



Phasell

Managing your learning

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1. Introduction

This document stands alongside the “Phase II Course Document”, the “Looking after You in Phase II” document, the “Personal and Professional Development” file and the “Code of Conduct of Assessment in Phase II”.

This document aims to bring together a range of important pieces of information that you will need to refer to during Phase 2. Becoming a doctor is much more than learning a set of information. You will need to take on a set of professional responsibilities, encompassing patients, colleagues and the wider society. You will need to look after yourself, both in terms of your own wellbeing and your learning. We will provide you with guidance and help. We are keen to ensure that you are well supported.

Acknowledgements:

I wish to acknowledge the help of students and colleagues in the production of this document. I have also been able to view documents from other medical schools and in particular acknowledge the input from the University of Edinburgh.

This document remains a work in progress. I hope that it will be useful to both students and teachers. I am happy to receive comments and suggestions.

David Heney

Phase II Co-ordinator

2. Learning in Phase II

Phase II is a logical progression from Phase I.

The General Medical Council in its document "Tomorrow's Doctors" specifies a series of learning outcomes in terms of knowledge, skills and attitudes which students should achieve by graduation. The GMC suggests that these learning outcomes should be achieved by curricula which are 'student centred', aiming to produce graduates with "approaches to learning based on curiosity and exploration of knowledge, rather than its passive acquisition."

The structure of Phase I of the curriculum is designed to encourage your development of an appropriate attitude to learning by a process of '*directed-student learning*'. In each of the modules you have been given clear learning outcomes - a specification of what you should be able to do. You were guided towards these outcomes by a variety of methods, including lectures to set the scene, work book material and research exercises to allow you to develop and explore your understanding. Our aim is that this structured approach will exemplify for you the approach that you will now need to take in Phase II, when you progress from *directed-student learning* in a structured environment to *student-directed learning* in the clinical environment, where learning opportunities present themselves in an unstructured way and you must be fully prepared to learn what you can, when you can.

There is nothing new about learning clinical medicine in this way. If you are to structure your own learning, then you must know what you are working towards. The Phase II curriculum is **not, therefore, defined by your timetable**, which in any case will vary from student to student. The curriculum is defined by **learning outcomes**. These outcomes, which form the main part of the "Phase II Course Document – Learning Outcomes", are 'competency based', that is to say they define what you should be able to do by the end of the course. This requires a good deal of knowledge. But competence is much more than just knowledge. It embodies the vital clinical skills of history taking and clinical examination, which you should have now acquired from the Introductory Clinical Course. You will need problem solving skills and 'clinical intuition' as well as the attitudes that are essential to effective and humane clinical practice. All these can only be gained by regular close clinical contact with patients followed by reflection and study about what you have seen.

Your timetable is a list of opportunities for you to achieve competence. Merely going through the motions of turning up at the appointed time and place will not make you a doctor. Students and doctors learn more from their patients than they do from their teachers or from books. You will need to listen to your patients, examine them and write down your findings. You will also need to think about patients' problems and discuss them with colleagues as well as studying books and papers. We have devised a means for you to do this yourself by collating a written portfolio which embodies the three-way interaction between patient, teacher and yourself, in a way which can be related to both the general and specific learning outcomes of the curriculum. You will be able to see your competence developing in a reassuring way as the course progresses. We will, of course, also provide formative feedback on our judgement of your progress, and assess you summatively to make sure that you have achieved the learning outcomes adequately.

We believe that the only way to learn how to be a doctor is to work alongside practising clinicians, and that this process of 'apprenticeship' requires relatively long attachments to individual clinical teachers. Medicine is an art as well as a science, and you must develop the appropriate attitudes required of a doctor.

This can only be achieved if you involve yourself fully in the clinical environment in which you are working. You will therefore undertake a series of long attachments which will give you a good opportunity to learn by 'apprenticeship'. Most hospital doctors, however, work as 'specialists', concentrating on a limited range of clinical activity. Patients, do not, however, present initially with labels indicating the specialty or even the body system involved in their illness. Most problems are dealt with in the community and any hospital phase is a small part of most illnesses. In hospital, the same problem may present to more than one specialist, and many problems will need the expertise of more than one specialist to solve. In primary care the way patients present will give you a good idea about common presentations, but less experience of uncommon but important problems. In hospital practice, the reverse can occur with some specialist units apparently devoted to a single disease. The learning outcomes will give guidance to the presentations and problems with which you should be particularly familiar.

In order to maintain the apprenticeship model and keep your experience as broad as possible we have therefore avoided arranging your attachments by specialty. Mostly, you will be attached to 'teaching partnerships' involving two or three clinicians from different but related specialties. We will ensure that you obtain experience in a proper range of clinical environments, including General Practice, which plays a full part in the partnerships later in the course, and by extensive use of District General Hospitals.

This arrangement means that students are spread over a number of hospitals. This gives very favourable student/staff and, more importantly, student/patient ratios. You should therefore integrate yourself thoroughly with the work of the firms and become the 'junior member'. This includes being 'on take' when the firm is on take, including nights and weekends. In this respect medical and surgical admissions units provide excellent experience. House Officers sometimes report that they wished they had obtained more emergency experience as undergraduates but the opportunities are available for the taking.

It is vital that your clinical education comes to reflect the changes in health care delivery which are occurring or about to occur. There is an increasing trend to deliver more care in the community, to develop outpatient rather than inpatient services, to shorten inpatient stay, and to increase day-case surgery. The new curriculum takes account of these changes.

In summary: Phase II provides you with a series of opportunities, via long attachments to multi-disciplinary clinical teams, to develop a specified list of competencies by a process of student centred learning which exploits the richness of clinical experience available to you.

3. Working as a professional

i) Professional Roles and Responsibilities

Your presence as a medical student on the ward, in clinics and in the community is a further step in taking on the professional role of a doctor. As a medical student you are considered to be an integral part of the medical team caring for those patients. Accordingly, you have access to patient information and will listen to discussions relating to the patients. Hopefully you will also contribute to the discussions with your own knowledge of the patient. In this context you naturally take on a range of professional responsibilities towards the patient.

At the same time you will also be taking on responsibilities to the medical and nursing team of which you are a part. Some of these responsibilities include normal courtesies and the need to respect divergent views of team members.

These principles of professionalism relate to the following areas:

Working with patients

- putting the care of your patient first;
- respect for the autonomy and rights of the patient;
- maintaining confidentiality;
- empathy and understanding for patients in all their diversity;
- communicating clearly and honestly with patients;
- courtesy towards patients and their families;
- keeping your relationships with patients professional.

Working to a good standard of care

- working within your own level of competence;
- striving for high quality in clinical practice;
- keeping knowledge and skills up-to-date in a changing scientific world;
- developing judgement to make sound clinical decisions;
- using good organisational procedures;
- communicating effectively with colleagues;
- respecting roles and expertise of colleagues;
- reflecting on and auditing your own and colleagues' practice to improve clinical care
- acting to reduce clinical risk;
- good team-working skills;
- maintaining a high level of teaching and support for students and colleagues.

Personal qualities

- altruism and compassion;
- honesty and integrity in professional and personal undertakings;
- responsibility and accountability for improving your own practice and that of colleagues;
- actively undertaking self appraisal of your knowledge, skills and attitudes;
- developing leadership skills;
- implementing personal and professional codes of ethics in day-to-day life;
- looking after your own health.

The wider world of medicine

- upholding professional self-regulation;
- active involvement in clinical governance;
- promoting justice within healthcare;
- patient advocacy.

The principles of professionalism are therefore both individual and collective. The GMC's booklets on good medical practice (<http://www.gmcuk.org/standards/good.htm>) offer guidance to students and doctors, and students are advised to become familiar with their details.

ii) Managing your time

One of the most important responsibilities is to manage your own time and commitments. Attendance at all scheduled presentations and timetabled events is a requirement of the course. Being a medical student should be considered a full time apprenticeship, and it is not possible, nor appropriate, to opt out of selected aspects of the course. Teaching sessions are compulsory. Requirements for individual blocks will be made at the beginning of the block. An appropriate professional attitude goes further than simple attendance. It is important to arrive on time and to have work ready when required. It also means contributing positively, sharing learning experiences and making a real contribution to the medical team and to your fellow students. If you are unable to attend for any reason the expectation is that you will let someone know. Exactly whom you inform depends on the circumstance and you need to exercise your own judgement.

iii) Attendance and Leave Entitlements

A high standard is set for attendance requirements. These are given in detail in the appendix at the end of this document - **Code of Conduct with regard to Attendance in Phase II and Leave Entitlements**. You should read them carefully. These requirements are set, not only to ensure that you learn efficiently but also so that you understand the professional attitudes and responsibilities that are inherent in good attendance.

The amount of annual leave available for students in Phase 2 is limited, and is equivalent to that of a house officer. We are fully aware that there will be a range of other occasions when you need to take leave. Again, these are detailed in the appendix. The key principle is that you must ask permission to take leave and you must keep the appropriate people informed.

If you wish to request leave you should email phase2@le.ac.uk and your email will be directed to the appropriate person.

4. Interacting with patients

i) Conditions for medical students on clinical attachments

To ensure that the interests of patients and NHS are safeguarded, the Department of Health and the profession have agreed on the conditions under which students may undertake clinical work. (*The Medical Students on Clinical Attachments Report*, NHS Management Executive, 1991). These guidelines are presently being revised. The points below are those that are of most importance and that you should be aware of:

The admission of a medical student to the premises of a Health Authority or a Trust is subject to the prior written approval of that body. Only *bona fide* medical students may have access to patients and take part in any clinical procedure involving patients, including all forms of clinical examination, even under supervision. You must be readily identifiable as a student e.g. by wearing a suitable lapel badge.

Before admitting a medical student Health Authorities and Trusts:

- should make any necessary inquiries into the health of students, and may request and arrange for them to undergo a medical examination as a condition of their attendance in hospital if they are satisfied that the interests of patients require it;
- must ensure that any clinical assistance by a student, whether or not on their premises, is given under the close supervision of a registered medical practitioner; save that where a student assists with a maternity case, the supervision of a registered midwife is acceptable.

You must in no circumstances:

- initiate, alter or stop the treatment of a patient on your own diagnosis;
- prescribe, request radiological examinations or other diagnostic investigations, or order blood to be cross-matched. If you complete an order form for any of these purposes, it must then be signed by the registered medical practitioner supervising you before it is executed;

When acting in an emergency, e.g. a cardiac arrest, you have the same rights and responsibilities as any other citizen.

ii) Responsibility of clinical teachers

Responsibility for the care of patients who interact with medical students rests with the clinical teacher. If the teacher is not the consultant in charge of clinical care of the patient, the explicit permission of the responsible consultant must be obtained. They must also satisfy themselves that adequate facilities are available for care of the patient, should there be a change in the patients condition during transfer or during the teaching session e.g. if resuscitation is required.

Essentially this means that the consultant to whom you are attached has responsibility for the care of the patient and you must ensure that the consultant or a designated member of the team knows that you are seeing the patient and knows what you are doing.

iii) Conduct

The medical profession is under scrutiny as never before. How you conduct yourself is important both for your interactions with patients as well as those with colleagues. The GMC has provided guidance to be found in "Good Medical Practice". Some topics are included below. There will be many other areas that will arise as you go through the coming years. You will see examples of good conduct as well as bad. You should take note of both and make a conscious decision as to who you will choose to be your role models.

iv) Dress code, hygiene and hand washing

It is important that you appear properly dressed on the wards. Your patients will expect you to look like a doctor and may refuse to be seen by you if you do not fit their view. You must adopt a dress code and personal presentation which projects a professional image and allows patients, teachers and colleagues to feel comfortable in your presence.

You should check with your consultant at the beginning of a block whether a white coat needs to be worn. This will vary depending on the clinical environment.

You must wear your name badge at all times.

Patients will expect appropriate standards of hygiene. Hand washing is vital to infection control and you are required to wash your hands on entering a clinical area and to use the alcohol gel or equivalent provided at the patient's bedside or cubicle.

v) Confidentiality

You have a responsibility, by law, to keep patients' data safe. The following important guidelines are taken from a document produced by UHL for everyone working within that Trust, but are applicable to all clinical settings.

A common sense approach to patient confidentiality

You should take care with the following:

- **Telephone:** if someone wants patient data – check caller and number are valid and phone back
- **Fax:** ensure that it is sent to 'safe haven' or recipient is there to receive fax.
- **Speaking to individuals:** do not discuss patient data unless necessary, if checking accuracy of data with patient i.e. in outpatients – ensure that others cannot overhear conversation.
- **Computer records:** take care not to leave patient data on screen unattended or for others to see. If using or setting up a database please register with the Data Protection Manager.
- **Paper records/notes:** notes should not be left on display or unattended, ensure that they are always put away securely. Please ensure that the location of records is recorded on HISS and seal if sending externally.
- **Accuracy of data:** ensure that all data you record on paper or electronically is accurate.
- **Disposing of data:** shred all patient identifiable data or take to nominated shredding area.
- **Clear desk policy:** ensure all patient data is cleared from your desk before you go home.

vi) Consent

Why is Consent Important?

To learn to be a doctor, you will need to have regular contact with real patients in real situations. These are real people with clear legal and ethical rights. You are likely to be seeing them at a time of illness and therefore considerable stress; despite this, the vast majority of patients are happy to see students. You should always remember, that this is an immense privilege and that your own education and that of students that come after you is dependant on people willing to allow you this privilege. As well as understanding consent relevant to being a medical student, an important outcome of the course is understanding consent for when you are a practicing doctor.

Additionally, there are clear legal implications if you act without consent. For example:

- If you touch someone without getting his or her consent, it can be considered to be assault.

The most important document for any doctor is the GMC's '*Seeking Patients' consent: the ethical considerations* (GMC 1998; www.gmc-uk.org/guidance/library/consent.asp). This is the guidance that the GMC and the Courts will expect you to follow. The Department of Health has also published guidance that the GMC and Courts will expect you to follow (DoH 2001; www.dh.gov.uk/assetRoot/04/01/90/79/04019079.pdf).

However, where student learning is concerned, whilst there is agreement on the importance of patient consent, there is much variation in practice.

What is Consent?

Consent is the informed choice of a competent patient, freely given.

Additional issues surrounding consent will be covered as part of the Ethics and Law strand of teaching, and will not be covered here.

What is consent necessary for?

It is often and wrongly assumed that the need for consent is solely required for the treatment of patients. In fact, consent extends to all aspects of the relationship between doctor and patient.

- **Studying and teaching**

Patients need to be asked for their consent to be involved in any part of the teaching process. Patients admitted to a teaching hospital are usually given written information that indicates that students are taught within clinical settings. Consent should be taken at the outset and is the responsibility of the clinical teacher. This is the case whether you are sitting in on a GP consultation or using the case study of a particular patient for a portfolio or presentation. If the consultant is present he/she should ideally introduce you as a medical student and ask if the patient minds if you are present. In many cases the consultant will simply ask you to go and see one of the patients on the ward. By doing this, the consultant is giving you permission to approach the patient. You must also be honest with patients and other staff – so describe yourself as a 'medical student' or 'student doctor' and not, for example, as a

'young doctor', 'colleague' or 'assistant'. You must clearly give the patient the opportunity to agree to you talking to them and examining them or to choose to say 'no'.

- **Confidentiality and disclosure**

You will need to seek consent to write up or present a case (whether as a portfolio case or not). You will need to make it clear what information will be included. ALL other information concerning patients should either be in the clinical notes or destroyed.

- **Discussing patients for teaching purposes**

It is good practice to seek specific consent to discuss a patient at a meeting or teaching session. Where this is not possible, it may be acceptable to present an anonymised case – seek advice from your clinical supervisor and ensure that the case is genuinely anonymous – You should avoid using initials if possible.

Who can get consent?

It is the responsibility of the doctor organising the teaching, giving the treatment or doing the investigation to seek consent. They can delegate the taking of consent, but it is still their responsibility to ensure it is taken properly. Students will not normally take consent for a treatment or a procedure.

Who can give consent?

Competent individuals:

- **Aged 18 and over**

Anyone aged 18 and over is assumed to be adult for the purpose of defining competence to consent. If the patient has learning difficulties or is possibly impaired in their ability to understand consent, by reason of, for example, head injury, dementia, medication, or anaesthesia, seek the advice of your clinical teacher.

- **Aged 16 – 17**

In most cases, young people in this age group are treated as if they were adults. They are assumed to be competent, and consent is valid if given voluntarily by a competent individual. The difference comes if they refuse a treatment. In certain circumstances this refusal can be overridden by someone with parental responsibility or the Courts.

- **Aged under 16**

You will be given specific guidance by your clinical teachers. On most occasions this will take place within the Child Health Block. Parents are usually present with the child. You, or the teacher, will need to get consent from the parent and in most cases also from the child. If the parent is not present you should not approach the child. If you find yourself in this situation, you must ensure that your teacher and the responsible consultant are fully aware and that appropriate arrangements and discussions have taken place.

The use of chaperones

For the purposes of these recommendations a chaperon is a third person (i.e. additional to the patient and to the student carrying out the examination) who is of the same sex as the patient and is either a medical student or a health professional. A relative of the patient is not a chaperon for the purposes of these recommendations.

A chaperon is different from a companion for the patient. Patients will sometimes want a friend or relative (companion) present during history taking and examination. In such circumstances the patient's wishes should be respected. In unusual circumstances the student may think that it is not appropriate for the companion to be present, in which case s/he should discuss this with a qualified member of the clinical team (normally one of the doctors). One purpose for the presence of a chaperon is for the protection of the student against false allegations of unprofessional behaviour and it is not appropriate for the patient's companion to fulfill this role.

If a chaperon is present students are advised to make a note of the chaperon's name at the appropriate place in the medical notes.

If a patient wishes to have a chaperon present and there is not one available then the examination should not be carried out.

If the student feels unhappy in carrying out an examination without the presence of a chaperon then it is advisable for the student to postpone the examination until a chaperon is present.

If during the course of an examination the patient says something, or behaves in a way that either suggests that the patient is unhappy for the examination to continue, or might be making a sexual advance, or might become violent, the student is advised to stop the examination and seek advice from a relevant health professional as to what to do.

In several situations (see below) patients should be offered a chaperon.

Vaginal examination. Students should not carry out vaginal examination without a doctor, nurse or midwife present. The Royal College of Obstetricians and Gynaecologists recommends that a female chaperon should be offered to all women undergoing vaginal examination. However, if either the student, or health professional present were female, it may not be absolutely necessary to have an additional person present at the examination. A summary of the guidance can be viewed at www.rcog.org.uk/resources/public/pdf/WP_GynaeExams4.pdf. Further information will be provided in your Obstetric & Gynaecology Block.

Rectal examination (both male and female) and female breast examination. All patients should be offered the possibility of having a chaperon present. Male students are advised to have a chaperon present when carrying out either of these examinations with female patients.

Male genitalia. All patients should be offered the possibility of having a chaperon present before testicular or scrotal examination is carried out including examination for inguinal hernia and hydrocoele. It is likely that students would be supervised by a teacher during an examination of this kind.

Female chest examination. Examination of the cardiovascular system and of the respiratory system of female patients normally requires touching (although not examination of) the breast. It is important that students, of either sex, explain the procedure and ensure that the

patient is willing for the examination to be undertaken. Students should also be sensitive to potential embarrassment. It is not normally necessary to specifically offer that a chaperone be present before conducting such examination. However, male students may sometimes prefer to have a chaperone present.

Examination of anaesthetised patients

When patients give consent for an anaesthetic and operation they need to be told what the operation involves. If they are not so told then the operation is potentially battery (i.e. illegal). It seems a reasonable interpretation of the legal position that the standard consent to the operation would cover consent for a medical student to take an active part in the operation (such as holding a retractor). However, the general consent for the operation is unlikely, from a legal point of view, to cover examination of the patient for students' own education. Battery is defined as any touching without consent. If a medical student, therefore, examines a patient (such as feeling a lump in the patient's abdomen) when the patient is anaesthetised, and when this is not part of the operative procedure, then, from a legal point of view, this would probably constitute battery. It is therefore recommended that any physical examination by a student on an anaesthetised patient where this is for student education (and not part of the operative procedure) should be undertaken only with the patient's prior valid consent. Students should refuse to carry out an examination when they do not believe that consent has been given.

Vaginal, rectal and female breast examination with anaesthetised patients. These examinations must not be carried out on anaesthetised patients without explicit valid written consent. Such consent may be obtained by the clinical teacher or by the student under guidance from clinical teacher. It should be noted that the consent process remains the responsibility of the consultant. During your O&G block you will be given specific guidance. In other blocks you must take care to ensure you are working under the direct supervision of the consultant responsible for the patient.

CONSENT FOR INTIMATE EXAMINATIONS

It is the policy of this Medical School that consent for a student to perform an intimate examination, (breast examination in women, or genitalia in people of either sex) should always be obtained by the supervising clinician or by the student under direct guidance from clinical teacher. It is your responsibility, as student, to document that this consent has been obtained, and record details of the process. You should always have a chaperone present for intimate examinations and you should record details of the chaperone in the patient record.

KEY POINTS

- All teachers and students need to understand the importance of consent during medical training.
- Consent is a key outcome of the curriculum. This can be assessed in summative examinations.
- Responsibility for all consent rests with the responsible clinician even if they delegate that responsibility. Students should use this guidance to make sure they are comfortable with such delegation.
- Any concerns should be taken to the relevant clinical team immediately. If this does not resolve the issue, contact the Phase II Coordinator in the Department of Medical & Social Care Education.

References:

DoH (2001) Consent: 12 key points on consent: the law in England. London, Department of Health

(1998). "Seeking patients' consent: the ethical considerations." from <http://www.gmc-uk.org/guidance/library/confidentiality.asp>

(2004). "Confidentiality: Protecting and Providing Information." from <http://www.gmc-uk.org/guidance/library/confidentiality.asp>

5. Looking after yourself

i) Seeking help – Student Support

Information on student support is given in your 'Looking After You in Phase 2' booklet.

We expect high standards of professional behaviour from all the students. We appreciate that this is a demanding requirement. Life in general, and medical training in particular, presents many stresses and challenges. In Phase II of the curriculum, students are often working in distant locations with less supervision and less contact with friends and staff. It is easy to feel isolated and unsupported. We are keen that this should not be the case.

All of the support mechanisms that were available to you in Phase I are still accessible. In addition you can contact the consultant responsible for your block, and this would apply especially if you had difficulties with attendance and delivery of work. The local Clinical Education Lead will provide advice and help. The undergraduate coordinators work hard to ensure your work arrangements are satisfactory and will gladly talk to you. The Medical Education office in the medical school has a team of people available to talk to. We are genuinely keen to know if you are having problems with the course or if there are difficulties that we might be able to help you with. We want to ensure that the doctors who qualify are ready to take hold of the opportunities that lie ahead. We see this as a shared task that we tackle together.

ii) Occupational Health

All medical students have access to Occupational Health services during their medical course. These services have recently been integrated with those of the NHS, who will be your future employer. The intention is to provide a seamless transition from undergraduate to postgraduate level. Most students will have already acquired a 'student health passport' in Phase I.

Remember to take your 'health passport' with you on attachments to DGHs.

iii) Learning difficulties

Phase II – Policy for Students with Dyslexia and related Specific Learning Difficulties (SpLD).

All students with dyslexia or related SpLD known in Phase I, should be identified to the Phase II AccessAbility tutors, Mrs Oppenheimer and Dr Heney, prior to commencing Phase II. An interview should be offered to review specific aspects of previous reports and recommendations to ensure appropriate support and information is available.

The University of Leicester Guidelines for Tutors and Markers will be adopted (specific details below). See: <http://www.le.ac.uk/accessability>

- If not already in contact with the AccessAbility Centre, students should be offered the opportunity to discuss the different demands of Phase II with a Learning Support Advisor.
- The Assessed Work cover sheet should be used for all written assignments including portfolios. It should also be available for all written examinations in Phase II as the “green sticker” system is being phased out. In examinations with short answer questions each being marked by a different examiner, the Assessed Work cover sheet will be used for the total examination rather than filling one out for each question.
- In written examinations students having extra time because of SpLD should ideally be examined in a separate room. Where constraints of space or invigilator numbers or other organisational difficulties exist, these students will be placed in an appropriate part of the examination room, away from exits etc.
- In accordance with advice from the B.M.A. and endorsed by the British Dyslexia Association, extra time will not be allocated for OSCE, OSCPE or Clinical examinations (www.bma.org.uk/ap.nsf/content/dyslexiaforstudents). However, students will be identified as dyslexic, and instructions about technique for questioning such students will be available on marking instructions at the examination.
- Information will be available from the AccessAbility Centre regarding support for students on placements and in the workplace.
- Students with other SpLD, or problems which affect their learning abilities, will be assessed on an individual basis.

6. THE LEARNING PORTFOLIO

Leicester Medical School has introduced a Personal and Professional Development (PPD) programme, which runs continuously from first year to final year. During Phase 2 of the course, students are required to put together a learning portfolio. This is a body of evidence of your learning. However, it needs to be more than a simple collection of information. It should also indicate how you have structured your learning and how you have reflected on your learning needs and career goals. The PPD workbook describes this in detail.

Identifying your learning needs

A key skill for all students in Phase 2 is to understand how to identify your own learning needs. This is outlined in the PPD file. This is central to becoming a self-directed learner. A learning portfolio then becomes the evidence of your learning and can be used by yourself as well as the medical school to judge your progress and learning needs.

For the purpose of this document, the evidence of your learning portfolio is divided into 2 sections:

Clinical Skills portfolio

Written portfolio

7 CLINICAL SKILLS PORTFOLIO

- Clinical skills are a key part of the undergraduate teaching programme.
- Communication skills, history taking, examination, investigation, problem solving and management are central to clinical education and are detailed in other documents (ICC, Phase 2 Course Document and Clinical Methods documentation)
- Practical clinical skills have always been taught throughout the undergraduate course in a variety of settings. The Phase 2 course document outlines many of the requirements and learning objectives. This document is an addition and explains in more detail the specific teaching of practical clinical skills.
- The increasing structure placed upon this teaching is driven by a number of factors including the views of students, clinicians and the General Medical Council (GMC). Tomorrow's doctors (2003) lists a set of defined skills.

With regard to these practical skills the GMC states:

“Graduates must be able to do the following safely and effectively:

Work out drug dosage and record the outcome accurately

Write safe prescriptions for different types of drugs.

Carry out the following procedures involving veins

 Venepuncture

 Inserting a cannula into peripheral veins

 Giving intravenous injections

Give intramuscular and subcutaneous injections

Carry out arterial blood sampling

Perform suturing

Demonstrate competence in cardiopulmonary resuscitation and advanced life-support skills

Carry out basic respiratory function tests

Administer oxygen therapy

Use a nebuliser correctly

Insert a nasogastric tube

Use a nebuliser correctly

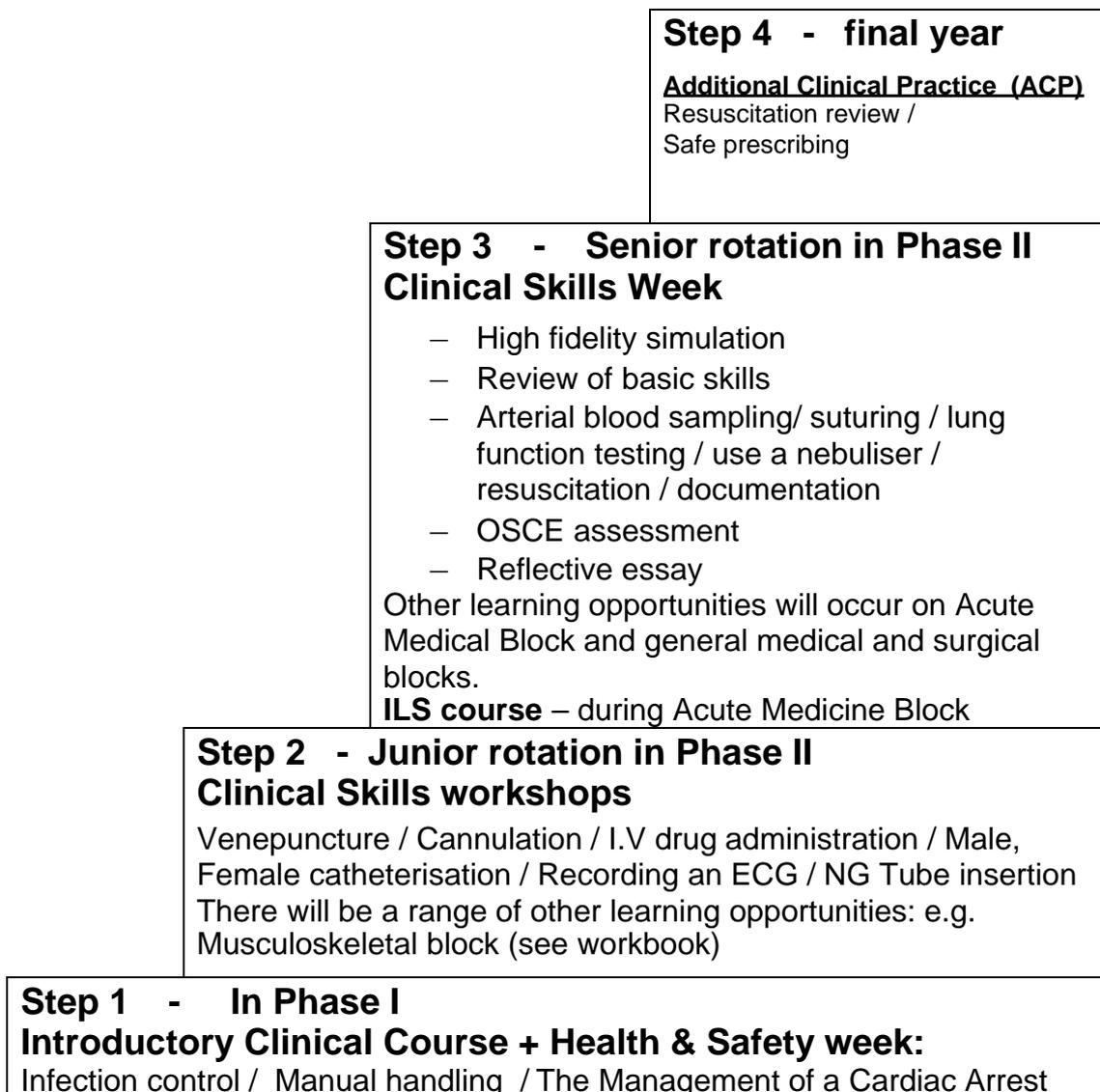
Perform bladder catheterisation”

This document outlines how you will access teaching in practical clinical skills and the requirements expected of you.

Principles of teaching:

- i) Clinical skills will be taught in a staged manner from Year 2 through to your final year.
- ii) The complexity of the skills will increase progressively via a skills ladder
- iii) A clear objective is that you learn to practice the skill in a safe environment under direct instruction
- iv) Clinical skills training will also be linked with your clinical training on the wards, where there will be opportunities to participate in some of the skills in a clinical setting with patients.
- v) We will also include high-fidelity simulations to allow you to incorporate team working, communication and process management in your learning.

The Clinical Skills Ladder



Step 1 - Phase 1

You have already completed step 1 during Phase 1. Remember that the details were provided in the Clinical Skills and Introductory Clinical Course Workbooks.

Step 2 - Clinical Skills Workshops

In the junior rotation, all students must attend a series of workshops, either in Leicester or at one of the District Teaching Hospitals.

You will be given a separate document containing details of the workshops and how to book for them. All students are guaranteed an opportunity to attend the appropriate workshop on one clinical site or another, and have to demonstrate satisfactory completion in order to graduate.

Step 3 - Clinical Skills Week

All students are allocated to a Clinical Skills week during the Senior Rotation

Aims for Clinical Skills Week

The Clinical Skills week is part of the skills ladder. Most students will already have undertaken a wide range of skills in a variety of settings. The clinical skills week has the following objectives:

- To consolidate previously learned skills
- To ensure that all students have completed training in core clinical skills
- To provide additional training in a simulated environment

Outline of Clinical Skills Week

The clinical skills week is full time over 5 days. It is based in the Clinical Skills Unit at the LRI. The first two days consist of a series of workshops which students rotate through. The remaining 3 days consist of a series of high-fidelity simulations which students do within teams. During these 3 days there is also a series of OSCEs to allow assessment of the skills and to provide feedback for the students.

Step 4 - Foundation Shadowing

Following completion of the Final Professional Examination all students will complete a 4-week attachment. The attachment will be based on the ward where your first FY1 post will begin.

Assessment of clinical skills

Your practical clinical skills will be assessed in a number of ways

- i) Attendance
Attendance is compulsory for all components of the skills programme
- ii) Performance in clinical skills workshop
- iii) Work-based assessment
- iv) Assessment within a team context during high-fidelity simulations
- v) Reflective essay during Clinical Skills week
- vi) OSCE at end of clinical skills week utilising Leicester Clinical procedure Assessment Tool (LCAT)
- vii) Assessment of safe prescribing during ACP block

Note: Satisfactory attendance and performance is a prerequisite to graduation.

The Leicester Clinical procedure Assessment Tool (LCAT)

The Leicester Clinical procedure Assessment Tool (LCAT) has been developed to complement the assessment of consultation competencies used in the clinical component of the Final Professional Examination. At present this is part of a research project (Dr R McKinley, Ms Tracey Gray). A pilot was run during the clinical skills week programme in 2005. The LCAT will be explained to you during the clinical skills week in the senior rotation.

Resuscitation Training for undergraduate medical students

Resuscitation is part of practical skills training and is included in the outline above. However, because of its importance, we have detailed a spine, specifically for resuscitation.

Principles:

- i) Each medical student will be given resuscitation training to ensure they are safe and competent at core resuscitation skills when they start their FY1 post
- ii) The training will spread over the whole of the undergraduate course with teaching elements running in every year from the 2nd year to the final year.
- iii) Resuscitation training is a compulsory part of the curriculum
- iv) Resuscitation training will link with a range of other skills
- v) Students will be formally assessed and signed off. This is a pre-requisite to graduation.

Resuscitation Training Programme:

Step 1

You will recall that you received training within the Health & Safety week as part of the Introductory Clinical Course. (Semester 3 for Health Science Graduates and semester 5 for 5-year cohort)

The training focussed on “**The Management of a Cardiac Arrest**”.

Step 2 ILS course

The ILS course will run during the senior rotation of Phase 2. It will be incorporated within the *Acute Care attachment*, which links A&E and AMU. This is a one-day course

There will be options for doing the ILS course at peripheral DGHs and at UHL. Students have to complete the course based on attendance and satisfactory performance.

Step 3 Resuscitation simulation and review

This is part of the 5th year *Clinical Skills Week* (July to December)

Students will complete skills-based scenarios using actors and working in small teams. There will also be a series of skills OSCEs, which will include resuscitation. Students will be assessed on attendance and satisfactory performance in the scenarios and the OSCE

Step 4 Resuscitation review

Additional Clinical Practice / Shadowing block. (June)

A resuscitation review will occur as part of the teaching delivered in the ACP block, which is taken after the Final Professional Examination and before graduation.

Students will be assessed on attendance. Students have to be signed off as satisfactory for resuscitation skills in order to graduate.

8 WRITTEN PORTFOLIO

The objectives of the written portfolio (Phase II objectives):

At the time of graduation, students should be able to:

1. Acquire for the individual patient the information necessary to formulate and test diagnostic hypotheses by:
 - a. Taking a history, considering appropriate physical, social and psychological aspects
 - b. Eliciting selectively normal and abnormal signs
 - c. Using investigations selectively
2. Formulate appropriate diagnostic hypotheses based on:
 - a. sound, scientific understanding of normal and abnormal structure and function and disease processes
 - b. appreciation of the social and psychological context of illness
 - c. understanding of the environmental, occupational and social factors in the causation of disease
3. Formulate management plans, if necessary by using information sources and appraisal of evidence, and apply the conclusions for the care of patients with common and uncommon, but serious conditions
4. Implement management plans by negotiation with patients and their relatives, other doctors and health care professionals
5. Recognise the economic and practical constraints of organisations concerned with the delivery of health care
6. Recognise personal limitations and seek help where necessary
7. Perform self audit and participate in the peer review process

Rationale

The undergraduate course and curriculum are defined by the detailed **learning outcomes** expressed as 'competences', which you must acquire to graduate. It is therefore necessary to provide you with the opportunity to both acquire and demonstrate successful acquisition of each one. A variety of learning and assessment methods is needed to address all the competences. Some can only be achieved and assessed by practice and direct observation of your clinical skills with patients. For example: the ability 'to communicate effectively and sensitively with patients and their relatives' is best developed and tested by observation with

feedback by your clinical teachers. It is therefore essential that you maximise your opportunities for this to happen. Other competences can be developed through self-learning and assessed from written evidence. It is the competences listed above that have been selected for enhancement and evaluation by the written.

Nevertheless, preparation of your portfolio will not be sufficient to fully develop the target competencies without input from your teachers. Neither will it be sufficient evidence that you have acquired the target competencies because - being a paper exercise - it will not fully demonstrate the quality of history taking, physical examination and hypothesis generation, but only the end result. It will complement, not substitute for clinical teaching and assessment. Involvement of teachers in the process is essential. The end result should be a permanent record of a three-way encounter between you, the patient and your teacher.

You are required to produce 36 items in the written portfolio prior to graduation. Twenty must be completed prior to ICE.

Written portfolio guidelines.

There are many learning activities that will allow you to achieve the above objectives. Our intention is to provide you the maximum flexibility and choice to allow you to progress at your own rate, to foster self-directed learning and to encourage you to maximise the learning opportunities that present. This is part of the student selected component of your curriculum.

Options for the written learning portfolio:

1. Clinical Case Report - standard

See guidelines.

At least 50% of portfolio; i.e. minimum of 18 clinical case reports

2. Clinical Case Report - modified

- a. Post mortem report
- b. Evidence based review
- c. Pathophysiology review
- d. Psychosocial review
- e. Pharmaco-therapeutic review
- f. Patient safety review

3. Reflective essay/review

A minimum of 3 reflective essays / reviews

- a. Career planning and Foundation Programme application
- b. Reflection on clinical skills
- c. Palliative care reflection
- d. Patient safety reflection / review
- e. Other

4. Audit

5. Oral presentation material

A maximum of 6 presentations will count for this portfolio

- a. Academic half day presentation
- b. General education block presentation / Speciality block presentation
- c. Patient Progress Presentation (as in AMU block)
- d. Conference presentation

6. Interprofessional Learning opportunity

- a. IPE strand activity

7. Essay

Clinical Case Report - standard

The clinical case report format is derived from the case record completed for patients on admission to hospital. However, it is not intended to be a copy of the patient's clinical record. Information necessary for the clinical care of the patient may not be relevant to your case report and vice versa. You will include sections that demonstrate your ability to understand and interpret the significance of your findings. You will need to utilise the knowledge, skills and attitudes developed in the Introductory Clinical Course to satisfactorily complete this exercise. You should also demonstrate your awareness of the social and psychological effects upon patients of physical illness.

Selection of cases

Patients do not usually present with a discrete diagnosis, but rather with one or more symptoms. Diagnostic reasoning consists of the formulation of hypotheses, which are then tested and refined by the history, physical examination and investigations. The clinical case report will form a record of this process and will enable the assessment of your achievements with the patients you have actually seen, rather than the cases you might have been expected to see.

Therefore, it is important that clinical case reports cases are defined in terms of **presentations**, rather than **disease or disease processes**. By the time you see a patient a diagnosis will often have been made and you will discover what this is, if only from the patient! Therefore teachers and students should regard each patient as an exemplar of a certain presentation; 'this is a patient with chest pain' not 'this is a case of angina'. What is important is your demonstration of your understanding and critique of the process by which the diagnosis was made and the patient managed.

The Phase 2 course document contains a list of presentations that most effectively cover the learning outcomes. You have a wide choice and you are encouraged to select learning outcomes and patients that match your interests and learning needs. The following presentations present important learning opportunities and your portfolio should contain many of the suggestions given below:

- recurrent central chest pain
- acute central chest pain
- recurrent wheezy breathlessness
- chronic productive cough
- progressive breathlessness

- chronic epigastric pain
- acute generalised abdominal pain
- chronic diarrhoea
- acute alteration in bowel habit
- acute renal failure
- chronic renal failure
- rectal bleeding
- weight loss
- collapse
- fits
- sudden unilateral weakness
- swollen painful leg

Note that most of these have 'qualifiers' - 'acute', 'recurrent' etc. which limit the possibilities, but which do not lead to a single diagnosis. Teachers will be able to make other suggestions, which are likely to be a selection from the problems general practitioners refer. Many cases you see in hospital, particularly in general medicine, are not completed episodes of disease and your portfolio must represent this continuum of care. It is important you include within your portfolio a selection of cases, which demonstrate the challenges to health professionals of the continuing care of incurable disease.

Constructing the portfolio

Each clinical case report in the portfolio must be word-processed using the standard template, copies of which are available from the Phase 2 web site. It is suggested that you write short notes rather than an essay or a series of abbreviated phrases. The length will depend on the complexity of the case but should not normally exceed a maximum of 1500 words or 5 A4 pages. Many students find it helpful to make additional notes on their cases to help in future revision; these need not be incorporated into the report. A portfolio case report is **not** a copy of the clerking notes, with some added features. It should summarise the experience of the episode of illness experienced by the patient, and in writing it you should demonstrate your ability to elicit and interpret information required to define and manage the patient's problem(s).

Confidentiality

Patients must be referred to by initials, not name. You should keep a separate hand-written note of the hospital number to enable you to access the records at a later date. You should inform the patients that you would like to make a special study of their problem and obtain their permission. You must record this in the hospital record and date it. You *must maintain the confidentiality* of their records at all times. Material should not be left on hard disk, and

floppy disks should be kept as safe and confidential as paper documents. Use the password function of Word to further protect confidentiality.

Format

You should present each case in the portfolio using a standardised template. Each case in your portfolio must be given a number in sequence as you complete it, which will allow cross-reference to the 'Summary of written learning portfolio'. In the header information about each case you will indicate which Portfolio Case presentation and Objective Number(s) from the Phase 2 Course Document are covered by the case.

1. Prediagnostic indicators

You should review the referral letter or initial information you have already gained about the patient to formulate some prediagnostic indicators.

2. History

You should include all **relevant** information gathered from the patient about this illness, co-existing problems, current drug treatment, significant past history and the social and family background. Indicate what are the patient's (or parent/guardian's) ideas, concerns and expectations about the problem and its management. Do not include a long list of irrelevant negative findings

3. Analysis of history

You must write down the most likely single cause of the patient's presentation and the other causes that need to be taken into account and the reasons for your choices. You should then give the findings you will look for on examination to help you decide between these possibilities.

4. Physical or mental state examination

To improve your skills of physical examination you should conduct a complete examination of the four major systems in all cases. In presenting your findings you should highlight those most relevant to your clinical problem solving by underlining them.

5. Investigation.

You should note down any key investigations, indicating how they have helped to resolve the diagnostic problem. You should attempt to indicate where investigations have not been helpful

6. Analysis of history and examination

You should write down what you now consider to be the most important cause of the patient's problem, any other likely possibilities and the reasons for your choice. These may, or may not, have changed in the light of your examination findings.

Formulation of the patients problem

Encapsulate the patient's problem in physical, psychological and social terms in a short statement (triple diagnosis). If the patient's problem is largely physical, psychological or social this should be stated and your reasoning explained. For example: *'A healthy 28 year old manual worker with a physically demanding job has been admitted for elective repair of his right indirect inguinal hernia. He is anxious about the procedure as he has a phobia about needles'* neatly encapsulates a triple diagnosis which provides much important information about his problem.

7. Management

You should use the mnemonic RAPRIOP to help you consider all the elements that might be included within a management plan for the patient.

Reassurance and explanation

Advice

Prescription/other medical intervention

Referral and team working

Investigation

Observation

Prevention

The order in which the elements are presented in your report will vary according to the circumstances of the case and the setting in which you encounter the patient. The above order is most logical for patients encountered in out-patients or a general practice surgery. For patients seen as hospital in-patients the order proposed in the template will be more

appropriate. Each aspect may not be relevant in every case, but should be considered. Various options and treatment modalities may be required under a single heading.

Investigation

Relevant investigations (i.e. those that will influence the diagnosis and/or management) and their results should be listed. If possible include illustrations of any microscopic pathology and imaging. Then describe how the result of each listed investigation contributes to either solving or managing the patient's problem. This section should include any planned investigations after the patient has had their immediate care.

Reassurance and explanation

You should write down in brief the actual words you would use to:

- appropriately reassure the patient
- explain the nature of the disease
- describe the management plan

Prescription/medical intervention

Drugs and the rationale for their use

To include those actually used, and any alternatives. Choices should be justified.

Operations

Details of surgical technique are not required.

Palliative medicine

If relevant, you should provide an account of the methods of symptom control available for the problem.

Critical care/management of emergencies

Observation

Include the role of observation, either short term (e.g. overnight in the presentation of an acute abdomen) or longer term (e.g. until outpatient review to assess response to treatment) in both diagnosis and treatment.

Referral and team working

You should discuss referrals made to other agencies and future referrals that may be required, particularly community services on discharge from hospital.

Advice

Those measures that the patient can take to alleviate the problem. This may include life-style advice (e.g. dietary changes after a myocardial infarction) or self help (e.g. exercises for a ligament sprain). You can include in this section: *Prevention*. These are opportunities for health promotion which are not directly linked to the

management of the problem. For example, a patient admitted with a leg fracture might be encouraged to use the reduced opportunities for smoking during admission as a stimulus to give up smoking permanently.

8. Discussion of the patient's problem

You should select one or two aspects of the patient's problem to discuss in a little more depth. This will vary depending on the case and which aspect you find of most interest. NOTE: you are NOT required to cover all aspects. Issues for you to consider include:

- Epidemiology, psychological issues, social issues, healthcare delivery issues etc
- Give a brief summary of the basic sciences relating to the patients' problem, demonstrating your awareness of knowledge acquired during phase I
- Check EBM information sources. What is the current best practice for looking after your patient?

9. The patient as a clinical context – and Impact on your learning

Use this section to reflect on you own learning.

Describe any aspects of the patient's presentation that you found challenging.

What further learning tasks have you set yourself as a result of this case?

Time-tabling and practical guidance

Start with a blank template printed out.

Select a patient. If possible agree this with your consultant. Ideally the patient should be newly admitted, or someone you do not know a great deal of background of. In other words, the less you know about the patient – the better! You need to work things out for yourself, not be told the answer. Find out the patients' name, age, gender and presenting complaint. Record these at the start of your template.

Complete Box 1 before you meet up with the patient. It starts the thought process. However, in other situations, you make take a history from a patient and subsequently decide to produce a case report.

Go and introduce yourself to the patient. Explain the purpose of the exercise and obtain their consent. Make sure you record their consent in the notes at some stage. Inform that patient that you will interview them, then go away, then come back later to examine them. Check that this will be okay with them, and insure that you do not interfere with any plans such as visiting relatives.

Take the history. Try to stay focussed. Try to work out what is wrong with the patient as you go along, and focus your questioning appropriately. Remember that sometimes a full systematic history is the only way forward.

Thank the patient, and then excuse yourself. Find a quiet spot where you can work. If necessary go to the library where you can have access to books and the internet and complete Box 2 and Box 3, taking time to reflect on the patient's history. NOTE: On some occasions you will prefer to complete your examination at the same time – especially if the patient has an acute problem.

Having decided how to proceed, go back to the patient to carry out your examination. Afterwards, look up any investigations you require in the patients' notes. Then retreat to your quiet spot.

Complete Box 4, 5 and 6.

Find a suitable opportunity to discuss your work so far with a doctor. Make any necessary adjustments.

Complete the first part of Box 7. Again, find an opportunity to discuss this. If necessary, complete boxes 4-7, then discuss. Then complete the second part of Box 7.

Go back to the patient to talk about their management. Find out whether or not they understand their management plan, and whether they are happy with it. Do they have any concerns about side effects etc? Remember that many patients are reticent about voicing their concerns to the consultant. This is your opportunity to be the patients' advocate and raise any concerns with the consultant. Complete the third part of Box 7.

At this stage, your work should have been done in rough, on paper, in handwriting. Find a suitable time (when you have plenty of time to do it in the library or at home) to transfer your notes to an electronic version of the template. At this point you should research and complete Box 8.

Finally, complete Box 9.

Print out two copies of your completed case report. Give one to your consultant for marking. Keep one for yourself in case the other copy gets lost!

CLINICAL CASE REPORT

N^o:

Patient Initials

Occupation

Age

Gender

Has the patient's permission, including for follow up contact by telephone, been sought and recorded in the case notes?

1. Prediagnostic Indicators

Before taking a history from the patient, use the information you already have about the patient to formulate some prediagnostic indicators

2. The Patient's History

Summarise the history in a clear and concise manner. Think how you would present this patient to a consultant

3. Analysis of the History

Based on the information gathered from the patient, consider the possible differential diagnoses and the reasons for and against your choices

Most likely:

For:

Against:

Features to look for on examination:

Investigation results to look for:

Less likely:

Unlikely, but important to consider:

4. Examination of the Patient

Summarise your findings below

5. Investigations

Note any relevant results below

6. Further Analysis and Working Diagnosis

Based on all of your findings so far, you should now select the most appropriate working diagnosis

Working diagnosis:

Evidence to support this:

Are there any other possibilities that need to be considered at this stage?

Problem List

7. Management

Formulate your own management for this patient using the RAPRIOP scheme

How does your proposed management plan differ from the actual management plan? Discuss this with a member of the team.

Discuss the management plan with the patient. How do they feel about their management?

8. Discussion of the Patient's Problem

Consider:

- Epidemiology, psychological issues, social issues, healthcare delivery issues etc
- Give a brief summary of the basic sciences relating to the patients' problem, demonstrating your awareness of knowledge acquired during phase I
- Check EBM information sources. What is the current best practice for looking after your patient?

9. The Patient as a Clinical Context

Were there any aspects of this patients' presentation that you found challenging? How did you overcome any difficulties?

What further learning tasks have you set yourself as a result of this case?

Modified Clinical Case report

Many patients will trigger a process whereby you will want to undertake a more detailed review of one particular aspect. Indeed the intention is that every clinical case report will encourage you to read around the topic. However, for the purpose of your written portfolio you may choose to focus on a particular area. There are also some clinical situations that do not fit neatly into the outline given for the standard case report. The following are some examples that you might choose:

- a. Post mortem report
- b. Evidence base review
- c. Pathophysiology review
- d. Psychosocial review
- e. Pharmaco-therapeutic review
- f. Patient safety review

In all cases you should following these principles:

- i) The clinical case must be linked with an identifiable patient or situation that you have encountered during the clinical block
- ii) The case must be linked with one of the objectives from the Phase 2 Course Document
- iii) You must give a brief outline of the patient and the relevant clinical issue.
- iv) You must clearly explain why you have chosen to focus on that one particular area.
- v) You should then cover that area in some depth. Exactly how you do this will be up to you. You must NOT simply copy from a text book or internet source or from Phase 1 material.
- vi) You must link the material back to the patient.
- vii) You should preferably discuss this with your consultant before starting. Your consultant is likely to have some useful ideas and suggestions. Some consultants may ask you to vary the exact format or structure. This is acceptable, and encouraged, providing it helps you to meet some of the Phase 2 learning objectives.

CLINICAL CASE REPORT - MODIFIED

N^o:

Patient Initials	Occupation	Age	Gender

Has the patient's permission, including for follow up contact by telephone, been sought and recorded in the case notes?

1. The Patient's History

Summarise the history in a clear and concise manner.

2. Summary; of examination and investigations

Highlight the key features of the examination and investigation.

These should be features that will contribute to your subsequent discussion or that have helped you to focus on the particular problem.

3. Summary of management

Highlight the key features of the management.

Again, these should contribute to your subsequent discussion

4. Identification of key problems

Based on all of your findings so far, identify the key problems or issues

5. Discussion of clinical issue

- Identify the particular issue which you have chosen to discuss and indicate how it relates to the patient's clinical problem or situation.
- Outline the method or resources you have used to obtain the information
- Provide an overview with suitable subsections
- Provide a summary or concluding paragraph
- List references if appropriate

6. The Patient as a Clinical Context

What further learning tasks have you set yourself as a result of this case?

REFLECTION AND LEARNING

Reflective practice is included as an important part of your learning portfolio to achieve the following:

- i) To help you manage your own learning through reflection on your performance in terms of strengths and weaknesses, and through identification of your own learning needs and how those needs may be met.
- ii) To help you work towards becoming an independent practitioner who is able to engage in reflection as a component of continuing professional development.

Functions of reflective practice

- To review and evaluate experience
 - Your thoughts and feelings
 - Your performance and behaviour
 - The impact on others
 - Your motives
 - Short term and long term consequences
- To use that to inform your planning of your future development
 - Important component of Continuing Professional Development (CPD) process
- To take on the role of managing (supervising yourself)

Revalidation

Doctors who want a licence to practice in the UK must demonstrate that they remain fit to practice. A key component is to encourage doctors to reflect meaningfully on their practice.

Reflective practice allows you

- To cope with situations that are difficult, challenging or disturbing
- To explore how you deal with patients in challenging situations
- To develop a sensitive approach to patients
- To monitor your career development
- To seek appropriate guidance and training
- To think carefully about how to proceed and fulfil your goals.

This work builds on elements from Phase 1. There will be a number of opportunities during Phase 2 to undertake a reflective task or write a reflective essay. Some of these will be compulsory, while others are optional. The following are some of the opportunities you will have:

- Career planning and Foundation Programme application
- Reflection on clinical skills
- Palliative care reflection

- Patient safety reflection / review
- Other

If you find a particular situation challenging, interesting, exciting or difficult, it may be that you would like to take the opportunity to reflect on it. I would encourage you to talk to your consultant or supervisor and ask if you could undertake a reflective exercise.

Format of a reflective essay.

The following are suggested headings, although you may want to vary this.

1. Brief description of clinical situation, patient problem, clinical skill or activity.

Describe the background and why you have chosen to reflect on this particular issue. What did you see or do? What issue relating to the patient has influenced you?

2. What was required of me?

How did you have to deal with the information or situation?

You may want to include background information at this stage – for example if you are reflecting on an ethical issue, you may want to have a summary of relevant ethical or legal issues.

3. How did I perform? What did I do well, what could I improve on?

4. What did I think / feel / cope?

E.g. how did you interpret the events; how did this make me feel.

Why have you chosen to reflect on this particular aspect?

5. How can this help me achieve what I want in the future?

What difference will this experience make?

How might this experience affect your work as a doctor? It may have reminded you of other professional or personal experiences that you have had.

Now what? – You might reflect on how you could direct your future learning. Maybe you felt that it added to skills you already have – if so how will you build on these? Has this had an impact on your future career goals?

Length of reflective essay: This should be approximately 2 sides of A4.

Foundation Programme Application

One of the reflective exercises relates to your job application. This is a central component of the PPD strand. The new FY1/2 application form requires a significant amount of reflection. It is important that you start that process early. The questions used in the application in 2005 are given below. These are certain to change over the coming year and you must check on the MMC and New Doctors WEB site for the latest forms.

As you progress through Phase 2 you will want to consider using some of your learning portfolio to link with these questions, so that you are well prepared when the time comes to complete the application. **The Medical School and Postgraduate Deanery will provide separate information and guidance on the application.**

Your application will count as one component of your learning portfolio to be included in your PPD file.

INDIVIDUAL QUESTIONS (taken from <http://www.newdoctor.org/> February 2006)

Question 1

Give 2 examples of your academic achievements and the significance of these for you (include distinctions, prizes etc). At least one example should be based on your experience as a medical undergraduate, the other is optional.

Question 2

Give 2 examples of your non-academic achievements and the significance of these for you. When a question asks you to explain the significance to you of an achievement, this explanation is an extremely important part of your answer. You must demonstrate that you have reflected on the significance of the achievement to your medical career.

Question 3

GMC "The New Doctor" guidelines:

http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Pick two of the seven principles of Good Medical Practice, state the principle and illustrate your qualities with respect to these. Please note that the seven principles can be found by clicking on "The Principles of PRHO Training" in the contents.

You must demonstrate that you know what the principle is and give a relevant, but different example for each principle selected. The illustration of your qualities should be appropriate to the principle and demonstrate insight and reflection.

Question 4

Identify your educational and personal reasons for applying for your first ranked Foundation School/Deanery or Programme.

When you identify your educational and personal reasons for applying to a particular programme, your answer should not simply list general reasons why someone might want to apply. Your answer should identify specific reasons and explain the personal relevance of these reasons to your educational or personal needs and career or personal development.

Question 5

Teamwork – Give 2 examples in which you have participated and contributed to the successful working of a team. Examples should identify your role and contribution to the team

You must clearly identify and explain two different examples of your experience of team working. Your answers should identify your specific role and contribution to the team and explain the significance of what you gained from the experience to your medical career.

Question 6

Leadership – Give 2 examples in which you have demonstrated your leadership abilities. You should identify your specific role and contribution as a leader.

You must clearly identify and explain two different demonstrations of your leadership abilities. Your answers should identify your specific role and contribution as a leader and explain the significance of what you gained from the experience to your medical career.

Medical AUDIT

What is a medical/clinical audit?

NICE states that medical audit is “A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.”

Audit is the study of some part of the structure, process and outcome of (clinical) care, carried out by those personally engaged in the activity concerned, to measure whether set objectives have been attained and thus assess the quality of care delivered.

Medical audit requires standard setting, data collection, comparison with standard's, review of data and standards, review of current practice, change in that practice and further data collection and comparison with the original data. This is the audit cycle. For the purpose of your audit, you will only undertake a component of the whole cycle.

Why do an audit?

- Educational value for participants
- (Im)prove effectiveness and efficiency
- It improves quality of care as both an outcome and by the process of performing the audit.
- To understand the link between medical audit and clinical governance
- There is a sense of personal and professional achievement. It may lead to a publication and can improve a CV.

How to start?

An audit is a large task. Each clinical area will have a programme of on-going audits. It is important that any audit you are involved in is clearly part of this on-going programme. You should do the audit jointly with your clinical partner and preferably linked up with one or two of the junior staff on the ward where you are based. In order to complete the audit in an appropriate timescale you will need to be realistic and focussed.

What to audit?

You should discuss this with your consultant or a member of the clinical team. You might also try and suggest a topic for an audit. The following are the sort of questions that are asked:

Structure: This refers to the input of care such as manpower, premises and facilities. Eg. 'Are the numbers of emergency appointments enough to cope with demand?'

Process: This refers to the provision of care (looking at what is done and how it is done) Eg. 'Are all patients on ACE inhibitors having urea & electrolytes checked?'

Outcome: This refers to the result of clinical intervention. Eg. 'Are patients on lipid reducing regimes achieving target cholesterol levels?'

Define the standards

This is where you say what should be happening.

Define the **standards** which you should be able to realistically reach of the area which you intend to audit. Set the **criteria** by which you will measure those standards

Compare your results against your defined standard. Is change needed?

Start with a **criterion**. A criterion is an item of care or some aspect of care that can be used to assess quality. The criterion is written as a statement. For example:

All patients with epilepsy should be seen at least once a year.

All patients on Warfarin should have their INR within the recommended limits

To make the criteria (statement) useful the **standard** needs to be defined. A standard describes the level of care to be achieved for any particular criteria. Eg. A standard may state: 90% of patients with epilepsy should be seen at least once a year; or: 100% of patients on warfarin will have their INR within the recommended limits.

Note: A standard can be a minimum standard (the lowest acceptable standard of performance), the ideal standard or the optimum standard. Optimum standards represent the standard of care most likely to be achieved under normal conditions of practice.

Collect the data.

Identify what data needs to be collected, how and in what form it needs to be collected, and who is going to collect it. Remember only collect information that is absolutely essential

Assess performance against criteria and standards. Use the information collected to identify any area of care below the predetermined standard. The results can then be used to develop an action plan.

Identify need for change – if appropriate

References. Only include key references used. Remember this is not a research project.

Note: if the audit is done by two or more individuals it is important to state that all have contributed equally or to identify who contributed to particular components.

OUTPUT

You can write the audit using the above headings or the format at the end of this section.

On some occasions the audit will be presented at an audit of clinical governance meeting. You may then have a PowerPoint presentation. Either will be acceptable, but will have to be signed off by your consultant.

Confidentiality and ethical issues

Ethical issues may arise in an audit project, or in other non-research survey work within the NHS. This does not mean that approval is required from the local research ethics committee. Legislation applies in the form of the Data Protection Act and the Human Rights Act, and specific guidance on good practice exists from professional bodies such as the GMC. One example of an area where ethical concern has been raised relates to staff surveys. Information may come to light that raises concerns for the well being of staff or patients. It is helpful to consider these possibilities before this sort of survey is undertaken and plan for what action may be required.

One of the key ethical issues relates to consent for the disclosure of identifiable data. You should ensure the following:

- Anonymise data where unidentifiable data will serve the purpose.
- Keep disclosures to the minimum necessary
- Collect only that data which is essential

Prior to starting the audit you must ensure that the consultant or appropriate senior member of the team has given agreement for you to go ahead with the audit.

1. What did you audit?

Identify the issue or problem or concern that you decided to audit.

Provide some information as to why this was chosen.

Is the issue linked with process, structure or outcome?

If appropriate, give some background information.

2. Criteria and Standards

What should be happening?

What criteria and standard did you choose?

How did you choose this standard?

3. The data

Explain what date you decided to collect?

How did you collect the data? **Remember only collect information that is absolutely essential**

Summarise the data

4. Assess performance

Use the information collected to identify any area of care below the predetermined standard

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5. Identify need for change

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ORAL PRESENTATION MATERIAL

Another key skill for all medical students is to learn to present material in an oral format. This will be important for all stages of your future career. You will have many opportunities to present material as you go through Phase 2. These are opportunities not only to think about the facts of the case but also to reflect on how you are able to talk to an audience and convey information clearly.

On certain blocks students will be presenting material on an almost daily basis on ward rounds, in clinics and in meetings. These are valuable, but they are not intended to count for the purpose of this portfolio.

If an oral presentation is to count for this portfolio it must meet the following criteria:

- i) It must be agreed with your consultant prior to the presentation
- ii) The case material must be worked up in detail (as if you were writing a case study). This means that you must collect appropriate evidence of history, examination and investigation material or appropriate review of the literature.
- iii) The presentation must be on PowerPoint; and you must demonstrate adequate skills in using this medium
- iv) The presentation must meet criteria to show the following:
 - Spoke with clarity
 - Used clear aids
 - Rapport with the audience
 - Good time-keeping
- v) You must be given feedback from your consultant on both the content of your presentation and the style of presentation.

It is likely that a number of set occasions will be labelled as being suitable for counting towards this portfolio. These will occur as follows:

- Academic half-day presentation
- General education block presentation / Speciality block presentation
- Conference presentation

Note: A maximum of 6 oral presentations will count for this portfolio

INTERPROFESSIONAL CASE STUDY

Mostly patient journeys through hospital services depend upon the interdependence of a range of professionals coordinating their unique professional specific skills, during the in-patient episode. For some of the patients you will study how the involvement of other health and social care professions affects the progress of patients along their care pathway. You should be able to identify and record several cases while compiling your portfolio of learning during Phase II of your training. A number of specific learning events related to interprofessional care are being planned. However, you do not need to wait for one of these before using this format.

These cases offer you the opportunity to consider your future medical role in liaising with other experts from nursing specialities, therapy e.g. physiotherapy, from social care such as the departments' social worker and also the voluntary sector other services such as translators. As these patients exist in all areas of practice you can identify them and include them within your core cases and also within your interprofessional portfolio for continuous professional development (Students commencing September 2005).

What are interprofessional competencies?

Interprofessional competence relates to your ability to become an effective member of a multidisciplinary team. It consists of some of the following elements:

- The ability to place patients/service users/clients centrally in your work
- The appreciation of the roles and responsibilities of multidisciplinary team members
- Effective communication (both written and verbal) within multi-disciplinary teams
- The ability to manage team conflict issues
- The building and sustaining of mature team-working relationships
- The development of mutual respect and value for team members

To fully demonstrate your developing interprofessional skills, which will become a life long professional learning responsibility, you can complete interprofessional studies using the following steps:

- 1) On completion of a complete history identify if the patient requires at least three different professional inputs during this in-patient episode. These can include medical, nursing, therapy, social care, voluntary sector, education, religious and others.
- 2) Complete discussions with these three different front line workers (or their colleagues from the same disciplines) on their role, responsibility and total care package for the chosen patient. You may be able to share your assessment during ward rounds. You should document their type of involvement in the case, their referral pathway, accessibility and their priorities for the patient. What does this agency perceive its strengths and weaknesses to be?
- 3) Reflect on the current coordination of these inputs to the case. What are the communication links? How are the respective inputs disseminated within the team?
- 4) Obtain the patients perception of how the team is working to assist them. Are the patient s priorities the same as the professionals? Do they understand who the team members are and what their roles are towards their care and well being?
- 5) Reflect on the total care package including the medical role. How effective is team care in progressing the patient along their care pathway. How does this team link with the next team along the care pathway? Develop solutions to problems you identify in the team working you observe.

CLINICAL CASE REPORT - INTERPROFESSIONAL

Nº:

Patient Initials

Occupation

Age

Gender

Has the patient's permission, including for follow up contact by telephone, been sought and recorded in the case notes?

1. The Patient's History

Summarise the history in a clear and concise manner, including key features of note from the examination and investigations.

2. Identify the multi-disciplinary team

Who is involved in this case? Identify the three agencies you will discuss this case with. You can discuss care with senior students. Highlight the respective roles and responsibilities in this case. Identify the amount of input from each and their projected input during the patients stay in this unit.

3. Multi-agency coordination

Identify how the team works together. How are the respective inputs coordinated? Is the team work patient centred, if so how is this achieved?

4. Patient perception of team working

Identify the patients understanding of team care. Do they understand who helps them and what they are responsible for? Do they feel their views are considered?

5. Your reflections and critique on team working in this unit

Does this team value each other and use each other's skills effectively? Is there a team spirit a sense of fun as well as mutual support? What solutions do you have to change service delivery to enable better team working?

ESSAY

Critical thinking, allied with clear and logical writing is an important skill to acquire. There are a number of topics that lend themselves to an essay format rather than the standard case study. You should note that an essay is not simply a textbook account of a disease. An essay is intended to reflect your own thoughts and ideas in relation to a topic.

We have based our guide for essays on those published by the BMJ - <http://bmj.bmjournals.com/advice/sections.shtml#education>

The BMJ outlines the following options for an essay:

i) Patient's journeys

“Journey articles should encompass how it feels to face a difficult diagnosis and what that does to relationships and quality of life. But these articles should not simply give one or more personal accounts of coping with illness: we want them also to provide reliable and widely available practical information and advice. Articles should underline the need to treat patients, rather than diseases, and to understand the impact such journeys may also have on patients' carers and families. Above all, these articles should tell doctors what really matters to patients and what help they need to make the most of their lives.” See the BMJ for additional advice and suggestions.

ii) Analysis and Comment

“Analysis and Comment articles aim to stimulate discussion, raise debate, and air controversies. These can cover any aspects of medicine and health which are relevant to an international general medical audience including sociological and ethical aspects of medicine; polemical pieces; and educational articles.”

iii) Ethics in Practice

“The aim of these articles is to provide a clear, up to date analysis of ethical issues confronting health professionals in their daily practice”. You should base the essay on a case or situation you have encountered on the wards. You should outline why the ethical issues raised by the case are relevant to clinical practice. Again, see the BMJ guidance for ideas and suggestions.

Word length: The essay should be between 1500 and 2000 words.

Follow the BMJ guidance for layout and referencing.

Useful guidance on writing essays can be obtained from the University Student Learning Centre - <http://www.le.ac.uk/slc/>

NOTE: You must discuss the essay with your consultant prior to starting. Your consultant should sign off your essay. You should also submit your essay to the Department of Medical & Social Care Education – phase2@le.ac.uk.

If appropriate, we would then recommend the 2 or 3 best essays each year to be submitted to the BMJ or Student BMJ.

Assessment of the written portfolio

Your clinical teacher is required to assess the degree to which you have attained the learning outcomes for each portfolio case. The following descriptors of performance will be used to assist in making judgements. The necessary documentation must be completed and forwarded to School Office.

Criteria for the award of grades:

- Excellent:** All significant issues have been considered. The student demonstrates an awareness of matters beyond those that must be addressed.
- Satisfactory:** All the important issues are considered. Any omissions are minor and unlikely to be of clinical significance for the diagnosis and management of a patient with this presentation.
- Borderline:** There are significant omissions of detail, or there are errors of fact or interpretation. These have the potential to lead to mistakes in diagnosis and/or management of a patient with this presentation.
- Unsatisfactory:** There are important omissions, or significant errors of fact and/or interpretation, which are likely to jeopardise the diagnosis, management or solution of the problem of a patient with this presentation. You will be unable to count this case against your total unless it is amended satisfactorily

ESSAY

The structure and contents of the essay will depend largely on that agreed with your consultant. Below is some guidance for marking the essay that largely matches those of the case studies.

Excellent: Excellent review of a wide range of relevant literature and use of primary and secondary sources. Excellent organisation of information with very good use of examples to illustrate points and justify arguments. Work shows clear independence of thinking and research skills. Excellent presentation in accordance with appropriate academic conventions.

Satisfactory: Good review of relevant literature and use of primary and secondary sources. Satisfactory organisation and use of examples to illustrate points and justify arguments. Work shows some independence of thinking and research skills. Satisfactory presentation in accordance with appropriate academic conventions.

Borderline satisfactory: Components of the essay are satisfactory. However, there are some areas that show a poor understanding or limited evidence of independent thinking.

Unsatisfactory: Unsatisfactory review of relevant literature and use of primary and sources. Poor organisation of information and use of examples to illustrate points and justify arguments. Little or no evidence of independence of thinking or use of research skills. Presentation may be poor.

REFLECTION ESSAY

Reflection is inherently a subjective process. There are no right or wrong answers. The assignment will not be given a mark, but will be deemed to have been successfully completed if the course leaders consider that the report shows that the student has begun to engage with the reflective process and completed the exercise in a constructive way.

Your clinical teacher should be asked to fill in the Phase 2 Formative Assessment end of block report form under the 'Written Portfolio' section. This form is then handed into the School Office.

Plagiarism

Take care when producing portfolio elements that they represent your own work.

Remember that plagiarism is a serious academic offence. *"Any action knowingly taken by a student which involves misrepresentation of the truth is an offence which the University believes should merit the application of very severe penalties."*

However, more often than not there might be no deliberate intention to cheat but offences results from misunderstanding of correct ways in which quoted text should be referenced - many students simply do not understand what plagiarism is.

The Oxford Dictionary defines plagiarise as: "to take somebody else's ideas or words and use them as if they were one's own."

To this we should also add the definition of **Collusion** as "the secret agreement or understanding between two or more people with the aim of deceiving or cheating others."

The University of Leicester WEB site contains lots of information and advice for students. See: <http://www.le.ac.uk/talent/plagiarism/>

Why do Students Plagiarise?

In many cases students will plagiarise for simple practical reasons:

1. Bad time management skills
2. Unable to cope with the work load
3. Lack of understanding

If you find yourself struggling for one of these reasons it is much better that you talk to your consultant or one of the Education Leads or to someone in the Medical School.

There are other reasons:

1. I want to see if I can get away with it
2. I don't need to learn this, I only need to pass it
3. The tutor doesn't care, why should I?

Again you need to remember that the main objective for the written portfolio elements is to provide a framework for your own learning. Not only will your learning suffer, but you will put your whole career at risk.

Getting Data from the Web

With increasing amounts of useful information available to students on the web, from informative pages to unpublished academic works, it won't be long before you want to incorporate some of this information into your own essays. Use of material from the web follows exactly the same rules as use of information from traditional printed sources: you are positively encouraged to use ideas, information and quotations in your own work as long as you do not try to pass them off as your own work. Any source you use, either directly in the form of quotations or indirectly as a basis for ideas and theories, must be acknowledged in your bibliography: any other use will be deemed as plagiarism, and will be punished heavily.

9. Assessing your progress

i) Formative assessment

This takes place at the end of each 8-week block and will incorporate feedback to students from teachers. Assessment will be both of attendance and competence. Failure to attend without good reason is regarded as unsatisfactory. A report form for each of you for each block will be issued to you by the School Office and are also obtainable from the undergraduate co-ordinators. You must ensure that this is completed and signed by your consultants, and that there is an opportunity for the contents to be discussed with you. Copies will be retained by the consultants concerned and by you, and you **must return the top copy to the School Office within one week of the end of the block**. You will not be considered to have completed a block satisfactorily until a satisfactory report, and a completed block evaluation form has been received. You must realise that it is **your responsibility to return this form**, and you will not be allowed to take the Intermediate or Final Clinical Examination if a full set of reports has not been received. If you cannot take the Intermediate Clinical Examination your course will be terminated.

ii) Summative assessment

There will be two summative assessments.

The first, the Intermediate Clinical Examination, takes place at the end of the junior rotation. You will be examined by clinical observation of your clinical practice. A pair of examiners will observe you taking a history from and examining two patients. You will be assessed against defined competencies which are closely related to the course learning outcomes. If there is doubt about your performance after this examination you will be recalled to an extended examination when you will be observed by a second pair of examiners consulting with three more patients. If you have still not reached a threshold standard in all the defined competencies then you will be allowed one resit of the Intermediate Clinical Examination after a period of remedial learning and teaching. If you remain unsatisfactory after resit, then your course will be terminated.

The second, the Final Professional Examination, taken at the end of the senior rotation, will be based upon the entire curriculum. There are two parts. First is an assessment by observation of clinical practice. This is an extended form of the Intermediate Clinical Examination involving observation of your clinical practice with a greater number and wider range of patients. Like the Intermediate Clinical Examination you will be assessed against defined competencies, and must achieve a threshold level in all to be satisfactory. Second, there are written papers. These will test your knowledge and clinical problem-solving skills by means of integrated 'patient management problems' whose content will range over the entire curriculum from semester 1 of phase 1. Questions will relate specifically to the course learning outcomes. You must be satisfactory in both parts of the Final Professional Examination to graduate.

Detailed information about the examinations, including the competencies expected will be found in the Code of Practice for Assessment in Phase 2. If you are unsatisfactory in either or both parts then you will normally be allowed to re-sit the entire Final Professional Examination once only the following November. Reaching graduation is also contingent upon your successful completion of Additional Clinical Practice.

10. Student feedback

The purpose of this guide is to help you to give effective feedback to the hospitals and practices that provide your clinical education. The best teaching to enable you to understand the knowledge, skills and attitudes that you require to become a doctor will be that provided by practicing doctors, whom you encounter in clinical settings. Some of these teachers will provide such inspirational role models that you may make a decision about your future career after a particular attachment. During your clinical education you will be taught by a large number of individual doctors, probably well in excess of a hundred. Inevitably some of these will teach you less well, either through lack of skill or motivation to teach.

It is essential for the Department of Medical and Social Care Education that we can identify where good teaching takes place so that the teachers can be recognised and rewarded. We also need to know where teaching is less good so that we can take the necessary steps to remedy this situation.

We have therefore devised a system to gather student feedback to clinical teachers that is feasible in terms of the time required for its completion. In order for the Department to make comparative judgements we require a very high percentage return. Any individual clinical teacher is likely to teach a small number of students each year. If only half the students provide feedback this is likely to be biased by the very small numbers involved.

We recognise that you do not receive any immediate personal benefit from completing the feedback - but without it we are unable to identify and remedy any defects in your education. Failure by students to complete feedback at a later stage of the course will directly affect the students following them. It is for these reasons that we have made it a requirement that satisfactory completion of each block of clinical education will depend on the submission of feedback. Please log on to le (learning environment) during the final week of each block. You can do this from any internet linked computer terminal using the following instructions. If you fail to do so you will be sent a reminder email after the first week of the subsequent block. Failure to complete feedback without written justification will be noted and render you subject to appropriate sanctions

If you encounter a serious problem with your teaching, or with an individual clinical teacher that needs immediate rectification you are encouraged to bring this to the attention of the relevant undergraduate coordinator or clinical education lead for the teaching unit to which you are attached. Such problems can also be reported in confidence to Dr Heney, Phase 2 co-ordinator

The Leicester Medical School has implemented the Learning Environment (this is called simply le[®]). It has been used by all first year MBChB students from September 2001. It has also been made available to students in Phase 2. The advantages for both students and the Medical School of using electronic means to collect and analyse student feedback are so great that the on-line system is also being used in phase two.

11. Appendix

Appendix i



Code of Conduct with regard to Attendance in Phase II

General principles:

- i) Phase II is a full time apprenticeship and is considered the same as full time employment.
- ii) Attendance throughout normal working hours and any programmed out-of-hours experience is compulsory.
- iii) There is no rule allowing a proportion of time off before a student is deemed unsatisfactory. Satisfactory attendance is 100%.
- iv) Students must notify the undergraduate coordinator if they are ill and unable to attend. The rules about self-certification and medical certificates are as if students were employed by the hospital.
- v) Much of the learning in Phase II is opportunistic and is dependent on students being within the clinical environment to make use of that particular opportunity. There are a large number of additional teaching sessions, which are arranged by consultants and other staff within individual hospitals. These are valuable and important and it is essential that students at the hospital avail themselves of these sessions. They form the basis of your learning and your preparation to be competent doctors.

Attendance at teaching sessions:

- i) Teaching session within partnership timetable. Some teaching sessions will be scheduled within the weekly timetable for the student partnership. These are compulsory.
- ii) Teaching sessions outside of the partnership timetable. As indicated above, many hospitals put on a range of additional teaching. These will fall into 3 categories:
 1. **Compulsory session.** Here the hospital and the Medical School have agreed that the sessions are an essential part of the curriculum

2. **Sign-up sessions.** For these, students will be expected to sign up at the beginning of the block or the week. Once you sign up you will be expected to attend and will be marked as unsatisfactory if you do not do so.
3. **Voluntary sessions.** For a number of other sessions attendance will be voluntary, although encouraged. The hospital will monitor attendance to decide if it is worth continuing with the sessions.

Attendance in Phase II:

The attendance at the end of the block must be signed off by the following:

- i) Consultant for the block. This will be on the 'Formative Assessment' form.
- ii) Undergraduate coordinator for the hospital. Each undergraduate coordinator will have access to attendance registers for a variety of the teaching events. They will also have feedback from the consultant staff within the teaching partnerships. The undergraduate coordinator will require evidence that the student's attendance is satisfactory in order for them to be signed off. The undergraduate coordinator will send a separate summary chart of attendance to the Medical School.
- iii) If your attendance is not confirmed as satisfactory on either form, you will be deemed to be unsatisfactory for the block.

Completion of 'Formative Assessment' Forms

You should return your end-of-block 'Formative Assessment' form to the School Office within a week of completing the block. If you are not able to do so you should contact the School Office immediately to explain why. Students who fail to return forms within 4 weeks without satisfactory explanation will automatically be graded as unsatisfactory for the block and referred to the Academic Progress Committee.

Consequence of unsatisfactory attendance

Any record of unsatisfactory attendance or performance will result in the block being graded as unsatisfactory and will be referred to the Academic Progress Committee.

Code of Conduct with regard to Attendance for Phase II

Leave entitlements

Any student requiring leave from the course must notify the Medical School to ask for permission. The following are the principles the Medical School will use to decide if permission will be granted:

1. **Compassionate leave.** If a close family member or close friend has either a severe life-threatening illness or severe accident then the student will be entitled to request compassionate leave. The same would obviously apply for bereavement. The amount of leave given would depend on the circumstances and will be dealt with on an individual basis.
2. **Educational activities.** A number of students request leave to attend medical conferences or other educational activities. Leave will be granted provided the student is contributing to the conference by giving a presentation or by having a poster presentation. Typically these would be the result of previous work within the course. There is an expectation that the student would be representing the University and enhancing the reputation of the Medical School. This would normally be allowed on only one occasion.
3. **Professional Development.** Some students will be members of committees. If these committees are part of the University structure, then attendance at the committee is accepted as part of the normal student activity. It is nevertheless important to inform the relevant consultant or undergraduate coordinator of any absence. Students may also be members of national committees. Any leave requirements should be discussed with the Medical School and decisions will be made on an individual basis. Providing the meetings are limited in number, then permission would normally be granted. The decision would also depend on the particular block involved and the timing of any assessments. There may be other events linked with professional development. In all cases, permission must be obtained and decisions will be based on the general principles already outlined.
4. **Extramural activities.** These activities would typically include sporting events or charity related events (such as those linked with MedSIN). Appropriate requests by students for leave on grounds of religion will also be considered. Other special events will be considered on an individual basis. Any request would have to be carefully and fully justified. The guidelines we will follow are:
 - i) The period of leave will be for a maximum of one week. The exact period will depend on the nature of the request.
 - ii) If the student is attending a sporting event or charity-related event, they must be doing so as a representative of the University. There is a clear expectation that their participation will enhance the reputation of the Medical School

- iii) The period of absence should not occur in a speciality block. If it does, then the request needs to be made well in advance so that alternative arrangements can be discussed. It may not be possible to make arrangements for certain speciality blocks and in this case, permission would not be granted.
- iv) The period of leave should not coincide with an assessment.
- v) An individual student can normally only make one such request during their time in Phase 2.

5. **Sabbatical / long-term leave.** A limited number of students will request leave for greater periods than those listed above. In these situations there is the likelihood that the leave will have significant implications for their educational progress. Any such request will have to be individually discussed. A decision would have to be made as to whether additional clinical time needs to be added on to the course in order for the student to be graded as satisfactory. The option of temporary withdrawal might be discussed. Depending on the decision, the outcome would be notified to the Academic Progress Committee and

6. **Maternity / Paternity leave.**

The Medical School understands that it is inevitable that some students, or their partners, will have a pregnancy during the course, and will need a period of leave. The first principle is that all students must meet the standards set by the Medical School and General Medical Council in order to graduate. Within that requirement, we will facilitate, as a minimum the provision of maternity leave on broadly the same term as if the student were in employment. It must be accepted however, that this will in some cases delay the date of graduation.

All women who become pregnant during the course will be entitled to take a minimum period of leave preceding and following the expected date of delivery. The nature of the medical course means that depending on the timing of the due date a student may need to take a much longer period than this minimum leave in order to return to the course at an educationally appropriate point.

Students are strongly advised to delay adoption of young children until after they graduate, but in the unlikely event of the adoption of a baby one partner will be entitled to the same period of post adoption leave as a student who has given birth to a baby.

- i) A woman who becomes pregnant whilst a medical student will normally withdraw temporarily and completely from the course before the expected date of delivery. The usual time for withdrawal will be at 34-36 weeks. This should be discussed with the Occupational Health Service who will provide appropriate advice.
- ii) The temporary withdrawal will normally continue for a period of 6 to 8 weeks post delivery, though the precise time of return will depend upon circumstances, so the period may be considerably longer

- iii) Depending on timing this may permit graduation at the normal time, or after a delay of about 4 months. However, if students elect for a longer period of leave graduation may be delayed for 12 months. There will be similar implications if the student is not able to sit either the Intermediate Clinical Examination (ICE) or the Final Professional Examination. The exact decision will depend on the individual circumstances and will be discussed with each student.
- iv) In Phase 2 every effort will be made to organise reasonably family friendly placements for the first block after return, but it must be recognised that any further concessions will, in an overstretched system, inevitably disadvantage other students and will not normally be allowed. If a speciality block is involved, then an attempt will be made to change the student's rotation so that this can be rescheduled. If this is not possible, then it may be necessary to discuss the timing of subsequent assessments.
- v) Some students may request a longer period of maternity leave. This would be discussed at an individual level.
- vi) All students whose partner becomes pregnant will be entitled to a short period of leave (normally 2 weeks) following the delivery of the child, provided that this does not coincide with major examinations (unless the student accepts that their graduation may be delayed as a result).

Examples:

- A student with an expected date of delivery during the junior rotation of Phase 2

The period of withdrawal will normally begin before the expected date of delivery, but a student may complete a block with the approval of the Occupational Health Service. The earliest return time is at the beginning of the block after 8 weeks post delivery, though a slightly earlier return may be allowed subject to occupational health approval. If only two blocks are missed it may be possible for a student to replace the elective with a block of placements and take the Intermediate Clinical Examination resit as a first sit. If satisfactory the course could continue to allow graduation at the normal time.

- A student with an expected date of delivery in the senior rotation of Phase 2

The same principles will apply as in the junior rotation, but the Final Professional Examination will normally be delayed until November, when it will be taken as a first sit. If successful the graduate will start Foundation Year at the second job of their rotation, with qualifying delayed by four months.

In summary unless the timing of delivery is exceptionally fortuitous a student taking one period of maternity leave should expect to graduate 4 and 12 months later than a student who is taking no leave. More than one pregnancy may delay graduation a great deal more, and put a student at risk of not completing within 7 years, which is a GMC requirement.

Sick leave entitlements. If students are ill they must let the undergraduate coordinator at the hospital know so that a message can be left with the relevant consultant's secretary. The student must then complete a sick leave form to be handed in to the undergraduate coordinator or the School Office. Students are able to 'self-certificate' for up to one week. The medical school will keep a record of all sick leave. If the student is ill for more than one week, then he/she must obtain a sick note from the GP or consultant. Where students are ill for prolonged periods or on repeated occasions, then this information will be reported to the Academic Progress Committee. An important part of this process will be to ensure that adequate support structures are in place for the student.

7. **NOTE:** if students find themselves having to deal with difficult situations and are concerned about taking leave, it is much better to come and discuss the matter early. This applies even if the medical school has to make contingency plans, which may or may not be required. In addition if an acute situation develops, the student should email the medical school and leave appropriate contact details.

Guidance for Undergraduate Coordinators.

On occasions, students may request leave from the undergraduate coordinator. The following principles will apply:

1. The period of leave should be for either half a day or at most for a whole day.
2. It should normally only be for one occasion in an 8-week block.
3. The same principles as those outlined above will apply.
4. The undergraduate coordinator will keep a record of any leave taken. The undergraduate coordinator will notify the Medical School of any absence without permission.

Appendix ii

Phase 2 - End of block assessment guidelines

- The end of block assessment is a valuable opportunity to provide students with constructive feedback. Feedback should include both positive strengths as well as weaknesses that need to be addressed. All students will have areas of weakness that need to be worked on and improved.
- For a small group of students the area of weakness identified is such that remedial action needs to be taken.
- All students who are graded as unsatisfactory for the block will be referred to the Academic Progress Committee (APC).
- The Academic Progress Committee will have at its discretion a range of measures that can be implemented as well as requirements that can be imposed on the student.
- It is important that the requirement imposed on the student should be a reflection of the weakness or area of neglect demonstrated by the student.

'Unsatisfactory' grade on End of Block Assessment

The following is a structure, which will provide the Academic Progress Committee with guidance as to the action they need to take:

1. Attendance

A 'Code of practice for attendance in Phase 2' has recently been introduced. The requirement for attendance in Phase 2 is 100%. Any student who is absent without permission from any part of the block will automatically be graded as unsatisfactory on attendance and referred to the APC.

It is likely that there will be a number of sub-groups:

- i) A student may have taken a short period of time off for a legitimate reason, but have failed to request permission from the Medical School.
 - The student will be sent a written warning and the matter noted by the APC. This can be dealt with by the Phase 2 coordinator and noted by the APC.
- ii) A student may have taken a short period of time off, but with no legitimate reason and also failed to notify the Medical School.
 - The student will be given a 'Best Efforts' warning by the APC and put 'on report'. The student will be closely monitored over the following blocks.
- iii) A student may have persistently and repeatedly missed compulsory teaching sessions and/or have been absent from the ward.

- The student will be called to attend the APC or an appropriate sub-committee and asked to account for his/her actions. The student will be given a 'Best Efforts' warning and the committee will have an option of imposing a further penalty at its discretion.
- iv) A student missed a large part of a block, but with a legitimate reason, such as ill health.
- The student's record will be reviewed by the APC. The committee will note the absence. A discussion will take place to optimise any remedial teaching requirements and future course work. The committee will keep future progress under review. The committee will reserve the right to recommend further action if a student missed a significant component of the course. It may be viewed that if the student has missed too much of the course that an extension of the course prior to taking the Intermediate Clinical Examination (ICE) or the Final Professional Examination (FPE) should be considered. This will be discussed at an individual level with the student concerned.

2. Portfolio performance

Written Portfolio

Students are required to complete 36 components of the 'Written Portfolio' over the course of Phase 2. Twenty written portfolio components need to be completed prior to ICE and 36 prior to the Final Professional Examination. The students therefore have options in some of the blocks as to exactly how many written portfolio components they complete.

If a student is graded as unsatisfactory for a written portfolio component then the following action should be taken:

- i) If an individual portfolio component is graded as unsatisfactory, the tutor will ask the student to re-write the portfolio component with suitable amendments, such that it can be graded as satisfactory.
- ii) If a student persistently has portfolio components graded as unsatisfactory, this may be an indication of underlying weaknesses of knowledge and organisation. The Medical School will keep a record of unsatisfactory portfolio components. If two or more blocks are found to have unsatisfactory portfolio components the student will be referred to the Academic Progress Committee.
 - The committee has an option of issuing a 'Best Efforts' warning or imposing a requirement to complete an increased number of portfolio components. The committee can also make recommendations as to other appropriate remedial teaching.
- iii) If a student fails to complete 20 written portfolio components prior to ICE, then the following action will be taken:
 - Student will be referred to the Academic Progress Committee.
 - Students must satisfactorily complete 20 written portfolio components prior to the time of the re-sit Intermediate Clinical Examination. This is a requirement for progression to the final year of the course.

- iv) If a student fails to complete 36 written portfolio components prior to the Final Professional Examination, then the following action will be taken:
- The student will be referred to the Academic Progress Committee.
 - The student will not be allowed to graduate until the required number of portfolios is completed.

Clinical Skills Portfolio

Students are required to complete a Clinical Skills portfolio.

- i) During the Junior Rotation, students must be signed off for workshops and for satisfactory demonstration of skills in the workplace. The required skills must be signed off prior to the ICE assessment. Students who fail to complete the clinical skills, or who are deemed to be unsatisfactory, will be referred to the Academic Progress Committee. Students who fail to satisfactorily complete the required clinical skills prior to the time of the re-sit ICE assessment will not be allowed to progress to the final year of the course.
- ii) During the Senior Rotation, students must attend a clinical skills week and complete a series of OSCE stations. If a student is graded as unsatisfactory for completion of their clinical skills portfolio, they will be referred to the Academic Progress Committee. The satisfactory completion of the clinical skills portfolio is a prerequisite for graduation.

3. Behaviour and attitude

Students must behave in an appropriate professional manner.

Student, about whom there are concerns regarding professional issues, will be notified to the relevant Clinical Education Lead

If the concerns remain after discussion, then the student will be referred to the Phase 2 Coordinator.

The Phase 2 Coordinator will review the matter. The following options are available consequent on the review:

- Referral to Student Support
- Referral to University support mechanisms

A small number of students will have persistent behavioural and attitudinal problems which impact on their progress in a clinical environment. If appropriate discussions fail to result in a suitable change of behaviour then the student will be deemed to be unsatisfactory for a block and referred to the Academic Progress Committee. In some situations, the abnormal behaviour may be such that referral to the Fitness to Practice Committee will be considered.

4. Clinical weakness

Students graded as unsatisfactory on academic and/or clinical progress, will be referred to the Academic Progress Committee.

- i) The normal expectation is that the APC will recommend that the student be required to take the extended stage of the relevant clinical examination.
- ii) If there is evidence of weakness related to general clinical competence or academic progress, then the student will be required to take the extended clinical examination.
- iii) If the tutor has identified a specific area of weakness linked with clinical competence, the best solution will be that remedial action is taken in the subsequent blocks with evidence of an improvement in that area. This will be possible if the block occurs early enough in either the junior or senior rotation. It will apply only to the general education blocks. The APC is able to issue a Best Efforts warning and make set requirements for future blocks.
- iv) The APC will normally recommend that the student take the extended stage of that clinical examination.

Summary of options available to the Academic Progress Committee with regard to unsatisfactory formative end of block assessment (note: The APC has a range of other powers for other situations).

- i) General warning for minor issues. Incident noted by committee
- ii) Recommendation for remedial teaching
- iii) Recommendation for student support
- iv) 'Best Efforts' warning
- v) Student put 'on report' and closely monitored
- vi) Student called to attend APC meeting and to account for their performance.
- vii) Extended clinical examination
- viii) 'Gross Neglect' warning.
 - Note: If a student is already on a 'Best Efforts' warning, the normal expectation is that he will move to a 'Gross Neglect' warning for subsequent unsatisfactory performance. This is at the discretion of the APC.
- ix) 'Gross Neglect with loss of automatic right to a re-sit examination in the event of being unsatisfactory in ICE or FPE'.