploring with the group. The issues of non-compliance are important and GPs face these issues every day with patients who refuse to take medications for a variety of reasons.

Please see **Appendix 2** for some useful points on “Negotiating skills”

These reasons could include:

- Side effects of medications
- Forgetfulness
- Lack of understanding with regards to why they are taking the medications and how important they may be
- Expense of prescriptions
- Generalized confusion over medication changes
- Simply can't be bothered

- Little concern over future medical issues – “we are all going to die anyway”. This can quite complex and causes can be multi-factorial; often previous family experiences play a part.

There is a difference between consciously non-compliant and unconsciously non-complaint, the latter being harder to address.

i.e. – Consciously non- complaint patients decide to not take the medication for a reason/reasons. They may or may not make you aware of this.

Unconsciously non-complaint patients are not just the patients who “forget”, they do not take it for a reason or reasons but have not knowingly made that decision.

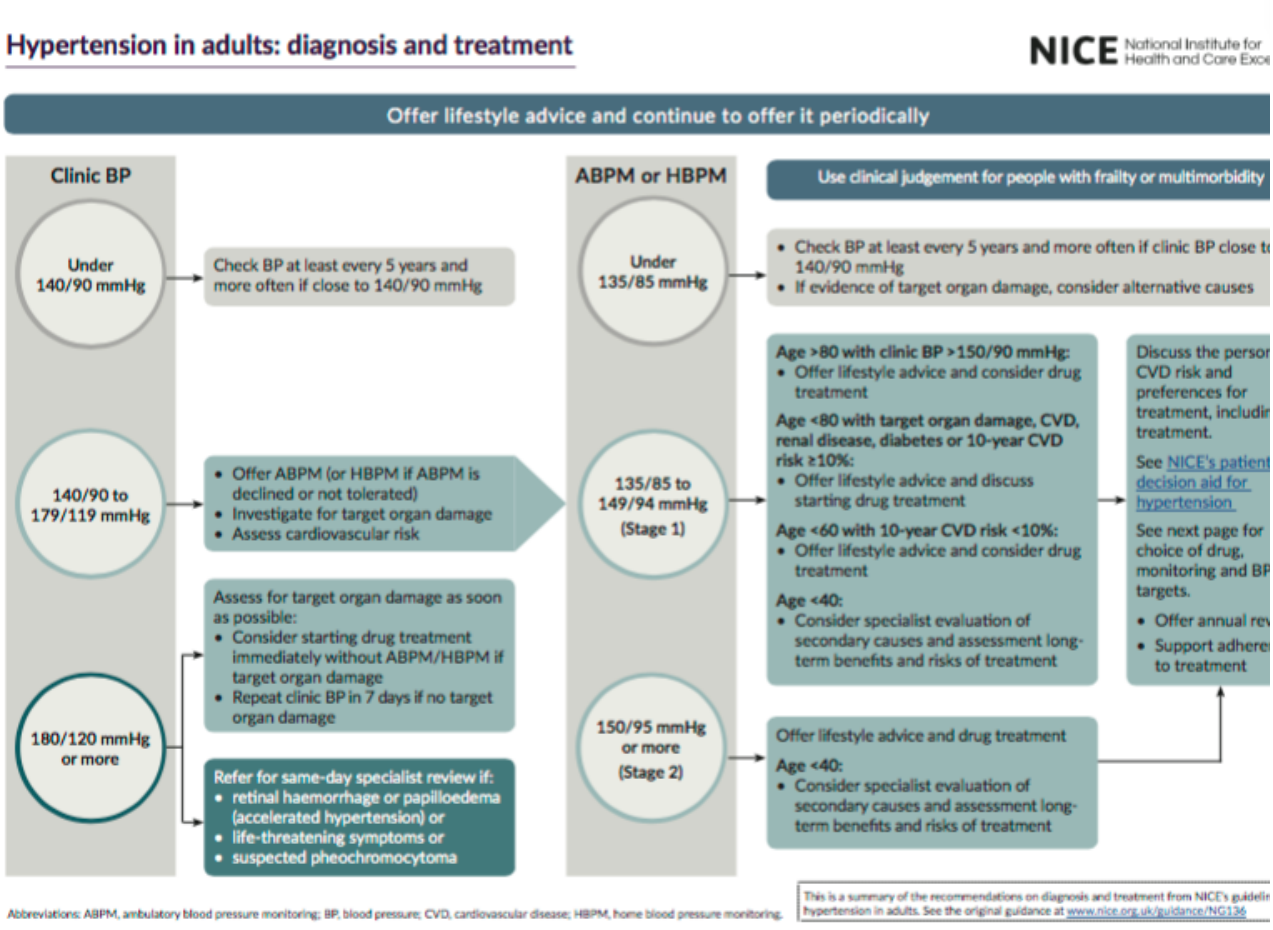
Background Information

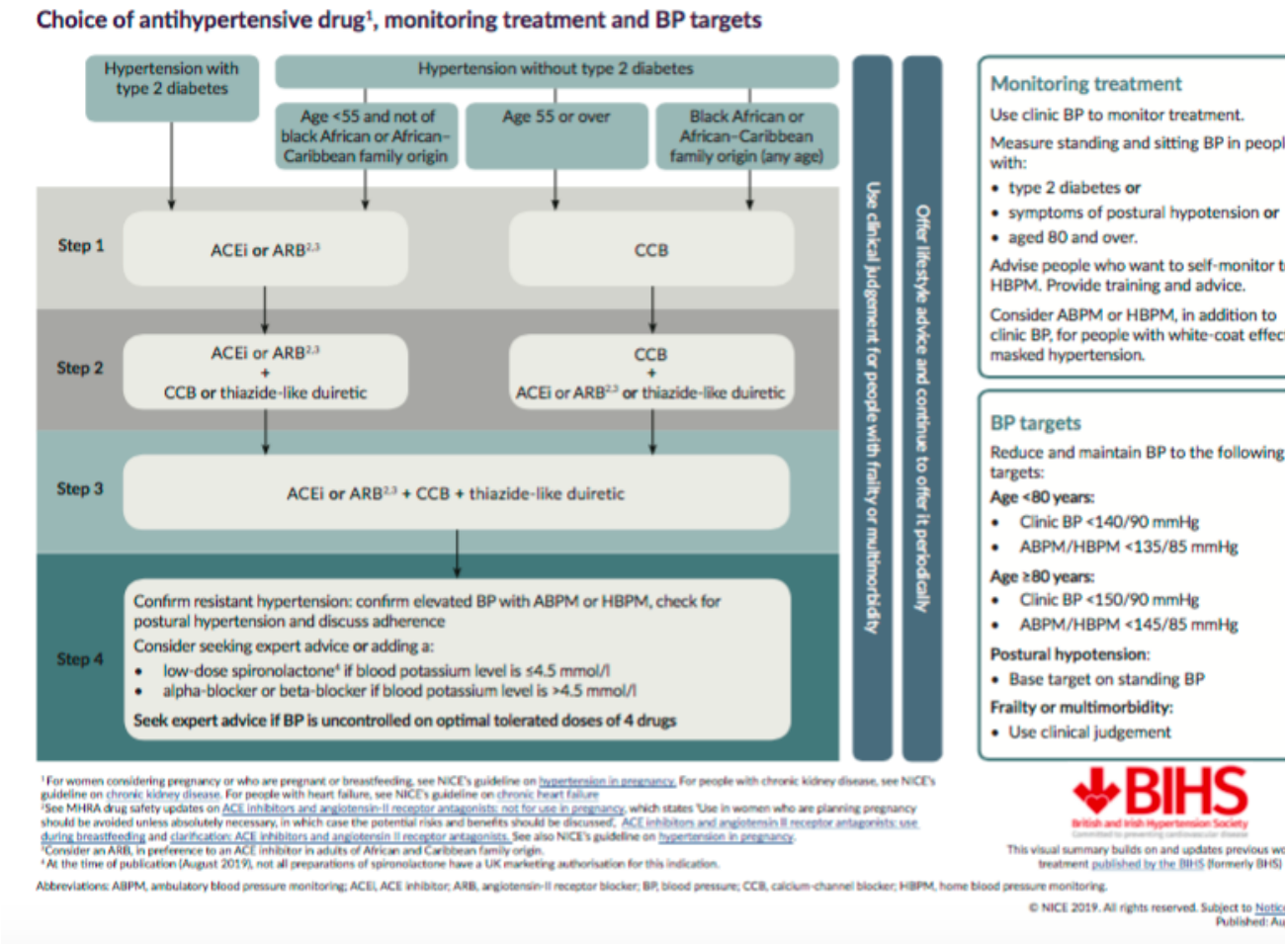
Cerebrovascular Accident

Risk factors

- Age: 75% of strokes happen in over 65 year age group.
- African-Caribbean origin
- Smoking, obesity, poor diet and excessive alcohol consumption are also risk factors for stroke.
- Hypertension
- Diabetes
- Hyperlipidaemia
- Atrial fibrillation

NEW NICE HYERPTENSION GUIDELINES, 2019





Case 6 HCOE – the Multimorbid patient

Student Information

Learning objectives

- Being able to take a clear and focused history, taking into account multiple medical conditions.
- Understand how management of conditions affect each other.
- Understand the psychological issues associated with multi-morbid conditions.

Student instructions

You are an F1 in a GP Surgery and the next patient is Mary/Martin Gallagher (72yrs old), they have been called in to discuss their worsening diabetes control. You know from their notes that their spouse died last year.

They will be seeing the Diabetes Nurse after your consultation to discuss adjustment of insulin dose and any possible medication change.

- Please take a focused history, concentrating on why their diabetes may have worsened.
- Please discuss ways in which their diabetes can be better controlled using conservative methods.

HBAIC last week – (8.4%/68mmol/mol)
– last yr 7.5%/58mmol/mol (target 7.5%/58 mmol/mol)
PMH:

- **Type 2 diabetes**
- **Hypertension (recent 132/81 - good)**
- **High cholesterol (good control).**
- **Generalised OA**
- **Chronic Kidney Disease 3A – recent 53 eGFR (mild to moderate)**

Simulated patient instructions

This station aims to allow the student to practice taking a patient centred history, whilst showing empathy to their general decline in function. Students should try to think of ways to help with your knee arthritis, help you eat better, possibly exercise more and aid your social isolation.

You have been asked to see the doctor to discuss your decline in diabetes control. You are seeing the diabetic nurse next to discuss changes to your insulin and possible medication change. You don't really check you BMs as you should. It's been well controlled for years. Since your wife/husband died just over a year ago (from a sudden stroke), you have not been leaving the house as much. You used to go on daily walks right around Victoria Park and enjoy cooking meals for you and your partner. It has been increasingly difficult to cook due to worsening knee pain and you have been finding it difficult to stand up for a length of time. You take regular paracetamol for this and use deep heat to rub in. It helps most of the time but hasn't of late.

If asked:

Your general day now consists of waking up at 6am, having a cup of tea (no sugar) with 2 pieces of brown bread with butter (sometimes jam). Read the newspaper and watch some TV. Maybe go to the shops or library. At lunch you have a ready meal, usually a lasagne or cottage pie. At dinner you maybe make a toasty with cheese. You don't have fizzy drinks. You have the odd biscuit or cake but only 2-3/week.

When you partner was alive, you would make both of you some porridge, with a banana and some nuts. At lunch you would make a roast chicken with some veg. Then dinner a light salad with some fish. You enjoyed cooking.

You know you have been feeling down since you wife/husband died, but you don't feel you are depressed. You are looking forward to your son and his family moving back from Australia next year.

You might have put on a little bit of weight. But generally been feeling well.

Background

Medical history- Type 2 diabetes, High Blood pressure, high cholesterol, appendectomy 10 years ago.

Drug history: Metformin 1g twice daily, Insulin – (Lantus (35 units at night), Novorapid (10-12 units – 3/day)), Atorvastatin 20mg at night, Ramipril 10mg once daily

Family history: Dad died of Lung cancer. Mum died of old age. You had an older sibling who passed away in a car accident 10 years ago.

Social History: You live alone. You daughter (Sandra) lives in Colchester and comes every month (she has 2 girls) and your youngest (Simon) lives in Sydney with his wife and 3 children (5 boy, 7 girl and 11 boy). You rarely drink and used to smoke in your 20s (10/day). You used to be a secretary in your late husband's business (Black Cab Mechanics).

Idea – You had not thought about your diabetic control for a while as it has always been quite good. You are disappointed it has got worse and would like to improve it, but not sure how to continue walking and cooking with the problems with your knee.

Concerns – You don't want your diabetes to get worse and develop other complications. You want to see your grandkids grow up. You are worried that if this continues it could be the start of your decline.

Expectations - You are hoping for some help with you knee but not sure what they can do. You expect the doctor to tell you off about your diet and not exercising.

You are amenable to help with your knee, more medication, physio, a stick or a supportive bandage. You are happy to be put in touch with local charities and services to keep you occupied and active. They also might suggest a referral to Occupational Therapy, you will accept this if it is explained what they might be able to do.

You recognise that you are still grieving but do not think you need bereavement counselling. You think this information of worsening diabetes is not all a bad thing and might push you to get a few things sorted that you had let slip.

Tutor notes

Take time to discuss this scenario before commencing as there may be some clinical queries that are worth addressing before student starts role-play.

Further Discussion Points

- This is a good example of dealing with complexity and managing multi-morbidity.

Background Information

"Being Mortal" by Atul Gawande is a good book that if a good example of trying to manage multi-morbidly.

BMJ 2015 - https://www.bmj.com/content/350/bmj.h176

The bottom line

- Multimorbidity is commonly defined as the presence of two or more chronic medical conditions in an individual and it can present several challenges in care particularly with higher numbers of coexisting conditions and related polypharmacy
- Practices should actively identify patients with complex multimorbidity and adopt a policy of continuity of care for these patients by assigning them a named doctor
- The adoption of a policy for routine extended consultations should be considered for particularly complex patients or the introduction of occasional "specific extended

consultations." allowing protected time to deal with problems encountered in the management of chronic diseases

It is associated with decreased quality of life, functional decline, and increased healthcare utilisation, including emergency admissions, particularly with higher numbers of coexisting conditions. The management of multimorbidity with drugs is often complex, resulting in polypharmacy with its attendant risks. Patients with multimorbidity have a high treatment burden in terms of understanding and self managing the conditions, attending multiple appointments, and managing complex drug regimens
Patients classified as multimorbid are estimated to be 1 in 6 in the UK and account for approximately one third of all consultations in general practice.

What is the impact of multimorbidity?

Box 1: Problems commonly experienced by patients with multimorbidity
Fragmentation and poor coordination of care

- Results from seeing multiple health professionals in primary and secondary care.

Polypharmacy

- Attendant risk of adverse drug events, potentially inappropriate prescribing, and problems with drug concordance

Treatment burden

- Results from the necessity of learning about and adhering to management plans and lifestyle changes suggested for different conditions and engaging with multiple healthcare professionals

Mental health difficulties

- Anxiety and depression are more common in patients with multimorbidity and can impact on patients' ability to manage other long term conditions
- Patients living in deprived areas are particularly vulnerable to multimorbidity that includes mental health conditions
- Those with cognitive impairment are also particularly vulnerable and may have added difficulties in managing their conditions.

Functional difficulties

- Functional difficulties increase with increasing number of conditions and in people aged more than 75 years

Reduced quality of life

- Associated with the number of chronic medical conditions

Increased healthcare utilisation

- Includes an increased risk of emergency admission to hospital

Box 2: Practice points for dealing with challenges in caring for patients with multimorbidity
Disorganisation and fragmentation of care

- Identify patients as having complex multimorbidity and adopt a practice policy of continuity of care by assigning them a named doctor

Chronic disease management

- Some evidence supports focusing on functional optimisation of patients with multimorbidity and on shared risk factors for several conditions, such as blood pressure and smoking cessation

- In the absence of meaningful clinical guidelines, clinical judgment is especially important in the decision making process

Medicines management

- Plan regular reviews (at least annually) of drugs (explicit prescribing tools for potentially inappropriate prescribing may be useful in reviewing polypharmacy)

Promoting patient centred care

- *Shared decision making*—asking patients at the outset of a consultation "What is bothering you most?" or "What would you like to focus on today?" can help prioritise management to those aspects of care that will have the most impact on patients

- *Self-management of multimorbidity*—research to date is mixed about the benefit of self management, but it may be an option for patients expressing an interest in group based support

Short consultation times

- Consider adopting a practice policy of routine extended consultations for particularly complex patients or introducing occasional "specific extended consultations," allowing protected time to deal with problems encountered in the management of chronic diseases

- Ensure practice systems are in place to maximise the value of the general practice consultation for both patient and doctor in reaching management decisions—for example, by seeing the practice nurse ahead of an appointment with the doctor

- Arrange multidisciplinary team involvement, where appropriate

What are the challenges of chronic disease management in multimorbidity?

- Inadequacy of single disease clinical guidelines
- Targeting function not disease
- Medicines management
- How can organisation and continuity of care be improved?
- What measures can be used to promote patient centred care?
- Shared decision making
- Self-management in patients with multimorbidity
- What can be achieved in a 10-minute consultation?

Role of MDT in Multimorbidity

- Practice Pharmacists help patients manage their medications but also deal with polypharmacy.
- Community Matrons hold a vital role for the overall overview of the patient and help with bridging issues with medical and social care.
- When a patient is also acutely unwell " An Integrated Care team" complied of Doctor, Nurse, Social Care, OT, and Physio help patients stay out of hospital or help them with transition post discharge while waiting to clinically improve. Virtual hospitals or Ambulatory Care help with patients to receive hospital care and daily monitoring without having to be an in-patient.

Ear, Nose and Throat Clinical Skills

Background

Community Locomotor has been running for a number of years focusing on Primary Care aspects of Dermatology, Musculoskeletal Medicine and Health Care of the Elderly. We also introduced ENT teaching to this week, as we felt it necessary to complement their secondary care teaching from a primary care perspective.

ENT teaching is limited in the medical school. There is some teaching in the Year 3, and in Year 4 all students have the opportunity to attend ENT lectures during a lecture week.

CBME has been interested in developing our ENT teaching, we recognise that a large proportion of our work as GPs requires ENT clinical knowledge. The teaching that we deliver in Community Locomotor gives us a unique opportunity to introduce some focused teaching for our Year 4 medical students.

Working with the ENT doctors we have developed a day of ENT teaching.

The current model of Central Community Locomotor is to have content focused lectures in the morning followed by simulated patient consultations in the afternoon. The clinical information delivered in the morning informs the content of the consultations in the afternoon. The simulated surgeries are a focused attempt to develop the consultation skills as an extension of the communication skills they learn in Year 3.

Outline for Virtual Teaching

We have arranged for students to have ENT lectures in the morning, virtually. In the afternoon we will be focussed on teaching ENT clinical knowledge and application. This is an important change from our usual focus on consultation skills.

We have developed an ENT Clinical Skills resource in the form of a PowerPoint presentation. Tutors will use the teaching resource to teach a variety of clinical skills through the afternoon. Unfortunately, due to the new format of teaching virtually we will loose the opportunity to practise their clinical skills with otoscopes etc

The skills the students will be taught are very much core skills within General Practice. The intention is not to provide an ENT speciality master class but rather to introduce students to basic ENT knowledge and by extension recognise that basic ENT knowledge are a core component of General Practice.

Intended Learning Outcomes

By the end of the ENT day students will:

- ✓ Have received lectures focusing on aspects of ENT in Primary Care
- ✓ Hearing Loss, otitis media, glue ear, otitis externa
- ✓ Rhinitis/sinusitis, nasal polyps, nasal obstruction, nasal fracture and epistaxis
- ✓ Neck lumps, tonsillitis/quinsy
- ✓ Appreciate the importance of ENT in primary care

- *Be able to examine an Ear, Nose and Throat/Oral cavity – not possible given virtual teaching*

Overview of the Afternoon

Each facilitator will start the group with a discussion and an agreement of group rules (see generic rules above for more details) and a brief discussion about the familiarity the medical students have with ENT. It is to be expected that students will feel that they have limited exposure to date.

ENT Teaching Resources

We have created an ENT Clinical Skills presentation. This PowerPoint has been written to allow facilitators to work through the slides with their groups. It is designed to allow tutors to focus on clinical aspects of ENT in primary care. We have tried to create a resource that guides students through thinking about history taking and examination skills. There are slides to review anatomy and images that highlight some important aspects of ENT in primary care.

We will provide most of the slides but not the clinical information and answers, so students can prepare for the ENT teaching in the afternoon.

ENT equipment

Otoscopes, Speculum, Tongue Depressors

We would be very grateful if you could bring your extra otoscopes, as there are limited supplies from clinical skills.

Feedback and Evaluation

We will be collecting feedback and evaluation through QR codes after the teaching. We will be helping to facilitate this and will be sending this to you once collated. We will obviously be very keen to get your feedback on delivering this teaching as well

Appendix 1

Student feedback form

Barts and The London School of Medicine and Dentistry

Feedback4You

CENTRAL LOCOMOTOR TEACHING - STUDENT OBSERVED CONSULTATION

Name of Student.....

Date.....

Presenting Complaint.....

DOMAIN	STUDENT COMMENTS	ACTOR COMMENTS	TUTOR COMMENTS
Non verbal Communication			
Verbal communication			
History taking			
Exploring Ideas, Concerns and Expectations			
Decision making			

Appendix 2

Appendix 2 - Negotiating skills (MSK – Case 2, 3,4 and HOE – case 2)
A large part of daily clinical practice involves negotiating with patients. It is in your best interests to develop good skills in this area in order to serve your patients well and reduce potential conflict. Improving your skills requires the ability to observe yourself in action and evaluate what you said and did and also learning to be open minded, respecting the others' thoughts and opinions even if they make little sense to you. You are most likely to navigate a win-win path through a potential conflict if the patient feels heard and understood and they understand your position and thinking.

Self-Observation.
As we communicate with others we are usually lost in the flow of interaction. To improve your communication skills you need to be able to observe yourself at the same time as you participate in conversations (reflection-in-action). It takes a while to grow into this participating and observing at the same time. At first we look back on conversations (experience) that we have had and try to understand what went well and what went badly (reflection-on-action). Gradually we can learn to bring that observing awareness into our conversations whilst we are having them (reflection-in-action). The final stage is to make use of our observations to enhance future consultations (revision).

Negotiating
1. Try to understand the other (use open questions and active listening)
2. Acknowledge their position (summarise what they have been saying e.g. "so you are concerned that there might be something serious going on" When they know you are on their side, they may relax and be able to listen better).
3. Explain your thinking, trying to use language and ideas that would be fitting to their health beliefs and understanding

Negotiating a mutual plan of action
- Discuss options
- Obtain the patient's views regarding need for action, perceived benefits, barriers, motivation
- Elicit the patient's reactions and concerns about plans and treatments including acceptability
- Take the patient's lifestyle, beliefs, cultural background and abilities into consideration
- Accept the patient's views and advocate an alternative view point as necessary
- Encourage the patient to be involved in implementing the plan, to take responsibility, to be self-reliant

- Ask the patient about support systems and discuss other support available

Managing patient aggression

There are three main rules:

1. Resist the fight and flight instinct our natural responses may include: fear (flight) or aggression (fight).
2. Manage your own mental and emotional state. You need to be calm to be effective Becoming aware of your emotions may help you to be proactive rather than reactive – choose your response in terms of words, tone of voice and body language (quiet voice, polite manner, submissive or open body language – arms hanging by sides, palms open).
3. Get curious about the other person's feelings and needs. Try to understand their position and reflect back that understanding. Allow the patient time to "ventilate" giving them full attention, often after a few minutes they do calm down. It may be more effective to acknowledge and apologise than to explain away or justify.

Appendix 3

Appendix 3 – Breaking bad news framework– See-Derm – Case 6, MSK – Case3, HcoE – Case 4)

Guidance for breaking bad news (based on Neighbours 5 stage model of breaking bad news)
It is important to make sure you are in the right environment and avoid being interrupted

Connect

- Try to see the world through the patient's eyes, and discover his agenda or priorities.
- Explore the patients ICE (do they already suspect this is cancer?)
- Be alert for unspoken as well as spoken answers. Feelings perceptible at the edge of the discussion will probably indicate the real state of affairs better than the facts actually discussed.

Summarise

- Reflect back to the patient the impression that you have gained of the situation. This shows that you have understood his/her feelings and gives the patient a chance to correct, refine and expand on them.

Hand over

- Answer the questions to the best of your ability and admit any uncertainties.

- Ensure that you hand over the knowledge in such a way as to allow the patient to remain empowered and keep control of their own life.
- Withholding information is also to withhold control and demeans the patient.

Safety Net

- Safety netting is the doctor checking where the patient is, often acknowledging his/her pain, grief or bewilderment - "this must come as an awful shock to you". It is recognising the feelings that lie behind the stunned silence
- If the patient's feelings are "allowed", he/she is more likely to pass through them and achieve some acceptance of the situation. Give the patient the opportunity to ask for further help.
- Avoid giving too much information all at once and give the patient the opportunity to ask for further help at a later date. Leave the door open for further discussion

Housekeeping

- The doctor reviews his/her own feelings. Giving bad news can be distressing

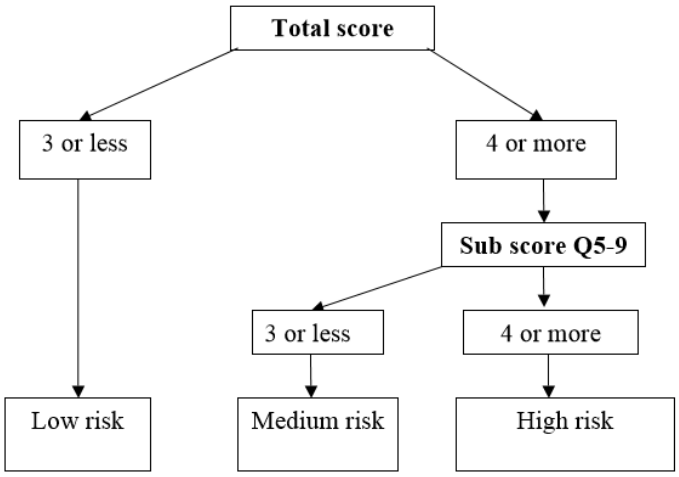
Why is breaking bad news difficult?

We experience fear: Of causing pain, being blamed, of our own mortality, of making things worse, of emotions being expressed, of helplessness as a doctor.

SPIKES – as a framework is also used. It is important to note these are principles and not to be followed in a robotic algorithm fashion.

Appendix 4

The STarT Back Tool Scoring System



Funded by Arthritis Research UK

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	**Agree** 1
My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
I have only **walked short distances** because of my back pain	☐	☐
In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
It's not really safe for a person with a condition like mine to be physically active	☐	☐
Worrying thoughts have been going through my mind a lot of the time	☐	☐
I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
In general I have **not enjoyed** all the things I used to enjoy	☐	☐

. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐ 0	☐ 0	☐ 0	☐ 1	☐ 1

Total score (all 9): _____ **Sub Score (Q5-9):**_____

Funded by Arthritis Research UK

Appendix 5

Appendix 5 Abridged Calgary – Cambridge Guide – All scenarios including Derm 2

TASK 1: INITIATING THE SESSION
Establishing initial rapport
1. Greets patient and obtains patient's name
2. Introduces self, role and nature of interview; obtains consent if necessary

Identifying the reason(s) for the consultation
3. Identifies the patient's problems or the issues that the patient wishes to address (e.g. "What problems brought you here today?" or "What would you like to discuss today?" or "What questions do you hope to get answered?")

TASK 2: GATHERING INFORMATION
Exploration of patient's problems
4. *Discover the biomedical perspective, patient's perspective and the background information*

4. Uses open and closed questioning technique, moving from open to closed
5. Listens attentively as patient tells their story, allows patient to complete statements without interruption and leaves space for patient to think
6. Facilitates patient's responses verbally and non–verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation

TASK 3: PROVIDING STRUCTURE
7. Summarises at the end of a specific line of enquiry
8. Attends to timing and keeps interview on task

TASK 4: BUILDING RELATIONSHIP
Using appropriate non-verbal behaviour
9. Demonstrates appropriate non–verbal behaviour: eye contact, facial expression, posture, vocal cues e.g. rate, volume, tone

Developing rapport
10. Uses empathy to communicate understanding and appreciation of the patient's feelings or predicament; overtly acknowledges patient's views and feelings

TASK 5: EXPLANATION AND PLANNING
Providing the correct amount and type of information
13. Chunks and checks: gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed

Aiding accurate recall and understanding
14. Organises explanation: divides into sections, develops a logical sequence

Achieving a shared understanding: incorporating the patient's perspective
15. Provides opportunities and encourages patient to contribute

Planning: shared decision making
16. Involves patient by making suggestions and checks if patient accepts plans.

TASK 6: CLOSING THE SESSION
Forward planning
11. Safety nets, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

Ensuring appropriate point of closure
12. Final check that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss