UNIVERSITY of TASMANIA | Rural Clinical School

MBBS Undergraduate Rural Clinical Programme 2020

Year 4 & 5 Medical Student Workbook for General Practice

Introduction

General Practice is 'the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.'
(RACGP, 2005) https://www.racgp.org.au/education/students/a-career-in-general-practice/what-is-general-practice

Aim

The aim of your 4th year General Practice rotation is to focus on common diseases managed in General Practice and to give a perspective on managing chronic diseases, managing minor illness and immediate care of acute severe illness.
Students should be able to draw up management plans in collaboration with patients. There is a strong emphasis on preventative medicine and continuity of care

The aim of the final year placement is for students to gain an immersion in Rural and Remote General Practice including participation in the health care provided in a community hospital or nursing home. In final year, students are expected to gain the skills required to be an intern in General Practice. This should include immediate care and management of patients with complex multi morbidity. Students should be able to draw up management plans in collaboration with patients.

Learning Outcomes

1. Plan and demonstrate competent history taking which allows formulation of a differential diagnosis and appropriate use of investigations.
2. Develop comprehensive management plans for common acute and chronic health issues.
3. Demonstrate an ability to collaborate with patients to develop a shared management plan and implement strategies for lifestyle change, prevention and health enhancement, utilising an evidence-based approach.
4. Value an integrative, patient centered approach to medicine, which examines the patient's perspective, considers the factors which impact on health and develops communication skills to create an effective patient doctor relationship.
5. Students should be able to work in a multidisciplinary team in primary care and understand how members work and communicate to improve patient care.

RCS Primary Care Team

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Course Delivery across Years 4 & 5

Students in Year 4 are allocated to attend a General Practice on Tuesdays throughout the teaching year. The aim of this longitudinal placement is to allow students to follow patients up over a period of four to five months and gain skills in Chronic Disease Management.

Students in Year 5 are allocated to a Rural or Remote Practice for 4 weeks. The aim of this placement is for complete immersion in General Practices with a rural and remote Primary Care focus including working in a rural hospitals or nursing homes. Students may arrange their own Rural and Remote Practice with permission from Dr Shires. Every Thursday afternoon from 12pm – 12:45pm there will be a Skype meeting with your RCS tutor to discuss cases you have seen during the week.

Year 4 GP teaching

Primary Care teaching will be on the Wednesdays & Thursdays of each group learning week

In the first term, students will be concentrating on history and examination skills and in the second term, we expect students to develop more management skills. Throughout the term, we expect students to follow up patients with new and chronic illnesses to gain perspectives in longitudinal care.
Each day students will have at least one session consulting and the other session is spent undertaking other primary care activities.
The Primary care activities that will support this learning are listed in the appendices and should be achieved during your time in General Practice.
Here is a list of common clinical presentations that you should be familiar with in **Appendix 4**.

GP supervisor

Students may work with one, or *across a team* of, GPs but the nominated GP supervisor will act as a mentor, responsible for all activities to do with Primary Care teaching and learning, including reviewing student clinical logbooks and written primary care tasks, completing the Clinical Attachment assessment and marking the oral chronic long case presentation in year 4.

Getting the most out of your GP placements

You will need to find out your expected start and finish times. You will need to arrive early and be ready to start at the time advised. **It is essential you advise the practice manager and Karen Lowe if you are unable to attend any of the sessions for any reason.**

The basics

- Ensure you have your name badge on at all times.
- Take the time to introduce yourself to all members of staff.
- Discuss the aim and outline of your GP rotation with your GP at the start of your rotation.
- Always be courteous and respectful of being allowed into a private practice.
- Remember the importance of appropriate professional behaviour and confidentiality. You are working in a small community where many of your patients will be friends and family of other students or health professionals.
- Only access the medical records of patients you are seeing and for whom you have consent. Many practices have a tracking system on their electronic notes. Unauthorised access to notes is a breach of professionalism and will be reported to the head of school for disciplinary action.
- Ensure you are appropriately dressed at all times
- **Mobile phones off**. If you wish to access your electronic device during a consultation to look something up, please ask permission and make sure that patient and supervisor know what you are doing and why.

Consulting Time

Practices will organise your consulting times according to space and the preference of the individual practice. We advocate wave consulting once you are established but this may not always be possible. Most students will get one session Consulting and another participating in other primary care activities each day.

Active Observation in Consultations

When observing:

- Note different communication styles and how the GP elicits the patient's agenda and checks understanding.
- For new presentations see how quickly you can reach a diagnosis and always consider what your own management plan would be.
- For chronic conditions observe the level of patient self-management, what routine follow-ups are undertaken and why and what medications the patient takes and why. Consider what the ideal management plan would be and why this might differ in that patient. You can then compare this with what your GP does. Be prepared to be questioned on your clinical reasoning.
- Always note which medications the patient is taking and consider what follow up or specific advice they should have for each of these.

- Use your logbook to keep a list during day of topics you want to look up. You can then ask your supervisor for further clarification.

Computer in General Practice

Most practices are fully computerised. There is a 'virtual' surgery in **Appendix 7** so you can familiarise yourself with the computer.

What should the non-consulting student do in General Practice?

Students can undertake a wide range of activities in this time developing procedural skills, interprofessional education, community liaison, audit and self-directed study. The non-consulting student can be called in to see / work with any of the other members of the practice team if they have something they feel would be of interest to the student.

Other Learning opportunities

- Visit residential aged care facilities
- Undertake home visits
- Attend home medication reviews
- Follow up their long cases
- Research on the conditions or medications they see in consultations
- Auditing
- Over 75 check
- A list of skills and non-consulting activities linked to CBL tasks are included in **Appendix 1 & 2.**
- Sample referral and discharge letters audits are supplied in **Appendix 5**
- Practices will have their own clinical audits; data can be obtained by searching the medical computer database or via the division search engine. If this is not available, we can supply this.

Team Work

Team work is a vital component of General Practice. Working with receptionists helps to develop an understanding of how practice works and how patients present to non-clinical staff.
Working with the practice nurse and other members of the team. Activities could include blood taking, immunisation clinics, dressings, developing GP management plans, practical skills INR testing, BSL, Spirometry, health checks etc.

Interprofessional Education

Interprofessional learning is important for medical student's education. Doctors need to understand other health professionals' role and how they contribute to health care for patients we see. Each practice and area offer a wide variety of learning opportunities.

Shadowing allied health professionals that attend the practice and arrange to visit allied health professionals in the community.

Students must spend at least one session with the community nurse, child health nurse and community pharmacist.

Other important allied health visits to arrange if student has not worked with these health professionals before.

- Podiatrist
- Physiotherapist
- Occupational Therapist
- Ophthalmologist
- Audiologist
- Psychologist
- Diabetes Liaison Nurse

It is for the student to negotiate with the practice the best time for these attachments and the type of attachments that are available in the area. If there are any problems arranging these please contact Karen Lowe on 03 6430 1668.

A list of attachments is drawn up. There is also a medical student induction sheet. **Appendix 3.**

Other sessions can be negotiated with the practice according to local opportunities and your learning needs. If you have problems arranging these please contact Karen Lowe on 03 6430 1668.

Primary Care Simulated Cases

Clinical Cases are available for self-directed learning in the consulting skills manual in appendix 11 these types of cases will form a basis for some of the formative and summative OSCE assessments In General Practice.

Community Engagement

General Practitioners play an important role in their communities. Students should experience some aspects of this wider role. Activities such as working with school groups and voluntary organizations are important learning experiences. We would like medical students to participate in teaching or

patient education in the community. If the practice has links that would facilitate this, then these activities could be undertaken on a Tuesday.

The RCS has teaching plans and resources for students wishing to teach on health careers, first aid, sexual health, drugs, and alcohol for year 7/8. Please contact Dr Shires for a copy of these.

The RCS will also organise activities through out the year that encourage students to take on an active teaching role with younger students and local high schools. Students involved in these activities will inform the practice if they occur on a Tuesday.

Course Assessment

Clinical Attachment: At the beginning of each General Practice placement, students should discuss their learning objectives with their GP Supervisor. These should reflect the MBBS objectives, students' interests, strengths and weaknesses. Supervisor feedback should be given to the student before completion of the attachment. At the end of each GP placement, students must submit an attachment report from the GP supervisor, which assesses the student on a variety of professional and personal attributes. If there are any issues during the semester, these should be discussed with Dr Shires as soon as they arise.

Clinical Log Book: Students should use the electronic logbook. These logbooks will include records of procedural skills and incorporate a range of cases. Students are not expected to record every case they have seen, rather only those cases in which they have had *substantial* involvement. As a general guide, students would be expected to record at least three cases from each day in general practice and these cases should cover a broad range of primary care issues, and the degree of detail recorded should enable the student to make a brief case presentation using those notes. Progress of student logbooks should be reviewed by GP supervisors on a regular basis

Procedural Skills: Students are required to be assessed across a wide range of practical and procedural skills, many of which will be encountered in General Practice. These should be recorded in the clinical logbook (see Appendix 3 for list of skills). Many of these skills can be taught and developed under the supervision of the practice nurse.

Year 4 Oral Chronic Rural Longitudinal Case

Students will follow up many patients during their attachment. Each student will present one case at the end of semester to the practice and GP liaison academic. The date and time of the presentation should be negotiated between the practice, the student and the RCS GP liaison academic.

Early in the attachment, students should discuss with their supervisor a suitable patient and ask if they can be followed up on the day that the student is in the practice. The patient should have a chronic illness, whether physical or psychological.

Follow up could include home visits, hospital admission/visits and GP, specialist or allied health provider appointments as appropriate. The case therefore needs to be relatively complex and should involve aspects of management that illustrate the particular constraints, psychological stressors and financial and other challenges experienced by patients in rural settings.

Each case should include details of a visit with the patient to a non-GP health care provider (eg. specialist, optometrist, and physiotherapist).

The details of the clinical case should be concisely stated, with the principal discussion focusing on how the chronic disease itself impacts on the patient and their family. The patient's ability to self manage and their GP and team care management plan discussed. The presentation should be about 15 minutes to allow 10 minutes for discussion. Details on how to find and present a case, with examples from previous years are available on MyLO. See the marking criteria Appendix 9

Year 5 assessments

Year 5 Complex Chronic Illness Longitudinal Case Including Complex Therapeutics:

This written assessment is part of the summative assessment for year 5 and is submitted for consideration of the School's therapeutics prize. Details of the marking criteria are included in the Faculty of Health Handbook and on MyLO. MyLO contains a guide to how to approach this essay a narrated PowerPoint and some examples from previous years.

Year 5 Oral Complex Chronic Illness presentation, ethics, and law activity.

See MyLO for presentation and examples for this assessment.

Appendix 1 - 18 Common GP problems:

Adapted from Bristol Medical School hand book using Australian BEACH data

Problem	Presentation	Learning objectives
Hypertension	The nurse said my blood pressure was high	Demonstrate how to diagnose and manage hypertension.
Asthma, angina	My chest feels tight	Describe how to diagnose asthma & angina, how to manage these chronic conditions.
Gastro-oesophageal reflux & alcohol dependence	I've got heartburn	Describe investigation & management of heartburn. Demonstrate ability to recognize alcohol dependence & offer help with stopping drinking.
Chronic obstructive pulmonary disease (COPD), heart failure & smoking	I get out of breath easily	Describe how to diagnose & manage COPD and heart failure. Demonstrate ability to help someone to stop smoking.
Diabetes and other chronic diseases	I go to the toilet more than usual	Screening and health checks Diabetes cycle of care and chronic disease management
Anaemia, hypothyroidism, insomnia, depression, early pregnancy, chronic fatigue syndrome	I feel tired all the time	List differential diagnosis of tiredness. Describe how to investigate anaemia. Describe presentation, investigation & management of each of these conditions. Medically unexplained symptoms Diagnostic uncertainty and safety netting
Depression	I feel useless	Be alert to possibility of depression and use skilful questioning to confirm diagnosis. Be familiar with at least one antidepressant drug.
Migraine, tension headache	I've had a headache for the last 2 days	Demonstrate how to assess a patient with a headache. Discuss treatment & prophylaxis for migraine.
Contraception	I'd like to go on the pill	Be familiar with at least one combined oral contraceptive pill. Demonstrate how to assess a patient before starting her on the pill and how to follow her up. Discuss methods of post-coital contraception.
Urinary tract infection, chlamydia & common STDs	It stings when I go to the toilet	Demonstrate how to manage simple UTIs and be alert to possibility of prostatic hypertrophy/cancer in men. Be alert to possibility of STDs causing dysuria. Feel confident in taking a sexual history.
Mechanical low back pain	My back hurts	Demonstrate management of back pain & discuss when investigation is warranted. Work place injuries
Common cancers: lung, bowel, prostate & breast	I'm losing weight; I'm still coughing; I've got a pain, I have to go to the toilet all the time; I've found a lump in my breast	Describe how these 4 common cancers might present and know how to reach a definite diagnosis. Describe how to manage a patient who is terminally ill as the result of any of these cancers.
Eczema	I've got this itchy rash	Recognise & demonstrate how to manage eczema.
Viral sore throat, glandular fever, tonsillitis	I've got a sore throat	Discuss management options for each of these conditions. Communicate the potential benefits & disadvantages to the patient.
Otitis media & externa	My ear hurts	List differential diagnosis of earache & management options for otitis media & externa.

Problem	Presentation	Learning objectives
Gastroenteritis	I've got diarrhoea	Describe management of food poisoning & oral rehydration.
Preventative care Screening and health checks	Can I have a check up Do I really need those needles?	Evidence base for health checks in different age groups and populations – 4-year-old ,45-49, over 75 and item numbers Screening programmes for breast, cervix, bowel, cancer and diabetes Shared negotiation around non screening tests eg PSA testing.
Skin damage, cancer	Can you check my skin	Common skin conditions and their management
Medically unexplained symptoms	Chronic pain or fatigue	Diagnostic uncertainty and safety netting
Sleep disorders	I can't sleep	Management of insomina
Dementia	My partner has memory issues / behaviour changes	Investigation and management of dementia
Arthritis	My hands/knee/shoulder/ hips hurt	Investigation and management of arthritis (such as osteoarthritis, rheumatoid arthritis)
Vertigo/Dizziness	I've been feeling dizzy	Investigation of dizzy turns. Management of common causes of dizziness and vertigo
Anxiety	I'm stressed out	History taking and management of anxiety
Obesity	It's my metabolism I just need a diet tablet	Management of obesity
Childhood injury prevention	My toddlers scalded himself	How to prevent childhood injury.

Appendix 2 – Procedural and Professional Skills List

GENERAL DOCTOR & PATIENT	
History, examination and management of common conditions	Subcutaneous and intramuscular injections
Oral Communication skills: case presentation	IV cannulation (including set-up and IV fluid administration)
Written Communication: Note writing, referrals, GPMP, Mental Health care Plans	Venepuncture for venous blood sample
Consultation skills: History taking, explaining, shared negotiation, Motivational interviewing	Measures blood glucose levels using finger prick testing
Investigations skills: Advise on appropriate investigations and organize paperwork	Administration of local anaesthesia
Management skills: Advise on appropriate management and organize paperwork	Ophthalmoscopy, fluorescein staining, eyelid eversion, using slit lamp
Mini-mental state examination, Mental state examination, Suicide risk assessment	Removal of foreign body in the eye, applying padding as appropriate
Medication management: IN clinic, Home medication review, Over 75 check	Foreign body removal - ear & nose
Admission and inpatient management of patients in community hospitals or nursing homes	External auditory canal irrigation, external auditory canal ear wick insertion
Observation of breaking bad news	Preparation for sterile procedures including hand washing.
Intimate examination skills: breast examination, vaginal examination, examination of the penis and scrotum, digital rectal examination, cervical screening test, taking swabs (such as a high vaginal swab)	Dressings
Samples, analyses and reads urinary dipsticks	Simple skin lesion excision
Blood pressure measurement, measurement of height, weight, BMI, waist circumference in adults and children	Surgical knots & simple suturing
ECG	Suture removal
Peak flow meter function testing Spirometry, inhaler technique	Simple swab using standard microbial collection

Appendix 3 – Nursing and Allied Health Attachments

Medical Student Induction Sheets

Name of staff member	
Position/ role of staff member	
Contact numbers	
What is their role in the PHCT?	
How do patients access their services?	
How do GP's access their services?	
What sort of cases do GP's refer?	
How do they normally liaise with GP's?	
Key areas to discuss	

Community Nurse - Key clinical management areas to discuss during induction

- Role of Community nurse
- ACAT team assessments
- Role in chronic disease management
- Role in care of the housebound
- Leg ulcers
- Post op care at home- early discharge
- Services available eg blood taking BP monitoring supervision of diabetes care etc
- Access to Aids and other essentials for daily living
- Falls / ‘gone off legs’
- Abuse of elderly, recognition and management
- Services for elderly
- Immobility - pressure sores, stiffness, muscle wasting
- Terminal care- Community Nurse Role and other agencies available.

Child Health Nurse - Key clinical management areas to discuss during induction

- Developmental surveillance – Child health and GP role
- Delayed development when to refer
- Growth, use of centile charts
- The normal newborn - examination, minor problems
- Jaundice in the newborn
- Infant feeding
- The baby that is always crying
- The screaming baby
- Rashes in the nappy area
- Won’t eat, won’t sleep problems
- Common congenital defects
- Tantrums
- Knock knees, bow legs and flat feet
- Clumsy children
- Handicapped children - medical and psycho-social aspects
- Physical handicap - cerebral palsy, muscular dystrophy
- Hyperactivity - ADHD
- Enuresis and soiling
- Constipation in children
- Failure to thrive - coeliac, cystic fibrosis, social
- Child abuse - at risk register, role of social services, place of safety order
- case conferences, child sexual abuse
- Cot death
- Laws relating to children

Appendix 4 - Virtual Surgery

- Look up notes
  Find out how to look at
    - results
    - previous notes
    - the letters
    - current medications
    - past medications

Use the practice 'phantom patient'

- Enter significant PMH eg IHD, allergies eg to penicillin, family history of diabetes
- Write in today's notes
- For the common conditions listed below develop short cuts
- (Set up your computer so you can have investigation strings and common templates in your favourites).
- Develop 'blood investigation strings' for diabetes, hypertension, and fatigue.
- Know at least one drug for treating conditions- for prescribers print out prescription
- Identify skills you may need to manage these conditions.
- Identify patient information leaflets you may need. If not on main system look at: http://patient.info/
  UK disease encyclopaedia and patient leaflets- linked to UK EBM
  https://www.betterhealth.vic.gov.au/conditionsandtreatment Australian Patient information leaflets

- Write a referral letter.
- Write a certificate.
- Write a Centrelink certificate.
- Write a worker's compensation certificate.
- Fill in a CDM template for the chronic conditions below
- Fill in a GP Mental Health Plan.

RCS has demo models of Best Practice and Medical Director

Log on to terminal Server

1. Open the "Medical Director and Best Practice Terminal Server" icon on the Desktop, and logon as yourself ensuring the server name is NWRCS
2. User: Dr Frederick Findacure
   Password: samples
3. Medical Director' icon
   Password: password
   Configuration: HCN Sample Data

Appendix 5 – GP MANAGEMENT PLAN

YOUR GP MANAGEMENT PLAN

NAME: **Mr John Zipper Test Patient** **DOB:** **01/01/2011**
DATE OF PLAN: **13/07/2012** **Review plan 6 months following original completion**

CHRONIC NEED	PROVIDER DETAILS	AGREED MANAGEMENT GOALS	REVIEW MONTH
	Dr Elizabeth Shires **6 Patrick Street** **Ulverstone 7315** **0364251611**	**Goals to keep healthy** **Stop smoking** **Quit line support** www.quitnow.gov.au **Phone** 131848/ 137848 **Weight** Aim for normal weight **Your Weight** **Your Goal** **Review** **Diet: Less**: foods high in cholesterol or animal fat, drinks cordials, fruit juice alcohol **More:** Fruit, Vegetables, Fibre, Fish, **Your Goal** -Reduce portion size, stop snacks, Drink water, Five portions a day of fresh fruit& veg **Alcohol**- no more than 2 drinks per day preferably less. **Salt** Lower salt intake: cut use of salt in cooking avoid high salt prepackaged foods, **Exercise** - Take regular exercise **Goal** Brisk walking for 30 minutes per day. **More advice** available from your GP or www.betterhealth.vic.gov.au	**Pap due** **Mammogram** phone 132050 **Immunisations** annual flu vax **Bowel Cancer screening** due from 50 **Diabetes Screening** due from 45 **Family history** of disease ask GP about screening
Asthma		**Asthma Goal : Self manage** to become Symptom Free through Asthma Action Plan **Asthma information** from Asthma Australia www.asthmaaustralia.org.au/intro/index.php •Take inhalers as prescribed, use spacer •PF or symptom monitoring for adjusting dose •Avoid triggers eg smoke, animals, dust, consider pillow and bed protectors •Avoid meds that make it worse eg NSAID's and aspirin **Keep physically active** **Attend GP** if symptoms not controlled: Annual review with spirometry before due	
Vitamin b12		**Low Vitamin B12 :Goal: maintain normal Levels** Iron and folate status Underlying cause 1 mg hydroxocobalamin IM, on alternate days for 2 weeks then 1 mg IM, once every 3 months. **C**onsider oral B12 if underlying absorption issues gets better **annual review due**	
Breast Cancer		**Breast Cancer follow up Goals: Prevention of complications and early detection.** Well being and activity goals maintained **Annual reveiw due:** Mammogram and U/S scan & Bloods and CA125 or tumour marker before review appointment Maintain Bones: Vitamin D and Ca supplements consider dexa screening	
COPD		**COPD Goal:** Reduce symptoms recognise and treat infections early •Take inhalers and medication as prescribed •Keep active, consider physio •Attend GP if increasing symptoms •Annual Spirometry next due •Self help materials available through the lung foundation http://www.lungfoundation.com.au/images/stories/docs/education/save_your_breath/save_your_breath.pdf	

YOUR GP MANAGEMENT PLAN Template

NAME: **DOB:**

DATE OF PLAN: **Review plan 6 months following original completion**

CHRONIC NEED	PROVIDER DETAILS	AGREED MANAGEMENT GOALS	REVIEW MONTH

Appendix 6 – Year 4 Assessment Forms

UNIVERSITY of TASMANIA

Clinical Attachment Assessment Form

Clinical Attachment Form: Supervisor's Report adapted from the Intern AMC assessment form

To be completed by supervising Specialist (or Registrar if more appropriate)

This Clinical Attachment Assessment form should be completed in consultation with the student who has been assigned to you. This forms a significant part of the student's portfolio and is an essential assessment requirement for passing the year. The student should be assessed at their year level.

Student Name	
Student ID Number	
Year of Study	
Rotation Discipline	
Dates of Attachment	
Assessors Name	
Assessors Position	

	Unsatisfactory	Borderline	Satisfactory	Above average	Excellent	Could not be assessed
Domain 1 - Science and Scholarship: the medical graduate as scientist and scholar						
Knowledge	☐	☐	☐	☐	☐	☐
Evidence based approach	☐	☐	☐	☐	☐	☐
Domain 2 - Clinical Practice: the medical graduate as practitioner						
History taking	☐	☐	☐	☐	☐	☐
Clinical examination	☐	☐	☐	☐	☐	☐
Evidence based Clinical management decisions	☐	☐	☐	☐	☐	☐
Can determine problem or differential list including patient management goals	☐	☐	☐	☐	☐	☐
Use and interpretation of investigations	☐	☐	☐	☐	☐	☐
Communication with patients and relatives	☐	☐	☐	☐	☐	☐
Medical record keeping	☐	☐	☐	☐	☐	☐
Safe and effective Therapeutics and fluids.	☐	☐	☐	☐	☐	☐
Procedural skills	☐	☐	☐	☐	☐	☐
Domain 3 - Health and Society: the medical graduate as a health advocate						
Understands social aspects of disease	☐	☐	☐	☐	☐	☐
Disease prevention and health promotion	☐	☐	☐	☐	☐	☐
Domain 4 - Professionalism and Leadership: the medical graduate as a professional and leader						
Professional approach	☐	☐	☐	☐	☐	☐
Patient confidentiality	☐	☐	☐	☐	☐	☐
Motivation and reliability, punctuality and attendance.	☐	☐	☐	☐	☐	☐
Participates in the teaching of others	☐	☐	☐	☐	☐	☐
Appreciation of ethical issues of clinical practice	☐	☐	☐	☐	☐	☐
Teamwork Communication with staff including clinical handover	☐	☐	☐	☐	☐	☐
Patient Centredness including safety, infection control and adverse reporting	☐	☐	☐	☐	☐	☐
Reflective student and demonstrates strategies for lifelong learning.	☐	☐	☐	☐	☐	☐

Supervisor Feedback

Areas of Strength:

Areas for improvement:

Overall assessment of student's performance during the placement:

☐ **SATISFACTORY TO PROGRESS** ☐ **HAS NOT MET REQUIREMENTS TO PROGRESS**
(please specify reasons below)

Reasons why student has not met requirement:

The following submissions should be attached to assist in making an assessment:

- **2 Mini-CEX**
- **Logbook briefly evidencing at least 10 patients seen per week**

Have you provided this feedback to your student? **YES** **NO**

Student Signature		**Date**	
Assessors Signature		**Date**	

If Supervisors or Assessors have any queries or concerns, please make contact to discuss:

Hobart Clinical School: Hobart.clinical.school@utas.edu.au
Launceston Clinical School: lcs.admin@utas.edu.au
Rural Clinical School: rcsstudent.enquiries@utas.edu.au

Year 4 - Complex Rural Longitudinal Case Presentation (GP) Oral Presentation Assessment (RCS Only)

This case should be of a patient with a chronic disease that the student has followed up over the months in practice

Case Identification	
Student name	
Assessor/s Name	
Date / GP Semester I or II	

	Performed Competently	*Performed but not yet fully competent*	*Not performed competently*	*Not performed*	*N/A*
Domain 1 Science and Scholarship: The medical graduate as scientist and scholar ***Domain 2 Clinical Practice: The medical graduate as practitioner*** ***A. DEMONSTRATES AN UNDERSTANDING OF THE UNDERLYING CLINICAL CONDITION/S AND Evidence based practice management for Chronic Diseases***					
Demonstrates ability to present patients history succinctly **History** including initials, sex, age, chronic disease, history of chronic disease, other co-morbidities, past / ongoing medical history, family history, drug history, social history	☐	☐	☐	☐	☐
Demonstrates appropriate knowledge of evidence based care for management of one of the chronic disease	☐	☐	☐	☐	☐
Adequately describes and discusses the management plan for the main issue for this patient	☐	☐	☐	☐	☐
Discusses differences in care from recommendations and why this has occurred Demonstrates an understanding of decision analyses e.g. medications, investigations for this patient; NNT and NNH for medications; Multi morbidity	☐	☐	☐	☐	☐
Domain 3 Health & Society: The medical graduate as a health advocate ***B. DEMONSTRATES AN UNDERSTANDING OF ISSUES RELATING TO THE RURAL CONTEXT: These can be positive or negative but should comment on at least one of the following aspects:***					
Impact on patient of living in a Rural Area	☐	☐	☐	☐	☐
Describes the follow-up process in which the student has engaged e.g., home visits, attendance at community based specialists, hospital admission / visits and GP Appointments and what they learnt	☐	☐	☐	☐	☐
Describes patients issues with their health and their self-management strategies and what impacts on these	☐	☐	☐	☐	☐
Demonstrates how patients psychosocial situation impacts on the management of their disease	☐	☐	☐	☐	☐
Includes a summary GP management plan of all the patients conditions in table form as a hand out for patient	☐	☐	☐	☐	☐
Domain 4 Professionalism and Leadership: The medical graduate as a professional and leader. ***C. DEMONSTRATES WELL DEVELOPED written and oral COMMUNICATIONS SKILLS:***					
Provides useful summary of current research and its impact on ideas about best practice re rural context and clinical management	☐	☐	☐	☐	☐
Demonstrated professional values through presentation	☐	☐	☐	☐	☐
Uses communication tools effectively	☐	☐	☐	☐	☐
Engaged audience in effective and relevant discussion issues raised by the case	☐	☐	☐	☐	☐
Kept to time, the presentation should be no longer than 15 minutes, with 10 minutes for discussion	☐	☐	☐	☐	☐
Assessment Feedback:					

OVERALL ASSESSMENT RESULT:	☐ *Excellent*	☐ *Good*	☐ *Satisfactory*	☐ *Unsatisfactory*

UNIVERSITY of TASMANIA

Year 4 – Long (Chronic/Complex) Case Report Assessment Form

(1,000 – 1,500 words)

Student name:	**Rotation:**
Assessor name:	**Date:**

Criterion	*Demonstrated Competence*	*Demonstrated but not yet fully competent*	*Not demonstrated competently*	*Not Demonstrated*
Domain 1: Science and Scholarship: The medical graduate as scientist and scholar				
Demonstrates ability to summarise the case including key features of clinical history, relevant problems and management plan	☐	☐	☐	☐
Shows throughout the report ability to interpret and integrate basic sciences (e.g. physiology, pathology) with clinical features and diagnostic reasoning	☐	☐	☐	☐
Report is legible with correct use of written English (except in the parts of the history and examination where conventional note form is appropriate) and is largely free of spelling errors.	☐	☐	☐	☐
Refers to relevant literature that is appropriately integrated, and referenced with VANCOUVER style	☐	☐	☐	☐
Domain 2: Clinical Practice: The medical graduate as practitioner				
Provides relevant history including demographics, past / ongoing medical history, family history, medication history, social history, allergies and in logical format	☐	☐	☐	☐
Outlines examination findings and investigations and links positive findings to problem list/diagnosis	☐	☐	☐	☐
Describes patients' goals/ expectations and assesses likelihood they would be addressed or met	☐	☐	☐	☐
Provides a relevant and prioritised problem list briefly describing the status of each problem. Provides evidence of diagnostic reasoning if differential diagnosis uncertain	☐	☐	☐	☐
Describes treatments including referenced evidence to support them (evidence based medicine). Shows how therapeutic decisions were made including rational use of medicines.	☐	☐	☐	☐
Domain 3: Health & Society: The medical graduate as a health advocate				
Describes any care coordination, team care, patient self-management and health promotion. Describes involvement of other team members and considers options available and options taken up. Includes Management Plan.	☐	☐	☐	☐
Shows understanding how other co-morbidities / personal / socio-economic / rural factors influenced diagnosis and management. i.e. social determinates of health	☐	☐	☐	☐
Indicates patients' ability to self manage and supportive factors and barriers to this.	☐	☐	☐	☐
Domain 4: Professionalism and Leadership: The medical graduate as a professional and leader				
Demonstrates professional and ethical approach and interdisciplinary learning. Identifies and addresses any relevant ethical issues that may have arisen.	☐	☐	☐	☐

Assessment Feedback:		
OVERALL ASSESSMENT RESULT:	☐ ***Satisfactory***	☐ ***Unsatisfactory***

☐ **REQUIRES RESUBMIT**	**DUE DATE OF RESUBMISSION:**	
☐ **NEW CASE REQUIRED**	**DUE DATE OF NEW CASE:**	

UNIVERSITY of TASMANIA

Year 5 - Chronic Illness Longitudinal Case including Complex Therapeutics Long Case History Assessment Form (3,000 words)

Student name:	**Rotation:**
Assessor name:	**Date:**

Criterion	*Demonstrated Competence*	*Demonstrated but not yet fully competent*	*Not demonstrated competently*	*Not Demonstrated*
Domain 1: Science and Scholarship: The medical graduate as scientist and scholar				
Relevant literature appropriately integrated, acknowledged and referenced with VANCOUVER style	☐	☐	☐	☐
Domain 2: Clinical Practice: The medical graduate as practitioner				
Case Summary: Succinct summary which could be used in patient hand over or referral letter 250 word limit	☐	☐	☐	☐
History including initials, sex, age, chronic disease, history of chronic disease, other co-morbidities, past / ongoing medical history, family history, drug history, social history. Written in a format to reflect clinical note taking.	☐	☐	☐	☐
Chronic Disease Management for diseases having significant impact on patient Relevant history, examination, investigations **and patient goals.** Relevant interventions / treatments are outlined with evidence to support them and compared to patient's actual treatment.	☐	☐	☐	☐
Therapeutic Issues For medications include NNT and NN to harm if available. Best practice vs actual practice for this patient and reasons for differences. Prescribing modifications required due to comorbidities and other factors such as patient disease, compliance, costs, drug interactions	☐	☐	☐	☐
Domain 3: Health & Society: The medical graduate as a health advocate				
Patient Self Management **Demonstrates an assessment and engagement with the patient's health literacy level** Patients understanding of condition and self management. Has explained patient's ability to self manage: supportive factors and barriers to this How other co-morbidities / personal / socio-economic / rural factors influenced management Involvement of other team members: Options available and options taken up. Students role in supporting patient self management.	☐	☐	☐	☐
Appendix: 1/2 page Summary Management plan which addresses all chronic disease, co-morbidity, includes medications, follow-up and Patients Goals of care for each condition. This should be in table form and patient centred ie no medical terminology. See example	☐	☐	☐	☐
Domain 4: Professionalism and Leadership: The medical graduate as a professional and leader				
Written work demonstrates professional approach. Report is legible with correct use of written English (except in the parts of the history and examination where conventional note form is appropriate) and is largely free of spelling errors.	☐	☐	☐	☐

Assessment Feedback:		
OVERALL ASSESSMENT RESULT:	☐ *Satisfactory*	☐ *Unsatisfactory*

☐ REQUIRES RESUBMIT	☐ DUE DATE OF RESUBMISSION:	
☐ NEW CASE REQUIRED	☐ DUE DATE OF NEW CASE:	

UNIVERSITY of TASMANIA

Year 4 & 5 Mini-CEX Assessment Form *(to be completed by Clinical Supervisor)*

Student Name:	**Date of Assessment:**
Year of Study: ☐ Year 4 ☐ Year 5	**Student No:**
Assessor:	**Assessor's Position:** ☐ JMO ☐ Registrar ☐ Consultant
Patient Problem:	**Speciality:**
Case Complexity: ☐ Low ☐ Medium ☐ High	**Gender:** ☐ Male ☐ Female **Patient Age:**
Focus of Assessment: ☐ History Taking ☐ Examination ☐ Diagnostic Reasoning ☐ Management ☐ Explanation	
Setting: ☐ Inpatient ☐ Outpatient ☐ Emergency ☐ General practice ☐ Other (please specify)	

ASSESSMENT	*To ensure safe, efficient and effective care on this aspect*			
	Requires Significant Input from Supervisor	***Requires some Input from Supervisor***	***Performs Task Independently***	**Unable to Assess**
Medical interviewing skills	*Interacts well with patient; Directs questions at key problems; Uses second order of questioning to refine focus; Integrates information from questions; Observes and responds appropriately to non-verbal cues; Considers a range of diagnostic options; Takes a history appropriate to the clinical situation*			
	1 2 3	4 5 6	7 8 9	UTA
Physical examination skills	*Conducts a systematic and structured physical examination; Shows sensitivity to patient's comfort and modesty; Detects abnormal signs when present and assesses the significance of these findings; Gets informed consent; Focuses the examination on the most important components; Integrates findings on examination with other information to clarify diagnosis*			
	1 2 3	4 5 6	7 8 9	UTA
Professional qualities/communication	*Shows respect for patient; Explains as well as asks; Listens as well as tells; Aware of potentially embarrassing or painful components of interaction; Respects patient confidentiality; Able to adapt questioning and examination to patient's responses; Presents clinical information in a clear and coherent manner*			
	1 2 3	4 5 6	7 8 9	UTA
Patient education	*Displays skills to enhance patient health literacy as explains rationale test/treatment; Provides information in a way that is clear and tailored to the patient's needs; Responds to patient and modifies or repeats information when appropriate; Listens to patient's wishes; Avoids personal opinion and bias. Demonstrates teach back.*			
	1 2 3	4 5 6	7 8 9	UTA
Clinical judgement	*Weighs importance of potentially conflicting clinical data; Determines appropriate choice of investigations and management; Relates management options to the patient's own wishes or context; Considers the risks and benefits of the chosen management / treatment options; Comes to a firm decision based on available evidence*			
	1 2 3	4 5 6	7 8 9	UTA
Organisation/efficiency	*Synthesises a collection of data quickly and efficiently; Uses appropriate judgement and synthesis; Demonstrates optimal use of time in collection of clinical and investigational data*			
	1 2 3	4 5 6	7 8 9	UTA

OVERALL PERFORMANCE FOR THIS PROCEDURE

What level of supervision did the student require for THIS procedure (please tick):	***Requires Significant Input from Supervisor***	***Requires some Input from Supervisor***	***Performs Task Independently***
	☐	☐	☐

GLOBAL PERFORMANCE FOR THIS PROCEDURE *(please tick)*
☐ **Requires Remediation** Gaps in knowledge or skills that you would not expect at this stage of the course. Concern about professional and patient safety.
☐ **Satisfactory** Standard you would expect for a student at this level at this stage of the course. Generally clinical competent with satisfactory communication skills and professionalism.
☐ **Excellent** Performing well above the student's expected level. No concerns about their clinical method, professionalism, organization, communication etc.

TIME TAKEN FOR OBSERVATION:
TIME TAKEN FOR FEEDBACK:

Assessor's Comments on the Student's Strengths:

Assessor's Suggestions for Student's Area of Improvement:

Student's Signature:		**Date**	
Assessor's Signature:		**Date**	

Appendix 7 – School of Medicine: General Practice Learning Objectives

General Practice

The following learning outcomes and discipline-related topics apply mainly to year 5 clinical rotations. They are included here for information as some areas will be encountered by students during their year 4 clinical rotations. This particularly applies to students at RCS undertaking the Longitudinal Integrated Placement in Rural General Practice and attachments to the Department of Emergency Medicine. Students will see most presentations from other disciplines in General Practice and will learn how to manage preventative care, uncertainty and multimorbidity.

Common Presentations for this rotation (2.1)	***Common Clinical Conditions for investigation and management on this rotation (2.7-2.13)***
Acute and Chronic presentations of all the other disciplines	**Acute and ongoing management of most conditions listed in all disciplines**
• The nurse said my blood pressure was high • My chest feels tight • I've got heartburn • I get out of breath easily • I feel tired all the time • I feel useless • I feel stressed • I need something to help me sleep • I've had a headache for the last 2 days • I want to lose weight • I feel dizzy • My joints hurt • I'd like to go on the pill • It stings when I go to the toilet • My back hurts • I'm losing weight; I'm still coughing; I've got a pain, I have to go to the toilet all the time; I've found a lump in my breast • Can you check my skin • I've got a sore throat • My ear hurts • I've got diarrhoea • Can I have a check up • I need a repeat script • Do I need all these tablets • I have 4 chronic diseases • This pain won't go away • Can I have a sick note • I hurt myself at work	• Hypertension • Asthma, angina • Gastro-oesophageal reflux & alcohol dependence • Chronic obstructive pulmonary disease (COPD), heart failure & smoking • Undifferentiated conditions Diabetes, anaemia, hypothyroidism, insomnia, depression, early pregnancy, chronic fatigue syndrome • Depression • anxiety • insomnia • Migraine, tension headache • Arthritis • Contraception • Urinary tract infection, chlamydia & common STDs • Mechanical low back pain • Early presentations of common cancers: lung, bowel, prostate & breast • Eczema, Acne ,psoriasis, fungal infections, skin cancer, sun damage, systemic features of disease. • Viral sore throat, glandular fever, tonsillitis • Otitis media & externa • Gastroenteritis • Screening, immunisation and health checks • Management of chronic disease • Polypharmacy • Multimorbidity GP management plan • Chronic Pain

Appendix 8 – Consulting Skills Cases

Year 4

General Practice

Student Manual

Consulting Skills Cases

Written by: Dr Emma Warnecke

Learning outcomes

Consulting skills tutorials will assist students in developing the knowledge and skills to be able to;

1. Plan and demonstrate history taking which allows formulation of a differential diagnosis and appropriate use of investigations.
2. Develop a comprehensive management plan for common acute and chronic health issues in General Practice and demonstrate an ability to guide a patient through this plan and implement strategies for lifestyle change, prevention and health enhancement, utilizing an evidence-based approach.
3. Value an integrative, patient-centred approach to medicine, which examines the patient's perspective (ideas, beliefs, concerns, expectations, effects on life and feelings), considers the factors which impact on health and develops communication skills to create an effective patient doctor relationship.

Case format

- At the beginning of the semester, you will have a review of your consulting skills.
- At the end of the semester, you will have the opportunity to practice these skills with the 12 cases in this manual. There are 6 diagnostic cases and 6 management cases. Most will follow the format below although some may have a slightly different skill that they are requiring of you – such as case 4.
- All cases build upon the skills and knowledge gained in year 3 consulting skills.
- All cases will require you to demonstrate your communications skills;
    - Introduction; Informed consent (explanation and consent for conducting consultation); Building rapport; Open ended questions; Active listening and reflective skills; Appropriate use of language; avoiding medical jargon; Clarification; Picking up of cues; Be aware of body language; Ensure good eye contact; Displaying empathy.
- All cases will require you to do pre reading and research at home. For diagnostic cases think of potential diagnoses and how you might distinguish between them in a consultation. For management cases formulate a management plan which you will guide the patient through. Feedback sheets will be completed for each case and there is the opportunity to record your session to facilitate enhanced feedback.

Diagnostic cases

- You will be given the presenting symptom. Example – 15 y.o. boy presents with a sore throat.
  Work through the following steps;
    - Introduce self, explain and seek consent for consultation then take a full history (including preventative health). Check on any information given in manual e.g. age.
    - Demonstrate your ability to obtain the patient's perspective (ideas and beliefs, concerns, expectations, effects on life and feelings)
    - Ask tutor for examination findings. You should ask for the specific findings you would like.
    - Your tutor will then ask you for your differential diagnosis.
    - You will discuss with your tutor how a definitive diagnosis could be made. This discussion includes the use of appropriate investigations.
    - Formulate an initial management plan including preventative opportunities and discuss this with your tutor.

Management cases

- You will not be required to take a history. Any necessary points on history and examination and investigations will be included in the case description provided in your student manual. Use the information given and proceed directly to the management phase of the consultation. Most of the management cases will require you to make a diagnosis from the information given. This will require you to do pre reading to ensure your diagnosis is accurate. Resources to enable this are given at the back of this manual.

- You will be required to lead the patient through a 10-step management interview;

    1. Tell the patient the diagnosis
    2. Establish the patient's knowledge of the diagnosis
    3. Establish the patient's attitude to the diagnosis and management
    4. Educate the patient about diagnosis
    5. Develop a management plan for the presenting problem
    6. Explore other preventive opportunities
    7. Reinforce the information
    8. Provide takeaway information
    9. Evaluate the consultation
    10. Arrange follow up

The student will be expected to state simply and clearly the diagnosis. This will be followed by questions about the patient's understanding of the diagnosis and beliefs surrounding the diagnosis and management. This should bring to light any fears, misunderstandings or concerns the patient may have. If the case has any particular issues this will be pointed out under the patient perspective section for each case. The student will then educate the patient, ideally using charts, models and diagrams and establish jointly a management plan with the patient. Students should recognise the patient as an expert in managing their own health. The management plan should be a collaborative plan. If the student uses jargon this should be pointed out in the debrief. A clear, ideally written plan of action should be agreed upon jointly between the student and patient to collaboratively manage the health issue. Preventive health issues will also be explored such as; screening for high blood pressure, diabetes or dyslipidaemia; immunisation; advice on exercise, alcohol, smoking, diet and weight management and other screening tools such as Pap smears or mammography where relevant. Use the RACGP guidelines for preventive activities.

Remember the World Health Organisation (WHO) definition of health; 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' - (WH0, 1946, updated October 2006. Constitution of the World Health Organisation, http://www.who.int/governance/eb/who_constitution_en.pdf Accessed 6 January 2010.)

It is therefore relevant to consider health enhancement tools such as stress management and social support in the consultation. Finally check the patient understands what has occurred in the consultation and ensure they are happy with the plan. Follow up will then be arranged as required.

The resources in your unit outline will provide valuable references for these cases.

General Practice is '*the provision of primary continuing comprehensive **whole-patient** medical care to individuals, families and their communities*.'

- (RACGP, 2005)

The debrief session (facilitated by your GP tutor) after each case is designed to allow you to enhance your teaching and learning opportunities. It is for positive feedback and to allow you to improve the next time you do a case. It will follow the format below. Please listen attentively to your fellow student performances. You can learn a lot from watching your peers and they will appreciate your feedback.

Debrief

- The student (e.g. the "doctor") says what they think they did well.
- The role player ("patient") says what was done well.
- The observers (tutor and other students) state what they thought was done well.
- The student reflects on what they could have done differently to make the interview more effective.
- The observers comment on those parts of the interview that could have been done differently. It is important to make positive suggestions about how the interview could have been modified. This is where you may bring up the preventative opportunities that may have been missed or other diagnoses you were considering etc.
- The "patient" makes positive suggestions about making the interview more effective.
- The student should be asked how they feel about the feedback they have received. This is a positive and useful learning experience. It is not about knowing all the answers but learning how to consult with patients. What did the student learn from the experience?

Note on medical actors playing your patients

Role players are highly skilled and trained medical actors. We use actors rather than actual patients to allow you to practice your consulting skills in a format where you are free to make and learn from your mistakes without the concern you will adversely affect a patient. It also allows you to try out various styles. The actors will play the roles as they have been instructed and therefore can have various hidden agendas or display particular emotions or behaviours for you to deal with. Previous student feedback has shown this to be a highly valued learning experience. ENJOY.

History Taking Feedback Sheet. 4th year Consulting Skills, General Practice

These are used to enable feedback to students and rotation coordinator on student performance. Students are also asked to complete these when observing the other students in their group to help them enhance their own performance by observing what they thought was done well by other students. Completed sheets will be given to you at the end of each case. Please keep in a safe place as you may be asked to provide copies as evidence of your performance.

Student Name: **Case:**

Areas of observation;

Introduces self -

Obtains consent –

Use of open-ended questions –

Makes patient feel at ease –

Establishes rapport / eye contact / empathy (non verbal skills) –

History taking;

HoPC – specific to case – e.g. pain questions

PHx –

Medications / allergies -

FHx -

SHx – smoking, alcohol, social situation, occupation, diet, exercise, drug use, current stressors -

Preventive health – e.g immunisation, screening tests -

Obtains patient perspective – (ideas and beliefs, concerns, expectations, effects on life and feelings) -

Appropriate language (no medical jargon) –

Asks for appropriate examination findings –

Appropriate differential diagnosis –

Use of appropriate investigations –

Formulation of management plan, including preventive issues and follow up -

Overall impression -

Management Feedback Sheet. 4th year Consulting Skills, General Practice

Student Name: **Case:**

Areas of observation

Introduces self -

Obtains consent –

Use of open-ended questions –

Makes patient feel at ease –

Establishes rapport / eye contact / empathy (non verbal skills) –

Tells the patient the diagnosis clearly and simply in appropriate language –

Establishes the patient's knowledge and understanding of the diagnosis –

Establishes the patient's attitude to the diagnosis and management –

Educates the patient about diagnosis –

Develops a management plan for the presenting problem –

Explores other preventive opportunities –

Reinforces the information –

Provides takeaway information –

Evaluates the consultation –

Arranges follow up –

Overall impression –

Case 1: A 34-y.o. man, Richard Ward presents with a recurring cough.

Take a full history, formulate a diagnosis and propose an initial management plan, including preventive medicine.

Case 2: A 40-y.o man, Martin Fuller, presents with fatigue.

Take a full history, formulate a diagnosis and propose an initial management plan, including preventive medicine.

Case 3: Roger presents with his 2-month-old daughter, Lily for her first vaccinations.

Take an appropriate history from the father (Roger), (daughter, Lily is asleep in her pram), including preventive medicine.

Case 4: John Smith, a 33-year-old new patient to your clinic presents complaining of tooth pain from an abscess requiring Endone.

Deal appropriately with this request.

Case 5: A 66-y.o. man, Paul Morris presents with back pain.

Take a full history, formulate a diagnosis and propose an initial management plan, including preventive medicine.

Case 6: Jack Reed, a 51-y.o. man presents with insomnia.

Take a full history, formulate a diagnosis and propose an initial management plan, including preventive medicine.

Case 7: A 69-y.o woman, Margaret Brown comes to see you for review of her blood pressure. You have been seeing her for the last 2 months since she moved from Sydney to Hobart to be closer to her daughter who had moved to Hobart several years ago for work. She reports no current health problems apart from her arthritis.

On your first appointment 2 months ago, you noted a blood pressure of 152/94. It remained at this level over repeated measurements during the consultation. You advised her to return in 1 month to have her blood pressure checked by the practice nurse. At that time, her blood pressure was 148/93.

You are seeing her again today for a further review of her blood pressure.

PHx – Osteoarthritis – knees and hips past 10 years. Knee replacement on the right.

Last cervical screening test and mammogram 2 years ago. Cholesterol levels normal when last checked 2 years ago.

Medications – Diclofenac 100mg daily. No known allergies.

FHx – father died from bowel cancer at age 60 y.o.

Social History – retired school teacher. Lives with husband who is well. 1 daughter – well. Non smoker. Drinks 2-3 glasses of wine most nights. Occasional walk but tends to aggravate her arthritis. Diet poor with frequent take away meals as tend not to like to cook. Loves licorice and consumes it on a frequent basis.

On examination: Appears well. BMI – 28. Waist circumference 88cm. HR – 80 b/min, regular, BP – 156 /95 mmHg, lying (average of 3 readings with automated BP machine). Also checked BP with your automated machine on her lower leg and the ABI (ankle brachial index) were 0.93.

Cardiovascular, abdominal, neurological and respiratory examination are unremarkable. Peripheral pulses all present. Fundi – normal. Thyroid - no abnormality detected.

Urine dipstick reveals no abnormality. Finger prick BSL is 4.8 mmol/L. ECG - normal.

- Outline your diagnosis.
- Outline your management plan.

Case 8: A 53-year-old woman, Vera Williams consults you for advice on her cholesterol. She has heard you have an interest in nutrition and seeks your opinion. This is the first time you have met her. Her usual GP had discussed medication to lower her cholesterol but she would like to try natural options first. She is not keen on medication because she has heard of side effects such as muscular pains and fatigue that can result.

PHx – Previously well. Menopause 52y.o, experiences occasional minor hot flushes, which do not bother her.

Last Pap smear and mammogram 6 months ago. Cholesterol was normal 5 years ago when last checked.

Medications – Nil. No known allergies.

FHx – father is 82 years old and has type 2 diabetes.

Social History – violin player with the Tasmanian Symphony orchestra. Lives with husband who is well. No children (unknown cause of infertility). Non-smoker. Drinks 2-3 glasses of wine most nights. Describes diet as reasonable. Occassional exercise.

On examination: Appears well. BMI – 27. Waist circumference 91cm. HR – 75 b/min, regular,

BP – 143 /79 mmHg.

Cardiovascular, abdominal and respiratory examination is unremarkable. Peripheral pulses all present. Finger prick BSL is 4.8 mmol/L. ECG - normal.

Investigations : Total Cholesterol – 7.3 mmol / L HDL – 1.2 mmol / L LDL – 5.3mmol/L Triglycerides – 2.9mmol/L

- Outline your diagnosis.
- Outline your management plan.

Case 9: A 21-year-old law student, Kylie Rogers, presents with 3 weeks of feeling exhausted and overwhelmed. She has been feeling low and unable to cope with the usual things in her life. She has also been experiencing intermittent headaches and when particularly agitated notices her heart beating fast. The headaches typically come on late in the day and feel like a tight band across her head. They are relieved with rest and never bother her sleep. She tends to keep irregular hours in her sleep between her social, study and work activities. She is usually so exhausted when she gets to bed she does not have any trouble sleeping. There are no neurological symptoms. The heartbeat is regular and she does not experience any chest pain with it. Her exercise tolerance is good. She plays in competition netball weekly with training sessions 2-3 times per week. She is still managing this and enjoys it. She describes it feeling great to get out on the court and stop thinking about things. 3 weeks ago, Kylie failed her law exams. She

has always been a high distinction student and does not understand what happened. She feels like a failure and is deeply upset by the experience. She has a meeting with the course coordinator next week. Her mood is low but there has been no suicidal ideation and she is still enjoys going out with her friends at the weekend and playing netball. She feels tense if she does not keep herself busy.

PHx – previously well.

Medications – Nil. No known medications.

FH – Nil significant

Social History – lives with friends in a share house. Works as a waitress in a local restaurant to support herself through university. Family lives interstate and also provides some financial assistance. Non-smoker. Diet – mostly take – away. Regular exercise. Drinks alcohol when out with friends – between 3 and 7 standard drinks on an evening out. This occurs once or twice a week. No illicit drug use. No partner at present.

On examination, Kylie presents well groomed and neatly dressed. She appears well, maintains good eye contact and converses freely. She is tense when discussing her studies and her affect is flat, however she displays an appropriate range of mood when discussing other areas of her life. No thought disorder is evident. She is alert and oriented and exhibits normal perception. She displays insight and wants assistance.

- Outline your diagnosis
- Outline your management plan.

Case 10: A delightful long-term patient of yours, 29 y.o Sally Green had just had her first baby. She comes to see you 5 weeks after leaving hospital with nipple pain. She has been breastfeeding since the baby; Eleanor was born and is a bit unsure if she is 'doing it right'. She expected to have some discomfort initially but the last week has become quite painful. Attachment is painful but during feeding, the pain settles. She also has a painful, red, swollen area on the upper outer area of her right breast. She has been feeling lethargic and off colour for the last couple of days.

PHx – previously well. No major illness or surgery. You have known her since her 20's and seen her through previous contraception issues and more recently pregnancy planning.

Last year Sally had a normal cervical screening test and she has never had an abnormal finding on any previous CST or Pap smear.
Medications – Nil. No known allergies.
FHx – Mother well but has osteoporosis. Father – hypertension. No siblings.
Social History – graphic designer, works from home. Allowed for 6 months at least maternity leave. She lives with her husband, Ron, who is an accountant. Non-smoker. No alcohol since been pregnant. Diet – reported as good with daily intake of fresh fruit and vegetable and frequent fish and only lean meats and low-fat dairy.
On examination: Appears well. Temp (tympanic) – 37.5 degrees celcius. HR – 80 b/min, regular, BP – 127 /82 mmHg
Nipples cracked and are tender and erythematous. Her right breast is generally tender and has an area in the upper outer quadrant, which is firm, tender, and erythematous.

- A diagnosis of nipple trauma and mastitis is made.
- Outline your management plan.

- **Case 11:** A 22-y.o woman, Maree comes to see you for travel health advice. She is going backpacking in Asia for 2 months in her university holidays with her best friend. She leaves in 2 months. She does not have definite plans. Her flight arrives in Bangkok and she plans to travel around Thailand and Laos.

PHx – previously well. No prior illnesses or operations. Had usual childhood immunisations.

Medications – nil. No known allergies.

FHx – aunty is undergoing chemotherapy for breast cancer.

Social History – lives with parents whilst studying law at UTAS. Has part time job waitressing. No current partner. Exercise – daily 30 minute run and weekly yoga class. Diet – good. Non-smoker. Occasional wine at weekends if out with friends.

- Outline your management plan, particularly in regard to education and planning for her travel.

Case 12: 17 y.o Lucy Saunders comes to see you to discuss her pregnancy. Her LNMP was 5 weeks ago. She did a urine pregnancy test yesterday, which was positive. She has told her parents, who are supportive. Her mother is in the waiting room.

PHx – previously well. Usual childhood illnesses including chicken pox.

Medications – nil. No known allergies.

FHx – nil significant.

Social History – lives at home with parents. In year 12 at college. Had boyfriend for past 12 months – good relationship. Has not told him yet.

On examination;

Bp – 121 / 72 mmHg. HR – 70 b/min, regular. Afebrile

Abdominal examination unremarkable.

Urine pregnancy test – positive.

- You confirm she is pregnant.
- Outline your management plan, particularly in regard to education and planning for her pregnancy.

Resources: Use the list of resources provided in your CBL workbook.