Coast City Country

General Practice Training

NOT "JUST A GP"

A SHORT HANDBOOK TO ASSIST THE DOCTOR NEW TO GENERAL PRACTICE.

1. TO WORK BETTER IN PRACTICE
2. TO PASS THE FELLOWSHIP EXAMS

(You should not, and are unlikely to, be able to achieve the second objective without extensive work on the first)

(*The title reflects a commonly held view that, if you are "just a G.P". you have not managed to make the grade as a specialist: it irritates G.P.s!)*

INTRODUCTION.

This is NOT a textbook of general practice. You should refer to appropriate texts or on-line sources for information when you require it.

WARNING Some of you may come to G.P. Training believing that the FRACGP is much easier than Fellowship of the other Colleges. It is impossible to make accurate comparisons, but we know that those who have held this view have had some nasty surprises. The scope of general Practice is huge!

These notes are designed to assist you to deal with some of the problems you will encounter when you first enter this most difficult of specialities. They have been developed over some years to cover some aspects of practice and many of the issues have arisen from practice visits. They refer to the process of practice, not to the content.

Contents

1. Patient centred consultation Page 3
2. Components of a consultation 4
3. Self Directed Learning 5
4. Web Based resources 6
5. Learning diaries 6
6. The 'Open' Question 7
7. Referral letters 10
8. Compliance/ Adherrence 11
9. ECT Visits 14
10. Useful 'add-ons' 18
11. Elements of a consultation 18
12. Resistance to antibiotics 21
13. How to say "No" to antibiotics 22
14. AMC and FRACGP Exams 23
15. Time management 25
16. Learning Plan 27

The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation, and all else in the practice of medicine derives from it.

Sir James Spence: Father of British Paediatrics.

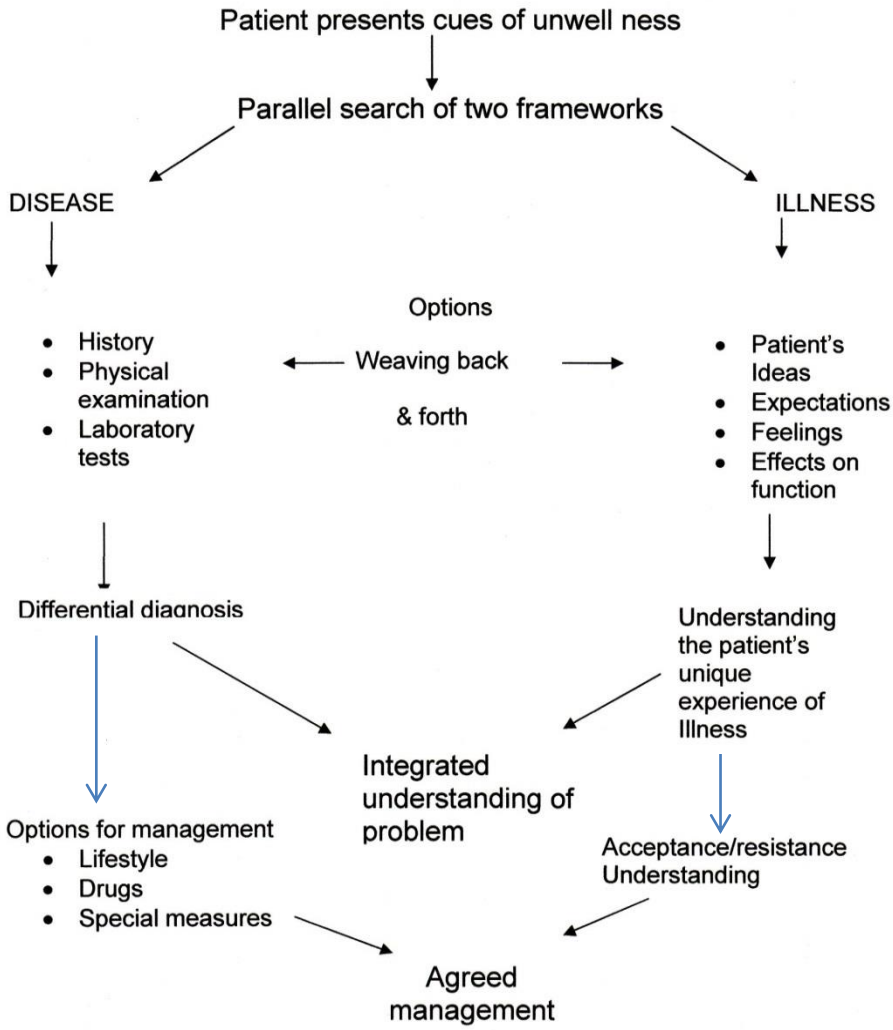
Now is your chance!

The dimensions of learning (Miller).

There is a natural progression:
Knows → Knows How → Shows → Does

At every stage learning is enhanced if it occurs in context. It is hard to recall information learned in isolation, and the transition from possessing information to applying it is far more difficult than is usually thought. Practicing the natural progression of learning from an early stage produces better results than learning the stages in isolation. The last stage, 'Doing', is of course much more prominent when the ex student becomes a doctor. The first three learning stages can be practiced with real patients in items 1,2,& 3 of the Patient Centred Consultation. If the learner practices using the model below it will become obvious that it also enhances the doctor patient relationship and explores what is realistic.

THE PATIENT CENTRED CONSULTATION



Adapted from "Patient centred medicine" Moira Stewart et al. Sage

Case 1. *A female registrar unexpectedly failed the women's health aspect of her Fellowship OSCE: a 48 year woman presented with hot flushes. The doctor immediately asked her a lot of questions to see if there were any contraindications to HRT. (This is the left side of the diagram). On finding there were none, she suggested that the patient might take it. At this point, the patient exploded that "she wasn't going take that stuff: it gives you breast cancer etc." This was the point of the exam station, but, by then it was too late to save the situation. Had she listened for a little longer and explored the patient's ideas/ attitudes (see top right of illustration) she would have easily passed. (see "The Open Question page 8)*

Case 2. *A lively 5 year old is brought to the G.P. because he has a number of bruises. They don't look anything much to worry about and it would be easy to reassure the mother: but this would have missed the point.* ***The question: What made you come about this today*** *would reveal that his cousin has Leukaemia and is covered in bruises. This can lead to a useful discussion relating to the real point of the consultation.*

It is important to understand that doctors are taught to diagnose Disease, and very frequently they try to push the patient into an appropriate box. (Case 1). The patient comes to you with an Illness which has specific meaning to them: it may be that they have no disease at all. It is vital to let them tell you about their illness. Doctors interrupt patients, on an average after 17 seconds and start asking disease orientated questions. The section on the "Open Question" (page 7) illustrates the advantages of letting the patient talk.

You can stop people from rambling on too long by saying" Can we hold it there for a moment and make sure I have got this straight". Then summarise briefly, and you may want them to carry on, or, if it is clear that they have a disease, you can start asking specific questions exploring your hypothesis about what disease they have. It is important that you talk 'to and fro', to ensure that you understand exactly what is going on, and later the patient understands exactly what you think is wrong, and the options for dealing with this. The patient may, or may not agree with your management suggestions- for example: many people like to try lifestyle changes first rather than go on to Blood Pressure tablets. That's fine if it is safe to do so: they may or may not lose weight and may end up on tablets. If you prescribe them against their will, they will not take them and will probably go to another doctor!

THE COMPONENTS OF A CONSULTATION-STOTT AND DAVIS

Many consultations have a number of components as outlined below. It is useful to remember this in practice, and essential in examinations, where the candidate is often given information that a Pap. Smear or Flu injection is overdue, and they are expected to 'flag' this, for action now or later.

The presenting complaint	**Follow-up of exiting complaints**	**Health promotion/ Disease prevention**	**Education in using the health system effectively**

Item 4 relates to encouraging patients to visit the same doctor, or practice, for conditions requiring monitoring such as blood pressure where continuity is important. They should learn to make appointments ahead and ensure that they do not run out of important medications. See Time management, page 20.

SELF- DIRECTED LEARNING

Medical schools vary enormously in their approach to teaching. Traditionally much of this has been by the Didactic presentation of facts in large lectures, followed by exams to test knowledge of the facts. This model remains an obstacle for many graduates especially those who have trained overseas. Problems in medicine require knowledge of some facts, and the ability to identify and to apply them to the case in hand. It also requires the ability to identify what else needs to be learned, and the capacity to combine these in order to deal with the problem.

There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.
Donald Rumsfeld

Often the last category presents the most problems and your supervisor maybe the best person to guide you.

Apart from lectures students learn to a greater or lesser extent from patients they encounter. There is, generally little emphasis, except in the more modern schools, on Self- Directed Learning (which is often Directed Self Learning). **General practitioners have to become lifelong learners**and this process must begin at the training stage if it has not already begun at an undergraduate level:

The stages of self-directed learning are:

- Need identification
    - Patient driven: recorded in a leaning diary and subsequent learning Plan
    - Curriculum driven
- **Focussed** learning from books or electronic sources which should be identified for future reference
- **Testing of knowledge**
    - By application to a patient. [Do not hesitate to look things up in the presence of patients and share your knowledge with them}
    - By discussion in a study group
    - By discussion with your supervisor or other doctors in the practice
    - By External Clinical Teaching Visits (ECTV)
    - Many journals (AFP) feature short questionnaires related to articles in that edition and the RACGP Check program regularly assesses facts.
    - There are banks of multiple choice questions(MCQ) available, but it is difficult to select any questions relevant to recent focussed learning. These should be used later in the training process in preparation for examinations.
    - By using the websites listed below, many of which provide assessments which can be done on line and provide feedback and repeats until you get it right. You can use the credits from these websites to add to your Learning diary.(see next section)

BMJ Learning	http://learning.bmj.com/learning/home.html	Some modules are free. Worth buying a subscription
AHC Media	http://www.cmeweb.com/gindex.php	Paid
e-healthlearning Learn anytime, anywhere.	http://www.e-healthlearning.com.au/MyCourses/tabid/65/Default.aspx	Mostly free
ThinkGP	http://thinkgp.com.au/	Free
gplearning The Royal Australian College of General Practitioners	http://www.gplearning.com.au	
md BriefCase AUSTRALIA	http://www.mdbriefcase.com.au/	Free
Medscape	http://www.medscape.org	Free
ACCESS Medicine Trusted Content. Instant Answers.	http://www.accessmedicine.com/caseHome.aspx	Thru RACGP website
cmecorner.com	http://www.cmecorner.com/index.asp	Free
medpage TODAY	http://www.medpagetoday.com/	Free
AFP	http://www.racgp.org.au/afp/	Free for members
The Royal Children's Hospital Melbourne	http://www.gped.rch.org.au/index.php?	Free
Dermatology	http://www.dermnet.org.nz	Free and very comprehensive

-

The appropriate curriculum for your needs are the **International Classification of Primary care (ICPC),** Google ICPC and select pdf ICP-2English; also http://curriculum.racgp.org.au Both are dauntingly exhaustive, but do, provide an essential list of issues.

LEARNING DIARIES: AN AID TO LEARNING!

In practice visits the issue of Learning Plans often comes up. The reaction is almost always negative: they are usually seen as a tedious bureaucratic requirement both for registrars and IMG doctors with RDN funding.

This short document is to try to convince you that **a Learning Plan is designed to help you, and is greatly assisted by a learning diary** and is based on sound educational principles:

Information learned in context is recalled far better than information learned in isolation.

- Information learned at, or near the time it is required, is recalled better than that which is learned later
- Information which is used/ recalled soon after initial acquisition stays in the brain for longer

Keep it Simple.

You see a new patient, Mr Brown, aged 52: his skin is a strange dusky grey colour. He complains of pain in his hands. On questioning, he is tired and thirsty. He has glycosuria. Depending on your experience you may or may not suspect that he has Haemochromatosis. Assuming that you don't, you start to investigate him for diabetes and arrange to see him in a few days. You mention this to your supervisor: you are not sure why he is a strange colour, and why he has painful hands- he has no obvious signs of arthritis. Your supervisor tells you he probably has Haemochromatosis. You don't know much about it and need to know more before you see him next week.

To start a **Learning diary**, buy a **small exercise book, or an electronic app,** which you can use in the surgery (instead of scribbling notes on those numerous bits of paper torn from the bottom of your prescriptions, which you all lose!)

For paper: rule it into columns

Date	Patient and clinical picture/Learning need	Learning Methods	Applied in Practice?
20/5/10	John Brown. ? Diabetes, funny skin, hand pain. ? Haemochromatosis ?Tests for Haemochromatosis: Treatment	Textbook	XXXXXXXXXXXXXXXXXXXXXXXX

You look this up in Murtagh, 4th Ed.page 167-169. When you have done this you can put this in your little book as the learning source.

When you see Mr Brown, you confirm his diabetes, but it is not the usual sort. He has a grossly enlarged liver. You order his iron studies, outline the probable management of his disease and arrange to see him again. When the tests confirm a very high serum Ferritin etc., you may order further tests for him and also arrange for screening of relatives as this is the most common serious single gene genetic disorder seen in our population. By this time you will have a clear idea of Mr Brown's complaint. I remember my first case of bronze diabetes vividly. Had I read it in a book one night it would not have stuck!

Once you have this information it is easy to refer to your exercise book, and write in the space below the original:

25/5/10	Haemochromatosis- Iron storage problem Diagnosis and management	Murtagh.4thED p167-169 (reference for future use.)	Patient reviewed and treatment started – venisection.

Use this to feed your Learning Plan. (Registrars are required to go to GPRime: this can be adapted to the format required.)

Note this entry is 5 days after the need arose. If the space is empty it reminds you that you have not followed this up. If you open your **Learning Plan** frequently it is no great hardship to fill in a few things near the time they arose and you will recall the issues easily. **A recent Inspection of Learning Plans shows that many Registrars sit down every few months** and make an entry, but if you do this you are indeed merely carrying out a tedious chore. A sample of what a learning plan might look like, but without dates is to be found at the end of this document. (Page 22)

THE OPEN QUESTION.

Doctors often think that asking open questions is going to take them longer. The example below shows quite the opposite. Almost identical information is received with very little Doctor talk.

Those taking exams should know that role playing patients are instructed to respond freely to open questions, but if asked a series of closed questions they just answer the question asked.

1. The Patient centred approach

Mr Smith is 70 years old. He is new to your general practice.

Mr S. Doctor I have been getting pain in my chest and I thought I had better have a check- up.

Dr. Tell me about it

Mr S. Well, I had a heart attack about 9 years ago, and the pain feels a bit like that, but it is very mild and only comes on when I exert myself. They put a stent in my arteries when I had the attack and I have been fine ever since. I hope I am not blocking up again.

I take my Lipitor regularly and my last blood test six months ago was pretty good- 4.5 I think. My sugar was OK too.

Dad died of a heart attack when he was 60, but of course they couldn't do much then, and he had diabetes and smoked all his life. I never took it up. My wife looks after my diet and weight very well.

Word count 152. Lines 9. Conversation time 50 seconds

Presumptive diagnosis: Myocardial Ischaemia in a man who has had a previous heart attack. Needs investigation/ referral

2. The doctor centred approach

Mr Smith is 70 years old. He is new to your general practice.

Mr S. Doctor, I have been getting pain in my chest and I thought I had better have a check- up.

Dr. Where is it exactly?

Mr S. It's in the middle of my chest low down behind the breast bone

Dr. Does it go anywhere else?

Mr S No I don't think so

Dr. It doesn't go down your arm or up into your neck?

Mr S No, I don't think so

Dr Does anything make it better or worse?

Mr S. Yes it seems to come on with exercise and goes away when I rest.

Dr. Have you had anything like this before?

Mr S. Well, I had a heart attack 9 years ago. The pain is similar, but this is very mild and O K when I am not exercising

Dr . How would you rate it on a scale of 1-10?

Mr S. Most of the time it is 0, when it comes on, I suppose about 3

Dr. When you had the heart attack, did they put a stent into any of your coronary arteries'?

Mr S. Yes; I can't tell you which one it was.

Dr. has anyone in the Family had this kind of trouble?

Mr S. Yes, dad died of a heart attack when he was 60.

Dr. Do you smoke?

Mr S. No I never took it up

Dr. Is there any diabetes or Blood pressure in your family?

Mr S. Dad had Diabetes. I don't know if he had any blood pressure problems

Dr. Have you been checked for Diabetes and Cholesterol?

Mr S. Yes I was last checked about 6 months ago. The diabetes was OK and the Cholesterol about 4.5 I think.

Word Count 283. Lines 25. This does include the headings, but each exchange occupies a little time and requires the doctor to think of the question and the patient to think of the answer. Conversation time 95 seconds

Presumptive diagnosis: Myocardial Ischaemia in a man who has had a previous heart attack. Needs investigation/ referral.

REFERRAL LETTERS.

Dear Doctor, thank you for seeing Mrs. X ? Heart. Not heart: lungs. *Dear Doctor, Thank you for referring Mrs. X.*

You will all be aware that many of the letters sent to the Emergency Department are of very poor quality: you quickly form opinions about the quality of the writer. Similarly, specialists form opinions about you from your letters. They comment that, apart from being easier to read, GP referral letters have got worse since the advent of computer generated letters. Many are one-liners. There is great confusion when the list of medications and the problem list have not been updated. There is a huge literature on medical problems arising from poor transfer of information between various sections of the health system. Many hospital discharge summaries are also very inadequate. A new electronic system (Personally Controlled Electronic Health Record- PCEHR) will be in place sometime: its success depends largely on the quality of the information put into it. The same applies to the GP referral.

Much of the GP letter is done already by the computer: the essentials it provides are:

- Your title and address, Provider Number and date
- Addressee
- Greeting
- Patient demographics

What you need to supply or edit

- ***Reason for the referral****: what do you want the specialist to do: tests, advice or continuing care?*
- *The patient's problem and what has already been done or found*
- *Brief chronologically accurate history, focused exam; positive and negative findings*
- *Results of tests already done, if relevant.*
- *Tests ordered: there are some which you* ***know*** *the specialist will need, so you can get them done while the patient is waiting for the appointment. When you order the tests you should ask for a copy to go to the specialist*
- *Your opinion. What the patient has been told*
- *What has been tried: what worked and what did not*
- *Any other specialists who have been involved*
- *Whether patient is in private health insurance if hospitalization is likely.*
- ***Up dated*** problem list- active and quiescent
- ***Updated*** current medications: include drugs the patient is allergic to or which have been ineffective or caused adverse reactions.

Especially in a group and training practice it is essential the updates are done routinely, so that the next doctor knows exactly what has been wrong and what the patient is taking by way of medication. This may be difficult, and time is a problem, but if everyone in the practice does it, you spend less time trying to work out what happened previously, and time is saved in the long run. Without this we cannot improve the quality of care to which we are all committed.

Getting this right is often a matter of learning how to use the software effectively

COMPLIANCE/ADHERENCE WITH PRESCRIBED MEDICATION

(Author: Prof Sandy Reid: adapted from educational materials developed at the University of Newcastle department of Behavioural Science in relation to Medicine. Rev. Oct 2013)

Knowing all about blood pressure is useless if the patient does not take the tablets

The term Adherence (Compliance) refers to the extent to which a patient follows the instructions provided by their medical practitioner. **It may be applied to change of lifestyle**, but in this context refers to prescribed medication. It has been estimated that up to 25% of hospital admissions are due to people not taking the medication they were ordered, or not taking it correctly. Most studies show 30-60% non-adherence where the objective is prevention, especially when treatment is to continue for a long period and it to counter a disease with no symptoms- Blood Pressure or hyperlipidaemia (two of the most common and expensive types of drugs). The literature on the subject is extensive, and is briefly summarised here.

Possible reasons for non-adherence: the practical implications of this will become apparent.

1. Socio-demographic characteristics:
   There is no evidence that age, sex or socio-economic status affect adherence in any predictable manner: anyone may be unreliable.

   Attitudes and beliefs: components of the health belief model affect patient adherence, in particular beliefs about:

   a. personal invulnerability to disease
   b. the negative aspects of illness on their lives (denial)
   c. the effectiveness/safety of treatment offered
   d. costs and barriers to treatment: side effects and effort involved with adherence
   e. Dr Google' opinion? (this is a more recent and very potent influence)

2. Knowledge: for adherence to occur, patients must understand
   a. What disease they have, and why it is important to treat it
   b. What medication to take, how to take it, how long to take it for etc.

   But while knowledge is essential it will not alone ensure compliance

3. Characteristics of the regimen: keep it as simple as possible
   a. Complexity: frequency of dose, number of tablets daily, duration of treatment
   b. Relationship of taking treatment to everyday routine: half an hour before a meal is hard to implement
   c. Combining medication with lifestyle changes: few patients will take long term tablets, exercise, lose weight and stop smoking all at once: yet this is often what doctors want them to do. Such changes must be dealt with singly over time.

Detection of Non adherence

1. "I know my patient" Unfortunately studies have shown that GP's estimate of their patient's compliance or non - compliance is no better than chance.
2. Monitoring attendance and following up on non-attendance. This works well for regularly injected medication such as those used in some psychoses. For self-administered medication,

attendance may not ensure adherence. Patients like to keep their doctor happy and remember to take their blood pressure tablets for a day or two before they see their doctor, whilst forgetting in between visits!

3. Monitoring the results of treatment: this may founder on the behaviour described above. Many conditions naturally vary over time.
4. Checking therapeutic effect and side effect is unreliable
5. Pill counts: the non-adherent patient may easily conceal this if they know their medication is to be counted. There is ample evidence that this occurs. People like to please their doctors and to conceal their own weaknesses!
6. Drug level measurement: this may be done on blood, urine etc. but only reflects the effects of the last few doses: it is expensive. It is important for some drugs such as Lithium and Carbamazepine.
7. Asking the patient. If this is done in a non-judgemental way in a relationship in which the patient understands clearly why treatment is being used, it may be the most reliable. Patients who admit to non-adherence can then be helped by adopting certain strategies, but an open collaborative doctor- patient relationship is the key to success. It is important to check adherence at every consultation.

Strategies which help adherence.

1. Find out what the patient knows about the disease you are treating
2. Reinforce correct understanding
3. Correct misunderstanding
4. Provide accurate information in language the patient can understand. Doctors acquire a vast technical vocabulary and often forget that patients have a more limited general vocabulary and no knowledge of technical terms. They will not understand ….*"peripheral atherosclerosis":* you have to adapt using homely similes, like " *water pipes clogging, furring up, or bursting".*
5. Check that the patient understands by asking them to explain it back to you
6. Find out the person's attitude to taking medication: many people have strong views about taking "drugs" and may want to pursue other alternatives or "natural therapies". Discuss this with them in a friendly non-judgemental manner, and if your treatment is essential, go over the reasons again, provide written information, website reference etc. It may take considerable time and several visits before a patient consents to taking the prescribed medication. It is their body: if you think treatment is important, respect their views and be prepared to revisit the problem: if you are dismissive they will go elsewhere or abandon medicine in favour of naturopathy.
7. Reduce the complexity of the regimen as much as possible. Our Newcastle studies showed that adherence for a tablet to be taken once a day (85%) is a little better than twice (76%) and much better than three times (37%), whereas four times a day before food is almost impossible!
8. Make it very clear whether a medication is to be taken long term. Many patients prescribed tablets for lowering BP or cholesterol, dutifully return to have their BP measured or get their results, and when the doctor says " that's fine" they go away happy that they have been cured and take no more medication.

Helping the patient to remember

Young hospital doctors write up medication charts and expect (not always correctly) that patients will receive the drugs ordered: this process may be reinforced by a visit from a hospital pharmacist. But this patient is soon discharged, sometimes with two days supply of tablets and instructions to "see LMO 1/52". This may result in no tablets for several days, and most elderly people do not know what

an LMO is, or what 1/52 means. So doctors in hospital or private practice must learn what information has to be given, and what steps should be taken to ensure that medication is taken.

1. Explicit categorisation is a term used to lay out the advice you are going to give to the patient, like the index of a book. It is useful in many contexts. *First I am going to tell you about the condition we are going to treat and why it needs to be treated, then I will tell you about the tablets I want you to take; how to take them; the reasons for taking them this way, and how they may affect you.*
   Similar strategies should be used for behaviour change and should be reinforced by concrete specific advice: "I want you to go for a brisk 20 minute walk four times a week: does that sound reasonable? " is much more effective than saying "You ought to take more exercise" Change takes time: don't be disappointed by early failure

2. There is a lot of detail to convey. Although some pharmacists go through the schedule with the patient many do not. Written instructions may be essential, or you may go over a computer generated (legible) script with the patient containing some of the information. What is needed is:
   a. Name of tablet, How many times a day
   b. Before or after food if it matters
   c. Restrictions (do not take this as well as your herbal remedy-St John's Wort)
   d. Side effects: if a drug may make someone vomit, tell them of the possibility: " this does make some people vomit". They do not appreciate being told, if they ring at 5.00pm having taken 2 tablets and been sick, "*Oh it's probably the tablets: I'll give you something else"*. Pre-empt this by saying "*the tablets I am going to give you are the best ones for the condition, but unfortunately they sometimes make people vomit: if they do, let me know and I'll give you something else."*
   e. What to do if a tablet is forgotten
3. Reminders
   a. Leave a note in a prominent place (fridge door) and tick off tablets as they are taken
   b. Involve spouse
   c. Place medication in an obvious place (but safe from the children)
   d. Associate the tablets with a routine: food, brushing the teeth
   e. For long term or complex treatment , especially for the elderly ensure that they use a Dossette Box which is laid out in compartments as indicated:

Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
Night	Night	Night	Night	Night	Night	Night

For Example: Your notes from her previous doctor may indicate that Mrs Brown is taking:

Cartia: 1 in the morning
Lasix : 40 mgs after breakfast
Slow K three times a day after meals
Sotacor 80mgs. 1 in the morning, half at teatime
Lipitor 40 mgs at teatime
Coumadin 3 mgs at teatime
Ventolin Inhaler 2 puffs when required.

Mrs B. may need help to translate this into:

Patient's instructions
After Breakfast: Take I Cartia, 1 Slow K. & 1 Sotacor.
After Lunch: 1 Slow K
After Tea: 1 Slow K, 1/2 Sotacor, 1 Lipitor, Coumadin (varies with INR)
Ventolin when needed for asthma

You should want to question this regime (think about it, then look at * at the end of this section); but realise that Mrs Brown has to translate your code into something she can actually implement, and also you should remember that she knows her tablets by their trade name: although you might write Sotalol, the chemist might provide Sotab, Sotacor (oblong and easy to take ½), Sotahexal or Sotalol-BC. (Realising this fact is important for people discharged from hospital on generic drugs- they may take their Frusemide as well as their Lasix).

The Dosette box is loaded once a week, and, if at 11 o'clock, Mrs Brown finds 3 tablets in the breakfast section she knows she has not taken them. Your instructions will have to tell her what to do if this happens.

(*****Why should Mrs Brown not be taking Sotacor (a beta blocker)? She has a condition in which it is contraindicated; did you work this out? If not look it up.)

EXTERNAL CLINICAL TEACHING VISITS (ECTV)

DEFINITION AND PURPOSE

Assessment: This comes in two forms, Formative and Summative. We have all suffered the latter: they are called Exams! Traditionally we were given a mark, and hoped that it was above the pass mark. If that was 65%, we never knew which parts we got right, and which 35% we did not know.
Formative assessment is designed to let the learner know how they are progressing, what they are doing well, and what needs to be improved. This is the specific function of an ECT visit.

An ECT Visit is an occasion in which an experienced medical educator sits in on a whole consulting session with a practitioner inexperienced in Australian practice for the purpose of assisting that person to function most effectively as a GP. Such visits are carried out on:

- PGPPP doctors
- International Medical Graduates (IMGs)
- RACGP Registrars: 5-6 such visits are a required part of training.
- ACRRM registrars who require many such visits as they constitute part of their summative assessment process. The reporting format for assessment varies.

These visits provide a unique opportunity for comprehensive **Formative Assessment** during general practice training. As the form is applied to several categories of doctor, they are in places referred to as trainees. As the visits are expensive in time and money it is important to maximise their efficacy.

TO BE OF VALUE THE ECTV REPORT MUST BE SUBMITTED WITHIN TEN WORKING DAYS OF THE VISIT. Reports beyond this time rapidly lose value as:

1. The visitor cannot recall the consultations in any detail
2. The trainee, similarly will have forgotten the sequence of events
3. **Claims for payment for ECTVs cannot be processed until reports have been received**

The ECT Visit is now recorded on a Samsung Tablet: the visitor should be thoroughly familiar with this before the visit.

All trainees, ECT Visitors and Supervisors will be supplied with this recently prepared booklet entitled ***NOT "Just a GP".*** This has been written to explain a number of aspects of general practice which have been found to cause problems to trainees. These aspects can be explored in more detail than is possible in a visit and some have been used in the form of handouts in MR LTG for some time.

SETTING UP THE ECTV VISIT

The usual time allocated is about 3 hours which depends on the practice schedules and the stage of training being observed.

The number of consultations scheduled is negotiated by the RTP when arrangements for the visit are being made. If possible the consultations should consist of a variety of patients: age; sex; new; follow - up. The doctor should also be asked to *select a patient's record which includes* ***a substantial referral letter*** before the visit and submit it to the Visitor for review. Relating the letter to a record reduces the risk that a model referral letter has not been written specially for the visitor!

CONDUCTING THE VISIT

1. Discussion/scene setting with doctor
2. Observation, notes and immediate feedback on 5-7 consultations booked usually at 30 minute intervals.
3. Discussion of issues arising out of each consultation: brief notes of these should be recorded on the tablet.
4. Discussion with the Supervisor if possible. Attention needs to be paid to how much time or otherwise of the nominated supervisor spends in the practice. GPT1 Registrars require a supervisor to be present 80%; GPT2 50% and GPT3 20% of the time.

Please assure the doctor that the reason for your presence is to provide feedback on their performance in a general practice consultation. You are there to help them with this difficult process.

Ask them to try to act as they would in everyday practice rather than putting on a special show for you as a visitor.

1. Doctors should be reminded that they must tell patients that they have a visitor sitting in on the consultation and check that is acceptable. (Patients should have already been warned by staff). Many visitors/trainees find it convenient to have the process described to patients as peer review of one doctor by another to ensure the patient of a doctor's on-going/continuous development: but do not let them think you are a medical student!

2. Many female doctors are consulted for Gynaecological problems and Pap Smears: if this is the case and the patient does not wish a male visitor to be present, they can be reassured that the examination itself will be private. This may save some exclusion.

3. Discuss the degree to which you, the visitor, might usefully be included in the consultation. Generally this involvement should be minimal, but particularly with basic trainees it can often be useful to model some aspect of the consultation e.g. an explanation where excessive jargon has been used and if the consultation has seriously gone off the rails, it may be necessary to tactfully restore order.
   Most agree to this, but they should be involved in the decision. Patients seem happy with the extra advice/ information.

Some issues which have arisen in ECT visits -true stories. (Sandy Reid)

Case 1. Mr Snedden is 58, he sees the registrar, in W Wyalong for the first time. He has noticed some blood in his motions and thought he ought to have a check-up.

The registrar did not ask about weight loss or family history.

He did a very cursory examination of the abdomen and a rectal examination and then sat down to write a path form for an occult blood test.

What should the Visitor do?

What did I actually do? *(my questions in italics)*

1. During the consultation.
(Soto voce) Do you think he might need a colonoscopy?

Registrar jumped at this and wrote out a referral and was about to give it to the patient.

It may take quite a long time for him to get an appointment: you might be able to get one more quickly if you phone the specialist: this is a new problem not just a routine follow up

Registrar phoned up and got an appointment in two weeks. Handed the referral letter and address to the patient……

What should he do about getting to Wagga?

Do you have a car?

Yes that's fine.

Yes it is Ok for him to get to Wagga, but what about getting back? Blank look.

He will have a good deal of sedation/ anaesthetic for the procedure and would not be safe to drive for several hours.

To patient: *Could someone drive you; or do you have anyone you could stay with in Wagga?*

Yes my sister lives there and I could stay overnight. Exit

2. After the consultation
How do you think that went?

Well I did mess up the appointment and the travel: I didn't think of that.

Anything else? Blank look.

What else might you have asked in the history?

Had he ever had this before? *Yes " Anything else?*

Any family history? *Yes " Anything else?*

Silence

First of all: you were going to do an Occult blood test: He has told you he is bleeding: a positive test would confirm this; a negative test merely means he was not bleeding that day, or that he did not collect the specimens well.

I would like to know if he ***had lost any weight*** *and would have looked at his conjunctiva for* ***anaemia*** *and perhaps done a blood count with a copy to go to the specialist.. If he had a rapid pulse that might help to indicate anaemia.*

What did the rectal examination tell you?

Well I couldn't feel any haemorrhoids or cancer.

*You cannot feel haemorrhoids on PR examination and you could only tell that there was no cancer within the reach of your finger. Personally I would have spared him that as he is going to have it looked at properly very soon. I don't think your abdominal examination gave you any real information****. If you decide to do an examination, do it thoroughly****. If his tummy is flat and soft with no masses, that's a help. If it is distended with ascites that also provides useful information.*
(Unfortunately this registrar never made the grade)

Case 2. This doctor has a very heavy Bangladeshi accent and talks fast. I was able to pick up most of what he said because I knew what he was talking about. But the patient was somewhat mystified.

The patient had a cold and a cough with bleeding from the right nostril when he blew his nose. This was examined and the bleeding identified as coming from the nasal septum. "Everyone at work seems to have had the cold and cough for months: it's very dusty."

The doctor then very quickly said he did not think antibiotics would be needed as he has a viral infection perhaps the problem was dust or hay fever and he might have to be tested for whooping cough, he also suggested that it would help his nose if he applied some Vaseline into the nostril.

The small font indicates the speed and obscurity of what was being said: a whole lot of things were said and were all mixed up. I intervened to try to clarify the issues.

- *Your problem is probably a cold which will clear itself up. It is quite common to bleed from the veins just inside the nose when you have a cold. Working in a dusty environment doesn't help: is there anything you could do at work which would get you out of the dust?*
- *It often helps to apply some VASELINE to the place which is bleeding (emphasise and write it down if the patient is not familiar with it)*
- *The best way to do this is to put some Vaseline on your little finger and apply it gently to the nasal septum (the bit in the middle which separates the two nostrils). Alternatively put the ointment on a cotton bud, put it inside the side of the nostril and then rub the inside of the nostril against the septum.*
- *If the cough goes on we might have to test you for whooping cough as there is quite a lot of it here at present-let's review that in a week or two.*

In my feedback in writing on the visit I made use of small font and then dot points to make these points. The Registrar subsequently told me that this was most useful.

Some useful "add-ons"

1. The patient has had a cold, and now has a cough with thick green sputum. The doctor examines the chest and says it is clear.

Patient looks puzzled.

Add: *That means the cough is doing what coughs are meant to do: it is getting rid of the rubbish. It's like when you blow your nose when you have a cold*

2 Registrars are used to **examining the chest** with the patient in a hospital bed. They very often ask the ambulant patient to sit on the examination couch while they examine the chest. This is a very awkward position and makes it almost impossible to assess symmetry of movement etc. It is much easier to examine with the patient sitting or standing. This examination is generally very badly done: it must be systematic, the axilla is often forgotten, and the stethoscope is often removed before the end of expiration when wheezes are best heard. When examining a baby, it is often best to start with the chest, which they don't mind: leave the tonsils until last. You may get a better idea of their abdomen with them sitting on their mother's knee than lying screaming on an examination couch!

3 A consultant physician in Newcastle told me that many people referred to him were **hyperventilating**. One does see quite a lot of this. Registrars are familiar with brown paper bags, but few people have them! I suggest "slow breathing" and show them and the registrar what I mean. *In 2,3 ,out 2,3, in 2,3, out 2,3. If this is done with the count at about 1 per second it gets the RR down to 10 and the alkalosis is rapidly reversed.* This can be done unobtrusively and may break the vicious circle of anxiety associated with hyperventilation. Relaxation strategies may also be needed.

4 Tension Headaches. Explanation: *the pain comes from tension in the muscles on the scalp associated with frowning and a clenched jaw, and immobility of the neck (often work related). Be aware of this and smooth the frown frequently, move the neck in all directions.* Doctor: abduct your arm while explaining. Explain that the Deltoid becomes quite sore even in that short time because our muscles are meant to move, not be tensed up all the time.

5 SE Asian registrar. 1655 hrs. Patient needs lipids and BSL to be measured. Explained quite well. Then "This test must be done fast"

Patient looked at his watch and obviously was wondering how!

I intervened to explain about fasting - to the great amusement of both.

ELEMENTS OF A CONSULTATION IN GENERAL PRACTICE

These are the aspects of a consultation which may be reviewed at an ECT visit, or by your supervisor. They are also aspects which will be assessed in the Fellowships exams. Read the various sections, which cover the consultation in approximately the order in which they would usually occur. Note the points of emphasis. In practice and in the examinations you should take a focussed, rather than a ritualistic approach. If the patient has a new problem, let them tell you about it before you start asking a lot of closed questions (see "The open question p 7.)

If there are aspects of this you do not understand, ask your supervisor.

1. **Check the records** of the patient you are about to see. If they are returning for results of tests, make sure you have looked at these before they enter the room and indicate that you realise their reason for the visit, rather than saying "What can I do for you?"

2. **Introduction of self and observer:** Patient should have been forewarned by the staff, but sometimes they forget. Make sure when you collect the patient from the waiting room that they know you have a senior colleague sitting in with you today as part of Specialist GP Training. Make sure the introduction is clear. If you introduce your ECT visitor at the door it makes it very difficult for the patient to decline.

3. **Personal Interactional skills:** Display warmth and when necessary, empathy. Establish eye contact when culturally appropriate. Engage with the patient. Eye contact may be regarded as aggressive by people of aboriginal culture. Australians generally like a good deal of personal space. Middle Eastern culture often adopts a close personal space. A consultation should be a conversation, not an interrogation. Ask the practice manager if patients are happy to see you: if not, why not?

4. **Consulting skills: Listen** to your patient, (see "the open question p7) do not interrupt prematurely, follow verbal cues, pick up non- verbal cues; use open questions, summarise and then move to closed questions appropriate to the case

5. **Language Skills:** Make sure you understand patient. When you explain to a patient, avoid medical jargon to ensure patient understanding. This is a criticism leveled at many doctors, especially specialists. Research shows that patients generally "shop around" until they find a GP they like and can understand. To be successful you need to speak English clearly. See Language page 17. If you need assistance with the language discuss this with your supervisor or your Medical educator.

6. **History:** Take an **appropriate** focused history which clearly defines the presenting complaint; establish a clear time line. Carry out an **Appropriate**: Systems review: PH; FH; Soc. H; adverse reactions/allergies; review relevant preventive activities. Your questions should explore a hypothesis. Summarise as often as necessary so as to check your accuracy understanding with your patient.

7. **Selection of Physical examination:** Direct this initially to the presenting complaint; vital signs and then carry out other PE as **appropriate. As with tests, PE is done for a reason and therefore should be done thoroughly.** Avoid ritualistic examination not relevant to presenting complaint or to routine continuing management. This applies also to exams. A man of 70 with tightness in the chest on walking up hill will not have splinter haemorrhages: a 20 Y.O. Aboriginal man with fevers and a history of rheumatic fever, who had a dental extraction 10 days ago may well have them.

8. **Conduct of Physical examination:** is systematic and appears well practiced. It is vital during the course of training to identify items of Physical Examination which are not well practiced, to look these up, and to practice the skills whenever appropriate. If you are going to do it, do it properly or you might as well not bother. You cannot learn examination in a few days before an exam!

9. **Choice of investigations varies with context of the consultation:** new diagnosis requires tests which will influence management. It makes sense in hospital, where beds are scarce and expensive, to carry out batteries of tests. In general practice tests can often be done sequentially. **Avoid routine multiple tests: the patient may have to pay a gap on each test ordered: if the patient is bulk billed we (the government) have to find the money.** Eg. If blood count is normal and Haemochromatosis is not suspected, Iron studies are seldom required. An ESR and CRP provide different information from a Blood count and they are a separate item number. Imaging is often costly: see guidelines on imaging for back pain, and headaches: be conservative.

10. **Interpretation of results of tests previously ordered.** These must be examined carefully. Have they contributed to patient care?

11. **Diagnosis/ Differential Diagnosis. (Where applicable).** Is this accurate and logical?

12. **Management Plan.** The patient must know quite clearly the sequence of events to expect: how to arrange for tests/referral; instructions for tests (Fasting?); how to obtain results; when to see doctor again. (Is it safe to drive after a colonoscopy?) (Treatment, see below). **This is an area which is frequently done badly, leaving patients confused and unhappy.**

13. **Pharmacological Treatment.** Is the treatment appropriate and in accordance with Therapeutic Guidelines (Specially Antibiotics)? Does the patient:
    a. Clearly understand what the treatment is for?
    b. Have you addressed issues of compliance - see p.10 Does the patient agree to take it: know exactly how to take it? Long term (BP)? Short course.
    c. Would a Dosette box, or Webster pack be appropriate?
    d. **IS THE MEDICATION LIST UP TO DATE?** If not it should be reviewed and updated

14. **Referral: Medical or Allied Health.** (Where applicable) Is the referral justified? See referral letter, p.9. Check with Allied health what sort of referral they like, and what conditions they treat. You should ask your supervisor, or ECT Visitor to review a recent referral letter to see whether they think it is adequate.

15. **Non Pharmacological Treatment: Patient education/behaviour change.** Agree on topic; ascertain patient knowledge, provide new information in plain English **as concrete specific advice:** ("You should walk for 30 minutes at least 4 times a week" **not** "You should take some exercise"); check to ensure understanding and any barriers to change; together go through any handouts which patient can take away; provide written instructions; use compliance aiding strategies (fridge magnet).

16. **Preventive Health care/Health promotion.** Have these been dealt with appropriately within the consultation or flagged as issues for attention at another time? (See Time Management p. 24). Was the activity explained adequately so that patient could give informed consent e.g. PSA?

17. **Medical records.** write an adequate account of the consultation; <u>particularly those which may have legal aspects.</u> (Use of computer below). Check that patient's past history is accurate. Re-check

that the medication list is current, and that medications which were ineffective or have been ceased are recorded appropriately.

18. **Time Management**. An ECTV is not a good example of everyday practice, but some idea of competence in this may be seen or should be discussed. It is one of the most difficult aspects of general practice. Issues which cannot be dealt with today can be arranged for another day so long as the patient sees the relevance of this: otherwise they may think you are using the delay as an opportunity to earn more money! (page 24)

19. **Use of computer:** It is important that your typing is skillful and you are familiar with the features of the program being used. Do not allow the computer to interfere with patient communication. "S/he talks to his computer all the time" There are free on-line typing courses. You are going to be typing for the rest of your life: if you are slow, a course is worthwhile.

20. **Handling of difficult situations.** Anger; drug seeking. Find out exactly what safety measures are in place in your practice. Discuss with your supervisor. If the patient seems to be getting angry, suddenly remember that you had to review a wound for the nurse, and exit quickly and get your supervisor. If a drug seeker is seriously angry, give them the script and record the interaction in your notes.

21. **Hand washing/cleansing lotion.** This is increasingly an essential part of practice, and failure of exams

22. **Remember that an ECT Visit is designed to help you so ask questions, discuss freely, listen to any comments about where you might do better. Do not be defensive. We are moving towards Videotaping consultations: everyone hates seeing themselves on video, but it is a great way to learn!**

RESISTANCE TO ANTIBIOTICS

A worrying proportion of General Practice records show extreme overuse of antibiotics e.g. Prescribing Amoxil for a child diagnosed (almost certainly correctly) with Hand Foot and mouth disease- known to be caused by Type A Cocksackie Virus. Amoxycillin or a Cephalosporin are prescribed frequently for URTI with or without a red eardrum in a child (usually), who is afebrile and normal to examination except for the above.

There are numerous articles which show that antibiotics' confer no benefit in these cases, but **more importantly that Bacteria learn to become resistant to antibiotics quite rapidly, and pass this ability to become resistant to other unrelated bacteria. All antibiotics enjoy a period of success and then become less and less useful as resistance develops. We are approaching a time when most of the antibiotics will become useless. Few new ones are being produced.**

IT IS IMPERATIVE THAT WE ONLY USE ANTIBIOTICS WHEN THEY ARE CLEARLY NEEDED.
In some practices patients happily accept 'no antibiotic' and in others they are prescribed freely. Meticulous microbiological GP based studies in Newcastle showed that almost all acute episodes of Respiratory infection in a Caucasian population were caused, or associated with a wide variety of viruses, and bacteria were seldom found.

How do you say " No"? See section on Page 22

Evidence-based recommendations

- Antibiotics for sore throat: (Use a narrow spectrum antibiotic if one is to be used at all) These confer some modest benefits. Symptom duration is shortened by 16 hours in proven streptococcal disease.
- Antibiotics for acute otitis media in children: These provide a small benefit, but with an absolute reduction in pain in only 5%. Most cases resolve spontaneously. Seventeen children must be treated to prevent one child having some pain after two days. Antibiotics have no effect on hearing problems or other complications. Note that a red eardrum accompanying an URTI does not imply O. M., the throat and nose are reddened as well.
- Antibiotics for acute bronchitis: These have a modest beneficial effect, but magnitude of the benefit is similar to the detriment from potential adverse effects. Patients with other symptoms of the common cold who have been ill for less than a week are not likely to show any benefits
- Antibiotics for the common cold: Patients receiving antibiotics did no better in terms of cure or improvement than those taking placebo and had significantly more side effects
- Antibiotics for acute maxillary sinusitis: In sinusitis confirmed by aspiration or radiography, penicillin improved clinical cures compared with controls. Current evidence is limited but suggests penicillin or amoxycillin therapy for 7–14 days.

Humans harbour 10^{14}bacteria. Antibiotics may affect commensals as much as pathogens, and they can pass on resistance genes.

See also **AFP Vol. 41, No 11 November 2012.**

HOW TO AVOID ANTIBIOTIC RESISTANCE

The development and spread of antibiotic resistance are consequences of antibiotic use — in medicine, agriculture and other areas, such as aquaculture. To reduce antibiotic resistance, we need to use antibiotics less and to use them prudently. As bacteria do not respect artificial boundaries between environments, this is essential in all areas of use. Strategies to decrease the development and spread of antibiotic resistance are shown below.

HOW TO SAY "NO" TO DEMANDS FOR ANTIBIOTICS.

It is essential to listen to the patient and to carry out an appropriate examination including taking the temperature. Let's suppose you are seeing a 4 Y.O. child with a cold and earache for 48 hours and the mother wants a prescription for antibiotics. Some of what follows may help.

"I understand what you have told me about Susan's symptoms and had a good look at her. She has a bad cold and earache, pain in her face and some fever.

There are many viruses which cause this kind of problem. The nose runs and looks red inside: similarly the sinuses, which are connected to the nose; the throat and the ear drums all become infected, look

red and are and painful. These symptoms are usually bad for 3-4 days and clear up in 7-10 days. Susan will probably be a bit deaf while she has this cold.

There are antibiotics which are effective against any of these viruses. I know that they are often prescribed, and that the patient gets better by the end of the course of antibiotics, but **nature copes with these things very well** and they would have got better without the antibiotics. Even severe tonsillitis, often viral, but sometimes caused by bacteria sensitive to penicillin, gets better on its own with only a few hours benefit from the penicillin and without the risk of acute allergy. Again: nature copes very well.

Every antibiotic goes through a period when it is effective against certain bacteria, but the bacteria quite quickly become resistant and they pass this resistance on to others. We have billions of bacteria in our bodies which are entirely harmless, but they pass on the resistance. There is a lot of anxiety in medicine that we are fast running out of effective antibiotics, partly because they are being prescribed too freely. I really don't think we should give Susan antibiotics for her problems"

"If Susan becomes more feverish and sicker, and if she develops a rash. she should be reviewed promptly by a doctor. It is not unusual for people to develop a cough as a cold progresses, but this usually clears up on its own. Sinus pain is helped by bathing the face with a hot face washer. The experts tell us that cough mixtures are not much good, but hot drinks with Honey and lemon sooth it, and Paracetamol or Nurofen helps with the pain. Adults find menthol lozenges helpful, but they are too strong for most children."

(Patients often look puzzled when they are coughing and you say "Your chest sounds clear" Add: "That means the cough is doing what it is meant to do: it is getting rid of the rubbish".)

THE AMC AND FRACGP EXAMINATIONS. SOME NOTES FOR CANDIDATES.

The format and content of the two examinations are quite similar: the AMC standard is set to be equivalent to the qualifying exam for an undergraduate in an Australian Medical School. The FRACGP standard is far higher and aims to measure competence to undertake unsupervised General Practice in Australia: a minimum of 5 years GP experience is expected: this is reduced by a year for those who complete formal GP training.

Preparation for both Written and Clinical exams.

Both exams aim to measure competence in dealing with reasonably common conditions. Your best guide and your most effective way to prepare is to keep a brief log or diary of the conditions you encounter in your everyday clinical work and to ensure that you know how to deal with them.

In practice this means deriving a **learning plan** (see Page 6) from your log which defines:

- what you need to learn
- how you propose to learn it
- and how you will decide whether you have mastered the subject: many of the electronic sources identified contain sections where you can test your knowledge.

For many of you, this is a new way of learning, but it is one you will have to use for the rest of your life.

Sources of information on paper.
There are a number of journals/ papers devoted to the management of common conditions. These include: The Australian Family Physician (AFP), the "How to treat" series in Australian Doctor (and the book derived from this), & the Australian Prescribers journal. The BMJ and the MJA often contain very useful segments. Be aware of the Therapeutic Guidelines series and the Australian Medicines Handbook. In addition to learning diary driven learning it is important to " read the news" as one would for every day events. Australian doctor and Medical Observer are both newspapers which serve this function and should be looked at. On line, Medscape (although American) is also often useful in drawing attention to recent recommendations which we may or may not adopt here. Six minute medicine (local) is also useful and quick.

Do not forget that both these exams include segments on:

- Physical Examination: standard texts are useful here, but stick to the "large print!". Develop an **understanding** of the examination rather than just learning the ritual.
- Medicine
- Surgery
- Paediatrics
- Non procedural obstetrics and women's health
- Mental health
- Legal and ethical issues

Whilst you will want to *refer* occasionally to your favourite textbook, do not try to prepare for these exams by trying, for example, to *read* Harrison's Textbook of Medicine. Refer frequently to John Murtagh's General Practice textbook. (He pronounces his name 'Murta'). The "Net" offers a vast amount of information. If you have good internet access, become thoroughly familiar with one or two sites. It is worthwhile, especially for FRACGP candidates, to join the RACGP: it costs money, but gives you access to The AFP, the Check program and a wealth of on-line learning material set at the right level with special assistance to those enrolled in the next exam.

What the clinical exams aim to measure.

Both aim to assess the candidate as a doctor. It is not sufficient merely to get the right diagnosis. Both are "station" exams of 8 minutes (two are double time in the FRACGP). Each station aims to measure *some aspects* of your performance, and is not designed to promote 8 minute medicine. You will be given information and told what you are required to do. Generally the areas you have to cover would be a *selection from* the following: (I have emphasised some places where candidates often show problems)

The issues which are examined are largely those defined in: The elements of a consultation" p.13

We have provided a brief description of the exam process in an early part of your course. Get on with Practice. CCCGPT has a number of exam discs you can borrow, but do not spend a lot of time on this early in your training. Attend Exam Preparation sessions when you are enrolled for the exam.

TIME MANAGEMENT

This is one of the most difficult aspects of general practice. The following provides some guidance on how to manage.

It is a busy Monday morning and the waiting room is full. You have not previously seen this patient, John Brown. The staff have fitted him in because he "just needs a prescription for his Blood pressure tablets as he ran out last week". He is 52 years old and overweight.

His blood pressure tablets are: Atenolol 50 mgs daily

- He is 52 years old and drives a truck, mostly long distance.
- He has had no problems with these tablets.
- He does not have a regular doctor, or go to one practice because he moves around a lot in his job, although he and his wife and two kids live locally.
- Most of the doctors he has seen seem happy with his BP.
- He has not had any significant illnesses.
- He has not had any blood tests done.
- His father died at the age of 68: something to do with his heart: He had a "touch of sugar". His mother is 74 and seems to be in good health.
- His brother who is 56 has high blood pressure
- He smokes about 25 cigarettes a day
- He does not drink alcohol or use any illicit drugs
- He realizes that he is overweight and **expresses some worry about his health in view of his father's problems**: as a truckie he eats when he can and often has fast food or a pie or two with chips.

Physical examination:

- He is grossly overweight: you can check the details next time
- BP today 165/100 (remember he has run out of his tablets)
- **You could just give him his tablets and say good bye**, **but this would be very poor medicine and would fail you in the exam. So what should you do?**

  DO NOT TRY TO DEAL WITH ALL THE ISSUES TODAY
- **Latch on to his expressed anxiety. Point out to John that it is most important that he be seen again to check the effectiveness of the tablets and do a more general health check but that you notice a number of other issues concerning his health which worry you.**
    - **He is dangerously overweight**
    - **His father had Diabetes**
    - **It is important to check his Fasting BSL, his cholesterol, and his kidney and liver function, as he is almost certain to develop Diabetes if he has not done so already.**

The best **plan of action** is: Provide the script: you should consider changing to an Ace inhibitor as he is very likely to have or to develop, diabetes. Write the forms for the tests, tell John where to go for the tests and emphasise they should be done fasting.

- Say that you **is really concerned about his health**, and explain that it is vitally important that a single doctor or practice act as his health advisor
- He needs to be seen to check the test results and BP, and to have a more comprehensive discussion and examination
- It would be most helpful if he would keep an honest food diary for the next week
- At the consultation next week, which should be booked as a long one, there will be time to discuss the issues above, as well as his weight and his smoking and plan what to do about his health in the future. Do not try to change all his bad behaviours at once- pick the most important first. It would be useful if his wife was to attend as well as she controls the food at home and women are much better at health matters than men!

LANGUAGE

It is very obvious from our own, and from the real exams; from ECTVs, and Exam prep. that language presents difficulties to those for whom English is not their first language. This includes some registrars and many IMGs. Allowance is made for this in the exams, but it is still a problem. We need to emphasise from the beginning that it is not enough merely to make oneself understood in broken English, it is important to become fluent. Many speak their own language at home. A session with an expert is not enough to make people fluent. Study groups could help if the topic is dealt with sensitively. Reading medical texts or the daily newspaper aloud has been shown to help. The problems arise from:

1. Lack of knowledge of the appropriate word.
2. Speaking too fast and without emphasis
3. Emphasis on the wrong syllable or letter (bloo**D** pressure sounds like blood**y** pressure)
4. Failure to understand exactly what the patient is saying

INDIVIDUAL LEARNING PLAN

This is a sample relating to the RACGP Domains of general practice. You can find them on the RACGP website. It is not suggested that you adopt all of these learning goals: you may feel perfectly comfortable in some areas. Add areas you wish to put into your plan and delete those where you do not think they need to be included. This is another way of looking at the "Things you may wish to learn"

WHAT DO I NEED TO LEARN	LEARNING OBJECTIVES	HOW AM I GOING TO LEARN IT?	TIMEFRAME
1. Communication skills and the doctor patient relationship			
What do Australians expect from their doctor that differs from my experience?	Patient centred consultation	'Patient centred medicine' Moira Stewart. Handout summary from CCCGPT	Read summary and learn to apply this model. Continuing
	The language of the GP Consultation	"I Feel Crook Doc" from CCCGPT	Brief. Refer as necessary
	The GP as a Therapeutic Agent Establishing rapport Opportunistic Health promotion	Murtagh	Continuing
Care Coordination, referrals and networking. Written Communication	Working with a team Referral letters/ Telephones	Practice manager, Supervisor, practice nurse, pharmacist. Referral letter handout CCCGPT	Continuing
2. Applied professional Knowledge and Skills			
Knowledge of Medical Problems: 1. Common 2. Treatable 3. Preventable 4. Dysfunctional, disabling or life threatening 5. Uncommon but serious 6. Undifferentiated	Gradual increase in knowledge of these conditions	From Learning Diary prompts noted when seeing patients. Educational LD model provided by CCCGPT Murtagh AFP/ Check How to treat series in Aus. Doc. Selected websites Registrar presentations teleconferenced from wagga alternate Thursday nights	Continuing

WHAT DO I NEED TO LEARN	LEARNING OBJECTIVES	HOW AM I GOING TO LEARN IT?	TIMEFRAME
Information Gathering Physical examination Skills	Increase in skills in these areas	Textbook on these subjects. Continuing practice with patients. Discussion with Supervisor	Continuing
Procedural skills	Skin checks for cancer Removal of skin lesions Use of liquid nitrogen Application of bandages/ POP Pap. smears Implanon	Supervisor Workshops on procedural skills run by CCCT Family Planning workshop	Continuing Date to be determined
Continuity of care	How this affects treatment, improves compliance and patient satisfaction	Practice: difficult when new to the practice	Gradual appreciation of the advantages
Cost effective treatment and investigations	Pharmacological treatment should be: The right drug given in the right dose appropriate to the condition being treated. Investigations must be done for a reason and not merely because they can be done, or for ritualistic reasons. Treatment and investigations are expensive to the country and to the patient	Prompted by learning Diary: Refer to AMH; Therapeutic guidelines Australian Prescriber and NPS. Standard Textbooks. Special: **Oxford Handbook Of Clinical And Laboratory Investigation** Third Edition Edited by Drew Provan $53	Increasing consciousness of the importance of cost in medicine
Critical Appraisal	I need to understand the nature and value of information available. Do the guidelines apply to my patient? How and where was the information gathered?	Discussion with colleagues, attendance at education sessions run by the Division and by CCC. Constant vigilance on this subject. Understand relative risk/ absolute risk/ NNTT.	Learn to adopt a suitably sceptical approach to information.
3. Population Health and the Context of General Practice			
Heath needs of special groups	What special groups there are in my area.	Discuss with supervisor and be alert with patients.	Be constantly alert to the issue

WHAT DO I NEED TO LEARN	LEARNING OBJECTIVES	HOW AM I GOING TO LEARN IT?	TIMEFRAME
	Aboriginal Refugee and Ethnic groups	When the issues arises, discuss with patient or local experts	
Knowledge of public Health problems	I need to be aware of the local epidemiology	NSW Health Bulletin available to most practices. Apart from Influenza epidemics, in Riverina watch for Ross River and Barmah virus, and Rove beetle rash. Also leptospirosis associated with mouse plague. Listen to the news: read local paper. Talk with colleagues	Continuing
Population based health Strategies	Immunizations Childhood Travel Preventive activities: Pap Smear Mammogaphy Preventive activities related to age as described in the RACGP Red Book.	Practice nurse Immunization Handbook Website on software gives country specific advice RACGP Red Book	Continuing
Community Resources	The resources available in the area of my practice	Practice manager/Nurse. Supervisor Probable local Directory on Software used in the practice	Find the sources and use when needed.
4. Professional and Ethical Role			
Lifelong learning and continuous professional development	Develop strategies including use of educational learning plan	Use Learning Plan regularly. Participate in College QA and CPD activities	
Teaching role	I need to develop skills as the practice takes students.	Discuss with supervisor and ME.	I am not ready for this yet. Skills will have to be developed over time
Self and Family care	Balance between work and family	Discuss with others including my family	Ongoing with fmily and

WHAT DO I NEED TO LEARN	LEARNING OBJECTIVES	HOW AM I GOING TO LEARN IT?	TIMEFRAME
			practice feedback
5. Organisational and Legal Dimensions			
Information management- patient and practice	How to use the practice software to maximum advantage. Record keeping Patient information sources	Practice manager Supervisor Experimentation	Early in my time in the practice
Medical records	My typing is very slow.	Find an on line typing tutor and practice regularly	Immediate.
Legal responsibilities	Regulations relating to the drug schedules Fitness to drive Regulations relating to drug classifications Regulations relating to reporting child abuse	Supervisor/ Pharmacist/ web sites Handbook in the practice Website Website.	Find out where to access these immediately
Practice management	Understand the various schedules MBS Items /PIP Items/DVA items. PBS Items and charges	Websites Practice manager Supervisor Pharmacist	Find out where to access these immediately. Apply knowledge when required.