University of Glasgow

School of Medicine, Dentistry & Nursing

MBChB Clinical Years Booklet (2023-2024)

Contents

1) Contacts 3
2) Foreword 5
3) Safety and Dress Code 6
4) Scottish Infection Prevention and Control Education Pathway (SIPCEP) 7
5) General Introduction to the Clinical Years – Operation Colleague 7
6) Phase 3 Clinical Practice Learning 8
7) Learning Outcomes and Learning Opportunities 9
8) Phase 3 to Phase 4 Transition 10
9) Phase 4 Clinical Attachments 11
10) Daily Routine in Phase 4 – You are now part of the team! 12
11) Specimen Week in Phase 4 13
12) Speciality Blocks 14
13) Formal Documentation of Work 14
14) Formal Documentation of Work - Student's Role 15
15) Formal Documentation of Work – Educational Supervisor /Assessor 18
16) Portfolio Cases 21
17) Portfolio Case Pro-forma (Medicine and Surgery Block Only) 23
18) Special Portfolio Cases 23
19) Reflective Commentary – How to get the most from it 24
20) General Medical Council (GMC) Themes 24
21) The Business End - End of Block Assessment & ePortfolio 26
22) Blocks requiring remediation including Preparation for Practice 27
23) Maximising Learning and Teaching in the Workplace 28
24) Near Peer Teaching Programme 32
25) Sports and Physical Activity 32
26) Clinical Years Reading List 32
27) Assessment Forms 32

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2) Foreword

This handbook is intended for students and teachers – we are trying to outline as many aspects as possible for the clinical years to help make sure that all students get the best possible training in their time with us.

Here we will try and explain what your aims should be in the clinical years, and how to make it as good a learning experience as possible.

We will hopefully answer any questions you have on this most crucial of transitions, but if there is anything else then don't hesitate to contact your Year Teams.

With our best wishes

Prof Matthew Walters

Prof Malcolm Shepherd

Dr Craig Napier

Mr Paul Glen

Dr Jason Long

Dr James Boyle

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3) Safety and Dress Code

It is vital that clinical areas are safe for both staff and patients, and it is the responsibility of everyone working in the NHS, including you as a medical student, to act to maintain these safe environments to facilitate this. Keeping staff healthy is an important foundation for keeping patients safe from harm too, and we in the School of Medicine want to make sure we keep you from harm's way also.

Injury – At the last survey we estimated that there is one needlestick injury per year group per year. If we don't cut this frequency, someone will inevitably contract a serious infective illness and ruin a promising career. You need to adopt proper procedures to minimise risk of needlestick injury for you and all co-workers. In the event of such an injury occurring, you need to follow standard procedures to keep the chances of resultant harm to an absolute minimum.

Cross Infection – Hygiene and clinical infection control have long been held in disregard by healthcare professionals, but the reduction in Clostridium Difficile and Ventilator associated Pneumonias (VAPs) have been two fantastic achievements in Scottish Healthcare – this is not the time to let sloppy or inadequate cleanliness ruin things.

General Safety – Should you witness any aspect of clinical care or behaviour that places wellbeing of staff, students or patients at risk, it is your professional duty to report this. No one is exempt from duty to raise concerns, and these should be brought to the attention of your Educational Supervisor or (if they are not available or the matter requires urgency in addressing) the nearest responsible qualified member of NHS staff.

Dress Code and Appearance – The University of Glasgow Policy on Religion or Belief states that the University imposes no dress code on its employees or students, except where a job or placement requires a uniform or protective clothing to be worn. It is however, recommended that all students purchase the UoG Medical Student Scrubs to be worn at all Clinical Placements, students should contact the Medical School Office to purchase these. The wearing of items arising from particular cultural/religious norms is seen as part of this welcome diversity. However, there are limitations to the above, for example medical students on placements in NHS Trusts or General Practices (www.glasgow.ac.uk/services/equalitydiversity/religionandbelief).

A "bare below the elbows" policy is implemented in most clinical settings and, with disposable gloves and regular hand washing it is part of a central proven strategy to control or minimise infection. This must be followed in all clinical settings including examinations. If you wish not to expose your forearms you may arrange for disposable oversleeves to be made available for you. You should contact your Year Administrator before the start of each clinical placement if these will be required.

Students, like providers of clinical care, must wear short sleeves, must not wear wrist watches or jewellery; must not wear ties or "white coats"; must wear their hair tied back or short; must keep their nails clean and short, and without nail varnish, or artificial nails. This policy may be subject to review and revision in line with changes to Health Board advice. In addition, student dress must be tidy and presentable, in keeping with patients' expectations; except for those with a moustache or beard, students should be clean-shaven; smart trousers are acceptable dress – very short skirts or low cut tops are not; extensive visible body piercing or tattooing is not acceptable, bare midriffs are not acceptable. Any member of staff who feels that a student's dress does not comply with the guidelines has the authority to refuse to allow the student access to patients. If a student feels they have been treated unfairly they should discuss the issue with the relevant Hospital Sub-Dean, Year Director or Medical School Administrator.

4) Scottish Infection Prevention and Control Education Pathway (SIPCEP)

All NES education resources on healthcare associated infections (HAI) / Infection Prevention and Control are now encompassed within the Scottish Infection Prevention and Control Education Pathway (SIPCEP). The SIPCEP is a staged pathway of infection prevention and control education. Please see https://learn.nes.nhs.scot/ for further information.

It is available free of charge to all Scottish health and social care staff and to Higher and Further Education Institutions in Scotland for inclusion in any health and social care related course. Staff from the independent and voluntary sector in Scotland may also access the pathway free of charge.

The aim of the pathway is to enable all staff to continuously improve their knowledge and skills around infection prevention and control as part of their role. Everyone should contribute to a healthcare culture in which patient safety related to infection prevention and control is of the highest importance.

You can access SIPCEP through Turas Learn, please review this page for information and to create an account.

5) General Introduction to the Clinical Years – Operation Colleague

So you've made it through the first two years – the days of learning arid facts are over and the time has come to start a new phase of your education, one that will last for approximately 40 years. Clinical placements will be where you learn the core skills that make you a doctor. The next three years should see you develop a degree of diagnostic precision, leading onto formation of management plans that will be shared and agreed with your patients and their families. The hard-won knowledge base you will acquire is vital, but no textbook can listen to patients and examine them. You must learn to listen, question, and clinically examine in order to integrate this knowledge base into clinical practice.

The Medical School and the Health Boards have the shared goal of tending to patient care while simultaneously fostering an environment that drives learning. While medical students' primary objective is to the develop their knowledge, skills, and behaviours, we wish to reinforce that they also have a responsibility to self-direct and enhance this process by contributing to the work of our clinical teams. We have identified five steps and ten strategies to enact your steady progression from apprentice to future colleague – please see Operation Colleague which is required reading for both clinical educators and students entering their clinical years.

6) Phase 3 Clinical Practice Learning

In Phase 3 learning about clinical practice takes place in **three settings**:

1. **Hospital** Clinical teaching and experience with patients
2. **Community** Clinical teaching with patients in General Practice
3. **Skills lab** Physical examination, clinical procedural and communication skills on campus

This document tells you the outcomes and learning opportunities we expect you should have from your experiences in the first setting – in hospital.

You have other documents:

- **Clinical History and Examination Manual**
- **Clinical Practice in the Community (GP Placement)**
- **Clinical Procedural Skills**

In hospital you will be allocated to a Clinical Teaching Fellow in either QUEH or GRI. There are 4 half days that follow a flipped classroom format with an explicit focus on history and examinations of the big 4 systems – cardiovascular, respiratory, gastrointestinal and neurology. In advance of each session, please visit the Phase 3 hospital visits page where you should review the history and clinical examination manual. We recommend you watch the interactive clinical examination videos on each system. Each half day is broken up into two constituent parts: bedside teaching and small group interactive clinical reasoning puzzles facilitated by a Clinical Teaching Fellow. Each puzzle with focus on a different top 4 presentations: chest pain, dyspnoea, abdominal pain and weakness so you can work together to first, generate a differential diagnosis and second, build, compare and contrast different illness scripts. For each visit, please consolidate your learning by working through the clinical reasoning theory to practice Moodle lesson for each of the top 4 presentations. Each lesson is interactive and will take you through the clinical reasoning process step by step. The hope that the Phase 3 hospital visits serve as a fun introduction to the clinical environment.

On campus you will have small group teaching on the following physical examinations:

- Breast examination
- Cerebellar examination
- Cranial nerve examination
- Mental state examination
- Paediatric history and examination introduction (via Zoom and Moodle lessons)
- Regional musculoskeletal examination
- Skin examination (via Zoom)
- Thyroid examination
- PVD examination

On campus you will have small group teaching on the following clinical procedurals skills:

- Cannulation
- Nasogastric tube
- Urinary catheterisation
- Suturing
- Mini-ILS training

On campus you will have 5 small group teaching sessions on communication skills.

7) Learning Outcomes and Learning Opportunities

In Year 3 there are specific **learning outcomes** for your clinical practice activities. The table below lists these, together with the **learning opportunities** that we have organised for each. You are expected to supplement these scheduled learning opportunities with whatever individual arrangements you can make. Please be pro-active.

	Learning outcomes *By the end of the year, you will have:*	Learning opportunities
1	• Become more proficient at history taking and the systematic examination of patients	• Practise in wards and in GP surgeries • Practise in Communication Skills sessions.
2	• Become proficient at writing up and presenting the history and examination of patients	• Practise in wards - selected patient 'work up'
3	• Become more proficient when undertaking the basic clinical skills *(As were first introduced during Years 1 and 2)*	• Revise in skills lab with videos • Practise in hospital and with GP
4	• Developed new clinical skills	• Introduced in skills lab • Practised in hospital and/or with your GP
5	• Become more proficient at basic communication skills. *(As were first introduced in Years 1 and 2)*	• Practise in hospital and with GP
6	• Developed new communication skills	• Communication Skills • Practise with communication skills tutors in 5 sessions; then observe and practise in hospital or with your GP.
7	• Be able to use hypothetico-deductive reasoning to understand patient problems	• In CBL sessions • With patients in hospital/community
8	• Expanded on 'paper case' patients studied during CBL by taking a history from, and examining patients with similar problems	• With patients in hospital and with GP, where possible
9	• Completed a study of a patient with chronic ill health over a six month period, preparing a written report on their specific illness problems and reflecting on how these determine the quality of their long term care	• In the community setting with the help of your GP Tutor. This is the Longitudinal Portfolio and is summatively assessed.

8) Phase 3 to Phase 4 Transition

To help with your transition from Phase 3 to Phase 4 we have a 'Transition Week' after your Phase 3 summative examination. During this week we continue your preparation for Phase 4 with small group sessions on the hospital setting, clinical assessment, handover and quality improvement. This week is supported by a transition page on Moodle with a hospital site wiki and resources created in partnership with senior students. All of the resources available here have been developed as part of an SSC project to help you in your move from the lecture theatre to the ward setting.

The Wiki has a page for each hospital where you could be based for your Junior Medicine or Junior Surgical attachments, with a wide variety of information from the different wards, to teaching, to accommodation and food at the hospital. The lectures during Transition Week will cover important information on what you are expected to do on your placements, assessments that you need to complete, and some top tips from the senior year students and CTFs.

We hope you find all of these resources extremely useful in your preparation for your clinical placements. Please email the Year 3 Inbox any questions or comments in the run up to your 'Transition Week' and the Y3 team will do their best to answer/address.

9) Phase 4 Clinical Attachments

You will undertake a rotation of attachments as follows:

Clinical Year 3

Junior Medicine:	5 weeks
Junior Surgery:	5 weeks
Anaesthesia (During Junior Surgery)	1 week
Junior SSC	5 weeks

Clinical Year 4 & Year 5

Medicine:	10 weeks
Oncology (During Medicine)	1 week
Critical Care (During Medicine)	1 week
Palliative Care (During Medicine)	1 day
Surgery:	5 weeks
Senior SSC:	5 weeks
General Practice:	5 weeks
Obstetrics & Gynaecology	5 weeks
Child Health:	5 weeks
Psychiatry:	5 weeks
Clinical Neurosciences/Cardiology	5 weeks
ENT/Ophthalmology	5 weeks
Emergency Medicine	5 weeks
Musculoskeletal Medicine	5 weeks

Please visit the Moodle page for each attachment. Each page will contain important information for each placement. While there is a lot of overlap between the page for each placement, each will have unique elements that you need to pay attention to. Common elements include a list of intended learning outcomes and logbooks to chart your interactions with your educational supervisor (ES) and a list of Glasgow Undergraduate Medical E-portfolio requirements. For example, most placements will include Portfolio cases, Mini-Clinical Evaluation Exercises (Mini-CEX), Case-based Discussions (CbD) and Clinical & Procedural Skills (CAPS) logs. Medicine and Surgery, however, also have Team Professional Activities (TPA) logs, clinical reasoning cases and Virtual Wards. TPAs are units of professional practice (tasks or responsibilities) within a team. Clinical reasoning cases are mapped to your top presentations and take you through the steps of clinical reasoning process with feedback with an additional small group debrief led by CTFs with an explicit focus on your clinical reasoning as you worked through the case. Virtual wards were created largely by our CTF team, are mapped to your top presentations and serve as another opportunity for deliberate practise alongside your clinical experience.

Think about what you are about to do in each block, which cases you wish to see and what you hope to gain. Goals set at the start will help make sure you get the best from each block. In all attachments you will be assigned to an educational supervisor (ES). You and your ES can

discuss your requirements, ESs should meet their student(s) for about one hour per week for this purpose. It is a good idea to negotiate the dates and times for each meeting and get fixed slots in your diaries at your induction meeting on the first day. They will also review your written portfolio cases and have been asked to observe you during the block taking a history, doing a relevant clinical examination and formulating a management plan on a patient. You will need to plan this with them.

During each attachment you will receive regular clinical teaching. This will be timetabled locally for students. There will be inevitable variation in the clinical experiences of individual students but by the end of Year 5 you will have covered the main components. However, if there are areas you and your fellow students wish to have covered during a block, ask your ES or Sub Dean - someone will help but they need to be asked. The level of knowledge was difficult to gauge during previous years and the clinical years are no different, but remember that you coped well previously. Have confidence in your ability to cope now. What is expected of you in any topic is that of a newly qualified FY1, so if you need help why not ask them? They are bound to be pleased to assist. The list of standard undergraduate textbooks will help define the appropriate knowledge on the Core Presentations but you should now be beginning to read review articles, journals, etc too.

Experience in the community will be an expected component of attachments. This may include, for example, partnerships between the hospital consultant and a local GP, as already happens for clinical practice sessions earlier in the course, attendance at shared care clinics or at speciality clinics in the community, visits to patients' homes with outreach staff, etc.

10) Daily Routine in Phase 4 – You are now part of the team!

To gain an understanding of what is expected of you and what you should expect of your attachment – please read Operation Colleague which outlines 5 steps and 10 strategies for you and your ESs success. Don't be fooled into thinking that the timetable of lectures and formal sessions is a list of the acceptable minimum attendance requirements. Your attachment to each ward during Phase 4 should be a signal to you that you are part of the team, and blank bits on the timetable should be utilised in and around your current unit. Becoming part of this team is a way to learn specific skills, but also to pick up and adopt the habits, behaviours, and attitudes that will propel and sustain you through your career.

The main person responsible for honing your clinical skills is you. Clinical supervisors can help by demonstrating and organising teaching, but you must attend and you must use your initiative to maximise each clinical opportunity.

All too soon you will realise that a doctor's time is scarce - anytime someone agrees to teach you they are deferring other work for later, so patchy attendance is noticed and reported. Similarly, patients agreeing to take part in teaching are offering themselves for free as a model to be practised on. To ignore or take that privilege (and honour) for granted is wasteful and rude. The best way to demonstrate your thanks for any teaching delivered is to show up for the next session.

11) Specimen Week in Phase 4

This is an example of what we have asked the local Sub Deans to cover.

It is not meant to be proscriptive but is meant to give a guide.

Teaching in core blocks should ideally consist of:

Clinical Teaching (1-2 sessions per week)

-60 minutes feedback/planning time with your Educational Supervisor

-clinical teaching: 2 x 2 hours from member of clinical team (maximum of 6 students/group)

Supervised Clinical Experience (2-4 sessions per week)

-Outpatients session and ward round

Community Experience (1 session per week)

-could replace/fulfil one session from above

Plenary/Fixed Resource Session (1 per week

Self-directed Learning (4-5 sessions per week)

-Finding/accessing patients

-Portfolio Cases

-Mini-CEX & CbD

-Resources on Moodle (e-learning)

12) Speciality Blocks

Specialty teaching arrangements will, as far as possible, be similar to those proposed for medicine and surgery but vary according to geographical and staffing constraints.

During medicine and surgery attachments you should participate in the core surgical specialties (dermatology, vascular, urology, neurosurgery and plastics etc.). Students are expected to gain experience in dermatology, palliative care, cases covering chronic disease and disability (in any speciality). NHS planning means some specialities are concentrated by regions, so some, e.g. dermatology and palliative care are not available everywhere.

Outpatient facilities are usually available so forward planning to organise necessary sessions will help here. Check availability of each subject on hospital websites and make sure you cover those cases while you are there. You do not wish to be left at the end of Year 5 with areas not covered. Discuss this with your ES at the beginning of your attachment. Remember SSCs can help extend your experience.

13) Formal Documentation of Work

Mini-Clinical Evaluation Exercise (Mini-CEX), Case-based Discussion (CBD) & Long Case

To request a CBD or Mini-CEX assessment from your Supervisor, you should log into the ePortfolio and send them a 'ticket', as with the End of Module Review.

During each block, the Educational Supervisors (or their deputies) have been asked to undertake two mini-CEXs, one on history taking and one on examination, and one CBD. You may have to remind them at your meetings. This is an opportunity for you to have formal assessment of your history taking, examination techniques and ability to discuss the different aspects of an interesting case. Your ES or a delegated assessor will complete the forms with you on GUMeP. If paper versions are used, please upload the forms to your personal library on GUMeP.

Students will be required to complete a long case instead of two Mini-CEXs and one CBD, in the second half of the 10 week medical block (only). Your ES should complete an Objective Long Case Assessment – an e-ticket can be generated from GUMep.

14) Formal Documentation of Work - Student's Role

a) The Mini-Clinical Evaluation Exercise (Mini-CEX)

As part of your assessment during the block, the ES will ask to observe you taking a history and/or performing an examination on a patient. This will be divided into sections: details of the marking schedules are included. The process comprises the ES observing you during a consultation and taking a history and/or performing an examination of whatever type. This could be in an outpatient consultation, interviewing a patient on a ward or interviewing relatives and all would be appropriate.

The mini-CEX evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as physical examination and clinical reasoning. The supervisor or the medical student can choose the patient and problem that will be observed.

Scoring should reflect the performance that you would reasonably expect for a student at your stage of training. It is likely that all year 5 students will be functioning at a level equivalent to that of an FY1 in most components.

The ES / Assessor should use boxes to give you **constructive and helpful** feedback. We ask the ES / Assessor to grade the complexity of each case and then to grade your performance in each section and to ensure that they give you feedback that is appropriately critical but not unpleasant to give guidance as to areas needing attention in future blocks. The form provides some structure to the exercise from the point of view of feedback and debriefing.

The mini-CEX should be undertaken as follows:

Clinical Encounter - The ES should observe the student taking a history and/or examining a patient and doing what they would normally do in that situation. This should take no longer than **15-20 minutes.** The ES should record a rating for each competency on the assessment form.

Debriefing and Feedback – This should take about **5 – 10 minutes.** It should be conducted in a suitable, quiet environment immediately after the assessment and should be constructive. **Please remember that virtually all students strive to do their best during assessments, and are keen to know how to do better.** The ES should expand on the reasons for any ratings "Below Expectations" and make practical suggestions for any remedial steps if appropriate.

PLEASE NOTE

The mini-CEX will form part of your assessment (but will NOT be the sole basis of assessment)

b) The Case-Based Discussion (CBD)

As part of your assessment during the block, the ES will ask to discuss a case in which you been involved. This will be divided into sections: details of the marking schedules are included. The case-based discussion is a structured discussion of a clinical case encountered by the student. The supervisor or the medical student can choose the case that will be discussed. You should prepare structured medical notes for the CBD and it may be useful if you were able to bring along the patient's case notes but make sure that this is appropriate and that you let the nursing/medical staff and ward clerk know.

The CBD evaluates a structured discussion of a clinical case which you have been involved in. Its strength is assessment and discussion of clinical reasoning. The supervisor or the medical student can choose the case that will be discussed. Each CBD should represent a different clinical problem, sampling from the various sections of the undergraduate curriculum. The form provides some structure to the exercise from the point of view of feedback and debriefing.

Scoring should reflect the performance that you would reasonably expect for a student at your stage of training. It is likely that all year 5 students will be functioning at a level equivalent to that of an FY1 in most components.

The ES / Assessor should use boxes to give you **constructive and helpful** feedback. We ask the ES / Assessor to grade the complexity of each case and then to grade your performance in each section and to ensure that they give you feedback that is appropriately critical but not unpleasant to give guidance as to areas needing attention in future blocks. The form provides some structure to the exercise from the point of view of feedback and debriefing.

The CBD should be undertaken as follows:

Discussion - The process is typically led by the student. The discussion should start from and be centred on the students own structured medical notes on the patient. The CBD includes seven rated question areas which are outlined on the assessment form. The ES should record a rating for each competency on the assessment form.

Debriefing and Feedback – It should be conducted in a suitable, quiet environment immediately and should be constructive. **Please remember that virtually all students strive to do their best during assessments, and are keen to know how to do better.** The ES should expand on the reasons for any ratings "Below Expectations" and make practical suggestions for any remedial steps if appropriate.

The assessment typically takes **20 minutes** including feedback and completion of the form. Not all question areas need assessed on each occasion.

It must be emphasized that the most important purpose of the assessment exercise is to provide the student with "formative" feedback (i.e. information that forms and develops the students practice). Conducted well this will have a significant impact on learning.

PLEASE NOTE

The CBD should form part of student's assessment (but should NOT be the sole basis of assessment)

c) Objective Long Case

The 'Long Case' was first introduced in Cambridge as an undergraduate assessment tool in the 19th Century. The 'Long Case' is rich in both authenticity and educational value. As part of your assessment during **your 10 week Senior Medicine block only**, the ES a will arrange for you to complete an objective long case. This replaces the Mini-CEX and CBD in the second half of your 10-week attachment.

The long case is designed to test your skills of history and examination as well as your ability to integrate the findings, and to summarise this to the observer. You will also be asked to offer a problem list, differential diagnosis and describe a plan of investigation and management plan. The assessor will directly observe you taking a history and performing an examination on a patient. This will be divided into sections: details of the marking schedules are included. This will usually involve interviewing a patient on a medical ward. Scoring should reflect the performance that you would reasonably expect for a student at your stage of training. We ask the assessor to grade the complexity of the case and then to grade your performance in each section.

The long case should be undertaken as follows:

The examination will last no greater than 60 minutes; in this time, you will see one long case. You will be given a brief introduction to the patient from the assessor and asked to 'perform a long case clerking (history and directed examination) on this patient'. You will then be observed for around 40 minutes while you carry out a history and directed examination. You will be told when you have 20 minutes left. You may wish to spend the last 5 minutes preparing your thoughts. The assessor will then spend 15 to 20 minutes on the following questions:

1. Please summarise this case and identify the main problems.
2. Please describe and justify your differential diagnosis, ranked from most to the least probable.
3. Please describe the investigations required to confirm you diagnosis.
4. Please describe the management and/or therapeutic measure you would take for this patient.

Debriefing and Feedback – This should take about **5 – 10 minutes.** It should be conducted in a suitable, quiet environment immediately after the assessment and should be constructive. **Please remember that virtually all students strive to do their best during assessments, and are keen to know how to do better.** The assessor should expand on the reasons for any ratings "Below Expectations" and make practical suggestions for any remedial steps if appropriate.

PLEASE NOTE

The long case will form part of your assessment (but will NOT be the sole basis of assessment)

15) Formal Documentation of Work – Educational Supervisor /Assessor

a) The Mini-Clinical Evaluation Exercise (Mini-CEX)

As part of student assessment during the block, the ES is asked to observe the student taking a history and/or performing an examination on a patient. This will be divided into sections: details of the marking schedules are included. The mini-CEX evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as physical examination and clinical reasoning.

The supervisor or the medical student can choose the patient and problem that will be observed.

Your scoring should reflect the performance of the medical student that you would reasonably expect at their stage of training. It is likely that all year 5 students will be functioning at a level equivalent to that of an FY1 in most components.

Please use boxes to give the student **constructive and helpful** feedback on performance (guided by your training experience which is available if you have not already had this). Care is needed to ensure that feedback is appropriately critical but not unpleasant. Please grade each section to give guidance as to areas needing attention in future blocks.

The process comprises the ES observing the student during a consultation and taking a history and/or performing an examination of whatever type; an outpatient consultation, interviewing a patient on a ward or interviewing relatives would all be appropriate. The form provides some structure to the exercise from the point of view of feedback and debriefing.

<u>Complexity of case:</u>

Low Complexity – Uneventful encounter, few demands made on student by patient

Moderate Complexity – A few difficult aspects of the consultation evident

High Complexity – Difficult due to unusual findings or demanding patient

The mini-CEX should be undertaken as follows:

Clinical Encounter - The ES should observe the student taking a history and/or examining a patient and doing what they would normally do in that situation. This should take no longer than **15-20 minutes.** The ES should record a rating for each competency on the assessment form.

Debriefing and Feedback – This should take about **5 – 10 minutes.** It should be conducted in a suitable, quiet environment immediately after the assessment and should be constructive. **Please remember that virtually all students strive to do their best during assessments, and are keen to know how to do better.** The ES should expand on the reasons for any ratings "Below Expectations" and make practical suggestions for any remedial steps if appropriate.

It must be emphasized that the most important purpose of the assessment exercise is to provide the student with "formative" feedback (i.e. information that forms and develops the students practice). Conducted well this will have a significant impact on learning.

PLEASE NOTE

The mini-CEX should form part of student's assessment (but should NOT be the sole basis of assessment)

b) The Case-Based Discussion (CBD)

As part of student assessment during the block, the ES is asked to discuss a case in which the student has been involved. This will be divided into sections: details of the marking schedules are included.

The case-based discussion is a structured discussion of a clinical case encountered by the student.

The supervisor or the medical student can choose the case that will be discussed. The student should prepare structured medical notes for the CBD and it may be useful if they were able to bring along the patient's case notes.

Your scoring should reflect the performance of the medical student that you would reasonably expect at their stage of training. It is likely that all year 5 students will be functioning at a level equivalent to that of an FY1 in most components.

Please use boxes to give the student **constructive and helpful** feedback on performance (guided by your training experience which is available if you have not already had this). Care is needed to ensure that feedback is appropriately critical but not unpleasant. Please grade each section to give guidance as to areas needing attention in future blocks.

Each CBD should represent a different clinical problem, sampling from the various sections of the undergraduate curriculum. The form provides some structure to the exercise from the point of view of feedback and debriefing

<u>Complexity of case:</u>

Low Complexity – Uneventful encounter, few demands made on student by patient

Moderate Complexity – A few difficult aspects of the consultation evident

High Complexity – Difficult due to unusual findings or demanding patient

The CBD should be undertaken as follows:

Discussion - The process is typically led by the student. The discussion should start from and be centred on the students own structured medical notes on the patient. The CBD includes seven rated question areas which are outlined on the assessment form. The ES should record a rating for each competency on the assessment form.

Debriefing and Feedback – It should be conducted in a suitable, quiet environment immediately and should be constructive. **Please remember that virtually all students strive to do their best during assessments, and are keen to know how to do better.** The ES should expand on the reasons for any ratings "Below Expectations" and make practical suggestions for any remedial steps if appropriate.

The assessment typically takes **20 minutes** including feedback and completion of the form. Not all question areas need assessed on each occasion.

It must be emphasized that the most important purpose of the assessment exercise is to provide the student with "formative" feedback (i.e. information that forms and develops the students practice). Conducted well this will have a significant impact on learning.

PLEASE NOTE

The CBD should form part of student's assessment (but should NOT be the sole basis of assessment)

c) The Objective Long Case

As part of student assessment during **the 10 week Senior Medicine block only**, you will arrange for your student to complete a formative objective long case that replaces the Mini-CEX and CBD in the second half of the 10-week attachment.

This long case is designed to test skills of history and examination as well as the students' ability to integrate the findings, and to summarise this to the observer. The student will also be asked to offer a problem list, differential diagnosis and describe a plan of investigation and management plan. The assessor will directly observe the student taking a history and performing an examination on a patient. This will be divided into sections: details of the marking schedules are included. This will usually involve interviewing a patient on a medical ward. Scoring should reflect the performance that you would reasonably expect for a student at their stage of training. We ask the assessor to grade the complexity of the case and then to grade your performance in each section.

<u>Complexity of case:</u>

Low Complexity – Uneventful encounter, few demands made on student by patient

Moderate Complexity – A few difficult aspects of the consultation evident

High Complexity – Difficult due to unusual findings or demanding patient

The long case should be undertaken as follows: Please meet the student on the ward, introduce yourself, and take them to meet the patient. Please ascertain that they have not met the patient before. Please inform the student that the total length of the exam is no greater than 60 minutes. Please inform them that you will let them know when 20 minutes have passed and that you will interrupt them after 40 minutes (if they have not already finished). Please instruct the student to 'perform a long case clerking (history and directed examination) on this patient'. Add that you will be observing them throughout - they will be expecting this. Please make sure that you are present for the duration of the exam. The student may wish to spend the last 5 minutes of this time preparing their thoughts. Please then spend 15 to 20 minutes on the following questions:

1. Please summarise this case and identify the main problems.
2. Please describe and justify your differential diagnosis, ranked from most to the least probable.
3. Please describe the investigations required to confirm you diagnosis.
4. Please describe the management and/or therapeutic measure you would take for this patient.

Debriefing and Feedback – This should take about **5 – 10 minutes.** It should be conducted in a suitable, quiet environment immediately after the assessment and should be constructive and helpful. **Please remember that virtually all students strive to do their best during assessments, and are keen to know how to do better.** The assessor should expand on the reasons for any ratings "Below Expectations" and make practical suggestions for any remedial steps if appropriate. Care is needed to ensure that feedback is appropriately critical but not unpleasant. Please grade each section to give guidance as to areas needing attention.

16) Portfolio Cases

You should complete 2 portfolio cases for each 5-week block, i.e. 4 cases in a 10 week block. Your Educational Supervisor will look at and assess your cases and return them to you before you finish the block. Each portfolio case should have a plagiarism assessment by Turnitin and the report should be given to your ES with the case. In your Medicine and Surgery attachments you should use the Portfolio Case Pro forma to complete your cases (See below). There is also a shorter 2-page proforma for your 'Cases of the Week'.

The case portfolios should consist of the following:

1. **Your** history of the problem from patient and not taken from the notes (present, past, drug, systemic enquiry, social, etc.)
   Please also ensure that patient details are anonymised!

2. **Your** patient examination – not taken from the notes.
   (CVS, RS, GI, CNS, MSKS)
   If you need help use the clinical examination videos.

3. A summary list of all the patient's problems (as you see them)
   A list of the differential diagnoses (with most likely highlighted)
   A management plan for that patient (how is the patient to be treated)

4. In an effective management plan you should ask yourself these questions:
   - Does the initial treatment cover the most relevant acute problems (review notes after you have decided these)?
   - What relevant investigations help make sure the initial most likely diagnosis is correct? (You make up your list. Check your list with the ones that have been requested.)
   - What are the results of those investigations (review the notes for these)? How do these help confirm the most likely diagnosis and help exclude some of the differential diagnoses?
   - Did the results alter your treatment plan?
   - Define the further treatment options for the remaining problems.

5. Ensure that you follow some patients through their discharge from hospital so you know what planning is put in place before they go home.

6. Write a short reflective commentary (500 -1500 words). In this you should try answering the following questions:
   - what have you learnt from the case?
   - how does the presentation compare to the classical textbook one?
   - what else have you learnt about other than the basic medical case?
   - how does the case relate to the GMC themed outcomes in "Outcomes for Graduates"? (details of the themes will be available on your Year websites).
   - In Medicine and Surgery Attachments please refer to the additional guidance within the portfolio case proformas on Moodle – please see below.

7. Your list of references and sources (to avoid accusations of plagiarism):

Textbooks (only a minor source at your level)
Journals (reviews and articles)
Senior medical staff (ask questions)
Junior medical staff (ask how they solve the problems)
Paramedical staff (social work, physiotherapy, OT, pharmacy)
Support staff (imaging, laboratory, etc.)
Hospital management (how do they help)

Ask yourself if you have just regurgitated what is in your references in your reflective commentary. If so you haven't made the best use of this opportunity and should at best only get an adequate assessment for these

8. On the first page of each portfolio you should highlight:

Name and matriculation number
Which block you were doing when you undertook this case
What is the primary diagnosis and which system is covered
Which other diseases you have read about in relation to this case
Which GMC theme your reflective commentary covers

Your predecessors have found these cases helpful to include in your portfolio and as a revision tool. It is an idea to keep copies to add to your 'paper cases' that you dealt with in previous years. The combination will be useful when it comes to revision.

Your ES might suggest changes that you may like to take into account for the next case and discussion. Remember the cases are designed to be for your learning purposes and not for your Educational Supervisor's!

Your portfolio cases are assessed only by your ES during your clinical years. They are not formally examined again, but they should be retained.

Remember you learn most by you identifying and solving the problems by asking relevant questions and finding the right answers. If you rely on others, they will learn and you will fall behind.

17) Portfolio Case Pro-forma (Medicine and Surgery Block Only)

Please find this in the respective pages on Moodle. This pro-forma guides you through your portfolio case by simulating the medical admission process. The pro-forma uses a number of tools to help you develop your clinical reasoning, prescribing skills and reflective practice. It also includes a structured feedback section to review your performance with your Educational Supervisor. It is important to also follow the prompt to complete a reflective commentary (see above). The pro-forma sections include:

1. Student details, GUID, Supervisor, Case Title
2. Presenting Complaint, History of Presenting Complaint
3. Systemic Enquiry, Past Medical History, Family History, Social History
4. Examination, Investigation results
5. Medicine Reconciliation Form
6. Summarise, Narrow Your Differentials, Analyse using hypothetico-deductive reasoning grids
7. Stop and Think, Problem List, Plan
8. IDEA Feedback, Performance, Action Plan
9. Student Kardex (Regular Parenteral)
10. Student Kardex (Regular Enteral)
11. Student Kardex (As Required Medications)
12. Student Intravenous Fluid Prescription Sheet

18) Special Portfolio Cases

In Year 4 only, in addition to the general portfolio cases, you will be required to complete an Ethics portfolio case covering a specific GMC theme for formative feedback. It would be worth your while to think about this during all of your attachments to identify relevant case problems. **Further information and deadline for submission can be found on MBChB4 Assessment Moodle page, section Ethics cases.**

You should submit the written case to Turnitin and your local ES for the usual review, as part of your portfolio cases in that block. The case will then be reviewed by the Director of Vocational Studies and his team who will formatively assess the case for you specifically with this theme in mind. There are also 3 winners per year for the MacInnes Ethics Prize judged by GP Markers.

19) Reflective Commentary – How to get the most from it

A narrow focus for reflective commentary is based simply on GMC themes 1 and 2. You can use a variety of different GMC themes and I would encourage you to do so. This block will give you opportunities to consider disability, rehabilitation, links with other health professions, teaching, discharge planning, public health initiatives, interactions with hospital management, as well as many of the others, and I would encourage you all to use the broadest list possible.

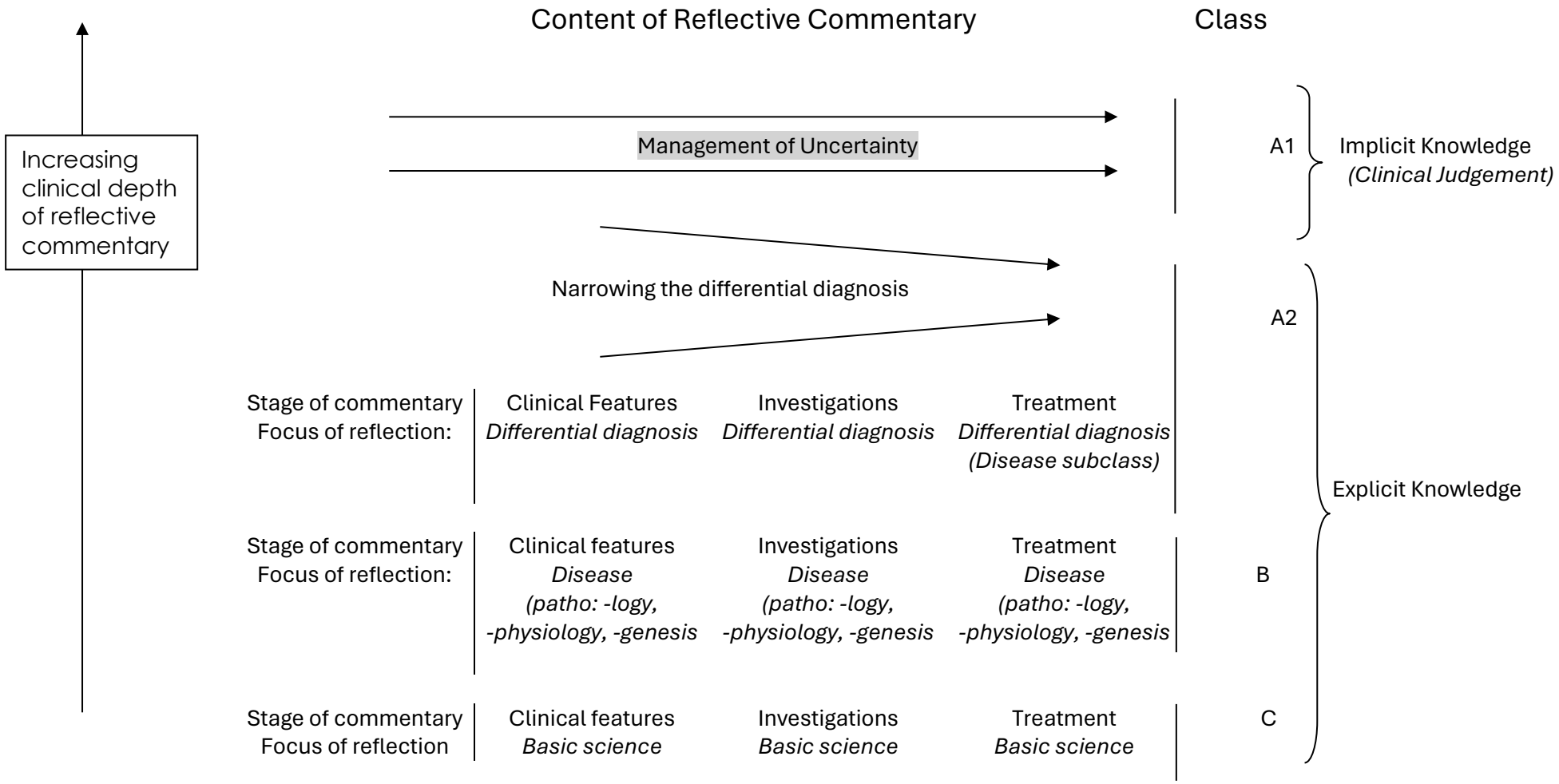
Your commentary can be disease focused. Most of the information in here will come from textbooks, guidelines, etc. While this is informative for you, you may get more out of the cases you discuss if you consider why one disease is selected on top of another from the differential diagnosis list. Remember that negative results often help to exclude diagnosis on the differential diagnoses list. If you start to think like this now then this begins to demonstrate that you can show clinical judgment, weighing up the overall situation, and how you consider managing the uncertainty that is present in each individual case.

Consider how each case presents in relation to the standard presentation, what signs are present or missing, suitability of appropriate investigations including predicted value accuracy, etc, and consider treatments for each of the conditions together with the complications that may arise from the therapy. You might find the diagram overleaf (taken from the BMJ) useful for thinking about reflective commentary and I would encourage you to use it in the future.

20) General Medical Council (GMC) Themes

Extract From Outcomes for Graduates

Medical students are tomorrow's doctors. To meet the standards of *Good Medical Practice*, graduates must make the care of patients their first concern. *Outcomes* for graduates sets out the knowledge, skills and behaviours that new UK medical graduates must be able to show.


Content of Reflective Commentary
Class
Increasing clinical depth of reflective commentary
Management of Uncertainty
A1
Implicit Knowledge
(Clinical Judgement)
Narrowing the differential diagnosis
A2
Explicit Knowledge
Stage of commentary
Focus of reflection:
Clinical Features
Differential diagnosis
Investigations
Differential diagnosis
Treatment
Differential diagnosis
(Disease subclass)
Stage of commentary
Focus of reflection:
Clinical features
Disease
(patho: -logy, -physiology, -genesis
Investigations
Disease
(patho: -logy, -physiology, -genesis
Treatment
Disease
(patho: -logy, -physiology, -genesis
B
Stage of commentary
Focus of reflection
Clinical features
Basic science
Investigations
Basic science
Treatment
Basic science
C

21) The Business End - End of Block Assessment & ePortfolio

At the end of each clinical attachment, your Educational Supervisor will complete an assessment of your performance in the block with you. This process should include information from other members of the local team. This assessment will take place on the Glasgow Undergraduate Medical ePortfolio (GUMeP), and is known as the 'End of Block Assessment'. Setting this requires that you submit a ticket – to do this, log into GUMeP and use the 'ticket' system to send an email to your ES. This email will include a link which allows the ES to complete the form in your account. ***We recommend that this is done as early as possible in the block's final week. Anyone who has not sent in a ticket by the Wednesday of the final week will be highlighted to the Year Team and may be subject to follow up from Head of UMS .***

GUMeP is based on the NHS Foundation Years ePortfolio, and students should develop the habit of recording professional development activities such as CBDs and Mini-CEX, and store portfolio cases. Gaining experience of it as an undergraduate will help you in your Foundation Programme. Access to GUMeP is at www.nhseportfolios.org and the Medical School will supply you with a username and password.

For your End of Block Assessment you will be assessed on a variety of parameters including ability to take a history, examine a patient, make a management plan and on communication skills (to include information from your Mini-CEX & CBD). You will also be assessed on your portfolio cases and more areas such as attendance, reliability, relationship with colleagues, knowledge base and ability to manage your own learning. By now it is expected that you will be in the adequate and above range, and >95% of students fall into this category.

There will be an option for a Block Lead or Educational Supervisor to award a ***Certificate of Merit***. Certificate of Merits were introduced so that commitment to clinical placements, rather than time in the library, was appropriately recognised. Certificate of Merits should be awarded particularly where students on placement have demonstrated excellent knowledge, competence, and a willingness and ability to be part of the ward team. Strong contribution to the unit's clinical work may take many forms (ward rounds, clinical tasks, on-call, case presentations, helping with clinical audits) and any and all of these could contribute to a Certificate of Merit. Obtained Merits will not affect the grade of degree awarded but will be awarded separately at the time of graduation when other markers of professionalism have been attained. Certificates of Merit may also count towards some of the scoring for the individual specialty-related prizes.

A few students do not manage to meet expectations of their ES in the End of Block Assessment which for some comes as a surprise. To avoid this, be proactive, get information from ESs halfway through the block. Download a copy of the assessment form, complete it yourself as you feel you are performing (a good exercise in self review), take it to your ES and ask them how they feel you are doing during the block. This will give you some guidance before the end of block.

Do not leave the block without requesting that your ES completes the assessment form. These should be completed in the final week of your block or as soon as possible after the end of the block. It is the student's responsibility to send a ticket to the relevant Educational Supervisor, and to chase this up if no sign off has occurred within the final week.

22) Blocks requiring remediation including Preparation for Practice

You may require remediation because of inadequate knowledge / skills or poor attendance. Students who receive 'Below Expectations' for 3 or more attributes, or for Attendance and Reliability only, or are deemed 'not to have met all placement objectives', and remediation is required will be required to discuss their performance with the Year Directors. Students requiring remediation will be required to repeat that discipline, the amount of time needing to be 'made up' (remediated) being decided between the Educational Supervisor for the block and the Head of Year.

Where a repeat block is required to be undertaken, this should ideally be done as soon as possible, to allow early remediation and prompt sign off to allow progression. There is limited space within the timetable to do this. Finishing the summer with a repeat block gives too short a time to have all relevant documentation completed, and students should be aware that completing a failed block should take precedence over going on an elective; if there is too much to catch up with, it may be that students will be required forego some or all of the elective study to allow successful completion of the block. Again, satisfactory completion of any remedial action should be recorded. If one or more blocks are not completed, then the student may not be eligible to progress.

23) Maximising Learning and Teaching in the Workplace

"Medicine is learned by the bedside and not in the classroom."

"He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all."

"Observe, record, tabulate, communicate. Use your five senses. Learn to see, learn to hear, learn to feel, learn to smell, and know by practice alone you can become an expert."

William Osler (1849–1919)

The father of modern medicine was right when he suggested that patient-orientated learning and teaching in workplace environments should be the cornerstone of your clinical years. The reasons for using patient-orientated learning and teaching in the clinical environment are that:

- it places all your learning in context.
- it prepares you for the type of clinical activities you will face when you graduate.
- it is an effective environment for clinicians to show you how things *should* be done; this is called 'role-modeling'.

Teaching during supervised learning activities (business ward rounds, business outpatient clinics, GP surgeries and theatre) can be challenging for your coach or supervisor. Your coach or supervisor needs to ensure that they are delivering high quality patient care at the same time as maintaining a learning environment that is safe for patients and supportive to you as a learner. By being realistic as well as strategic, an effective learner and teacher can maximize opportunities during supervised learning activities whilst minimising disruption even in the busiest of clinical settings. It is important that you both purposely practice during (with real-time feedback) and reflect soon, after any supervised learning activity to direct you're learning effectively. Reading, discussing, solving problems and questioning what you know about a patient's problem the same day or the next day means that the information will be stored in your memory in such a way that it will be more likely to be recalled when you need it most. For a complete list of the 10 strategies to maximise your learning please refer to Operation Colleague.

BUSINESS WARD ROUNDS and GP SURGERIES**

During a business ward round or GP surgery you have the opportunity to observe a clinical team or GP in action. This supervised learning activity is rich in authenticity and available learning materials (inpatients, inpatient and GP case records, clinical portal data, images, drug kardex and nursing observations). Your coach or supervisor will make you feel part of the clinical team and where possible will encourage you to be an active participant rather than a passive observer. Learning and teaching on a business ward round or GP surgery can take place as follows:

Patient or Task allocation: Your coach or supervisor may allocate you a patient to clerk when they arrive on the ward or in the practice, observe their investigations, follow them up. In hospital setting you may be asked to follow the patient daily and then take responsibility for presenting them to the team on ward rounds. If you haven't been on the ward round before then your coach or supervisor may ask you to review the case records and present a case or part of a case later in the round. This can be daunting at first but gets much easier with

practice. One way to approach this is do a **'SNAPPS'** presentation:

Summarise briefly the history and findings (some background but only pertinent facts)

Narrow the differential (just 2 or 3 relevant possibilities)

Analyse the differential by comparing and contrasting the possibilities (weighing the evidence for or against each diagnosis)

Probe the preceptor (your coach or supervisor) by *asking* questions about or alternatives to clarify any difficult or confusing issues

Plan management of the patient (good time for feedback from your coach or supervisor)

Select a case-related issue (a potential gap in knowledge/skills or area of ongoing interest/uncertainty) for self-directed learning

Your coach or supervisor may give you a task before the ward round such as reading out the latest patient observation or looking for drug interactions in the kardex or EMIS/VISON in GP. This can be an opportune time to be observed performing a clinical and/or procedural skills (CAPS).

Think Aloud: Your supervisor may use a 'think aloud" strategy to talk through their clinical reasoning during a ward round. Clinical reasoning describes the thinking and decision-making processes associated with clinical practice. Experienced clinicians rely heavily on Type 1 thinking in day-to-day clinical reasoning. This type of thinking is fast, intuitive, pattern recognizing type of thinking using heuristics (mental shortcuts) and may not be obvious to you during clinical activity. This type of thinking develops over many years by being able to use forward thinking to compare and contrast illness scripts (disease specific packets of information including epidemiology, temporal pattern and a syndrome statement generated by knowledge and experience). By thinking out loud your coach or supervisor can help you learn from their Type 1 thinking by communicating how they have processed the information provided and weighed up the evidence presented. They can also clarify the factors that influenced their decision as well as uncertainties that exist and why. This is why it is so important that you see as many cases as possible during your clinical years. By building up as many of your own illness scripts of common conditions as possible you will steadily improve your pattern recognition and forward thinking. This can be supplemented by completing virtual patient cases online.

One-Minute Preceptor: Your coach or supervisor (your preceptor) may use this set of micro-skills when they know something about a case that you need to know or want to know. This technique will encourage you to own the problem and identify gaps in your knowledge, skills and attitudes. This can be particularly useful in developing your clinical reasoning skills where the ability to process information and test hypotheses are very important. Your coach or supervisor will spend no more than one minute asking the following questions:

1. Get a commitment from you.

Ask you to commit to what you think is going on?

2. Probe you for supporting evidence.

Why have you made this decision?

3. Teach you general rules.

One or two.

4. Reinforce what you did right.

Be specific.

5. Correct one or two errors you have made (if any!).

Tell you what you did not do right.

Tell you how to improve for the next time.

Half and Half: Your coach or supervisor may suggest you stay for half the ward round or surgery and then work towards an agreed learning objective for the second half with a view to reporting back at the end of the round or surgery. For example for the half of the round/surgery you could complete a **'One minute paper'** using your notepad on each case. After each case you spend no more than one minute answering the following questions: What were the two most significant things you learned? What question/s remains/s uppermost in your mind? What do you still not understand?

Shadowing: Your supervisor may ask you to shadow your coach or other team member performing their clinical activities (pharmacist, staff nurse, practice nurse, ANP) during and immediately after the ward round or surgery. Again, this is an opportunity to complete your CAPS.

****** If your supervisor has the appropriate time then they may invite you to a **'Teaching Round'**. This takes on a different format to a 'Business Round'. More information of what to expect can be found in this paper which is available with your GUID: Muhammad Ali Abdool & Don Bradley (2013) Twelve tips to improve medical teaching rounds, *Medical Teacher*, 35:11, 895-899

BUSINESS CLINICS in Hospital or Community Settings

Just like ward rounds learning and teaching in outpatient clinics can be serve as excellent supervised learning event. During a clinic you can exposed to a large amount of clinical material over a relatively short period of time that you may not have had the opportunity to see in the inpatient setting (for example the management of chronic illness). In an outpatient setting, patients may be well and this can give you an insight into how illness impacts daily living. Your coach or supervisor will be allocated a relatively short amount of time with each patient (around 30 minutes for a new patient and 15 minutes for a return patient) and therefore it can be stressful for them to run the clinic to time for patients. **Many of the techniques outlined for the business ward round will work for a business outpatient clinic** although task allocation (other than observation) is often not possible with time and space in the clinic setting at a premium (hence why teaching clinics are such a rarity). Sitting in with your coach and supervisor is likely to be your only option. If this is the case it is important that you sit strategically in the consultation room so that you are able to make eye contact with both your coach/supervisor and the patient. This will encourage you to be active participant rather than passive observer. Again it is important that you purposely reflect on the experience soon after a supervised learning activity to direct learning away from the clinic. Your coach or supervisor may agree a learning objective to complete and discuss at your next scheduled encounter. Additional methods of learning and teaching at clinic are as follows:

Boomerang: Your coach or supervisor may ask you to follow the patient to investigations or during review by other members of the multi-disciplinary team and then report back. For example in a fast track TIA clinic or Diabetes return clinic.

Tag-Team: Your supervisors may ask you to rotate between clinic rooms to increase your exposure to different consultation styles, level of experience and/or sub-specialty expertise.

Shuttle: Your supervisors may ask you to breakout for self-directed study in a central area and then call you in to see interesting cases as they arrive.

Post clinic meeting: Some clinics will have short focused post clinic meetings to discuss cases reviewed by postgraduate trainees or interesting or complex cases. Ask your supervisor if you can participate. **It is important not to miss out on this opportunity should it arise.**

THEATRE

Attending the unfamiliar environment of the operating theatre for the first time as a medical student can be daunting. Preparing for your time in theatre, however, can help you overcome any perceived barriers to this supervised learning experience that has the potential to transform your surgical attachment. Learning and teaching in theatre can be maximized as follows:

Get familiar: Your coach or supervisor should give you a guided tour of the department so you know where you are. This should include the changing room (and the necessary attire), the pre-operative bay, anaesthetic room, correct theatre, scrubbing area (an ideal time to learn how to scrub up correctly and how to work within the sterile environment), recovery bay and coffee room.

Know the procedure and follow the patient: Most elective surgeries are admitted to a 'same day admission' area on the day of their operation, having undergone pre-operative assessment a week or two before. Finding out which cases are on when you will be in theatre in advance will allow you to familiarize yourself with the anatomy and pathology of this case, as well as their investigations. You will normally have the opportunity to speak to and examine the patients before they are taken through to theatre, where you can usually see their anesthetic. If a catheter or NG tube is required before their operation starts this may be an opportunity to perform or observe a procedural skill. Reviewing the patient before their operation, seeing their procedure and visiting them on the ward afterwards allows for a good portfolio case and understanding of the patient journey.

Avoid syncope: This is not uncommon with one study finding that around 1 in 10 of students reported an episode of near or actual syncope. Standing in one spot in a warm operating theatre for long periods of time can be taxing to your autonomic nervous system. Try and keep well hydrated and have something to eat beforehand. If you any prodromal symptoms make sure to let someone know in good time and they will direct you to somewhere safe to sit.

24) Near Peer Teaching Programme

The **'Near Peer Teaching Programme'** was established in 2014. The aim of the programme is to encourage Foundation trainee's participation in clinical teaching across the region, whilst providing a means of assessing and enhancing the quality of teaching.

Foundation trainees attend a **'Training Days'** to gain some grounding in teaching theory, as well as practical skills. Following this training, tutors create teaching events which are advertised to you via an easy-access online system, allowing you to register for the event. The system collates feedback and teaching activity across the region. By participating in the programme you should benefit from teaching provided by clinical teachers nearer to your level of experience, and in turn help Foundation trainees practice their skills, gain experience and get invaluable feedback.

Foundation trainees develop a teaching event based on an area of the undergraduate curriculum. This works on a 'first come first served' basis. We recommend 4-6 students per event. The event is advertised on the **'Tutorial Booking System' (TuBS)**, where you can sign up and access any details of venue/time/required equipment. Please ensure that the event doesn't not clash with the timetable you have agreed with your Educational Supervisor. Following the event, you can provide feedback via TuBS, which will generate a certificate of attendance which can uploaded to GUMeP. The Foundation trainee can then also generate a certificate of teaching with a summary of your feedback. We can then collate your feedback to assure the quality of the programme. **Please sign up to TuBS via https://tutorialbooking.com/** to receive email alerts of new upcoming events. We recommend that you log on to review the event list at least a couple of times per week to maximise your learning opportunities. Some events maybe circulated via Moodle also. To find out more information about the programme please use the contact:

foundationteachers@gmail.com

james.boyle@glasgow.ac.uk

25) Sports and Physical Activity

We know that the setting of a good work-life balance helps keep doctors happy, healthy, and highly functioning. In this regard, the School of Medicine is keen that students adopt healthy habits from the earliest of stages in their career. Wednesday afternoons have always been regarded as the traditional time for weekday University sports, if we expect you to keep busy outwith the hours of 9-5, then it is reasonable that you can take time to look after yourself. In short, if you can take part in sports without harming your learning opportunities, it is in your interest to do so. This is not permission to skive or (metaphorically) soft pedal, but a way to get you into the habit of combining hard work and hard play.

26) Clinical Years Reading List

Please review Booklist **here.**

27) Assessment Forms

Next page contains exemplar forms for Mini-CEX, CbD, Objective Long Case, and End of Block Assessment Form.

Mini-CEX (Glasgow)

Students are required to complete at least 2 Mini-CEX (1 History & 1 Examination) by the end of block assessment and feedback session. It is the student's responsibility to organise this.

(Anonymised data may be used for research, audit or evaluation

Trainee's Name:

Firstname Lastname

Date*:

01/02/2024

Assessor's Name*:

Assessor's position*:

-- Please Select --

Assessor's registration number (if appropriate):

Assessor's email*:

Have you been trained in providing feedback?*:

- Yes
- No

Clinical setting*:

-- Please Select --

Patient problem/diagnosis*:

Focus of encounter*:

- History
- Examination

Case complexity*:

- Low
- Middle
- High

Please rate the following areas. All 'below expectations' scores must be justified in the comments box at the foot.

U/C if you have not observed the behaviour and feel unable to comment.

History Taking: (Elicits history and allows patient to elaborate / Asks relevant clinical questions / Current treatment, allergies / Past medical history and family history / Social history including risk factors)*:

- Below Expectations
- Around Expectations

- Above Expectations
- U/C

Physical Examination: (Obtains verbal consent for physical examination / Performs physical examination appropriately and completely / Uses relevant instruments in a competent manner)*:

- Below Expectations
- Around Expectations
- Above Expectations
- U/C

Communication Skills: (Uses clear understandable language / Shows appropriate non-verbal skills during the interview / Shows appropriate rapport/empathy)*:

- Below Expectations
- Around Expectations
- Above Expectations
- U/C

Clinical Judgement: (Uses relevant details to confirm or refute working diagnoses / Sets up acute management plan and explains problem prioritisation / Makes rational use of investigations to help identify pathophysiology / Utilises drug therapy safely and rationally)*:

- Below Expectations
- Around Expectations
- Above Expectations
- U/C

Professionalism: (Checks patient's name and gives name / Responds appropriately to patient perspectives)*:

- Below Expectations
- Around Expectations
- Above Expectations
- U/C

Organisation/Efficiency: (Exhibits well organised approach / Sensible management of interview time and interaction)*:

- Below Expectations
- Around Expectations
- Above Expectations
- U/C

Overall Clinical Care: (Makes appropriate long term management plan including team working where appropriate)*:

- Below Expectations
- Around Expectations
- Above Expectations
- U/C

Student's comments on performance on this occasion:

Assessor's comments on performance on this occasion (please focus on those areas performed well and also identify areas for development)*:

Agreed actions:

This information is shared with the student and the educational supervisor.

Contributor Name*:

Contributor Designation / Job Title*:

Contributor Registration Number (e.g. GMC, NMC, GDC):

Contributor Email Address*:

CbD (Glasgow)

The student is required to complete at least one CbD before the end of block Assessment & Feedback Session. It is the student's responsibility to organise this.

Anonymised data may be used for research, audit or evaluation.

Trainee's Name:

First name Last name

Date*:

01/02/2024

Assessor's Name*:

Assessor's Position*:

-- Please Select --

Assessor's Registration Number:

Assessor's Email*:

Have you been trained in providing feedback?*:

- Yes
- No

Clinical Setting*:

-- Please Select --

Patient problem / diagnosis*:

Focus of Encounter*:

-- Please Select --

Case Complexity*:

- Low
- Middle
- High

Please rate the following areas. All 'Below Expectation' scores must be justified in comments box. U/C if you have not observed the behaviour and feel unable to comment.

Clinical Assessment: (Understood the patient's story / Made a clinical assessment based on the appropriate questioning and examination)*:

- Below Expectations
- Around Expectations
- Above Expectations

U/C

Investigation and referral: (Discusses the rationale for the investigations and necessary referrals / Understands why diagnostic studies were ordered and performed, including the risks and benefits in relation to the differential diagnosis)*:

Below Expectations
Around Expectations
Above Expectations
U/C

Treatment: (Discusses the rationale for the treatment, including the risks and benefits)*:

Below Expectations
Around Expectations
Above Expectations
U/C

Follow-up and future planning: (Discusses the rationale for the formulation of the management plan including follow-up)*:

Below Expectations
Around Expectations
Above Expectations
U/C

Professionalism: (Discusses how the care of this patient, as recorded, demonstrated respect, compassion, empathy and established trust / Discusses how the patient's needs for comfort, respect and confidentiality were addressed / Discusses how the record demonstrated an ethical approach, and awareness of any relevant legal frameworks)*:

Below Expectations
Around Expectations
Above Expectations
U/C

Overall Clinical Care: (A global judgement based on the above question areas)*:

Below Expectations
Around Expectations
Above Expectations
U/C

Student's comments on performance on this occasion:

Assessor's comments on performance on this occasion*:

Please focus on those areas performed well and also identify areas for development.

Mark for Excellence?*:

Yes
No

Agreed Actions:

This information is shared with the student and Educational Supervisor.

Objective Long Case Assessment (Glasgow)

Trainee's Name:

Firstname Lastname

Date*:

01/02/2024

Assessor's Name*:

Assessor's Position*:

-- Please Select

Assessor's Registration Number*:

Assessor's Email*:

Long Case Title*:

Case Complexity*:

- Low
- Moderate
- High

Please rate the following areas:

Professional Approach to Patient (Uses an appropriate approach with introductions and verbal consent gained. Establishes trust and provides clear instructions. Demonstrates awareness of any mental and physical discomfort and is appropriately compassionate and empathetic)*:

- Above Expectations
- Around Expectations
- Below Expectations

HISTORY TAKING (Elicits the history in a fluent, timely, efficient and systematic way complete with details of presenting complaint, history of presenting complaint etc) *:

- Above Expectations
- Around Expectations
- Below Expectations

The history is accurate with the correct facts established*:

- Above Expectations
- Around Expectations
- Below Expectations

PHYSICAL EXAMINATION (Performs a directed examination in a timely, efficient and systematic way demonstrating correct examination technique)*:

- Above Expectations
- Around Expectations
- Below Expectations

Confirms correct examination findings:

- Above Expectations
- Around Expectations
- Below Expectations

CASE PRESENTATION (Records details of the history and examination in a legible, orderly and accurate way)*:

- Above Expectations
- Around Expectations
- Below Expectations

Summarises the case clearly and accurately*:

- Above Expectations
- Around Expectations
- Below Expectations

CLINICAL ACUMEN (Identifies an orderly list of problems and offers a logical differential diagnosis)*:

- Above Expectations
- Around Expectations
- Below Expectations

Describes a logical sequence of investigations*:

- Above Expectations
- Around Expectations
- Below Expectations

Describes an appropriate management plan and demonstrates knowledge of therapeutic options*:

- Above Expectations
- Around Expectations
- Below Expectations

Student's comments on performance on this occasion*:

Assessor's comments on performance on this occasion*:

Agreed Actions*:

Contributor Name*:

Contributor Designation / Job Title*:

Contributor Registration Number (e.g. GMC, NMC, GDC):

Contributor Email Address*:

End of Block Assessment (Glasgow) 2023-2024

Trainee's Name:

First name Last name

Supervisor's Name*:

Supervisor's Email Address*:

By completing this form you are confirming that you are in a position to make an informed decision on this student's performance in this block. If you do not feel able to do this, please email the relevant Year Team for the form to be re-allocated.

- **Year 3:** med-sch-y3mbchb@glasgow.ac.uk
- **Year 4:** med-sch-y4mbchb@glasgow.ac.uk
- **Year 5:** med-sch-y5mbchb@glasgow.ac.uk

Location*:

Block Speciality*:

-- Please Select --

Once submitted, this form is stored in the student's ePortfolio account.

Professional Attributes

A: Attendance and Reliability:

- Above Expectations
- Around Expectations
- Below Expectations

B: Ability to manage own learning:

- Above Expectations
- Around Expectations
- Below Expectations

C: Relationship with team:

- Above Expectations
- Around Expectations
- Below Expectations

Clinical Competence

D: Knowledge:

- Above Expectations
- Around Expectations
- Below Expectations

E: History Taking:

- Above Expectations
- Around Expectations

- ○ Below Expectations

F: Clinical examination skills:

- ○ Above Expectations
- ○ Around Expectations
- ○ Below Expectations

G: Clinical reasoning:

- ○ Above Expectations
- ○ Around Expectations
- ○ Below Expectations

H: Communication skills:

- ○ Above Expectations
- ○ Around Expectations
- ○ Below Expectations

Formal Assessment

I: Standard of Portfolio Cases:

- ○ Above Expectations
- ○ Around Expectations
- ○ Below Expectations

J: Mini CEXs:

- ○ Above Expectations
- ○ Around Expectations
- ○ Below Expectations

K: Cased-based discussion:

- ○ Above Expectations
- ○ Around Expectations
- ○ Below Expectations

L: Long Case (Senior Medicine only):

- ○ Above Expectations
- ○ Around Expectations
- ○ Below Expectations

M: Has the student reached the required level of supervision in each of the Clinical and Procedural Skills - CAPS (see logbook)?:

- ○ Yes
- ○ No
- ○ N/A

If no, please list clinical skills not completed:

N: Was this form filled in by student and Educational Supervisor together?*:

- ○ Yes
- ○ No

O: Overall rating*:

- ○ All placement objectives achieved with Merit
- ○ All placement objectives achieved
- ○ Not all placement objectives achieved - specify next course of action below

Next course of action if objectives not achieved:

If you have selected Below Expectations for any domain from A-H above please select appropriate next course of action from the list below. Please note that if 3 or more domains are ticked as Below Expectations, a meeting with the Year Director will take place to follow up:

-- Please Select --

Please comment on your response below. Please outline any additional time/assessments the student is to undertake if relevant:

All placement objectives achieved with Merit if you are recommending this student for a merit, please note the reason below, keeping your description to c20 words. A merit can be granted for activities including (but not limited to):

- Extra attendance / involvement in e.g., on-call activity
- Presenting at unit meetings
- Writing an audit
- Completing a piece of written work (e.g., case history, case series)
- Significant contribution to the handling of a difficult or particularly complex case

What did the student do well?:

What areas need to be improved?:

Did this student's performance (knowledge, skills, attitudes and behaviours) suggest they are making continuous progress towards being a trusted member of a clinical team? If the answer is No, please outline why.*:

- Yes
- No

Please comment on your response above:

Feedback to team: Has the student completed the electronic feedback for this block?*:

- Yes
- No
- Don't Know

Supervisor has reviewed student's Turnitin Report for portfolio cases*:

- Yes
- No

Contributor Name*:

Contributor Designation / Job Title*:

Contributor Registration Number (e.g. GMC, NMC, GDC):