Queen Mary
University of London
Barts and The London

GP3
INTEGRATED CLINICAL STUDIES

YEAR 3: 2018 - 2019

STUDENT HANDBOOK

This handbook should be used together with the Academic Regulations and the Student Guide. It provides information specific to Barts and The London School of Medicine and Dentistry (SMD), while the Student Guide gives information common to all students of the College.

The Academic Regulations provide detailed information on all aspects of award requirements and governance.

NOTHING IN THIS HANDBOOK OVERRIDES THE ACADEMIC REGULATIONS WHICH ALWAYS TAKE PRECEDENCE.

The School's handbooks are available on QMPlus.

The Student Guide is available from the SMD Student Office; the Student Guide and Academic Regulations are also available on-line at:

www.arcs.qmul.ac.uk

The information in this handbook was correct at the time of printing. In the event of any substantial amendments to the information herein, the SMD will attempt to inform students of the changes.

The College cannot accept responsibility for the accuracy or reliability of information given in third party publications or websites referred to in this handbook.

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INTRODUCTION TO GP3

Welcome to your GP3 block! We hope you enjoy your time with us.

Primary care is exciting, complex and with endless variety. GPs encounter patients at the start of their healthcare journey and work collaboratively with them through their whole lives. As expert medical generalists, they diagnose a wide range of conditions and combine their medical knowledge with a broader view of the patient and their role in society to treat everyone individually and compassionately. Doctors cannot meet all the needs of all patients alone and GPs work closely with members of the multidisciplinary community team to deliver comprehensive patient care. As a huge and intensively used resource, primary care uses creative and innovative models of working to provide patient care and respond to changes in community demand.

The GP3 block primarily incorporates MB3 and CR3 (and to a lesser extent, Met 3A) conditions, with a focus of **integration of clinical knowledge across systems** that is more realistic as to how patients present in Primary Care.

For GP3, you will be spending one day per week at your designated GP Practice for the whole attachment (except for RLH/Barts students who will spend two days less). This longer attachment to the same GP practice comes in direct response to previous student feedback.

This is a not only a great opportunity to develop an awareness how the conditions seen in a hospital setting both present and are managed in Primary Care, but start developing your skills in managing patients that may have several conditions simultaneously and how they impact upon each other.

This new handbook reflects the increasing shift of patient care into community settings and also the expectation that all graduates have a deeper understanding of the complexities of Primary Care even if they choose not to follow a community care career pathway.

It has been put together with both Student and GP Tutor input, and any feedback about how it and be improved for future students and tutors is gratefully received!

Contacts

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YEAR 3 TIMETABLE

GP Tutors have requested an overview of the Year 3 student timetable in order that they can better address student learning needs when they arrive for placement on GP3.

	Term 1	Term 2	Term 3
Grp A	CR3	Met 3A inc 1 week GP	Met 3B/GP3
Grp B	Met 3B/GP3	CR3	Met 3A inc 1 week GP
Grp C	Met 3A inc 1 week GP	Met 3B/GP3	CR3

CR3-Cardiovascular, Respiratory, Haematology (term is hospital based).

Met 3A-Surgery, Gastroenterology, Cancer and Palliative Care (including 1 week in GP)

Met 3B-Endocrine, Renal, Infection, Breast, Urology and Introduction to ENT

All year 3 students also complete a week's teaching in Public Health, as well as several central teaching weeks in clinical and communications skills over the academic year.

As GP3 is a stand-alone module in Year 3, you are neither at an advantage or a disadvantage as to what term you are on placement with us.

Index Conditions

The list below (although not exhaustive) reflects conditions that we commonly see and manage in Primary Care. Please see both CR3 and Met 3B handbooks for full lists of Index Conditions and their associated Compas Learning Outcomes.

CR3

Cardiovascular	**Respiratory**	**Haematology**
Hypertension (1° and 2°)	Asthma	Anaemia (microcytic, macrocytic, normocytic, CKD)
Ischaemic Heart Disease inc. Lipid Management	COPD	Haemaglobinopathies
Heart Failure	Presentations of Lung Cancer in Primary Care	Presentations of Haematological cancer in Primary Care
AF plus other arrythmias		

Met 3B

Renal	**Endocrine**	**Infection**	**Urology**	**Breast**
CKD	Diabetes	Respiratory/ENT	OAB	Breast Lumps
AKI	Pre-Diabetes	Urinary	Prostate	
Renal Stones	Thyroid disease	Skin		
Presentations of Renal Cancer in Primary Care	Presentations of Endocrine Cancer (eg neck lumps) in Primary Care	Recognition of Sepsis in Primary Care	Presentations of Urological Cancers in Primary Care	Presentations of Breast cancer in Primary Care

Consideration of Met 3A Index Conditions (these conditions can present independently or alongside CR3 and Met 3B conditions in GP3).

- Surgery-pre-op & post-op management including recognition of complications.
- Gastroenterology-common presentations in primary care-GORD, IBS, Liver disease
- Cancer-recognition of cancer in Primary Care - see Year 2 Cancer week lecture.
- Palliative Care-patients discharged to community services for Palliative Care.

Please also be aware of the Compas General Outcomes for General Practice and Community Care:

- **Medical knowledge: CLINICAL FEATURES of DISEASE**
  - **Cancer**
    1. **Compare the presentation of malignancy in primary care and secondary care and palliative care in the community and hospice.**

- **Clinical skills: HISTORY**
  - **Taking a History**
    1. **Be able to take and record a patient's medical history, and recognize the role of taking a focussed history**
    2. **Be able to present a coherent summary of a patient's medical history**

- **Clinical skills: PHYSICAL EXAMINATION**
  - **Examining the Patient**
    1. **Attain competence in the general examination and key systems examinations, namely cardiovascular, respiratory, abdominal and basic neurological examinations**
    2. **Be introduced to ENT in primary care and begin to carry out ENT examinations**

- **Clinical skills: FORMULATING A TREATMENT PLAN**
  - **General Principles of Patient Management**
    1. **Learn to apply theoretical knowledge to clinical practice in cardio-respiratory, gastrointestinal, metabolic and some neurology areas**
    2. **Recognize the importance of a holistic approach, with particular reference to chronic disease management and palliative care**

    1. **Examine the interface between primary and secondary care and the integration of community and hospital services**

- **Clinical skills: SUPPORTING PATIENTS and IDENTIFYING ABUSE and NEGLECT**
  - **Preventative care and Screening**
    1. **Begin to demonstrate skills in promoting behaviour and lifestyle change**

- **Professional issues: WORKING IN TEAMS**
  - **General Outcomes for Working in Teams**
    1. **Demonstrate effective communication skills (verbal, non verbal and written) with patients and with professionals within the primary care multidisciplinary team**

- **Professional issues: ETHICS and LAW**
  - **Good Medical Practice: Ethico-Legal Responsibilities of Patient Care**
    1. **Debate ethical issues pertinent to primary care**

Assessment

Students are assessed on their attendance, professionalism and clinical knowledge displayed on placement. This is an online assessment completed with the GP Tutor at the end of the placement.

Logbook Requirements for GP3

Students are required to complete the following activities and get them signed off in the logbook during their time on their primary care attachment:

- **Observed Short history taking** – 5 to be completed in the GP component
- **Observed Case Presentation** – 5 to be completed during whole attachment (Hospital & GP)
- **Marked Written cases**- 5 to be completed during whole attachment (Hospital & GP)
- **PBL attendance and reflection** – 2 cases to be completed within the GP attachment (to be advised which by Met 3B Module lead). Logbook must be signed by GP Tutor for PBL.
- **Practical skills** – as outlined in the logbook-blood pressures, urine dips, ECGs
- **Common and Important conditions** – as outlined in Met 3B learning outcomes-observe & read up
- **Observed procedures** – observe & read up
- **Observed examinations** - Cardiovascular, Respiratory, Abdominal, Nervous & Other- 5 to be completed during whole attachment (Hospital & GP).
- **Continuity Exercise** – Identify a patient with an acute exacerbation of a condition and follow them up on two further occasions during the placement in regards to ongoing management.

Suggested Activities on Primary Care attachment

The **content of the teaching sessions** will vary from practice to practice, and with the availability of different types of patients. However we recommend you include a balance of the activities listed below:

- Directly observed consultations/clinical skills with a GP Tutor.
- Tutorials and case presentations with GP Tutors and/or other Primary Care colleagues.
- Visit a housebound patient and report back to the GP Tutor after to discuss the pre-arranged learning objectives.
- Nurse- led clinic – general clinics but looking at specific objectives, i.e. common presentations or complications, medication, etc. with suitable supervision/discussion opportunities.
- Accompany patient to an outpatient appointment and explore their thoughts before, during and after the consultation (**note students to take ID and contact hospital prior to attending any OPA**)
- Specialist Nurse-led clinics eg Diabetes and CKD clinics-assisting or running (latter with remote support but previous Year 3 students have run chronic disease clinics; seeing patients, checking blood pressures and urines and recording on templates).
- Practice nurse home visits, other PAMS home visits eg physio, OT, social work.
- Attendance at Unplanned Admissions/ICM/Palliative Care meetings to discuss MDT management of patients and identify key roles of MDT in patient's care.
- Opportunity to get involved and present audits being undertaken within the practice.

Please contact the Year 3 GP Module Lead and/or Administrator directly if you have any problems with the GP aspect of your attachment. Contact details are found in the Year 3 CBME area of QMPlus.

Common Presentations

One of the challenges of general practice is taking patient symptoms and trying to make medical sense of them. This is where the skill of history taking lies – asking the right questions to guide you towards a diagnosis. In general practice it is not possible to ask every question of every patient and so the key is to allow the patient to talk as much as possible and ask questions that aim to draw out their story so that you can begin to construct a narrative of their health, whether that is the physical, mental or social aspects.

With that being said, it is helpful to have an idea of some of the possible underlying diagnoses for common presentations in primary care as this can help you to focus your consultation. Listed below are some of the common presenting symptoms in primary care – you might find it helpful to go through each of these symptoms and consider underlying diagnoses from the different systems: cardiac, respiratory, haematological, renal, endocrine, etc.

- Shortness of breath (SOB)
- Chest pain
- Tired all the time (TATT)
- Feeling faint
- Swollen legs
- Neck Lumps

History Taking Dilemma #1 in Primary Care: "The Patient doesn't have a presenting complaint!"

Patients can present to their GP with acute problems as in a hospital setting, but equally present for a review of their blood pressure or their medications, or a review of their ongoing chronic condition (including mental health), or a review of a resolving acute episode.

History Taking Dilemma #2 in Primary Care: "The Patient has LOTS of presenting complaints!"

Patients often come to see their GP with a list of issues to discuss and you will see clinicians use various strategies to manage this. In GP3, often patients are brought in specifically to speak to you, so in your clerkings you may want to explicitly focus upon one of their conditions (presenting complaint being "diabetes review" for example) and collect information about their other issues as part of your review of symptoms in order to generate a comprehensive problem list for when you present the case to your peers and your GP Tutor.

Continuity, Multimorbidity, Complexity, Uncertainty

These terms describe four key concepts that underpin Primary Care work. You may wish to consider these concepts during your longitudinal GP3 attachment and complete the suggested activities.

Continuity

Continuity encompasses several aspects, including the consistency of care with a healthcare professional over time, quality of the interpersonal relationships between healthcare professionals and patients, and availability of information about the patient. General practitioners value continuity of care, often considering it to be a core value of their profession, while many patients value a personal doctor to coordinate and integrate their care. Continuity of care is associated with reduced hospital admissions and reduced outpatient services (BJGP, 2013), but is under threat from new models of care. ***PLEASE COMPLETE THE CONTINUITY EXERCISE IN THE MET 3B/GP3 LOGBOOK. HOW DID CONTINUITY HELP HERE?***

Multimorbidity

This is defined by NICE as the presence of two or more long-term conditions (LTCs). It is associated with decreased quality of life, fragmented and poorly co-ordinated increased usage of healthcare, polypharmacy and psychological distress. In UK General Practice, 1 in 6 of all patients have two or more LTCs, including 65% of patients over 65 years and 80% of those over 85%. The most common pair of conditions are osteoarthritis and a cardiometabolic condition (e.g. hypertension or diabetes). A common triad is a cardiometabolic condition, a painful condition (e.g. arthritis) and a mental health condition (e.g. anxiety or depression). ***ON YOUR GP3 MODULE KEEP A RECORD OF THE PATIENTS YOU MEET AND HOW MANY OF THEM HAVE MULTIMORBIDITY. WHAT IS THE IMPACT OF MULTIMORBIDITY ON THEIR PHYSICAL AND MENTAL HEALTH?***

Complexity

You will hear patients being described as ‘complex’ in Primary Care although no one clear definition exists-are they medically complex (e.g. multimorbidity with polypharmacy and multiple providers) or are they either psychologically and/or socially complex? Often if patient complexity is not explicitly recognised and articulated, these patients can be challenging to manage. ***AIM TO DEFINE WHAT IS MAKING THESE PATIENTS COMPLEX WHEN YOU MEET THEM.***

Uncertainty

There are many consultations where there are no straight answers, no clear diagnosis and no obvious treatment, where guidelines and decision-making protocols do not lead to a satisfactory outcome. Without strategies to address uncertainty (such as safety-netting and discussing with peers) it can become a source of stress to GPs. The concept of uncertainty links closely with the Medically Unexplained Symptoms lectures as discussed in Year 3 Term 3 central teaching.

ON YOUR GP3 MODULE, OBSERVE PATIENTS THAT PRESENT WITH A PROBLEM THAT DOES NOT HAVE AN IMMEDIATE ANSWER, AND HOW THE GP MANAGES IT.

Social Prescribing

The terms ‘social prescribing’, ‘community referral’ and ‘non-traditional providers’ have all been used to describe a way of expanding the range of non-medical options that could be available to healthcare professionals when a person has needs that are related to socioeconomic and psychosocial issues.

Many people in the UK are in situations that have a detrimental effect on their health. The Marmot Review provided comprehensive analysis on the causes and consequences of health inequalities in England. Factors contributing to health inequalities can include financial, educational, poor housing, low self-esteem, isolation, relationship difficulties, and physical and mental health problems. There are also more people who are living longer and struggling to cope and adapt to living with Long Term Conditions which can’t be addressed by a clinical consultation.

A GP can quickly work out that the traditional options might have only a limited impact if, for example, poor housing is a factor in a person’s emotions; finance and employment concerns also have an adverse impact. It has been estimated that around 20% of patients consult their GP for what is primarily a social problem.

Social prescribing supports the individual, families, local and national government, and the private, voluntary and community sectors to work in collaboration. When done well, it allows people to self-manage their personal situation whilst experiencing physical, emotional and social challenges. Social prescribing can offer many people a personalised and flexible offer of support back to health at a pace that is appropriate to the person.

Some GP Practices either refer to a link worker or have their own Social Prescribing lead to signpost patients to non-medical activities with the aim of improving their wellbeing.

Examples of Social Prescribing activities include:

- Joining an exercise class, a walking group, a cycling group
- Joining a healthy cooking class
- Joining an art class as a form of expression of mental health
- Volunteering at a community garden or community cafe. Visiting an isolated person.
- Walking a dog for a neighbour.

DURING YOUR ATTACHMENT, BECOME AWARE OF THE SOCIAL PRESCRIBING OPTIONS EITHER DIRECTLY OFFERED OR SUGGESTED BY GPs OR OTHER PRIMARY CARE COLLEAGUES. TALK TO PATIENTS ABOUT HOW THESE ACTIVITIES HAVE IMPROVED THEIR HEALTH AND WELLBEING.

MDT in the Community: who does what?

GPs work with a wide range of professionals from other disciplines and often directly refer to colleagues in the multidisciplinary team (MDT) both within their practice and localities. You will look at this more deeply in your Met 3A week in GP, but it is also helpful here to understand the range of professionals in Primary Care and their roles. If you have a chance to attend your practice meeting then try to get an understanding of which professionals are in attendance and their roles – this may help you to enhance your understanding of how a community team works together to benefit patients.

Care Navigator

Their aim is to ensure that patients are able to participate fully in their daily life and their community. They help patients to identify and access systems and support available within their local health and social care sector. Roles may include: assistance with filling out forms, referral to social groups, help arranging transport to attend social groups/appointments, helping to identify available support from housing, benefits or debt management services. They are generally funded through third party organisations, e.g. charities, and therefore their availability is more vulnerable to being cut.

Dietician

Dieticians aim to promote good health and prevent disease through food. They advise people to help them make informed and practical choices about their food and nutrition. They also assess, diagnose and treat dietary and nutritional problems. Some have a role in teaching and informing the public and health professionals about diet and nutrition. They work in both community and inpatient settings but their roles differ somewhat. Hospital dieticians tend to focus primarily on short-term malnutrition and sudden changes in dietary intake, e.g. post-surgery. Community dieticians also assess and treat malnutrition but may also help patients with longer-term nutritional problems, e.g. obesity-related diabetes, or anorexia, to address their diet over time.

Health Care Assistant (HCA)

HCAs work under the guidance of a qualified health care professional (usually a nurse). They deliver more routine health care such as health checks, phlebotomy and health promotion work.

Health visitor

They work with children under 5 and their families to ensure that all children receive the best possible start in life. They provide postnatal (and occasionally antenatal) support to families by offering advice on feeding and parenting skills such as behaviour management, preventing accidents etc. They assess children's growth and development at regular stages (usually first few weeks, 1 year, 2.5 years, and preschool as a minimum)

Midwife

Community midwives look after women both antenatally and immediately postnatally (first 14 days after birth). Teams commonly come to practices to see women and specialist midwife teams exist

for complex pregnancies, e.g. teenage mothers, mothers with addiction and/or mental health problems

Occupational therapist (OT)
The primary goal of the OT is to enable the patient to participate in activities of daily living. They often carry out home visits to gain a more accurate understanding of the patient's life. This may involve: advising on how to approach a task differently, using specialist equipment to facilitate daily tasks, adapting the living/working environment.

Palliative care nurses
These specialist nurses work with patients at the end of their lives. They help with medications, physical and emotional support of patients and their families to ensure that the end of their life is peaceful. Macmillan nurses are a particular type of nurse who work with oncology patients and also have a lot of experience in end of life care.

Pharmacist
Pharmacists have a strong scientific background in pharmacology and the use of medications. They are able to rationalise medications with a patient, monitor their concordance, discuss side effects and suggest safe ways to take medications, e.g. particular time of day, dosset box, observed dosing for controlled drugs.

Physiotherapist
Physiotherapists focus on building strength and health through physical activity. They are experts in musculoskeletal health and a subset of physiotherapists have undergone further training to become extended scope practitioners. Extended scope practitioners have more experience and expertise and are able to work with more complex musculoskeletal problems, diagnose patients and sometimes request appropriate scans.

Podiatrist
They work with people's feet and legs. They diagnose and treat abnormalities and offer professional advice on care of feet and legs to prevent foot problems. In the NHS, they see many patients at high risk of amputations, such as those suffering from arthritis or diabetes, and can give advice on both toenail and foot conditions

Practice nurse
Nurses see patients in the practice to promote health and prevent disease. They may have a number of roles including wound management, travel health advice and vaccinations, family planning and women's health including cervical smears, smoking cessation.

Psychologist
Psychologists work with patients in the community who are suffering with depression, anxiety or other mental health difficulties. They offer psychological therapy but are not responsible for the diagnosis or medical management of mental health conditions.

Social worker
Social workers work with individuals and families to help them live more successfully. Meet with individuals and/or their families to discuss their specific needs and try to implement support to help with this. This may involve putting in a care package, advising the patient of available support groups or financial support, meeting regularly with the patient/their family to monitor and review progress. Social Workers also perform capacity assessments and take lead in safeguarding of adults and children.

Speech and Language Therapist (SLT)
They provide treatment, support and care for patients with communication and/or swallowing difficulties.

Do not forget the range of administrative staff that are based at the practice and in the community also! On your GP3 attachment, aim to spend some of your time with the administrative support to more deeply understand the complexity of how Primary Care is organised.

Recommended Reading

Resources on QMPlus-Year 3 Integrated Clinical Studies webpage-list of commonly used guidelines and documents.

Further Reading

Some websites to stimulate reflection, thought and discussion:

Out of Our Heads - a range of medical student and clinician artwork
My daft life - a blog by Sara Ryan who is a mother and learning disabilities researcher about many things but including her perspective on her son Connor who died in an NHS care institution from a seizure
Kate Granger - an elderly care registrar who died from sarcoma in July 2016 who started the campaign Hello, my name is
Betabetic - a complex endocrine patient writes a blog on her healthcare experiences
Which Me Am I Today - Wendy Mitchell's experience of living with dementia. She has also written a book called Somebody I Used to Know
A Better NHS - a blog focusing on the political changes that affect the NHS from a general practice perspective

Some books to stimulate reflection, thought and discussion:

Being Mortal by Atul Gawande
This is Going to Hurt by Adam Kay
The Immortal Life of Henrietta Lacks by Rebecca Skloot
Also human: the inner lives of doctors by Caroline Elton
The State of Medicine: Keeping the Promise of the NHS by Margaret McCartney
The Digital Doctor: hope, hype and harm at the dawn of medicine's computer age by Robert Wachter
It's all in your head: stories from the frontline of psychosomatic illness by Suzanne O'Sullivan

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