MBBS
Undergraduate
Rural Clinical
Programme
2017
Year 4 & 5 Medical Student
Workbook for General Practice
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Introduction

General Practice is ‘the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.’
(RACGP, 2005 < http://www.racgp.org.au/whatisgeneralpractice

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 multimorbidity. 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 centred 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 4-5 month period and gain skills in Chronic Disease Management.

Students in Year 5 are allocated to a Rural or Remote Practice for 5 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 hospital or nursing homes. Students may arrange their own Rural and Remote Practice with permission from Dr Shires.

Year 4 GP teaching
Primary Care teaching will be on the Wednesdays 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 identity 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 get 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 communication styles, how the GP elicit 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 log book 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 nursing homes or undertake home visits with other GP’s,
- Attend home medication reviews,
- Follow up their long cases,
- Research on the conditions or medications they see in consultations.
- Audit
- 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 data base 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 offers 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 hasn’t 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 and drugs and alcohol for year 7/8. Please contact Dr Shires for a copy of these.

The RCS will also organise activities throughout 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 log book. These log books 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 log books 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 log book (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, 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 4 Written Chronic Rural Longitudinal Case:** A written submission of a Chronic Rural Longitudinal Case should be submitted at the end of semester 1. This is usually the same patient that you have presented. This gives the student the opportunity to write in detail about the management of chronic disease for their patient. **MyLO contains a guide to how to approach this essay and some examples from previous years. See marking 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 and 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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Presentation</th>
<th>Learning objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>The nurse said my blood pressure was high</td>
<td>Demonstrate how to diagnose and manage hypertension.</td>
</tr>
<tr>
<td>Asthma, angina</td>
<td>My chest feels tight</td>
<td>Describe how to diagnose asthma &amp; angina, when to refer &amp; how to manage these conditions.</td>
</tr>
<tr>
<td>Gastro-oesophageal reflux &amp; alcohol dependence</td>
<td>I’ve got heartburn</td>
<td>Describe investigation &amp; management of heartburn.</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD), anaemia, heart failure &amp; smoking</td>
<td>I get out of breath easily</td>
<td>Demonstrate ability to recognize alcohol dependence &amp; offer help with stopping drinking.</td>
</tr>
<tr>
<td>Diabetes, anaemia, hypothyroidism, insomnia, depression, early pregnancy, chronic fatigue syndrome</td>
<td>I feel tired all the time</td>
<td>List differential diagnosis of tiredness.</td>
</tr>
<tr>
<td>Depression</td>
<td>I feel useless</td>
<td>Be alert to possibility of depression and use skilful questioning to confirm diagnosis. Be familiar with at least one antidepressant drug.</td>
</tr>
<tr>
<td>Migraine, tension headache</td>
<td>I’ve had a headache for the last 2 days</td>
<td>Demonstrate how to assess a patient with a headache.</td>
</tr>
<tr>
<td>Contraception</td>
<td>I’d like to go on the pill</td>
<td>Be familiar with at least one combined oral contraceptive pill.</td>
</tr>
<tr>
<td>Urinary tract infection, chlamydia &amp; common STDs</td>
<td>It stings when I go to the toilet</td>
<td>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.</td>
</tr>
<tr>
<td>Mechanical low back pain</td>
<td>My back hurts</td>
<td>Demonstrate management of back pain &amp; discuss when investigation is warranted.</td>
</tr>
<tr>
<td>Condition</td>
<td>Symptom Details</td>
<td>Management Options</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Common cancers: lung, bowel, prostate &amp; breast</td>
<td>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</td>
<td>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.</td>
</tr>
<tr>
<td>Eczema</td>
<td>I’ve got this itchy rash</td>
<td>Recognise &amp; demonstrate how to manage eczema.</td>
</tr>
<tr>
<td>Acne</td>
<td>Can you do something for my son's acne?</td>
<td>Recognise &amp; demonstrate how to manage acne</td>
</tr>
<tr>
<td>Viral sore throat, glandular fever, tonsillitis</td>
<td>I’ve got a sore throat</td>
<td>Discuss management options for each of these conditions. Communicate the potential benefits &amp; disadvantages to the patient.</td>
</tr>
<tr>
<td>Otitis media &amp; externa</td>
<td>My ear hurts</td>
<td>List differential diagnosis of earache &amp; management options for otitis media &amp; externa.</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>I've got diarrhoea</td>
<td>Describe management of food poisoning &amp; oral rehydration.</td>
</tr>
<tr>
<td>Screening and health checks</td>
<td>Can I have a check up</td>
<td>Evidence base for health checks in different age groups and populations – 4 year old, 45-49, over 75 and item numbers</td>
</tr>
<tr>
<td>Skin damage, cancer</td>
<td>Can you check my skin</td>
<td>Common skin conditions and their management</td>
</tr>
</tbody>
</table>
## Appendix 2 – Procedural and Professional Skills List

<table>
<thead>
<tr>
<th>GENERAL DOCTOR &amp; PATIENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>History, Examination and Management of common conditions</td>
<td>Subcutaneous and IM Injections</td>
</tr>
<tr>
<td>Oral Communication skills: case presentation</td>
<td>IV cannulation (including set up and IV fluid administration)</td>
</tr>
<tr>
<td>Written Communication: Note writing, referrals, GPMP, Mental Health care Plans</td>
<td>Venepuncture for venous blood sample.transpose</td>
</tr>
<tr>
<td>Consultation skills: History taking, explaining, shared negotiation, Motivational interviewing</td>
<td>Measures blood glucose levels using finger prick testing</td>
</tr>
<tr>
<td>Investigations skills: Advice investigation, organize paperwork</td>
<td>Administering local anaesthesia</td>
</tr>
<tr>
<td>Management skills: Advice and organize paperwork for appropriate management</td>
<td>Ophthalmoscopy Fluroscein - staining of cornea</td>
</tr>
<tr>
<td></td>
<td>Slit lamp use Eyelid eversion</td>
</tr>
<tr>
<td>Mini-mental state examination, Mental state examination, Suicide risk assessment</td>
<td>Eye foreign body removal including padding as appropriate</td>
</tr>
<tr>
<td>Medication management: IN clinic, Home medication review, Over 75 check</td>
<td>Foreign body removal - ear &amp; nose</td>
</tr>
<tr>
<td>Admission and inpatient management of patients in community hospitals or nursing homes</td>
<td>External auditory canal irrigation</td>
</tr>
<tr>
<td></td>
<td>External auditory canal ear wick insertion</td>
</tr>
<tr>
<td>Observation of breaking bad news</td>
<td>Preparation for sterile procedures including hand washing.</td>
</tr>
<tr>
<td>Intimate examination skills: Breast Examination, Vaginal examination and swabs/ pap smear, DRE</td>
<td>Dressings</td>
</tr>
<tr>
<td>Samples, analyses and reads urinary dipsticks</td>
<td>Simple skin lesion excision</td>
</tr>
<tr>
<td>Blood pressure measurement Height, weight/BMI adults and children</td>
<td>Surgical knots &amp; simple suturing</td>
</tr>
<tr>
<td>ECG</td>
<td>Suture removal</td>
</tr>
<tr>
<td>Peak flow meter function testing Spirometry, inhaler technique</td>
<td>Simple swab using standard microbial collection</td>
</tr>
<tr>
<td>Name of staff member</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---</td>
</tr>
<tr>
<td>Position/role of staff member</td>
<td></td>
</tr>
<tr>
<td>Contact numbers</td>
<td></td>
</tr>
<tr>
<td>What is their role in the PHCT?</td>
<td></td>
</tr>
<tr>
<td>How do patients access their services?</td>
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<tr>
<td>How do GP’s access their services?</td>
<td></td>
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<tr>
<td>What sort of cases do GP’s refer?</td>
<td></td>
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<tr>
<td>How do they normally liaise with GP’s?</td>
<td></td>
</tr>
<tr>
<td>Key areas to discuss</td>
<td></td>
</tr>
</tbody>
</table>
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 previous notes
  - results,
  - 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, 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

- 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 NWRC
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**

<table>
<thead>
<tr>
<th>CHRONIC NEED</th>
<th>PROVIDER DETAILS</th>
<th>AGREED MANAGEMENT GOALS</th>
<th>REVIEW MONTH</th>
</tr>
</thead>
</table>
| **Asthma**   | Dr Elizabeth Shires  
Ulverstone 7315  
0364261611 | **Goals to keep healthy**  
- Stop smoking  
- Quit line support: www.quitnow.gov.au  
- Phone: 131845/137848  
- 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 vac  
- Bowel Cancer screening due from 50  
- Diabetes Screening due from 45  
- Family history of disease ask GP about screening |
| **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. Consider 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 review due:  
- Mammogram and US scan & Bloods and CA125 or tumour marker before review appointment  
- Maintain Bones: Vitamin D and Ca supplements consider dexas screening |  |
| **COPD** |  | COPD Goal: Reduce symptoms recognize and treat infections early  
- Take inhalers and medication as prescribed  
- Keep active, consider physio  
- Attend GP if increasing symptoms  
- Annual Spirometry next due  
### YOUR GP MANAGEMENT PLAN Template

**NAME:**

**DOB:**

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

<table>
<thead>
<tr>
<th>CHRONIC NEED</th>
<th>PROVIDER DETAILS</th>
<th>AGREED MANAGEMENT GOALS</th>
<th>REVIEW MONTH</th>
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# Appendix 6 – Year 4 Assessment Forms

## 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.

<table>
<thead>
<tr>
<th>Student Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Student ID Number</td>
<td></td>
</tr>
<tr>
<td>Year of Study</td>
<td></td>
</tr>
<tr>
<td>Title of Attachment</td>
<td></td>
</tr>
<tr>
<td>Dates of Attachment</td>
<td></td>
</tr>
<tr>
<td>Doctor to whom student is assigned</td>
<td></td>
</tr>
<tr>
<td>Attachment Supervisor</td>
<td></td>
</tr>
<tr>
<td>Supervisor’s address/phone number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 1 - Science and Scholarship: the medical graduate as scientist and scholar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
</tr>
<tr>
<td>Evidence based approach</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2 - Clinical Practice: the medical graduate as practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>History taking</td>
</tr>
<tr>
<td>Clinical examination</td>
</tr>
<tr>
<td>Evidence based Clinical management decisions</td>
</tr>
<tr>
<td>Can determine problem or differential list including patient management goals</td>
</tr>
<tr>
<td>Use and interpretation of investigations</td>
</tr>
<tr>
<td>Communication with patients and relatives</td>
</tr>
<tr>
<td>Medical record keeping</td>
</tr>
<tr>
<td>Safe and effective Therapeutics and fluids.</td>
</tr>
<tr>
<td>Procedural skills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 3 - Health and Society: the medical graduate as a health advocate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands social aspects of disease</td>
</tr>
<tr>
<td>Disease prevention and health promotion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 4 - Professionalism and Leadership: the medical graduate as a professional and leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional approach</td>
</tr>
<tr>
<td>Patient confidentiality</td>
</tr>
<tr>
<td>Motivation and reliability, punctuality and attendance.</td>
</tr>
<tr>
<td>Participates in the teaching of others</td>
</tr>
<tr>
<td>Appreciation of ethical issues of clinical practice</td>
</tr>
<tr>
<td>Teamwork Communication with staff including clinical handover</td>
</tr>
<tr>
<td>Patient Centredness including safety, infection control and adverse reporting</td>
</tr>
<tr>
<td>Reflective student and demonstrates strategies for lifelong learning</td>
</tr>
</tbody>
</table>
Supervisor Feedback

Areas of Strength:

Areas for improvement:

Overall assessment of student’s performance during the placement:

Satisfactory to progress
(please circle)

Has not met requirements to progress
(please circle & specify reasons below)

Reasons why student has not met requirement:

Have you sighted student Logbook & Log of Skills? YES / NO

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

________________________________________  __________________________________________
Student’s signature  Please print name

________________________________________  __________________________________________
Supervisor’s signature  Please print name

________________________________________
Supervisor’s position

(Specialist, registrar or attachment co-ordinator) please circle your role(s)
Chronic Disease GP Longitudinal Written Case Assessment (1,500 words)

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 1 Science and Scholarship: The medical graduate as scientist and scholar</strong></td>
<td></td>
</tr>
<tr>
<td>Relevant literature appropriately integrated, acknowledged and referenced with VANCOUVER style.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Domain 2 Clinical Practice: The medical graduate as practitioner</strong></td>
<td></td>
</tr>
<tr>
<td>History including initials, sex, age, chronic disease, history of chronic disease, other co-morbidities, past / ongoing medical history, family history, drug history, social history</td>
<td></td>
</tr>
<tr>
<td><strong>Chronic Disease Management</strong></td>
<td></td>
</tr>
<tr>
<td>For the Chronic Disease that has the most impact. Relevant history, examination, investigations and patient goals.</td>
<td></td>
</tr>
<tr>
<td>Relevant interventions / treatments are outlined with evidence to support them and compared to patient’s actual treatment.</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td><strong>Domain 3 Health &amp; Society: The medical graduate as a health advocate</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Patient self-management</strong></td>
<td></td>
</tr>
<tr>
<td>Patients understanding of condition and self-management. Has explained patients 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Appendix include: Summary GP Management plan, included use of template provided, or practice 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. See example</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Domain 4 Professionalism and Leadership: The medical graduate as a professional and leader</strong></td>
<td></td>
</tr>
<tr>
<td>Written work demonstrates professional approach and interdisciplinary learning.</td>
<td></td>
</tr>
</tbody>
</table>

**Overall assessment:** Satisfactory Requires Remediation/Resubmit Unsatisfactory

**Comments:**
Complex Rural Longitudinal Case Presentation (GP) Oral Presentation Assessment - Year 4
This case should be of a patient with a chronic disease that the student has followed up over the months in practice

<table>
<thead>
<tr>
<th>Case Identification</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Student name</td>
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</tr>
<tr>
<td>Assessor’s Name</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Date / GP Semester I or II</td>
<td></td>
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</tbody>
</table>

| 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 patient’s history succinctly |
| 1. History including initials, sex, age, chronic disease, history of chronic disease, other co-morbidities, past / ongoing medical history, family history, drug history, social history |
| 2. Demonstrates appropriate knowledge of evidence based care for management of one of the chronic disease |
| 3. Adequately describes and discusses the management plan for the main issue for this patient |
| 4. 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; Multimorbidity |

| 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: |
| 5. Impact on patient of living in a Rural Area |
| 6. 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 |
| 7. Describes patients issues with their health and their self-management strategies and what impacts on these |
| 8. Demonstrates how patients psychosocial situation impacts on the management of their disease |
| 9. 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. |
| 10. Provides useful summary of current research and its impact on ideas about best practice re rural context and clinical management |
| 11. Demonstrated professional values through presentation |
| 12. Uses communication tools effectively |
| 13. Engaged audience in effective and relevant discussion issues raised by the case |
| 14. Kept to time, the presentation should be no longer than 15 minutes, with 10 minutes for discussion |

Assessment Feedback:

<table>
<thead>
<tr>
<th>OVERALL ASSESSMENT RESULT:</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Borderline / Unsatisfactory</th>
</tr>
</thead>
</table>
# Year 5 Assessment Forms

**Chronic Illness Longitudinal Case including Complex Therapeutics**

**Long Case History - Year 5 (3,000 words)**

<table>
<thead>
<tr>
<th>Student Name: Click here to enter Student Name</th>
<th>Rotation: Click here to enter Rotation</th>
</tr>
</thead>
</table>

## 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.
- **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 co-morbidities 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
  - Patient’s 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.

## Domain 4: Professionalism and Leadership: The medical graduate as a professional and leader
- **Appendix:** 1/2 page Summary Management plan which addresses all chronic disease, co-morbidity, includes medications, follow-up and patient’s goals of care for each condition.
  - This should be in table form and patient centred ie no medical terminology. See example
- **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.

## Overall assessment:
- Satisfactory
- Requires Remediation/Resubmit
- Unsatisfactory

Click here to enter Comments

<table>
<thead>
<tr>
<th>Assessor Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Click here to enter Assessor Name</td>
<td>Click here to enter date</td>
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</tbody>
</table>
Chronic Rural Longitudinal Case Oral Presentation Assessment Form

This case should be of a complex patient usually with multi morbidity

**Oral presentation**
- Concise summary of the patient and their health issues: 5 minutes
- Presentation of one area of complex management or therapeutics or ethical raised by this patient's care: 5 minutes
- Class Activity: Questions or activity for the group to answer on how to approach this issue: 10 minutes

<table>
<thead>
<tr>
<th>Case Identification:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Student Name:</td>
<td></td>
</tr>
<tr>
<td>Oral Presentation Date:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Demonstrated Competence</th>
<th>Demonstrated but not yet fully competent</th>
<th>Not Demonstrated</th>
<th>Not Demonstrated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Clinical Practice: the medical graduate as practitioner</strong></td>
<td>DEMONSTRATES AN UNDERSTANDING OF THE UNDERLYING CLINICAL CONDITION/S AND MANAGEMENT ISSUES for Chronic Diseases</td>
<td></td>
<td></td>
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<tr>
<td>Demonstrates ability to present patients history succinctly</td>
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</tr>
<tr>
<td>1. History including initial, sex, age, chronic disease, history of chronic disease, other co-morbidities, past/ongoing medical history, family history, drug history, social history</td>
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<tr>
<td>2. Demonstrates appropriate knowledge of Evidence based care for management of multi morbidity</td>
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<tr>
<td>3. Describes Patients self management strategies and what impacts on these.</td>
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<tr>
<td>4. Includes a summary GP management plan of all the patients' conditions in table form as a hand out for patient</td>
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</tr>
<tr>
<td><strong>Domain 3: Health and Society: the medical graduate as a health advocate</strong></td>
<td>ABLE TO IDENTIFY AND DISCUSS significant teaching and learning aspects of the patients case (related to CBL topics, themes)</td>
<td></td>
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<tr>
<td>Demonstrates how patients' psychosocial situation impacts on the management of their disease. Impact on patient of living in a Rural Area</td>
<td></td>
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<tr>
<td>5. Demonstrates how patients' psychosocial situation impacts on the management of their disease. Impact on patient of living in a Rural Area</td>
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<tr>
<td>6. Adequately describes and discusses the main issue or challenge for this patient</td>
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<tr>
<td>7. Demonstrates an understanding of decision analyses eg. medications, investigations for this patient. NNT and NNH for medications. Differences in care from recommendations and why this has occurred Multi morbidity issues</td>
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<tr>
<td>Demonstrates an understanding of issues relating to the Rural Context:</td>
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<tr>
<td>8. These can be positive or negative but should comment on during presentation</td>
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</tr>
<tr>
<td><strong>Domain 3: Health and Society: the medical graduate as a health advocate</strong></td>
<td>Teaching, assessing and appraisal. WELL DEVELOPED COMMUNICATION SKILLS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates WELL DEVELOPED COMMUNICATION SKILLS:</td>
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<td></td>
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<tr>
<td>9. Concise presentations within time limits. Kept to time. The presentations should be no longer than 10 minutes, with 10 minutes for Group activity and discussion</td>
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<tr>
<td>10. Provides useful teaching topic derived from case summary Identified current research and its impact on ideas about best practice re multi morbidity rural context and clinical management.</td>
<td></td>
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<tr>
<td>11. Uses communication tools effectively during group activity Engaged audience in effective and relevant discussion issues raised by the case.</td>
<td></td>
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</tr>
</tbody>
</table>

**Overall assessment:**  Satisfactory  Requires Remediation/Resubmit  Unsatisfactory

Click here to enter Comments.

Assessor Name  Click here to enter Assessor Name.  Date  Click here to enter date.
## 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

<table>
<thead>
<tr>
<th>Requires Significant Input from Supervisor</th>
<th>Requires some input from Supervisor</th>
<th>Performs Task Independently</th>
<th>Unable to Assess</th>
</tr>
</thead>
</table>
| **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 patients 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 for 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):**

<table>
<thead>
<tr>
<th>Requires Significant Input from Supervisor</th>
<th>Requires some input from Supervisor</th>
<th>Performs Task Independently</th>
</tr>
</thead>
</table>

**Assessor must complete Global Performance on Page 2 – please turn over**
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:**

<table>
<thead>
<tr>
<th>Student’s Signature</th>
<th>Assessor’s Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Appendix 7 – School of Medicine: General Practice Learning Objectives

Outline of Curriculum Areas in General Practice (RACGP 2007)

| Aboriginal and Torres Strait Islander health | Men’s health |
| Acute serious illness and trauma | Mental health |
| Aged Care | Multicultural health |
| Children’s and young people’s health | Musculoskeletal health |
| Chronic conditions | Occupational health and safety |
| Common Problems in general practice | Oncology |
| Critical thinking and research | Pain management Palliative care |
| Dermatology | Philosophy and foundations of general practice |
| Disability | Population health and public health |
| Doctor’s health | Practice Management |
| Drug and alcohol medicine | Rural General Practice |
| Genetics | Sexual health |
| GPs as teachers and mentors | Sports medicine |
| Integrative medicine | Undifferentiated problems in general practice |
| | Women’s health |

Students should be able to demonstrate that they have, and can safely and appropriately apply, the following skills and knowledge:

1. Consulting Skills

   - In all settings consider the **patient’s perspective** (ideas, beliefs, concerns, expectations, effects on life and feelings) and have an understanding of the dynamic relationship between the disease, the illness (the patient’s experience of the disease) and the person.

   - **Clinical skills**
     - Be able to take an appropriate history and perform a physical examination (including of children and pregnant patients) relevant to the presenting issue(s)
     - Be aware that you are treating the patient with a disease and not the disease in a patient i.e. that you are delivering whole-patient care.
     - Be aware that general practices and practitioners vary in the care provided dependant on the context of the patient, their family and community, and the capabilities of the GP and their team.

   - **Diagnostic skills**
     - Be aware of common presenting symptoms in General Practice and the potential causes.
     - Be aware of the need to deal with uncertainty and early presentations that may not lead to a clear diagnosis at a particular consultation.
     - Be aware of the need to provide a safety net to diagnostic formulations and how the use of time may reveal a clearer diagnosis.
     - Be able to formulate a differential diagnosis for the presenting issue(s).
     - Demonstrate appropriate use of investigations and screening tools.
     - Be familiar with the network of diagnostic services that can be used both in the private and public systems of health care.
     - Be aware of the need to guide the patient through the process of accessing health care, aiming to minimise harm.
Communications skills – demonstrate effective communication skills within the context of a consultation.
These include:
- Appropriate opening and closing of a consultation
- Obtaining informed consent
- Building rapport
- Using open ended questions with specific questions only to clarify detail
- Speaking clearly
- Demonstrating active listening and reflective skills
- Using appropriate language, avoiding medical jargon
- Picking up patient cues
- Being aware of body language
- Making eye contact
- Developing an open, relaxed, respectful manner, recognising the patient's expertise in patient centred holistic care.

Management skills
- Be able to manage common emergencies occurring in General Practice (e.g. acute anaphylaxis, acute asthma, acute pulmonary oedema, snake bite, hypoglycaemia, status epilepticus, AMI, unstable angina).
- Have a working knowledge of Australian resuscitation guidelines.
- Understand the role of Care Plans in General Practice.
- Develop an approach to a management consultation. This includes establishing the patient's existing knowledge and perspective of the diagnosis and management, patient education, considering preventative and health enhancement opportunities, evaluating the consultation, providing take home information and arranging follow up.

Educative Skills
- Develop skills to educate patients in regard to their health issues and ways to enhance their health.
- Involve the patient as an active participant in their health.
- Be able to assess the stages in the cycle of behaviour change and implement effective lifestyle change using basic motivational interviewing techniques.
- Have an awareness of Health Promotion.
- Understand that patient self management is an ideal aspect of chronic disease management and how this might be delivered.

Counselling skills
- Have an initial understanding of some commonly used techniques.
- Use a patient centred solution orientated/problem solving approach.
- Have an understanding of the factors influencing mental health.
- Have an understanding of stress and stress management and be able to teach some simple relaxation techniques.

Be familiar with evidence based psychological therapies and their use. Prescribing Skills
- Be aware of the guidelines for use, dosing, limitations, side effects and interactions of common medications and the resources available to assist in prescribing less commonly used medications.
- Have an understanding of the evidence base for use and drug interactions of commonly used Complementary Therapies.
- Be aware of resources available to assist in rational prescribing such as the National Prescribing Service (NPS).
- Be aware of the recommended contents of the General Practitioner's 'doctor's bag' and their uses.
Understand the role of the Home Medicines Review.
Have an understanding of the legal aspects of prescribing such as prescribing to minors and scheduled drugs.
Understand the practical prescribing issues in the Australian health care setting such as writing a script and obtaining an authority.

- **Co-ordination of Care Skills**
  - Be able to write a referral letter to another health professional.
  - Be aware of the range of resources and referral options available to assist patients.

- **Complex Consultations**
  - Develop an approach to more complex consultations such as:
    - Dealing with strong emotions – grief, angry patient etc
    - Crisis intervention
    - Delivering unexpected or ‘bad' news
    - Non English speaking patients and use of interpreters
    - Issues of violence
    - Sexual health issues
    - Travel medicine
    - Drug seeking patients
    - Refugee health
    - Adolescent medicine
    - Behaviour change and motivation in the unaware / unmotivated patient
    - Multiple problems – define priorities and develop plan.

2. Personal and Professional Development

- **Australian Health Care System**
  - Have an understanding of Medicare Australia health funding and practical issues for General Practice such as item numbers.

- **Self Care**
  - Understand the concept of stress and apply strategies for self care and stress management.
  - Be familiar with appropriate resources to assist doctors in self care.
  - Be aware how to maintain a healthy and balanced lifestyle and how to apply behaviour change strategies to you.

- **Ethical, legal and professional aspects of medical care**
  - Understand the guidelines for professional conduct – boundaries, confidentiality, duty of care
  - Be able to deal with uncertainty in medical practice
  - Understand the need for continued professional development in a medical career
  - Understand medical information is constantly changing and being updated and you will be engaged in a career long process of learning.
  - Be confident in medical information technology
  - Be able to work effectively as a member of a team in health care
  - Understand the role of Medical Council of Tasmania
  - Have an understanding of particular prescribing issues – prescribing to minors, self prescribing
  - Have an understanding of certification issues – WorkCover, Death Certification, Motor Accident Insurance Board (MAIB).

- **Evidence based practice**
  - Understand the use of an evidence based approach to medical care
  - Understand the resources available to assist in practising evidence based medicine.
- **Role of research**
  - Understand the opportunities for and role of research in General Practice
  - Be competent in performing a literature search and critically appraising medical research.

3. Community Health

- Be aware of the personnel, resources and agencies available in the community to assist patients in both urban and rural areas, their roles and how to access them.
- Understand of the role of various allied health care professionals.
- Have an understanding of the provision of services to disadvantaged groups.

The current National Health Priority Areas (2009) are cancer control, injury prevention and control, cardiovascular health, diabetes mellitus, mental health, asthma, arthritis and musculoskeletal conditions, and obesity.

Students are advised to access the following reference with regard to the activities that they will encounter in general practice attachments:

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, utilising 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 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 so as 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.

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 which 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 Pap smear 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.


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 heart beat 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
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 Pap smear was 1 year ago and they have always been normal.

**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 and 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.