Warwick
Medical School

MB ChB Phase II

Clinical Teachers Guidance

2010

Foreword

This document sets out briefly the structure of the 4-year graduate entry accelerated MB ChB Warwick Medical Schools course and more specifically the organisation of the Phase II part of the course. It is aimed to summarise, but not replace, information from a variety of sources including the Phase II Course Document ("The blue book") and the on-line Code of Practice for assessment in Phase II. Definitive answers for specific curricular and assessment issues are contained in the course documents and codes of practice.

It has been put together to provide you with a reference companion for your clinical teaching. If you have any questions please refer to the relevant section in this document and the accompanying Phase II Course Document in the first instance. If this does not answer your query then please contact either the local Undergraduate Co-ordinators, Associate Clinical Directors, Director of UG General Practice Medical Education or other appropriate local teaching Lead, or us directly. Our contact details can be found in Appendix A.

The publication of this new guide coincides with key changes in the student portfolio system, the end of block assessment form for students and the arrival of International Medical School (Malaysian) students. Those involved in supervising student portfolios or supervising them on their clinical blocks should read sections 2.1, 6 and 8 and appendices D, E, F and G before the start of block 1 in March 2010.

Thank you for your continued support. We hope you enjoy your teaching role.

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Professor of Clinical Education and Research
Director of Institute of Clinical Education
Warwick Medical School

Dr Colin Macdougall
Phase II Co-ordinator
Associate Professor in Medical Education

Contents

1 Overall structure of the course

The course is divided into 2 parts, Phase I and II; Phase I lasts 1.5 years and Phase II lasts about 2.5 years. These are not the same as the old pre-clinical and clinical courses as much clinical work, including pathology and Clinical Skills are in Phase I. The main distinction is the site where students learn. Phase I is mainly at the Medical Teaching Centre at University of Warwick and the Clinical Sciences Building at the University Hospital in Coventry. In Phase II learning is almost entirely in clinical areas, hospitals, community trusts and general practice.

The overall approach to both Phases has been to apply modern educational ideas to the medical course. In particular the course has been planned in 3 stages:

- The setting of objectives - what do the students need to be able to do?
- Developing the learning framework - how are they going to learn how to do it?
- Developing methods of assessment - how do we (and they) know that they have?

These stages must be congruent with each other. If the objectives are not clear, students will use other sources (usually other students) to find out what to learn, and that information may or may not be accurate, and teachers have no guidance for provision of learning opportunities. If the learning framework is inappropriate then students and teachers become frustrated. If the assessment is not of the objectives then the whole course is destroyed, as students will always work to the assessment.

2 What will students have done by the time they get to Phase II?

Students who enter the course via Warwick University are all graduates.

Phase I is a modular course and is outlined below. The modules cover all the major systems of the body (including pathological and clinical topics), social and behavioural sciences and public health. For a detailed and current description of each module please refer to the Warwick Medical School website – http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb

Semester 1	Semester 2	Semester 3
Essentials of Clinical Medicine	Clinical Skills 2	Clinical Skills 2
Health in the Community	Health Psychology	Values in Medicine
Gastrointestinal System	Infection and the Immune System	Introduction to NHS
Health and Disease in Populations	Musculoskeletal System	Mechanisms in Clinical Pharmacology
Molecules and the Human Body	Cardiovascular System	Urinary System
Clinical Skills 1	Reproductive System	Human Lifespan
Inter-Professional Learning Pathway	Mechanisms of Disease	Neurobiology
Histology & Embryology	Developing Interview Skills for the Consultation	Respiratory System
Integrated Learning	Integrated Learning	Special Study Module
		Integrated Learning
CASSM		

Clinical Stream

In the first year students have undertaken a course on communication skills and clinical examination of the normal subject. Students then complete the Clinical Skills Course which is a hospital-based 'half-day attachment' running over 24 weeks from November to June with an additional 6 week refresher course in September/October. Students must pass an assessment in this to proceed. By the time they start Phase II students should therefore have a good grounding in clinical history taking and examination of both the normal and the abnormal.

2.1 International Medical University, Malaysia, Students

In common with a number of mainly UK, US and Australian medical schools, Warwick Medical School will be accepting a small number of medical students from the International Medical University (IMU) in Malaysia directly on to Phase II of the Warwick Medical School MB ChB course. These students will begin Phase II with the current 2008 cohort of students in January 2010.

These new students will be subject to the same rules, regulations and procedures as our current Warwick Medical School students. It is possible that the numbers will increase over coming years but we do not expect to take more than ten students in any one year.

2.1.1 Background of the students and integration to the course

The students will carry out their basic training in Malaysia, and then come here to complete their clinical training. This includes a version of phase 1 of our course. Training opportunities are limited in Malaysia and this is an opportunity for these students to gain valuable clinical experience in a UK healthcare setting. The Malaysian students will have completed an equivalent level of education and training to qualify for our graduate-entry course including graduating with a BMedSci. In addition, we will also run a short course for these students to ensure they are integrated into the UK health care system.

Prior to their arrival we will be providing them with information about Phase I of the course and as soon as they arrive we will be providing them with an induction programme designed to ensure that they are well prepared to enter Phase II. This is led by the Medical School IMU coordinator (details in Appendix A) who can also provide advice if there are concerns about any of these students in the first few months after their arrival on the course. Once they complete phase II, we understand that they will be eligible to apply for a Foundation Programme in the UK.

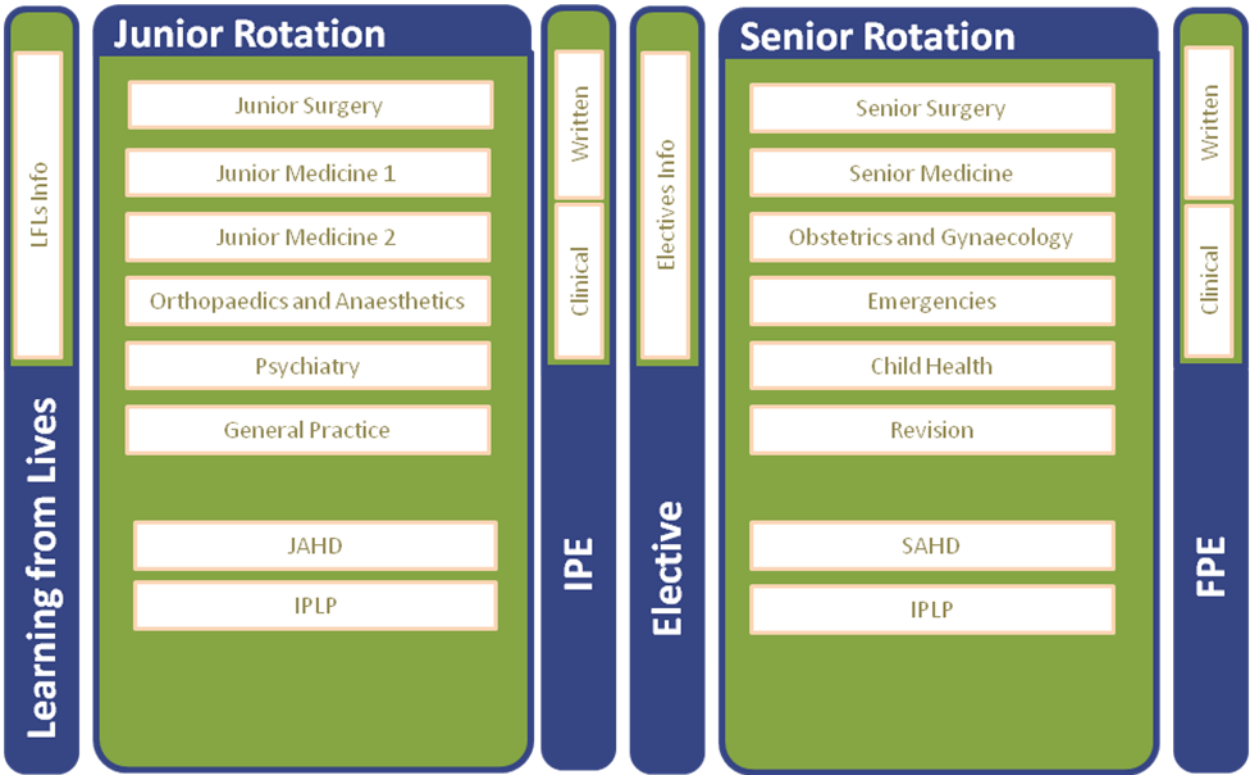
2.1.2 Expectations of IMU students

IMU students entering phase II will have an equivalent level of preparation to the local WMS students they will be joining. They will also have a brief transition course to orient them to the local NHS and to UK clinical settings. It is likely, however, that they will take a few weeks to adapt to the pattern of clinical learning in the UK and therefore may need some extra consideration and guidance during their first few blocks.

Any concerns about individual students, whether IMU entrants or those who have completed phase I at WMS should be dealt with as outlined elsewhere in this guide.

3 Structure of Phase II

Phase II starts with a 3 week period of multi-professional learning ‘Learning from Lives’. There then follows a Junior and then a Senior Rotation:



The Junior Rotation

This runs from January of Year 2 to Easter of Year 3.

- Students start with a transitional service user, community based block, Learning from Lives.
- They then complete six 8-week attachments. These consist of four blocks of General Clinical Education (Junior Surgery, Junior Medicine 1, Junior Medicine 2, Orthopaedics & Anaesthetics), plus one block of Psychiatry and one block of General Practice teaching. At the end of the Junior Rotation students take the Intermediate Professional

Examination (I.P.E.) involving clinical cases and a written examination, which students must pass to continue with their studies.

The Senior Rotation

- All students have their elective block immediately after the Intermediate Professional Examination.
- Students then progress into six further 8-week attachments. These consist of one block of Obstetrics and Gynaecology, one block of Child Health and four blocks of General Clinical Education (Senior Medicine, Senior Surgery, Emergencies, Revision).
- The Emergencies and Acute Care block has been recently developed as a new general block.
- Block 12, immediately prior to finals, is a general block for all students and is structured as a revision and review block and includes a short revision course and ‘mock’ clinical and written examinations.

In April/May of Year 4 students undertake the Final Professional Examination (F.P.E.) followed by a period of Foundation doctor (F1) shadowing and supported teaching known as ‘Additional Clinical Practice’ (ACP).

4 Objectives for Phase II

4.1 Objectives

The objectives for Phase II are set out in the Phase II Course Document (“the blue book”). They are stated in general terms in the first part of the document and in more detail later. The objectives are all expressed as 'competencies' i.e. that students should be able to do something in a satisfactory way. If they can, then they must also possess the relevant background knowledge. They mostly also express a level of how well students should perform; for example either acting alone or with others; to initiate management or to manage a problem alone. They have been developed by a large number of senior staff, junior doctors and students. There are no speciality labels in these objectives; the divisions are body systems.

4.2 How should students plan their learning?

The Phase II course is very flexible. The ‘General Clinical Education’ blocks allow students to get to know a department and their teachers well and vice versa. To get the necessary breadth to their learning, however, students need to be aware of how they are doing and how to address their learning needs. This requires input from their Clinical Educational Supervisor but also all their teachers.

All students have an identified Clinical Educational Supervisor (see sections 10 and 11). This individual will meet them throughout Phase II of the course. The role is primarily about helping them assess their educational needs and plan their learning and is additional to their day to day clinical teachers.

The Clinical Educational Supervisor is also a key person for pastoral care, advice and careers support and may be a useful contact if you have concerns about a student that cannot be addressed via the other feedback and assessment systems.

4.2.1 Learning Planning

With the Clinical Educational Supervisor’s support, students should turn up at an attachment with a learning agenda. They will record the key points of this on the block feedback form (see section 8.1 and Appendix D). Students and teachers will need to discuss these flexibly – students cannot expect a given teacher to deliver on every educational need they have identified and teachers cannot expect students to slot into a rigid attachment which does not reflect the student’s strengths and weaknesses.

4.3 What should consultants do about the objectives?

The objectives are primarily for the benefit of the students and it is largely their responsibility to plan how to meet them with the support of their Clinical Educational Supervisor. Many can be met in a variety of clinical situations including General Practice. Consultants can assist by reviewing each student's achievement at the start of each attachment and pointing out which new objectives can most readily be met on their unit. Progress can then be reviewed during the block, when the portfolio presentations are undertaken and at the end of block assessment meeting.

5 General Clinical Education Blocks

5.1 Concept of General Clinical Education Blocks

Although the concept of clinical attachments in medical education goes back generations there has often been little thought about what should happen in them. The course therefore has a more explicit structure and purpose than is usual particularly in the 'general clinical education' blocks. The features contained within the General Clinical Education blocks are *'partnership arrangements'* and the '*portfolio*' concept (section 6).

Most clinical teachers will be involved in providing General Clinical Education Blocks. The title subsumes general medicine, general surgery and all the medical and surgical specialities. In order to stress the general nature of medical education the blocks have no sub-speciality labels, although there is an appropriate split between those that are broadly 'medical' and broadly 'surgical'. One block is a mixture of Orthopaedics and Anaesthetics.

5.2 What are students expected to do on the General Clinical Education attachments?

Students should clerk patients, attend ward rounds, clinics and theatre sessions. They should involve themselves in the acute 'take' and in the day to day work on the wards with junior and senior staff. In recent years there has been an erosion of these traditional duties and this should be resisted. The reasons behind this erosion are many but include part-time attachments, the break-up of the traditional 'firm' structure, and NHS reforms with an emphasis on increased throughput and efficiency. You should help students plan an appropriate amount of out of hours and 'on take' duties and can rightly expect students to attend.

5.3 Teaching partnerships

Students are attached in each block to a teaching 'partnership'. Each partnership normally consists of a physician who accepts 'acute take' patients and a sub-specialist physician. Attachments in surgery are currently under review and use slightly different models in Junior and Senior rotations. Students are nearly always attached in pairs; this is the best ratio of students to teachers and patients in the country but is only achieved using attachments from a wide range of specialities.

The partnership idea is an attempt to get round a fundamental dilemma in clinical education. Students can either be attached for long periods to relatively few units or for short periods to many. The former emphasises the apprenticeship model but may narrow experience. The latter the reverse. Long attachments also help to foster appropriate attitudes. By forming partnerships between consultants with differing interests and making attachments relatively long-term the aim is to have the best of both worlds. All the partnerships consist of at least two consultants. The model is for at least one to be a 'generalist' with acute take responsibilities and the other 'specialists'. Although not a strict division, the first teach mainly on in-patients and the second mainly on out-patients. Although the prime responsibility for teaching is on consultants, junior staff particularly Specialist Registrars should also be involved.

5.4 How are the partnerships supposed to work?

It is essential that the partners agree a realistic weekly timetable for the students. This should be based around the commitments of their firms. It is not necessary to fill all the time, indeed one half-day should be kept free for students to work on portfolio cases (see later). For Junior Rotation students Tuesday afternoons, and for Senior Rotation students Friday afternoons are reserved for the 'Academic Half Day' (see section 7). Out-of-hours 'on take' or emergency experience should definitely be included. The week does not have to divided equally between the consultants indeed usually students will require more time with the 'generalist' to enable them to follow the in-patients through their stay. Students can legitimately negotiate changes to the timetable to meet their objectives assuming changes can be accommodated. This must be negotiated and agreed in advance, preferably at the start of the block. Students may also wish to attend teaching or clinics outside the partnership. This should again be planned with you and appropriate.

Problems have arisen when students are expected by their various consultants to be in two places at the same time. An agreed timetable should avoid this. Although there is always the unexpected, in general, timetabled sessions should either take place or be cancelled with sufficient notice to enable students to plan something else.

At the beginning of a new attachment try to:

- look at the timetable to ensure it remains practical
- establish any weak spots the student has recognised and identify how these can be worked on

- be aware that students generally have a high regard for consultants and give enormous weight to their comments, even those that may have been intended as trivial. It is not acceptable to humiliate students, nor is it acceptable to undermine the efforts of the Medical School or of colleagues.
- encourage the students to be self motivated and to take advantage of every opportunity to learn.
- ensure students are clear about the 'out of hours' attendance appropriate to learning in your clinical team.
- book time with students to teach them and to listed to and feedback on their portfolio presentations. This is particularly important as they must present the case to you and can therefore no longer submit a portfolio case on paper after the block has finished.

During the attachment you should:

- supervise the students portfolio cases and try to ensure a good patient mix
- consciously involve the students in bedside teaching on wards (on call and on ward rounds)
- encourage the students to shadow other members of the healthcare team to gain experience
- give students precise information regarding when and where to meet for teaching sessions
- be explicit about your expectations regarding their preparation for a session
- be aware of the students prior learning and of the course requirements (the Phase II Course Document will assist you with this)
- discuss with students how they are doing – both positive and negative issues – whenever they are with you
- discuss difficulties with or concerns about the course or other teachers with your Undergraduate Co-ordinator, Specialty Lead, Associate Director of Studies in your Trust or the Phase II Co-ordinator.

Towards the end of the attachment you should:

- ensure you are able to meet your students to give them formal feedback and assessment and to discuss the experience they have had during the block

5.5 What is the place of ward-based tutorials?

The best tutorials are usually those that take a clinical case-based rather than a disease-based approach. Sometimes however, tutorials to a large group of students are used as a substitute for bedside teaching. This is very much the exception as students can learn facts from books but they can only learn clinical medicine at the bedside and then only if they have feedback on their performance.

Most skills are general skills acquired throughout the course but some more specific skills are best learnt in sessions which are specially timetabled at the beginning of each 8 week block. They should be strictly confined to the teaching of skills not knowledge. Skills in neurology, ENT and ophthalmology are good examples. Giving students the skills they require when they require them will help them make the most of their attachment.

5.6 How much teaching should I be giving the students?

Your individual teaching commitment will be defined in your job plan and this will be agreed between your Associate Director of Studies and the responsible authority in your organisation. For guidance a consultant participating in a teaching partnership can expect to deliver 4 hours of face to face teaching per week and have in their contracts further time allotted for participation in other Medical School activities such as examinations.

6 Portfolios

6.1 The Portfolio concept

This is discussed in detail in the Phase II Course Document and in Appendix E and F of this document. The aim of clinical learning overall is that students should learn primarily from their patients. The idea of the portfolio system is that each student focuses on 36 specific patients during their clinical course and uses the guidance to record and present their clinical thinking and to explore additional issues of evidence base, ethics, epidemiology etc. Having presented the case, the student also receives detailed and constructive feedback. The Course Document lists a number of presentations which students should focus on. These have been chosen deliberately as presentations not diseases and should lead students to think critically about the possible disease processes which underlie each presentation. Students often need help on selecting appropriate patients. The balance of their portfolios will also be reviewed by the student's Clinical Educational Supervisor.

Students are required to compile a portfolio of 36 case studies during Phase II, of which at least 20 case studies must be completed and presented by the time of the Intermediate Professional Examination (I.P.E.). Those failing to complete the required number will be subject to a penalty at the discretion of the Academic Progress Group.

6.2 How should consultants use the portfolio concept?

The portfolio system works best if teachers are able to review each patient with the student at the bedside as part of their regular teaching session and the analysis sections can then become a distillate of the discussion between teacher and student. The Course Document has a suggested timetable for this.

Portfolios must also be presented before the end of the Block. Dates and times need to be booked with your students well in advance to ensure this happens.

6.3 Will students spend too long on the portfolio to the detriment of other work?

Students sometimes see the writing up process as a un-necessary chore that takes them away from the wards. However, without such a concrete endpoint the exercise would probably soon go by default. Further, the writing process itself; particularly the writing of the analysis sections should prompt critical thinking by students and help to fix details in the mind. However portfolio work must not be to the detriment of other experience. The standard is not that of a presentation but that of the routine house officer clerking with the clinical thinking made clear. There are also strict word and time limits on the process (see guidance in the Phase II Course Document).

7 The Academic Half Day

This is the only large-group teaching in Phase II. It takes place in the lecture theatre in the Clinical Sciences Building at UHCW. There is a Junior programme on Tuesday afternoons for students in the Junior Rotation (2nd/3rd years) and a Senior programme for Senior Rotation students (3rd/4th years) on Friday afternoons. Both use a lecture-based format followed by case discussions either in large or small groups.

The Junior programme is built around 'Images of Disease' and combines the insights of pathology (in its widest sense) and radiology in making disease processes clear to students. The Senior programme is devoted to Pathology and 'Management' including therapeutics.

Academic Half Days are a compulsory element of Phase II and student attendance is carefully monitored. Student's timetables should therefore ensure they are able to attend.

If you are interested in leading an Academic Half Day session please contact the Phase II Office who will put you in touch with the Junior or Senior Academic Half Day lead.

8 Assessment

8.1 Formative Assessment

Formative assessment is information given to the student to help them learn and develop. To learn effectively, students need to be aware of their strengths and weaknesses. This requires good quality information and guidance from their clinical teachers. Whilst this needs to be done supportively, it doesn't help students if they are unaware that teachers have concerns about them. Also, many students worry that they are not performing well when there are no concerns and this cause unnecessary distress or causes them to focus on the wrong areas of their learning.

Although such feedback should be integral to all teaching encounters, clinical supervisors need to feedback to their students more formally in the middle of each block of teaching and to record strengths and areas of development on the end of block assessment form (see Appendix D). This is a formal record of these issues for the student's benefit, not a substitute for ongoing day to day feedback. Please note, if you are concerned about a student you should seek advice during the block (see section 11).

8.2 Summative Assessment

Summative assessment is for formal tracking and assurance of progress and of course completion.

Students are assessed at the end of each block. This is by means of a form which needs completed at the end of the block (see Appendix D). The forms have changed recently and teachers should read the guidance on completion and grading on the back of the form carefully (Appendix D)

The key changes are:

- Clinical teachers need to simply log the number of portfolio cases completed during the block. A grade is no longer required. Please see the guidance on portfolios (Appendix E). Importantly, any concerns that the student may have not seen the case described or that any of the presented material is not their own work must be notified to the school office (details are on the portfolio feedback form, appendix G).
- There is a new section for students to complete at the start of the block. You should remind them to show this to you.
- There is now an additional grade of 'Good' between satisfactory and excellent.
- There are clear grade descriptors on the back of the form (see appendix D). Please check these every time you grade a student to ensure you are grading them appropriately and equitably.

Additional notes

Feedback forms and grades are most use if they are the written record of a more detailed discussion. Students disserve to know the basis of any judgement you have made. If you record concerns (Borderline or Unsatisfactory) you must give examples to help the student understand the nature of your concern. It is also very helpful to give examples of where things have gone better, in order to give a balanced picture of performance and capability. Students who are unsatisfactory in a block will undergo more extensive testing in the extended summative clinical examinations described below.

8.2.1 Examinations

There are two summative examinations in Phase II. The Intermediate Professional Examination (I.P.E.) is in Spring, usually March, of the 3rd year and the Final Professional Examination (F.P.E.) is in April/May of the Final Year. The I.P.E consists of Extended Matching Questions (EMQ) and Multiple Choice Questions (MCQ) and observation of clinical practice and the Final Professional Examination, written papers and observation of clinical practice. The Final written papers will be one paper of short answer questions and one paper of EMQ / MCQ.

8.3 Clinical Assessment

The need for assessment of clinical practice creates a major problem as clinical examinations are difficult to mount and expensive. We therefore use 'sequential testing'. This

tests all students on a specified number of cases. Those who are not clearly satisfactory see additional cases, thus scarce resources are concentrated where they are needed most; in assessing more accurately those students around the pass/fail margin. The second part of the examination is not a re-sit but the collection of more data. All the data is used in reaching a final decision.

The clinical assessments in both examinations are in the same general format. For I.P.E. all students are observed by pairs of examiners consulting with 2 patients presenting with common clinical problems. Where more information on their performance is required students are observed consulting with a further 3 patients. For F.P.E., students are observed by pairs of examiners consulting with 4 patients presenting with common clinical problems and where more information is required students see a further 4 cases.

8.3.1 Intermediate Professional Examination

The examiners first give a brief introduction about the patient to focus the discussion. The student then takes a focused history and performs the relevant examination under observation. The examiners then ask for the likely cause for the problem and an assessment of the underlying pathophysiology. Management questions are not asked. Students also sit a written paper.

8.3.2 The Final Professional Examination

This is similar with 2 examiners observing a focused history and examination for 15 minutes. The student leaves the room and then has a further 15 minutes to compile a problem list and a management plan. The student then returns to the examination room, where the Examiners review the problem list, discuss any available investigations and possible management options a clear structure is provided. The student then explains the problem and management plan to the patient. Assessment in both examinations is by reference to 'consultation competencies'. To give teachers a guide to preparing their students, they are given in full in Appendix H and can be learnt in more detail at the ongoing Examiners Training courses (contact your local Undergraduate Co-ordinator for more details).

Students are also required to sit two written papers for their Finals examinations and complete a satisfactory period of Additional Clinical Practice.

8.3.3 Categories of Competence and Component Competencies for Clinical Assessments

Please see Appendix H for a copy of the Categories of Competence and Component Competencies for Clinical Assessments (adapted Leicester Assessment Package).

9 Feedback

The Medical School has an online feedback system to collect information regarding students' experiences on their attachments. The findings are collated and reports are sent to Associate Directors of Studies and Specialty Block Leads, if relevant. Associate Directors will then share the feedback with consultant partnerships as appropriate including a single summary sheet designed to be included in consultant appraisals. Up to date information can be gained from your local Undergraduate Co-ordinator.

10 Student Support

The Medical School has a variety of mechanisms to assist students as no one mechanism can address all possible contingencies and different students will need to access different assistance in different ways. As a teacher you will often be able to offer much informal and some formal academic, clinical and personal support, careers advice etc. If issues arise that require more input, please consider the following:

- The student's Clinical Educational Supervisor (see Section 4.2 and 11), contact via Senior Tutor and pastoral care co-ordinator, or the student support assistant (contact details in Appendix A)
- The Pastoral Care Co-ordinator (as above)
- The Associate Director of Clinical Studies at your Trust or appropriate Specialty Block Lead and/or the Undergraduate or Specialty Block Co-ordinator (see Key Contacts list on page 18)
- That the student's Phase I Personal Tutor still maintains informal email contact during Phase II and can be contacted via the Phase I Administrative Officer (see Appendix A)

11 Concerns about a student

Where there are academic concerns, these should be discussed with the student in the first instance. They can also be fed into the student's Clinical Educational Supervisor – this contact can be facilitated by the Student Support Assistant or Academic Lead for the Educational Supervisors scheme (see Appendix A). Advice can also be sought from the Associate Directors or Speciality Leads or the Phase II Co-ordinator. If these concerns are significant, the student must be graded as unsatisfactory in an appropriate category (Attendance, Clinical Performance, Attitude) and examples given in the box provided or on an additional sheet if necessary. Where there are personal or pastoral issues the student should be encouraged to approach their Clinical Educational Supervisor or our Pastoral Care Co-ordinator. Clinicians can clearly raise issues with the Pastoral Care Co-ordinator directly although it is usually more appropriate if the student makes the initial contact.

11.1 Health Concerns

During the four year MB ChB course the majority of students will suffer from some health problems. All students are required to be both registered with a General Practitioner and also recognise and address their own health needs.

There are however occasions when a teacher may be concerned about a student's health; this may be either physical or mental health.

It is important to realise that the prime role of a clinical teacher is to teach, offer guidance and to assess students. Clinical teachers should not act therapeutically for a student except in exceptional circumstances (such as being the only specialist available locally for the given condition). They should therefore not offer medical advice or services unless the student is, exceptionally, their registered patient and they should not refer students to other clinicians for advice or treatment.

Having said that clinical teachers have additional skills in the recognition of illness that non clinical teachers in Universities may not have.

Where a student is failing or struggling academically this should always be referred to the block lead, if there is one, or the Phase I or Phase II Co-ordinator as appropriate for the student (see Appendices A and B). This referral should include any useful observations

which could include any concerns about health although this should focus on examples or observations rather than diagnostic hypotheses.

Where there is not an academic concern or failure there are four options.

(a) If a student attends acutely unwell and there is any concern about patient safety they should be sent home. If relevant, they should also be told to attend the local occupational health department. Such instances might include when they may have an infectious disease and there is a risk that they may have already infected patients or other staff. The clinical teacher should make a brief note of this and forward it to the school office and the Medical School.

(b) If there is concern about their own safety (for example, an apparent mental health crisis) the Medical School Office must be contacted. Please call the Phase I Administrative Officer (024 7657 3813), Phase II Administrative Officer (024 7657 4496) or the Assistant Registrar (024 7657 3111) in the first instance. They will contact the Senior Tutor / Deputy Senior Tutor or the appropriate Phase Co-ordinator. Out of normal office hours contact Security on 024 7652 2083 or internal extension 22083

(c) If the health problem is less acute but is felt to be significant and perhaps unrecognised then this should be drawn to the attention of the Senior Tutor at the Medical School. Their details will be available from your local undergraduate office or medical school administrator (Appendix A). This is especially important if the clinical teacher feels there are personal or patient safety issues. Good practice would be to discuss this with the student although in exceptional circumstances this may not be appropriate and the teacher should seek advice from the Senior Tutor. If however the health problem is relatively mild it may be appropriate for the teacher to simply ask of the student whether they have sought appropriate medical advice, and to suggest that they do.

(d) Clinical teachers can also complete a ‘Notification of Concern’ form (appendix C).

12 Summary

Having a local medical school is a challenge but also an opportunity. There is much to do to help our students succeed, but, especially as graduate entrants, they also bring much with them. As a local clinician, you will be increasingly working with our medical graduates and many are now saying the effort is worth it.

There are also many opportunities to improve your teaching skills and, for some, to develop teaching as a key part of their career. More information is available via your Specialty Lead, Undergraduate Co-ordinator or Practice or Trust Lead or the Phase II Office.

Appendix A

Medical School Key Contacts

Title	Name	Contact
Director MB ChB Associate Professor Communication Skills	Dr Jane Kidd	Email J.M.Kidd@warwick.ac.uk Phone - 024 7657 4785
Assistant Registrar	Mrs Lara McCarthy	Email Lara.McCarthy@warwick.ac.uk Phone - 024 7657 3111
Senior Tutor, Academic Lead, Educational Supervisors Scheme, Phase II Pastoral Care Co-ordinator	Ms Deborah Markham	Email d.h.markham@warwick.ac.uk Phone - 024 7615 0206
Student Support Assistant	Mrs Violeta Miller	Email V.Miller@warwick.ac.uk Phone - 024 7615 0475
Phase I Co-ordinator	Dr Phil McTernan	Email P.G.McTernan@warwick.ac.uk Phone - 024 7674 014
Phase I Administrative Officer	Ms Ann Davies	Email A.Davies@warwick.ac.uk Phone - 024 7657 3813
Phase I Assistant	Miss Jenna Curtis	Email J.L.Curtis@warwick.ac.uk Phone - 024 7675 3815
Phase II Co-ordinator	Dr Colin Macdougall	Email Colin.Macdougall@warwick.ac.uk Appointments via Jane Padfield Email Jane.Padfield@warwick.ac.uk Phone - 024 7657 4761
Phase II Administrative Officer	Mrs Sue Cooper	Email S.M.Cooper@warwick.ac.uk Phone - 024 7657 4496
Phase II Assistant	Mrs Jane Padfield	Email Jane.Padfield@warwick.ac.uk Phone - 024 7657 4761
Reader in Clinical Skills	Dr Vinod Patel	Email Vinod.Patel@warwick.ac.uk Phone - 024 7657 3812

General Practice Co-ordinator	TBC	Email GPEducation@warwick.ac.uk Phone - 024 7657 3808
General Practice Assistant	Ms Jane Harman	Email J.B.Harman@warwick.ac.uk Phone - 024 7615 0607
International Medical University, Malaysia (IMU) student coordinator	Dr Linda Maxwell	Email Linda.maxwell@warwick.ac.uk

Appendix B

NHS Trusts Key Contacts

Associate Clinical Director (UHCW)	Mr Ian Fraser	Email Ian.Fraser@uhcw.nhs.uk Phone - 024 7696 8793
Undergraduate Co-ordinator (UHCW)	Sandra Davidson	Email Sandra.Davidson@uhcw.nhs.uk Phone - 024 7696 8793
Associate Clinical Director (George Eliot Hospital)	Dr Asok Venkataraman	Email asok.venkataraman@geh.ac.uk Phone - 024 7686 5141
Undergraduate Co-ordinator (George Eliot Hospital)	Sam Cook	Email Samcook.getec@geh.nhs.uk Phone - 024 7686 5024
Associate Clinical Director (Warwick Hospital)	Dr Chris Marguerie	Email Christopher.Marguerie@swh.nhs.uk Phone -01926 495 321 (Rheumatology Dept)
Undergraduate Co-ordinator (Warwick Hospital)	Jo Williams	Email Jo.Williams@swh.nhs.uk Phone - 01926 495 321 ext 4411
Assistant (Warwick Hospital)	Nicky Hand	Email Nicola.Hand@warwick.swh.nhs.uk Phone – 01926 495 321 ext 8190
Associate Clinical Director (The Alexandra Hospital, Redditch)	Dr Kamal Nathavitharana	Email Kamal.nathavitharana@worcsacute.wmids.nhs.uk Phone - 01527 512 163
Undergraduate Co-ordinator (The Alexandra Hospital, Redditch)	Lorraine Murphy	Email Lorraine.Murphy@worcsacute.wmids.nhs.uk Phone - 01527 503 030 x 44644

Child Health Lead Clinician	Dr Prakash Satodia	Email prakash.satodia@uhcw.nhs.uk Phone - 024 7653 8894
Child Health Administrator	Karen Stanley	Email Karen.Stanley@uhcw.nhs.uk Phone - 024 7696 8794
Psychiatry Lead Clinician	Dr Bart Sheehan	Email B.Sheehan@warwick.ac.uk Phone - 024 7657 4387
Undergraduate Co-ordinator (Psychiatry)	Teresa McIntryre	Email Teresa.McIntyre@covwarkpt.nhs.uk Phone - 024 7696 7931
Obstetrics and Gynaecology Lead Clinician	Dr Sasha Rajendran	Email Sasha.Rajendran@uhcw.nhs.uk Phone - 024 7696 7377
Obstetrics and Gynaecology Co-ordinator	Angela Malin	Email Angela.Malin@uhcw.nhs.uk Phone - 024 7696 8792
Orthopaedics Lead Clinician	Professor Damian Griffin	Email damian.griffin@warwick.ac.uk
Orthopaedics Administrator	Kerry Kyte	Email Kerry.Kyte@uhcw.nhs.uk Phone - 024 7624 6500
Anaesthetics Lead Clinician	Dr Cyprian Mendonca	Email Cyprian.mendonca@uhcw.nhs.uk
Acute/Emergency Lead	Dr Viviana Elliott	Email V.C.Gutierrez-de-Elliott@warwick.ac.uk
Senior Surgery Lead Warwick Hospital	Ms Deborah Markham	Email d.h.markham@warwick.ac.uk Phone - 024 7615 0206
Senior Surgery Lead George Eliot Hospital	Mr George Mathew	Email George.mathew@geh.nhs.uk
Junior Surgery Lead	Mr Ling Wong	Email ling.wong@uhcw.nhs.uk
Junior Academic Half Day Lead	Ms Colette Marshall	Email Colette.marshall@uhcw.nhs.uk
Senior Academic Half Day Lead	Dr Alec Price-Forbes	Email alec.priceforbes@uhcw.nhs.uk

Appendix C

Warwick Medical School

Notification of Concern

Student Name: (Block Capitals)		
Phase II - Cohort:	**Stream:**	**Block:**

Nature of Concern:

1. a) Absenteeism:
   List dates of consecutive absenteeism:

   b) Has a member of staff been in contact with the student to seek information/offer advice? If so who? What advice was given?

   c) Has the student provided a sick note from their GP?
   (This would be required by the Medical School)

2. Conduct

3. Poor academic / clinical performance

4. Suspected mis-use of alcohol/drugs (Trust must provide evidence)

5. Other

Report from: (Block Capitals)	**Date** **Telephone No:**

Role in relation to this student eg: Consultant / Educational Supervisor
Undergraduate Co-ordinator / Librarian / GP Tutor
Other (please specify)

Signature:

Please return to:
Phase II Administrative Officer, Medical Teaching Centre, Warwick Medical School, University of Warwick, Coventry, CV4 7AL.
Telephone: 024 7657 4496. Email: S.M.Cooper@warwick.ac.uk
The appropriate member of staff will then be notified.

Index of concern (please circle)

1. **Not overly concerned: but needs highlighting**
2. **Tentative concerns: need to be aware**
3. **Major concerns: Action required. Please contact the Medical School IMMEDIATELY**

ASSESSMENT FORM FOR GENERAL CLINICAL EDUCATION BLOCKS

Student Name:	**Cohort:**	**Block Number:**
Consultant:	**Ed Supervisor:**	

Full guidance notes (including grade descriptors) are printed on the back of this form

KEY TARGETS FOR THIS BLOCK (Student to complete and show to the Consultant at the **start of the block)**

1.
2.
3.
4.….

PORTFOLIO CASES (Consultant to complete)

Please circle the number of completed portfolio elements you have reviewed with this student during this block. Please see the portfolio feedback form for guidance. 0 1 2 3 4 5

FORMATIVE FEEDBACK

What are this student's greatest strengths demonstrated during this block?

(Consultant to complete at the **end of the block**)

What are the most important areas for development, based on evidence during this block?

(Consultant to complete at the **end of the block**)

SUMMATIVE ASSESSMENT FOR THE BLOCK (Consultant to circle appropriate grade)

Please **comment** as fully as you can. Any unsatisfactory grades must include examples.

Attendance	**U B S G E**	*(Grade descriptors on back of form)*
Clinical Performance	**U B S G E**	
Attitude	**U B S G E**	*(Please continue on an additional sheet if required)*

Consultant Signature ……..…… Trust ……..

PRINT NAME ……..…… Additional sheet appended Yes / No

School Copy - White

Guidance Notes

This document is in duplicated form.

The student is responsible for: Discussing their plans for the block with each Consultant, and showing them the 'Key Targets' section of this form during week 1 of the block.
Arranging to meet the Consultant during the last weeks of the block to discuss how the block has gone and to complete the form. The Consultant should keep the pink copy.

The Consultant is responsible for helping the student plan their learning on the block as well as organising and planning teaching around their clinical practice. This form must be completed with care as the feedback is important for the students, is kept for the duration of their course and will be used in the final assessment of their suitability to qualify. For further information, see Clinical Teacher Guidance book (also at http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_08/documents/) or contact the Phase II Administrative Officer, Warwick Medical School on 024 7657 4496.

What to do with each copy;
The Consultant should keep the pink copy for their records and in case of queries later.
The student should keep the blue copy and hand in the white and the yellow copy to the school office no later than 2 weeks after the end of the block. The yellow copy will be forwarded to their Educational Supervisor.
The student must keep the blue copy. Students may be required to present their block report forms at any point during the clinical course.

Portfolio cases

Students will present portfolio cases to Consultants and receive feedback using a standard form. The student may have to repeat this if there are significant concerns. (For full guidance see http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_08/portfolio).
Consultants need to record the number of portfolio presentations the student has completed under their supervision during this block. Any concerns about authenticity or plagiarism should be urgently reported to the Phase II Coordinator, Warwick Medical School. CV4 7AL

Assessment Grade descriptors;

Attendance	**U** **B** **S** **G** **E**	Did not attend sufficiently to gain satisfactorily from the block (irrespective of reason for absence) Attended sufficiently to only just gain satisfactorily from the block (>80% attendance) Attended sufficiently to clearly gain satisfactorily from the block (including relevant out of hours sessions) Attended all relevant sessions punctually. Made clear additional efforts to seek out clinical experience. Attended all relevant sessions punctually. Made exemplary efforts to seek out clinical experience. .
Clinical Performance	**U** **B** **S** **G** **E**	Not able to take histories, examine and/or problem solve at a level to gain from available clinical exposure Demonstrates sufficient skills most but not all of the time Demonstrates sufficient skills in history, examination and problem solving to gain from clinical exposure Often demonstrates skills above that expected for this stage of the course, including patient management Consistently excels in clinical encounters for this stage of the course, including patient management
Attitude	**U** **B** **S** **G** **E**	Exhibits attitudes or behaviours that cause concern for a future doctor (please describe fully) Mostly exhibits behaviours in clinical work and with colleagues appropriate for a future doctor but I have some reservations (please describe fully) Consistently exhibits behaviours in clinical work and with colleagues appropriate for a future doctor Has a high standard of behaviour in clinical work and with colleagues for this stage Exemplary behaviour, application and approach to clinical studies and work with colleagues

Appendix E

Guidelines for Phase II Portfolios for Students and Teachers

Introduction

The student portfolio is an important part of the Phase II programme at Warwick Medical School. It is important that they are taken seriously – both by students and teachers, but also that they do not come to dominate Phase II learning. These notes explain the rationale behind the portfolio as a whole, the choice and balance of cases and how each individual case as well as the portfolio as a whole should be completed and marked. They are written for the benefit of students, teachers and clinical educational supervisors and, whilst some sections will apply to one group more than another, it is important that all have access to all the relevant information.

General Remarks

Students see many patients – some briefly, some in depth, some once, some through the course of their illness, some along with other doctors and students and some on your own. The Phase II portfolio helps to make the most of these opportunities, by providing a structure to help gain more from a group of cases, selected by students with the help of their teachers, helping to integrate issues such as epidemiology, ethics, psychosocial issues and evidence based medicine with real cases that they have seen and can remember.

Key Points

- Students need to complete 36 satisfactory portfolios during Phase II – at a rate of about 3 to 5 a block (1 to 3 per teacher per 8 week block).
- They will need guidance in choosing suitable cases based on their own educational needs and the balance of cases they have seen previously.
- Although 36 cases need to be satisfactorily completed, the important gain from putting together a portfolio is in the **choice of cases**, the **discussion of the case** with members of the team and the **formative feedback** provided to the student on the case by the relevant clinical teacher – both on the assessment form but more importantly **face to face**. This requires **organisation** by the student to book time strategically with their teachers to plan which cases to see and to go through them afterwards, but also **commitment** from the teachers to ensure that they go through them for the benefit of the student's learning.

- The portfolio log (downloadable from http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_08/portfolio/ is the student's guide to the balance of what they have done so far and should be used to guide portfolio planning and be discussed with their clinical educational supervisor.
- The portfolio feedback form provides a structure for teachers to provide feedback.

The case

The portfolio 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 or may not be relevant to the portfolio. The format includes sections that allow the student to demonstrate ability to understand and interpret the significance of findings.

Students will need to utilise the knowledge, skills and attitudes developed in the Essentials of Clinical Medicine to satisfactorily complete this exercise. They will also need to demonstrate their awareness of the social and psychological effects upon patients of physical illness. Their learning from Phase 1 will assist them in showing how knowledge of basic clinical and behavioural sciences together with their experiences in the family and community placements is essential in clinical practice.

Appendix F

Changes to the Portfolio System 2010

Warwick Medical School uses case portfolios during both Phase I and Phase II of the curriculum. Many of you will be aware that there have been concerns about how this system has developed over the years. This concern was echoed by the General Medical Council review team when they accredited the school.

The portfolio system has now been reviewed and changed. This new system has been trialled with students and experienced markers and is now being used by all students from Block 1. This document explains the changes and has links to relevant guidance.

Key changes

The most important change is that the new portfolio system is designed to be less like a written project and more like a case based discussion.

Students will still select a series of cases, with guidance from their teachers and clinical educational supervisors, and will write these up, much as they would in patient case notes. They will then use this written record as a basis for presenting the case to their supervisor. This presentation can be either 1:1 or, if teachers wish, to a small group of students and teachers.

The feedback to the student has been made more detailed. The form is based on the sort of case based discussion models that are well known to many clinical teachers. The portfolio is also no longer ‘satisfactory’ or unsatisfactory’. The supervisor will use the feedback form (the student will bring along a copy) to give written feedback. If the presentation is felt to be of an insufficient standard, it will need to be re-presented after feedback.

How to use this guidance

Section 1 will be of interest to those who are used to the old system and want to know more detail about why it is being changed. It includes links to downloadable versions of the full review report and associated documents.

Section 2 provides a step by step guide to using the new system. Those who want to start with a simple 'how do I do it' guide should start here.

Copies of the forms can be downloaded from:
http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_08/portfolio/

1 Background to the changes in the portfolio system

Warwick Medical School completed a review of the portfolio element of the Phase II course in 2007. For those who are interested, full copies of the review data, report and conclusions are available at: http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_07/portfolio

In brief, the portfolio element of the Phase II curriculum had started as a formalised case write up with additional elements but had increasingly becoming a series of sometimes substantial pieces of written work, often increasingly distant from the original case. In addition, marking was inconsistent and there was some evidence of plagiarism.

Recommendations

The portfolio review assessed the educational roles of the portfolio system and how best to improve it to deal with the identified problems. The summary recommendations in full are available at: http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_08/portfolio/section1
The most relevant outcomes were as follows:

- The portfolio system should be fully and consistently re-aligned as **a key learning tool** with any other roles (particularly assessment and ranking) being removed or adapted.
- That the portfolio remain based around a series of **clinical cases**
- **Students will be required to participate in the portfolio** system by **presenting** a specified number of portfolios in a given block. The requirement would be to present these not for them to have reached a specified standard. This could be a group or 1:1 presentation.
- The focus would be on **formative feedback to the student** on the presentation. A standard model would be available.
- **Poor presentations would be repeated** following feedback
- **The required number would remain around 36** but this could change as part of ongoing curriculum review.
- **No grade would be allocated.**

- **Students producing notably excellent or concerning work would have this noted as a part of their overall end of block report.**
- The portfolio form would be developed to:

1. Promote the **writing and answering of an evidence based question** rather than simply noting ‘evidence’
2. Give clearer guidance on **indicative word limits**

- **The list of suggested and core cases be reviewed and shortened** to focus students of those that are key. The students ’portfolio summary should also **highlight completion of a balance of these core cases**
- **Some supported compulsory core cases**

2 Operation of the portfolio system from 2010

WMS students need to complete 36 portfolio elements during the course of Phase II. This requires completion of 3 or 4 per student per 8 week block, or about 1 every 2 weeks.

The endpoint of each case is to verbally present a case and receive written feedback on a standard form. This is going to need better planning from both students and teachers to ensure that appropriate times are booked sufficiently well in advance. This should not, however, be more work for teachers than the old portfolio system.

Planning

Each **pair** of students will need to see and present about 8 cases a block between their two consultant supervisors. This is best organised as a regular session on student timetables. Where this is not possible, consultant teachers and students will need to plan well in advance to allow sufficient opportunities to discuss cases.

Some specialities and clinical teaching partnerships may choose to present in groups to allow more discussion, perhaps with all the students in a unit presenting together to relevant teachers or the two consultants in a teaching partnership reviewing the portfolio presentations together. They can also be reviewed on a 1:1 basis.

Selecting cases

Students have access to a list of suggested portfolio cases to help ensure a balanced portfolio. They will also record the portfolios they have completed and will have particular areas they need to focus on. They will need guidance on how and when to find these patients and this is often best done in the first week of a block. It is most appropriate for the case to be one that is known to the consultant teacher as this will allow more insightful feedback.

Seeing cases

Students may see relevant cases in a number of clinical areas including ward, outpatient and primary care setting. Students benefit from being observed taking histories and/or examining patients and this should be done for the portfolio cases whenever possible and appropriate.

Writing up the case

Students will download a form. This is designed to be more like a normal 'clerking' than the old form. Importantly, it is designed with size limited boxes. This is to avoid one of the key problems of the old system – that portfolios were getting longer and longer. Students will need to focus their thoughts to keep within the limits. Copies of the form can be downloaded from http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_07/portfolio as can a 'guidance form' with notes on each section.

Presenting

Students will present their case verbally to their consultant supervisor. As noted, this can be 1:1 or in a group setting. The process is modelled on case based discussions with the outcome being the discussion rather than the case write up. Marks are recorded by the supervising consultant and this is the basis for formative feedback to the student.

Feedback

The feedback form is completed by the supervisor who will need to talk through positive aspects and areas for development. It is likely that this feedback will identify strengths and weaknesses. If the supervisor feels the presentation has substantial problems, then it will need to be re-presented following feedback.

The student then needs to retain a copy of the form for their portfolio and to review with their clinical educational supervisor. The number of portfolio cases completed by the student will be logged on the end of block form.

The following presentations present key learning opportunities and student portfolios should contain all of the following seventeen:

- 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

Portfolio summary

The portfolio should demonstrate student achievement of the specified course objectives as a series of cases, which are **exemplars** rather than **examples.** An example is a typical case that illustrates a particular point whereas an exemplar will draw together, illustrate and assist understanding of many issues. As such the cases should help students to draw together different aspects of their skills, for example, clinical medicine, interdisciplinary working and ethics. To help ensure they demonstrate breadth of learning, they need to complete the summary grid. This is available as a spreadsheet from http://www2.warwick.ac.uk/fac/med/study/ugr/mbchb/phase2_07/portfolio

Teachers and Clinical Educational Supervisors need to help students ensure that they acquire a breadth of skills from a wide range of presentations, people and situations. The completed grid should reflect a rich variety of differing combinations of presentations.

It will not be possible or necessary to present every possible combination of options but there must be a reasonable balance between them. Clinical Educational Supervisors will review this with students at regular meetings

Plagiarism

Please remember that although written primarily for students benefit, portfolios are pieces of written work that form an important part of the MB ChB programme. They are therefore covered by the University of Warwick regulations on plagiarism.

Please see http://www2.warwick.ac.uk/services/quality/categories/examinations/plagiarism/

- Portfolios must be students original work
- Any work of others must be clearly attributed
- Students should be especially careful when compiling the ‘evidence based’ section. It is clearly necessary to use external sources but they should be referenced with care. If

quoting from a source, this must be in quote marks and referenced. Students cannot ‘cut and paste’ directly from an evidence source unless they make it clear this is a direct quote.

- In general a good portfolio should combine available evidence with a student’s own brief critique.

Section by Section Guidance for Students

PORTFOLIO CASE	Block LFLs	Portfolio number *This is 0 to 36 in your personal portfolio*	12	Printed: 16/02/2010
Name		**Supervisor**		
Mr Keen Learner		Dr Makeyouwell		

Case Details			
Initials	**Age**	**Gender**	**(Keep separate list of identifier e.g. Hospital number)**
AB	57	Male	Do not enter anything here

Case Profile – ***This is to help you and your educational supervisor check the balance of the cases you have in your portfolio. This information should also be recorded on your portfolio summary sheet. The course doc ref is the relevant section number from the Phase II course document. The secondary ref is just in case the patient's presentation covers more than one learning outcome and the suggested portfolio case number can be found at the end of each section of the course document.***

Setting: Primary Care **Seen:** Home

Urgency	Speciality area	**Course doc ref**	**Secondary ref**	**Suggested portfolio case No.**	**Age group**
Routine	Medical	.	.	.	Neonatal

Referral information
Summary of key information

Source of referral: Self

Mr AB presented to the emergency department of University Hospital with….. etc.
Like all boxes, this is size limited, in this case to 200 characters (not 200 words).
****

Comments (How this case fits in with the rest of your portfolio)
My portfolio cases so far have focused on surgical and long term cases. This is an acute case of a common problem that I saw from arrival in ED…… (again, 200 characters only)**********

History

Record your information (Presenting info, co-existing problems, current treatment, significant past medical history and the social and family background) as you would in patient case notes

Date
25/12/2008
Time
8:45

Record your main history here. There are 1800 characters available which should be plenty as the aim here is to write a history as you would in a patient's notes. You do not have to completely fill the box - the size limitations are a maximum, not a minimum.

All size limited boxes limit other things as well. You cannot change the font etc, do a word count or spell check. In terms of word count and spell checking, do remember that this is supposed to be a clerking of a patient, not a published case report. You will need to get used to expressing yourself succinctly when you are working as a doctor and you will not be able to spell check your medical notes.

If you like bullet points or numbered sections, these can be done manually;

1. You will have to use spaces to indent text if you want to.
2.

or using any normal symbol;

Issue number 1

Issue number 2 etc.

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This area of asterisks will give you an idea of how many characters you have to complete your history. This has proved sufficient in all early trials of this form. You will probably find it difficult to get the length right the first few times but should get used to it.

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Physical examination

(Add space to hand draw any relevant diagrams)

Date 25/12/2008 Time 09:15	Examination findings should be completed here. Occasionally you will want to record findings with a diagram. It is not possible to 'cut and paste' a drawing into this box. If you want to add a drawing, make a space using carriage returns; And draw by hand on the printout. We are exploring ways of inserting diagrams although as this is not something that can be done for a regular clerking, this may or may not be appropriate. **********
	Name: **Signature:** **Title:** *Junior Phase 2 Student*

Formulation of the patient's problem(s)

This should consist of a problem list comprising;
(1) Differential Diagnosis (2) Factors for and against each differential (3) Psychological factors (4) Social factors

This box has been increased in size since the initial trial and may need to be enlarged further - please provide feedback to your Phase II Management Group student representative. However, remember, this is supposed to he the sort of formulation you would write in a patient's notes - so it isn't an essay on diagnosis - just key issues and key factors for and against.

1. MI - correct site of pain and previous cardiac history but duration of symptoms not classical
2. GORD - etc…….
3. Other issue……..

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Investigation

List investigations that will help in establishing a diagnosis, assessing severity, assessing prognosis etc. Identify which you would do urgently

Investigation	Urgent?	How this will help
FBC	No	exclude anaemia
ECG	Yes	reasoning for ECG……..
Other investigation x	No	

Management

This should include all relevant management steps including medical (symptomatic and curative), surgical, referral and team working, social, lifestyle etc…. Drug treatment should be listed on a mock prescription form.

This is one of the most important sections. You need to consider what you would actually do for this patient as they presented to you. You need to be ready to justify what you have chosen to do when you present the case. This will be a challenging section for those at the start of Phase II but will get easier as you progress. You are likely to need to discuss this section with your supervisor or a member of their team before completing. Also, beware of just seeing what the admitting team did and presuming it was correct. If an investigation or management strategy seems unhelpful, insufficient or excessive, be ready to discuss it with the team (often later with acute emergencies) to come to your own view about what should have been done.

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If you feel the patient needs a prescription, you should complete a mock prescription form and indicated here that you have done so	See attached prescription form ☒

Explanation

State how you would explain your current hypotheses, investigation and management plan in terms appropriate to the patient/carer

It is slightly artificial typing out something you would usually say. However, it is important to get into the habit of finding appropriate ways of discussing often quite complex and emotive issues with patients

****

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****

Outcome

A description of the progress of the patient as far as possible. This should include consideration of further issues to be resolved INCLUDING DISCHARGE PLANNING where relevant.

If possible, find out what happened to your patient. Some patients are happy to be contacted later to find out how things went - although you must seek specific permission from them to do this. This is particularly important if the issue is long term or the diagnosis unclear at the time they leave the service you are attached to.

****

****

Evidence based care and issues for research

A consideration of the evidence concerning one aspect of the presentation/ pathophysiology /investigation/ management/ psychosocial issues.

State an evidence based question:

Write a clear, relevant question here. For example, 'What is the evidence that investigation x is better than y in a patient of this age presenting with symptom z?

Provide a summary of available evidence and a conclusion

Having asked a relevant question, you then need to aim to answer it. You should use the main evidence based medicine sources initially (you can indicate below which you have used). You should be aware of all of these from phase 1 and the web link below directs you to them on the WMS website.

This section is about asking relevant evidence based questions and finding how to use sources to answer them efficiently. You are not writing a research paper or a CASSM project.

It may be that you pose a relevant question and are then unable to find a clear cut answer. This is as important a learning point as actually finding clear answers to questions.

****

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****

****

References (maximum 5)

If you have used the sources noted on this form, you do not need to reference in full, simply tick them below.

Evidence based medicine sources used:					
NICE	Cochrane	Bandolier	BMJ clinical evidence	SIGN	Other (State)
☐	☐	☐	☐	☐	☐ (40)
(See http://www2.warwick.ac.uk/services/library/main/tealea/sciences/medicine/ebm/)					

Commentary

Commentary on an additional aspect relevant to the case: (Epidemiology, Psychology, Ethics or Health Care Planning):
Epidemiology

You need to balance out the areas you consider across your portfolio as a whole. These should be recorded on your portfolio summary and reviewed with your clinical educational supervisor. Ensure that this is your own work. You will need to access relevant sources but you MUST follow University plagiarism guidance (search on the University web site or copy or follow the link from the portfolio website

****
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Impact on your learning

Briefly note what you have learnt from this case

Be brief. This is a short note to focus you on what you learnt here to help you in choosing future cases.
****
****

Complete the following with your supervisor when you present the case;

Needs	Learning plan
1. 2.	Complete this section with advice from your supervisor. If there are concerns about presentation, you may need to repeat it. If this is the case, find out all you can about what the issues are and how to ensure you achieve what is necessary for this and future cases.

Appendix G

Student to complete	**WMS PORTFOLIO FEEDBACK** **Student Name:**	**Block** LFLs	**Nº:**
	Case identifier (e.g. hospital number)		
	Brief description of case: (125)		

Setting:	**Age gp:**	**Course doc refs:**	**Commentary focus:**
Primary Care	Neonatal	. .	Epidemiology

Complexity of case in relation to stage in the course: High ☐ Average ☐ Low ☐

	Below expectations	Borderline	Meets expectations	Above expectations	Well above expectations	Unable to comment
Medical record keeping	☐	☐	☐	☐	☐	☐
Clinical assessment	☐	☐	☐	☐	☐	☐
Investigations & reasoning	☐	☐	☐	☐	☐	☐
Management plan	☐	☐	☐	☐	☐	☐
Prescription	☐	☐	☐	☐	☐	☐
Evidence base	☐	☐	☐	☐	☐	☐
Commentary	☐	☐	☐	☐	☐	☐

Anything especially good

Suggestions for development

Agreed action

Portfolio needs re-presented **Yes / No**

I confirm that this case was presented to my service on the date stated in the case write up: ☐
(If the case is not personally known to the supervisor this MUST be checked (via notes, booking system, results systems etc. The student will have a record of the unit number). If you cannot confirm this or believe the case may be fully or partly plagiarised contact the Phase II Coordinator, Warwick Medical School. CV4 7AL

Supervisor name

Signature	Date

Appendix H

Categories of Competence and Component Competencies (F.P.E)

History Taking

- **Introduces self to the patient**
- **Puts the patient at ease**
- **Enables patient to elaborate presenting problem fully**
- **Listens attentively**
- **Seeks clarification of words used by patients as appropriate**
- **Phrases questions simply and clearly**
- **Uses silence appropriately**
- **Recognises patients' verbal cues and non-verbal cues**
- **Identifies patients ideas, concerns and expectations**
- **Considers physical, social and psychological factors as appropriate**

Clinical Examination

- **Performs examination and elicits signs correctly**
- **Uses diagnostic instruments competently**
- **Displays sensitivity to patient's needs during examination**
- **Washes hands competently and at an appropriate moment**

Problem Solving

- **Seeks relevant and specific information from the patient to help distinguish between working diagnoses**
- **Generates appropriate working diagnoses or identifies the problem depending on circumstances**
- **Seeks relevant and discriminating signs to help confirm or refute working diagnoses**
- **Correctly interprets and applies information obtained from the patient's history, examination and investigation**
- **Applies knowledge of the basic, behavioural and clinical sciences to the identification of the patient's problems**
- **Identifies and applies knowledge to the management of the patient's problems**
- **Is capable of recognising the limits of personal competence and acting accordingly.**
- **Exhibits a well-organised approach to gathering and giving of information**

Patient Management

- **Reaches a shared understanding with the patient.**
- **Collaborates with the patient in negotiating a mutually acceptable plan.**
- **Provides appropriate advice on self care.**
- **Utilises drug therapy safely and rationally with regard to sound pharmacological principles.**
- **Orders appropriate investigations and interprets results correctly.**
- **Makes discriminating use of referral.**
- **Is able to act on appropriate opportunities for health promotion.**
- **Arranges appropriate follow-up.**
- **Checks the patient's level of understanding**

Relationship with Patients

- **Maintains friendly but professional relationship with patients with due regard to the ethics of medical practice**
- **Uses empathy to encourage the patient to express feelings and thoughts**
- **Supports the patient in coping with the situation**
- **Demonstrates an awareness that the patient's attitude to the doctor (and vice versa) affects achievement of co-operation**

Clinical Examinations Grade Descriptors

A **Capable in every component to a high standard**

B **Capable in all components to a satisfactory standard, and a good standard in many**

C+ **Capable in all components to a satisfactory standard**

C- **Capable in a majority of components to a satisfactory standard, inadequacies in some components**

D **Demonstrates inadequacies in several components. No serious defects**

E **Demonstrates inadequacies in many components, or one or more serious defects**

Examiner judgement is necessary to determine the meaning of the qualifiers **some**, **several** and **many**. Grades are allocated against a category of consultation activity. The number of component competences ranges from 4 to 10 in particular categories; additionally, inherent factors within the assessment may affect a student's performance (e.g. a patient who is hard of hearing or does not speak English). Therefore it is not possible to specify the precise number of inadequacies to mandate the award of grades C-, D and E.

Inadequacies in competences would be indicated by those that are performed incorrectly, inappropriately or omitted when required. However, the extent of the inadequacy will not significantly affect the delivery of satisfactory heath care to the patient.

Serious defects are those that have the potential to threaten patient safety, with the risk of producing significant morbidity.

A and B grades may be awarded at all assessments. These grades contribute to merit and distinction in the Finals Clinical Examination. They are NOT anchored by the performance of qualified doctors at any level. Rather they are related to significantly exceeding the C+ level of attainment.

C+ is equivalent to the satisfactory performance at the level of a newly qualified doctor

‘B’ grade should be awarded if performance significantly exceeds that of C+ (a good standard in many components and is satisfactory in all).

For ‘A’ Grade to be awarded, performance to a higher than satisfactory standard is expected across ALL components of the category. There should, therefore, be no evidence on the feedback sheet of scope for improvement in that category.