

# **Quality Assurance of Basic Medical Education**

A supplementary report on School of Clinical  
Medicine and School of Biology,  
University of Cambridge

December 2008

**General  
Medical  
Council**

Regulating doctors  
Ensuring good medical practice

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## The GMC's role in medical education

1. The Education Committee of the General Medical Council (GMC) sets and monitors standards in medical education. The standards for undergraduate medical education are set out in the publication *Tomorrow's Doctors*.
2. In order to ensure that UK medical schools maintain these standards the GMC runs a quality assurance programme, which involves regular assessments and visits to schools. This programme is called Quality Assurance of Basic Medical Education (QABME) and is carried out on behalf of the GMC Education Committee by a team of medical and educational professionals, student representatives and lay members.
3. The team makes determinations as to whether these schools are meeting the standards in *Tomorrow's Doctors* after analysing extensive school documentation and completing a range of quality assurance activities at the school and partner institutions. The determinations in this report have been endorsed by the GMC Education Committee.

## **Introduction**

4. This is a supplementary report for the 2006/07 quality assurance report to the GMC Education Committee on the established medical school at Cambridge (the School).

5. The 2006/07 report required a follow-up visit to the School in 2007/08 to confirm the progress of the revised Stage 3 (Year 6) of the curriculum. Additionally the Education Committee emphasised the importance of checking the School's progress in ensuring Fitness to Practise Committee structures and procedures are robust and that the School is enhancing student perspectives on whistle blowing.

### **The QABME team**

6. The visiting team members appointed by the Education Committee to undertake the quality assurance visits were:

Professor Anne Garden (Team Leader)  
Professor Peter McCrorie (Deputy Team Leader)  
Professor Roger Barton  
Dr Roger Bloor  
Mr Philip Brown  
Dr Jennie Johnston  
Professor Philip Milner  
Ms Raisha Nurani  
Professor Maurice Savage  
Professor Olwyn Westwood

7. Miss Elizabeth Leggatt (GMC Education Quality Officer) supported the team.

### **Follow-up visit in 2007/08**

8. The team conducted one quality assurance visit on 11 April 2008.

9. The findings of the team have been reached by reviewing documentary evidence submitted by the School and undertaking the following activities:

- a. Observation of a range of Stage 3 teaching sessions.
- b. Analysis of blueprints for the final examinations.
- c. Discussions with Stage 3 students and staff responsible for Stage 3 co-ordination and management.

## The report

### Summary of our key findings for 2007/08

10. We are satisfied that the structure and delivery of the revised Stage 3 of the curriculum is consistent with the standards of *Tomorrow's Doctors* and commend the School on the enthusiasm of staff involved in its development and delivery. The standard of observed teaching was satisfactory and resources and equipment for teaching sessions good. We therefore found that, subject to the requirements in paragraph 16 of the 2006/07 report, the School's MB BChir programme meets the requirements of *Tomorrow's Doctors* in accordance with Section 5(3) of the Medical Act 1983

11. The findings in this supplementary report should be read in context with the requirements, recommendations and findings of innovations and good practice in the Cambridge QABME report of 2006/07. The School is due to provide a detailed report on its progress towards the 2006/07 requirements and recommendations at the end of 2008, as part of the GMC's annual monitoring process.

### Requirements

12. There are no further requirements in the findings of this report.

### Recommendations

13. There are no further recommendations in the findings of this report.

### Areas of innovation and good practice

14. We commend the School on the following areas of innovation and good practice identified on our follow-up visit:

- a. The structure of dermatology teaching in Stage 3; formal teaching as preparation for the clinical attachment (see paragraph 23).
- b. The death and dying course which was well conceived, structured, prepared and taught (see paragraph 26).

## Curricular outcomes, content, structure and delivery

### Outcomes and content

15. The new Stage 3 (Year 6) is composed of: a Review and Integration (R&I) week, a four week SSC block, a four week senior general practice (GP) block which includes palliative care, a nine week senior medicine block, a second R&I week, a nine week senior surgery block, a nine week acute care block, one week of self directed study, final examinations and one week shadowing their destination Foundation Year 1 (F1) post. Dermatology, ear, nose and throat (ENT) and ophthalmology are integrated throughout the R&I weeks, GP and hospital placements. The themed blocks are a mix of specific taught sessions and structured placement based teaching within the context of a clinical team or a general practice. The central ethos in the new Stage 3 is preparing for practice and students complete placements of significant duration at a single site to give them an opportunity to integrate into clinical teams whilst demonstrating the full range of outcomes.

16. The Cambridge Graduate Course (CGC) is a very similar programme to the standard course. It has a three week GP placement rather than the four week placement of the standard course. There was no major difference in the approach or evaluation received from students on the CGC.

### Structure

17. Students were positive about the structure of Stage 3; especially the immediate life support training, the simulator session and the online pharmacology module. However they expressed concern that they would only have one week of revision prior to their final examinations, due to the length of their attachments.

18. The Stage 3 student selected components (SSCs) consist of a four-week poster project and three longitudinal group projects on topics chosen by the students. Stage 3 SSCs have a strong science and research basis and students are advised not to undertake a purely clinical SSC. Stage 3 students did not consider spending four weeks on the SSC poster project the best use of their time. We noted variability in the standard of the poster projects and encourage the School to ensure the content is appropriate for final year students. Stage 3 students reported that choice of topics for the group project had been limited. They spent one half day a week for six weeks during each major Stage 3 placement in groups working towards a final presentation.

## Delivering the curriculum

### *Supervisory structures*

19. The School provided evidence of quality management across all regional placements to improve relationships with regional hospitals. The School receives regular evaluation from teaching staff across the regions. Core academic and curriculum management staff visit teaching sites regularly to meet teaching staff. Teaching staff are also provided with training in the use of the Education Resources web.

20. We reviewed the student end of placement evaluation, submitted in a new online format and noted that it provided excellent overall evaluation and raised useful areas for the School to further consider.

21. The School confirmed that the online format had been very useful and although data is submitted anonymously, issues relating to specific practices could be identified and addressed. The School is trying to improve the quality of student evaluation and engage students in the process by holding sessions on how to give useful and constructive evaluation. Online student evaluation is anonymous but the School has the ability to trace inappropriate comments.

### *Teaching and learning*

#### Structured teaching sessions

22. A sociologist had been recruited to integrate the four strands of the course: Preparing for Patients, Medical Sociology, Medical Ethics and Introduction to the Scientific Basis of Medicine in the preclinical programme. A seminar based sociology course was being developed to begin the next academic year, consisting of five supervisions occurring weekly for eight weeks to supplement the lecture course. This is designed to link the core sciences with other areas of the curriculum.

23. In Stage 3, dermatology teaching consists of two days of core and case-based lectures, to prepare students for clinical placements that follow immediately afterwards. The core and case-based lectures were well designed to prepare students for the clinical attachment. The School reported that as a result of this format the student perception of dermatology had improved significantly. The structure of the core dermatology teaching was well received by students and they were keen that this style be introduced to other specialities.

24. ENT and ophthalmology use a similar structure to that of dermatology, with one day of formal lectures providing a structure for the attachments that follow. Students reported that the attachments in ENT and ophthalmology were variable and in particular found the usefulness of the ophthalmology clinics depended heavily on the desire of the clinician to engage in teaching.

25. The School stated that one of the biggest changes to Stage 3 of the curriculum had been in the area of acute care and the recognition of critically ill patients. Students undertake a weekend on-call in critical care and are encouraged to review the patients they have seen.

26. The death and dying course is a comprehensive two day teaching programme with progressive role play opportunities. We observed a facilitated communication skills session on death and dying and considered it to be interesting and effective teaching. The session was engaging and interactive with role play which encouraged student contribution. Stage 3 students found the session very valuable and suggested it could be further improved by incorporating a session on explaining the grieving process.

27. We observed a teaching session on intensive care unit (ICU) ethics that contained relevant material and was led by a knowledgeable, responsive facilitator, but which could have been more interactive for students.

28. We observed the simulator session, in which all Stage 3 students participate, and considered it to be an excellent facility, providing students with the opportunity to practice clinical skills and interventions in a safe and confidential environment. Stage 3 students we met were enthusiastic about the variety of teaching tools used in this session.

29. We observed case presentations by surgical students that we found promoted self directed learning, but appeared to be a largely passive experience for those students not presenting cases.

30. We noted last year that the pharmacology and therapeutics teaching was of a high standard and this was reflected in the evaluation from Stage 3 students who rated it highly.

#### Placement based learning

31. As reported above, Stage 3 students rotate through a four week GP placement and three nine week blocks based at a hospital; in senior medicine, senior surgery and acute care. During each nine week block they are based on a single hospital site.

32. Students interviewed were very positive about the four week residential blocks at GP surgeries, we noted that this matched the student evaluation in the 2007 General Practice Education Group annual report.

33. Students are given the opportunity to look after a small group of patients under supervision, present cases on ward rounds and work with the entire care team. Students are expected to say which tests they would do and are told from the outset that the placement is focused on patient management.

34. Stage 3 students reported that on hospital placements they were also given the opportunity to teach Year 4 students who were on the same clinical team, which they found rewarding.

35. We noted that most Stage 3 students had responded positively in the evaluation summary for the period from October to December 2007 after their first placement. Overall students were positive about surgery placements and reported accompanying their own patients to theatre, scrubbing in and observing the process fully. In addition each student has a weekend on call, which enabled them to observe emergency surgery. Students did not rate the supervision on surgical placements as highly as other areas. This was echoed by students we interviewed who reported variation in teaching time with clinical supervisors.

36. Stage 3 students we interviewed reported that undertaking a nine-week placement on the same firm had allowed them to integrate fully into a care team and experience what it is like to be an F1. The School had given them a letter to hand to the consultant on their hospital placements, which stressed that the focus of their attachment is clinical patient management, unlike the Stage 1 (Year 4) students who attend at the same hospitals but focus on learning new skills. As a result Stage 3 students were satisfied that they were fully prepared for the Foundation Programme. However they stated that they did not always get a broad range of experiences on the ward as there was a conflict between their integration within a team at the expense of personal ward work.

37. Students are provided with log books to complete during placements, which detail the intended outcomes for the placement, the clinical opportunities available and tasks and procedures which students are expected to undertake. Stage 3 students reported that log books were helpful as a guidance document and had motivated them to attend dermatology, ophthalmology and ENT clinics. However Stage 3 students reported that for their first placement these tasks were presented as compulsory and students were required to obtain signatures to reflect this. They felt that this was unrealistic and resulted in spending time chasing signatures rather than concentrating on learning opportunities. Whilst students reported that this requirement had appeared to relax for the second placement onwards, this was not yet reflected in log-books that we reviewed, resulting in Consultants interpreting the requirements differently. Students also perceived a dichotomy between being encouraged to be self-directed learners during the first five years of their course and the amount of signatures they are required to collect during Stage 3. They considered this detrimental to the overall educational experience. We encourage the School to review the number of activities which students are required to have formally signed-off on placement in Stage 3.

38. Last year, clinicians reported an improvement in students' clinical skills, which they related to increased patient contact throughout the course. While there are some issues with variation in teaching received from clinicians, the new Stage 3 further increases students' interaction with patients and early student evaluation indicates that they are learning with a view to F1. Most student evaluation was good or excellent and students stated that they had experienced a good amount of patient contact. The curriculum for Stage 3 has been redesigned to prepare students for F1 and we commend the School's efforts to increase patient contact in the new Stage 3.

### *Learning resources and facilities*

39. We observed a range of resources and facilities during the scheduled activities and noted:
- a. The ICU ethics teaching session had good IT and presentation facilities.
  - b. The room used for a small group session on death and dying was a good size with an open layout that allowed students to participate fully, with encouragement from the facilitator.
  - c. The seminar room used for a teaching session around surgical case presentations was well equipped.
  - d. The simulator was an excellent teaching resource, with excellent support from the simulator team (two technicians, one consultant and one facilitator).

### **Assessing student performance and competence**

40. We previously observed the implementation of a wide range of examinations, and our findings in relation to these are contained in the main report.
41. During this additional visit we assessed the coverage of the Stage 3 examinations, discussed Stage 3 students' perceptions of their preparedness for the examinations and the feedback they had received during Stage 3. We also discussed examination setting and the review processes with staff at the School.

#### The principles of assessment

42. We reviewed the blueprints for the clinical and written final examinations and the Stage 2 (Year 5) paediatrics and obstetrics and gynaecology OSCEs and were content that the blueprints indicated comprehensive examinations covering the curricular themes. The blueprint reviewed for obstetrics and gynaecology was adequate but not of the same standard as those seen in other disciplines. We encourage the School to share blueprinting examples across disciplines to foster good practise.
43. The clinical examination (Final MB paper 5) blueprint contained six 15 minutes stations and five 7.5 minutes stations with one rest station. In the simulated clinical encounter examination there were 10 communication stations covering the full range of themes and subjects.
44. The written examination contained 30 extended matching questions and 150 single best answer questions, covering medicine, surgery and other specialties. Professional attitudes and behaviour of students is assessed through six structured essay questions covering law, ethics and public health. The School had identified a minimum number of questions by speciality and theme, to ensure the number of

questions is proportionate to curriculum time. We found the written examination to be thoroughly blueprinted, containing a broad range of topics.

### Assessment procedures

45. Each Stage 3 exam paper has a working group with a lead who meets with other leads to review the performance of the examination paper and to plan the next set of examinations. These working groups feed into the Assessment Committee which has an overview of all assessments and ensures sampling across papers is appropriate.

46. Stage 3 students interviewed were positive about their upcoming final assessments and reported that the Objective Structured Practical Examination (OSPE) at the start of the autumn term had been helpful preparation for their final year and a good refresher after returning from their elective. Students also reported that completing the OSPE had helped them become a more useful member of their clinical team.

47. Students reported that having practical skills signed-off at Addenbrookes Hospital had proved problematic as this could only be completed by the Clinical Skills Co-ordinator, who was not always available. We discussed with the School the students' suggestion that responsibility for signing-off clinical skills should be given to a range of healthcare professionals.

### Appraisal

48. The School reported that the introduction of mid-point assessments in Stage 3 had enabled students to discuss their progress on placements. Stage 3 students welcomed mid-point assessments and stated that they were helpful when carried out as designed, particularly if students were experiencing difficulty. However students reported that these had so far been inconsistent resulting in variable benefit. Students reported receiving consistently good levels of feedback while on GP placements.

49. During the visit we noted that the appraisals in Stage 3 mirrored the style of appraisal used during the foundation years.

### Student progress

50. The School reported a change to the assessment at end of Stage 1. Previously formative, this academic year students were required to pass the clinical and communication skills stations. Any student who fails this assessment will be given remedial teaching and must resit. If they fail this resit the School will ask the student to leave the course. This now provides a specific early exit point for students who are struggling academically.

51. In the 2006/07 report we found the School's Fitness to Practise (FtP) Committee structures needed to be more robust and asked the School to ensure the appeals panel includes an experienced medical practitioner. During the visit the School was invited to provide an update on early changes to its fitness to practise procedures.

52. Cambridge University regulations prohibit faculty staff from becoming members of the Appeals Committee. However the School is working with the University to recruit an external clinician to sit on the Appeals Committee and we strongly endorse this approach.

53. Currently issues of student conduct are discussed at informal weekly meetings and the FtP committee meet only when required. The School intends to supplement this with a formal Progress Committee that will meet once a term to decide whether to escalate conduct issues to FtP proceedings. The School intends the Progress Committee to be in place by the next academic year. However it reported that the establishment of this committee may need University rather than faculty approval, which may take longer. The Clinical Dean currently maintains a list of students who have issues but the School reported that it intends this responsibility to be transferred to the Progress Committee. We support the plans for a Progress Committee as positive steps towards a more robust system for dealing with students in difficulty and fitness to practise issues.

54. In the 2006/07 GMC report we advised the School to develop methods to enhance student perspectives on whistle-blowing. The School reported that it has audited its coverage of whistle-blowing and that its policy is covered in ethics teaching, is listed in the student A-Z guide and has been supplemented by email reminders. This was triangulated in interviews with Stage 3 students who mentioned recently receiving an email on whistle-blowing and reported that the culture at the School is generally supportive.

## **Acknowledgement**

55. The GMC would like to thank the schools of Biology and Clinical Medicine at the University of Cambridge and all those we met with for their co-operation during the course of the review.



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Professor Peter Rubin  
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18 November 2008

Dear Peter

**Re: Final report of QABME visits to Cambridge Medical School 2007 / 2008**

Thank you for sending the final report on the supplementary QABME visits that occurred in 2008. We were very pleased to receive this and appreciate the additional time and effort made by the visiting team to undertake the supplementary visit to our new Stage 3 (final year) programme.

We have no specific comments to make in response to this report and look forward to its publication on the QABME website alongside the main report.

With best wishes

Yours sincerely

Dr Diana F Wood

cc: Professor P Sissons, Regius Professor of Physic, School of Clinical Medicine  
Dr Don MacDonald, Director of Medical & Veterinary Education, Faculty of Biology

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