Work Experience Resource Guide
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Introduction—Work Experience for sixth formers

The original idea for this project back in 2008 was the thinking from Paul Main and Joy Main on trying to address the perceived disadvantage that a non-medic in the family/no private school person has in getting to medical school. Our ideas have gradually developed since this time. Prospective medical students are required to have had some medical work experience. Any with children planning on medicine will know that. They will also know how time consuming it can be to find a colleague who will provide appropriate experience. It can be done when the student has medical parents or parents with friends who are in the profession. What this process does therefore is often exclude those students without these connections.

GP's who provide 90% of the face to face care in the NHS are ideally placed to show the art and science of medicine in practice and some of the attributes required. Demonstrating patient centred medicine and perhaps influencing for life a future doctor in the care they take of their patients.

Since 2008 the Severn Faculty of the Royal College of General Practitioners have facilitated work experience for students from all walks of life who wish to become doctors as a local initiative. We put together this portfolio of ideas and information from GP’s currently offering work experience. All of us who have these students are uplifted by their enthusiasm, stimulated by their questions and impressed with their commitment. We have addressed concerns of confidentiality and also identified frequently asked questions and issues.

All local schools were informed about this resource—which is offered only to pupils with the required GCSE grades that make them real candidates. They are required to complete an application form and we then do our best to match the students with GP surgeries willing to accept work experience students within a reasonable travelling distance.
Guidelines

Age Restriction

It seems sensible to restrict actual patient contact/observational experience to those students already committed to applying to medical school—i.e. sixth formers. Those who have completed GCSE and are continuing study (so that is six formers and some who go to college). However it is not unusual to be asked about work experience for 14 and 15 year olds. It is a great privilege for a student to be allowed to stay in the room whilst a patient discusses their problems and the student needs to be, and seem, mature - 16 therefore has to be a cut off point. There is a place though for being personally available to those younger to discuss medicine as a career without involving patients. Some practices invite students into the practice but do not allow them to sit in for normal consultations but perhaps allow them to see one or two “safe patients” during the day.

Required GCSE Grades

Universities will not consider students applying for medicine if the GCSE results are not of appropriate standard the current requirement seems to be 8 A/A*. It is not therefore reasonable to offer work experience to students who are unlikely to or have not achieved these grades. We are not setting up barriers but being realistic about the process. With potentially many students wanting the opportunity it is not appropriate to offer work experience to those not able to end up on a medical course. Some practices adhere to this very firmly— others allow those with an interest in allied health professions and nursing to gain from the experience.

Expectations of the student

The student must be aware of the nature of strict confidentiality. It would seem appropriate to ask for a signed agreement to that effect. Appropriate dress should be clean and neat. Jean and tank tops are not appropriate the trouser/skirt and clean shirt/blouse look is necessary.

The student is expected to be considerate and aware of the patients feelings, be able to sit without fidgeting/sighing etc and be aware that difficult issues may be raised by the patient. The student must be able to accept that physical examinations, some of them intimate, may need to be carried out and that they could be excluded from these. (Examinations requiring exposure of the patient can be done behind the curtains out of sight of the student).

Students need to be aware that it would be inappropriate to stay in a consultation with a patient they know socially—however tenuous this might be. They should also be aware that some patients may be unhappy about an audience and should accept that some patients will ask them to leave.

Expectations of the patient

Patients need to be introduced to the student as a sixth former doing work experience and feel comfortable that they have the right to ask the student to leave at any time during the consultation. Ideally patients should be warned when they book an appointment and there may be an argument for written consent, although this could then make it difficult for the patient to ask the student to leave during the consultation.

Expectations of the doctor/the practice
Guidelines

The doctor agreeing to take on the student is there to allow an insight into the job. There is a argument that the job should go on as normal with the student observing. If possible there should be some protected time during and after surgeries to discuss what has happened in the consultation, in the context of the patient’s life and that of the NHS as it is. However an experience that the student feels is too passive may hinder learning because of the lack of involvement.

It would seem appropriate to discover what the student feels about previous experiences, what they want from their time in the practice and what their expectations of a medical career are—from personal experience or only from ‘ER’. Perhaps they have a medical role model already. Many students have a sketchy knowledge about terms like PBL etc and what medical courses consist of. These are worth exploring but courses in all universities are consistently developing. The doctor should be able to access or pass on information—GMC, BMA websites etc. Students like to talk about their UCAS personal statement and it is important to give appropriate feedback, so it is useful to know what things the Universities look for in general. We are not experts in university applications, each university looks at things in their own way anyway, but we should be able to chat generally about campus/non campus, London/not London, PBL early/PBL developing through the course.

The Practice itself can be a resource—chronic disease nurses, other partners, medical students, foundation doctors, specialist visitors who do surgeries in the practice have a variety of patients and their problems dealt with to add to the experience. It can be helpful to explain the work of all the people in the PHCT if the student is unclear and discuss ‘hot topics’ from the news etc. A few practices will try and bring back a medical student who has visited the practice in the past—and support them in answering questions about personal statements and what the life as a student is.

What is the point?

The point is to give the student an insight into the work of a doctor and provide some talking points for interview/personal statements. It is very hard for sixth formers as many doctors and hospital departments have a restriction to those over eighteen years old—clearly too late for the medical applicant. In general practice we have the flexibility to make our own decisions and also know the patients we are seeing. We deal with the hard medical facts and the sensitive emotional side of a consultation. Demonstrating the art of medicine and the magic of the consultation and then be able to explain it, is a gift worth sharing.

Dr Jo Fleming
How other practices deliver the scheme.

INTRODUCTION

Many practices deliver a variety of options varying from a half day to a full week and involving time with a variety of professions, time seeing people with ill health, teaching, support for the student to apply effectively. There is no right or wrong method—but the more we can inspire the doctors of the future to have a passion for general practice the better it will be for our talented workforce.

Example A:
My course is a small annual programme for five or six students in year 12 at school, who aim to apply to medical school. I take students who have no medical support in their background and who are struggling to make sense of the challenging process of gaining work experience trying to construct a high quality personal statement and preparing for the demanding interviews they will face.

The course aims to teach to the requirements of medical school admissions, whilst exposing the students to realistic work experience that will inform them about the doctor patient relationship, living with disability in the community and the make up of the primary health care team. We also deal with health inequalities, ethical issues, how to differentiate between the many courses offered and how to use life and work experience to inform the application. We end by looking at preparing for the interview.

My own ‘hidden curriculum’ is to instil into the students values that will provide for their journey towards being doctors—patient-centred attitudes that will enable them to question any future teaching that does not place the patient at the centre of care. They are idealistic when they apply and my hope is that this most important aspect of role modelling will provide for their future journeys as doctors.

TOPIC ANALYSIS

Introduction

In the five two hour sessions provided the following topics are addressed.

- Medical schools and the courses they offer—the academic and professional journeys and how their differing needs are addressed in course development—education paradigms such as problem-based learning and how they inform course development.

- Attributes sought in successful candidates and how the student can use their own life and experience to inform their application.

- Health inequalities.

- Meeting patients, hearing their story and presenting their findings to the group—living creatively with disability in the community.

- Meeting the primary health care team and learning about their roles, especially new role models for health care in the community, for example drug counsellors or advanced primary nurses.

- Understanding some ethical issues.

- Preparing the UCAS personal statement and preparing for interview.
**How other practices deliver the scheme.**

**Topic details:**

- Teaching about the types of medical school course offered, linked to the academic and professional journeys and educational theory of active learning.
- Analysis of attributes being sought by medical schools and understanding of how to use work and life experience to inform this aspect of application.
- Details of work experience opportunities.
- Housekeeping—planning future sessions.

**Objectives:**

**Product objectives -**

- Understanding of the difference between traditional, integrated, problem based learning courses and newer courses and the ability to decide what’s right for them.
- Understanding the importance of their own research into courses.
- Using the information from medical schools to construct an understanding of the characteristics being sought and how they can use their life and experience to illustrate them.
- Understanding of the nature of the work experience programme and planning of mutually acceptable timings.

**Process objectives -**

- Understanding of group confidentiality and behaviour.
- Understanding of the academic and professional journeys and how these concepts have informed medical school curriculum development.
- Understanding of how changing education precepts have informed the development of new medical courses, for example, course integration and problem based learning.
- Enhancing their perception of the value of their own experience and enabling them the to see how it can be used.
- Introducing them to reflective practice and reflective accounts as process.
- Encouraging active work and learning.

**Teaching methods:**

- Didactic teaching of the ‘clusters’ of characteristics of different courses and how educational needs of the academic and professional journeys have played driving roles.
- Didactic teaching about how education theory has driven newer courses.
- Active group work—sharing identified institutions, reasons and guidance.
- Discussion leading to shared identification of the characteristics sought in the successful applicant.
- Group work—identifying life skills to inform application.
- Suggestions regarding how to use work experience to inform application.

**Assessment:**

- Formative assessment of activity and responses during group work.
- Formative assessment in subsequent sessions, of understanding of material from first session.
- Summative assessment—gaining of offers of places at medical school.
**Evaluation:**

- Personal reflective evaluation by the teacher as the sessions progress—‘evaluation in action’.
- Informal evaluation at the end of session regarding usefulness from students.
- Indirect evaluation from peer feedback.
- Evaluation sheet at start of subsequent session, to evaluate preceding session.
- Evaluation sheet at end of course.
- Discussion with fellow educationalists regarding value, appropriateness and how to target most appropriate students.

**Session 2—Inequalities in Health**

**Aim:** to develop understanding of what it means to be poor in the UK and the effect of poverty on health.

**Topic details:**

**Practical**—drive around Hartcliffe noticing:

- Few shops trading in the heart of the estate.
- Nature of social services and housing office ‘fortress’.
- Who’s about—single parent mothers, babies and buggies; unemployed maybe addicts; truanting school children; elderly disabled.
- Housing—walk up flats; high rise blocks; difference between council and owner-occupied property; concrete cancer.
- Environment—burned out cars; litter; needles in playgrounds; communal washing lines.

**PowerPoint presentation**—the Health Wealth Gap.

**Objectives:**

**Product objectives** -

- Ability to identify physical differences between their familiar environment and this one of socio-economic deprivation.
- Ability to identify difference between people in the streets in Hartcliffe and their home environment.
- Ability to identify different housing types and infer problems for residents.
- Ability to describe characteristics of the consultation in socio-economic deprivation; the problems caused by ill health and educational deprivation.
- Ability to describe the composition of the community primary health care team.

**Process objectives:**

- Ability to understand issues raised by health inequalities and educational deprivation.
- Ability to ‘read’ environmental signal and reflect upon their meaning for people.
- Ability to understand the need for ‘unconditional positive regard’.

**Teaching methods:**

- Practical experience of the area—guided drive around with discussion
- PowerPoint presentation with active engagement of learners. Print out of slides.
How other practices deliver the scheme.

**Assessment:**
- Formative assessment—informal through assessing individual responses to questions.
- Summative—whether the student gets offers from medical school.

**Evaluation:**
- Informal ‘round’ at end of session, asking what’s the most important thing the student has learned and whether there remain any questions or hot topics.
- Informal feedback via student network.
- Evaluation sheet—to be completed at the start of each subsequent session after opportunity for reflection.
- Final evaluation sheet at the end of the course.

**Session 3—Meeting the Patients**

**Aim:** to visit a patient in two’s to learn about the effect of illness and disability and coping mechanisms in the community. The present the findings to the group afterwards.

**Topic details:**

*Introduction* - briefing about the patients, how to listen and what to ask.

**Practical**
- Visiting a patient in two’s hearing and clarifying the story.
- Visiting patient in nursing home in group.
- Return to health centre to present findings to the group.
- Introduction to ‘end of life’ ethics.

**Objectives:**

**Product objectives:**
- To be able to list to a patient’s illness narrative and ask appropriate questions to aid understanding.
- To be able to describe adaptation and coping mechanisms employed in the home to maximise quality of life.
- To be able to ‘present’ the patient’s story to the group in a structured and sequential way.
- To be able to describe three ethical issues relevant to the end of life.

**Process objectives:**
- To experience the nature of the relationship between student and patient and carer as the root of the practice of medicine.
- To understand how adaptation to disability can enable quality of life to be maintained.
- To experience and gain confidence in the process of case presentation.
- To become aware of the presence of ethical dilemmas in the everyday.

**Teaching methods:**
- Direct exposure to patients without the teacher present.
- Visit to nursing home with the teacher.
- Small group work—both presentations and discussion.
How other practices deliver the scheme.

Assessment:

- Formative—informal feedback from students and patient later.
- Summative—whether students are offered medical school places.

Evaluation:

- Informal evaluation from students at the end of the session.
- Informal evaluation from patients and carers at a later date.
- Evaluation form to be completed at the start of subsequent session.
- Evaluation form at end of course.

Session 4—Meet the Primary Health Care Team

Aim: to familiarise the student with the different roles that make up health care in the community, including new and innovative roles.

Topic details:

Introduction to the roles in the PHCT.

Practical—Ten minutes spent with each Treatment Room nurse, District Nurse, Health Visitor and Chronic Disease management Nurse learning about their roles. Ten minutes spent with each innovative role practitioner—Drugs Counsellor, Nurse Practitioner, Pharmacist and Advanced Primary Nurse

Consolidation—group discussion of roles to access understanding.

Computer System—teaching about the use of computer and analysis in primary care.

Objectives:

Product objectives:
- To be able to list the members of the primary health care team and briefly describe their role.
- To understand the new roles developed and why.
- To be able to describe five domains of information held on computer and their everyday use.

Process objectives:
- To understand teamwork, skill mix and delegation and how these aspects are used in primary care.
- To understand the importance of information technology in data storage and retrieval and accountability.

Teaching methods:

- Brief presentations by members of PHCT.
- Preparation and debriefing by teacher.
- Practical demonstration of information technology use in primary care.

Assessment:

- Formative in-group discussion and questioning.
- Summative—quality of UCAS personal statement and whether student is offered medical school place.
How other practices deliver the scheme.

**Evaluation:**

- Informal verbal at end of session—seeking initial comments on learning that’s taken place from students.
- Evaluation sheet to complete at start of next session.
- Evaluation sheet at end of course.

**Session 5—Ethical Issues, Personal Statement and Preparing for Interview**

**Aims:**

- To raise awareness of the embedded nature of ethical issues in the practice of medicine.
- To stimulate reflection on the preparation of high quality personal statement.
- To raise awareness of the need for active preparation for interview.

**Topic details:**

- Ethical issues—will follow the details in the Gagne topic analysis.
- Didactic teaching about models for personal statement construction, linked to medical school requirements.
- Didactic teaching about preparations for interview.
- Housekeeping—hot topics—any questions.

**Objectives:**

**Product objectives:**

- To stimulate reflection and debate in the group around three topical ethical issues.
- To raise awareness of three ethical issues encountered in the cases already met.
- To teach the need for a structured, relevant personal statement.
- To teach aspects of necessary interview preparation.

**Process objectives:**

- That students come to understand that ethical decision and attitudes permeate the culture of medical practice.
- That students become aware of how to use their personal and medical experience to construct a reflective and relevant application.
- That students come to realise the journey of preparation is better made in advance than in their interviews themselves.

**Teaching Methods:**

- Scenarios with questions to stimulate discussion within the group around current topics of ethical relevance.
- Socratic questioning to elicit understanding of relevance of ethics to cases already introduced.
- Taught points regarding structuring personal statement.
- Taught advice regarding preparation for interview.

**Assessment:**

- Formative in group discussions.
- Formative—quality of draft UCAS personal statement.
- Summative—whether students are offered medical school places.
How other practices deliver the scheme.

TEACHING AND LEARNING METHODS

Please refer back to lesson plans.

The teaching methods used are as follows:

- **Didactic teaching**, always with a handout—education theory behind different courses; aspects of preparing for interview.
- **Group work**—mutual teaching about courses at difference medical schools, discussion to identify desirable attributes for applicants, presentation of cases after patient visits, seminar style. Socratic style questioning to elicit understanding of ethical issues.
- **Field work**—drive and walk around socio-economically deprived area. Visit to patients in home without teacher. Visit to nursing home.
- **Given scenarios**—for consideration of ethics in the abstract.
- **Meeting**—with primary health care team members.
- **PowerPoint presentations**—on health inequalities.
- **Practical demonstration**—on information technology used in the practice.

Preparatory work:

- Because much of the material is experiential and outside the existing knowledge of the student, there is no over-riding need for intensive preparatory work to inform the sessions. I have set preparation before the first session, in terms of looking up information about medical schools, but have never found it has been attended to in the detail I am able to encourage during the session.

TWO TOPIC ANALYSES DEMONSTRATE THAT THERE IS A HIERARCHY OF CONCEPT TEACHING THAT CAN BE USED EVEN AT THIS EARLY STAGE AND THAT LEARNING IN BOTH THE COGNITIVE AND AFFECTIVE DOMAINS CAN BE ADDRESSED.

**Topic Analysis**—ethics teaching—demonstrates a hierarchy of complexity in ideas.

1. **Simple, concrete learning**—visit to elderly nursing home resident with end stage cancer who fears admission to hospital. What factors might affect whether the doctor decides to admit her or not?
2. **Learning of principals**—learning to hear, understand and respect the patient’s point of view and wishes, introduction of another abstract scenario at this point—the elderly lady who doesn’t want treatment because her husband has died.
3. **Learning of concepts**—the concept of the patient’s wishes being a part of all decisions made about medical care.
4. **Problem-solving using concepts**—scenario of Gillick competence—clear cut in law. Scenario of health care rationing, e.g. Herceptin—not as yet clear cut in law.
How other practices deliver the scheme.

Topic Analysis—choosing a medical school—working with the head and the heart.

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<thead>
<tr>
<th>Cognitive domain</th>
<th>Affective domain</th>
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<tr>
<td>1. Teaching about different courses—traditional,</td>
<td>Understanding that course quality and reputation are more important than</td>
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<tr>
<td>integrated, PBL, innovative.</td>
<td>university reputation.</td>
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<td>2. Internet use to identify all UK medical schools.</td>
<td>Ability to overturn own prejudice and select on basis of evidence.</td>
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<td>3. Analysis of courses using taught information</td>
<td>Ability to compromise between quality of course and desirability of location.</td>
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<td>4. Identification of suitable courses.</td>
<td>Approaching institution and experiencing different aspects of its marketing—welcome,</td>
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<td></td>
<td>student centredness etc.</td>
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<tr>
<td>5. Prioritisation of choice medical schools</td>
<td>Using heart and head in final decision making.</td>
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<td>6. Visiting selected medical schools to confirm choices.</td>
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Just a final thought -

Bransford and Lampert found research suggesting that some features of effective teaching behaviours are common across all the post-compulsory sector. These appear to be:

✦ engagement with students on a personal level
✦ excellent subject knowledge
✦ demonstrating ‘care’ in relationship with students
✦ purposeful teaching
✦ attention to feedback
✦ a commitment to keeping promises

These factors, apart from subject knowledge, lie in the affective domain. They characterise the teachers described by Parker Palmer (1998, The Courage to Teach) who ‘refuse to harden their hearts, because they love learners, learning and the teaching life’.

Dr Joy Main
Mock Medical School Interviews

Here are a few suggestions of questions you might ask whilst conducting a mock medical school interview.

Why this Course/City?
- Why this university?
- Why have you chosen our course in particular?
- Do you know the structure of the course?
- Is there anything about this course that suits your personality or your style of learning?
- What do you know of our City?

Personal
- What have you enjoyed most about your A Level Studies—why did you do an Arts subject?
- How do you learn best?
- What are your personal strengths and weaknesses?
- Can you tell me about a difficult experience you had doing your work experience?
- What situations tend to make you angry?
- What are your interests outside medicine - how important are interests outside medicine to doctors? What else do you plan to do at Medical School?
- What books have you read recently that you have enjoyed or found interesting? Why?
- We have had a record number of applications for the Medical School this year—why should we choose you?
- What will you do if you don’t get offered a Medical School place?
- What has been your best experience of being in a team? Why are teams important in Medicine?

Medicine
- Why do you want to be a doctor?
- Why are doctors so often criticized in the media?
- What lessons can we learn from the recent MMR issue?
- Are computer skills important in Medicine and Why?
- What are the health care implications of an ageing UK population?
- How can a knowledge of Biology help us to thwart the predicted Flu epidemic?

Ethics/Other

Doctors have to make difficult decisions -
- A recent issue has been the abortion of a foetus with a cleft palate—what do you think of that? How can doctors get help with these decisions? The abortion act permits abortion for substantial risk of major handicap—how ‘major’ should that be—if at all?
- Recent debate in the BMA about whether it will be possible for people to donate their organs for a fee.
- Should all patients be entitled to the newest cancer treatment?
- Is Euthanasia ever right? - there are currently political discussion about the possibility of allowing doctors to end patients’ lives in certain situations—how do you feel about this?
- How can we prevent another Shipman?
- What do you think about the relationship between Medicine and the Pharmaceutical Industry?
- Do you feel that alcoholics should be offered liver transplants?
- Why haven’t you applied for a Nursing Course?
- What would be the implications for the NHS if there was a ‘flu pandemic this year?
- Is there a place for private Medicine?
- What are the best features of the NHS?
- What are to worst features of the NHS?
- How can a study of the Arts benefit Medical Schools?

Dr Colin Burgess, Dr Bill Foster and Dr Rob Mackay
Some principles to guide you ...
Four irreducible principles that govern all decision making in clinical practice.

- Autonomy
- Beneficence
- Non–maleficence
- Justice

Autonomy
- The capacity of people to make their own decisions.
- To be fully autonomous you might need to have all the information and feel free and un-coerced.

Beneficence
- This encourages the GP focus on what he feels is ‘acting in the patient’s best interest’.
- This may not necessarily coincide with what the patient wants.

Non-maleficence
- ‘Primum non nocere’
- Firstly do no harm
- Gross harm—Shipman
- Subtle harm—Side effect of drugs given for self-limiting conditions

Justice
- Nothing to do with legal retributive justice
- Is population based
- This refers to distributive justice
- Helps authorities and organisations to allocate resources fairly according to need

Further reading suggestions
‘doctors Dilemmas decisions’ - Ben Essex, BMJ Publishing Group 1994

Dr Bill Foster
**Confidentiality Agreement**

All people working in the health service need to adhere to stringent levels of confidentiality.

It is vital that patients, when seeing their family doctor or practice team are assured of this.

This agreement indicates that, as a prospective medical student, you agree to abide by these levels of confidentiality whilst in the practice, and afterwards and not discuss any confidential information that you may become aware of during your visit to the practice.

If there are any doubts as to what should remain confidential you should contact the practice to discuss the matter.

Breaches of confidentiality, whenever they occur are very serious occurrences and for employees can result in instant dismissal from their job.

Name of prospective student: .................................................................

Date of visit to practice: .................................................................

Signature of agreement: .................................................................

*Kindly provided by The Park Medical Practice, Shepton Mallet*
Please use this to compare if you have been to other practices.

1. What number of patients are cared for at this Medical Practice?

2. What are the local industries in this area? What about deprivation? What illnesses are likely to be more common than where you live?

3. What number of clinical professionals provide this care?

4. How many people are seen in the practice in 1 year?

5. In the NHS, what is the approximate percentage of ‘contacts’ made in primary care and secondary care for people’s health?
6. Who are the other members of the primary health care team? What is their training? What patients do they see?
7. What are the common conditions—acute and chronic—seen in general practice?

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<th>Acute Condition</th>
<th>How Common?</th>
<th>Comments</th>
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<th>Chronic Condition</th>
<th>How Common</th>
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8. What conditions are not treated in general practice? Why

9. What does a practice nurse do?

10. Find out about a prescribed medication.

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<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>How much does it cost to obtain a prescription?</td>
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<td>How much does the drug cost for 1 month of treatment</td>
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<td>How many prescriptions for this drug are given every year in the practice?</td>
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<td>How much would this be across the country?</td>
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11. Should prescriptions be free for all people?

12. What use do computers play in primary care?
13. What impact does sickness have on an individual person? - choose a condition and comment on the impact of the problem?

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<th>Social Effect</th>
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14. Produce a prescription for Mickey Mouse—paracetamol 500 mg two tablets four times a day for two weeks.

15. How much of general practice is a business and how much is about caring for the community?
13. What are your views on:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Response</th>
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<tbody>
<tr>
<td>Euthanasia</td>
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<tr>
<td>Treating diseases caused by smoking</td>
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<tr>
<td>Termination of pregnancy</td>
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Dr Steve Holmes