

EDUCATION COMMITTEE

**REPORT OF THE VISIT TO THE SCHOOL OF CLINICAL MEDICINE
UNIVERSITY OF CAMBRIDGE**

7- 8 FEBRUARY 2001

We should like to express our thanks to the Regius Professor of Physic, the Clinical Dean, the Postgraduate Dean and those who spent time organising the visit programme and discussing the undergraduate curriculum and the pre-registration year with us.

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List of acronyms mentioned in the report

ALS	Advanced life support
BLS	Basic life support
BOD	Biology of Disease
CAL	Computer assisted learning
CCC	Clinical Curriculum Committee
CBCU	Clinical and Biomedical Computing Unit
CGC	Cambridge Graduate Course
CGC	Cambridge Graduate Entry Course
CPD	Continuing professional development
CSDRU	Clinical Skills Development and Resources Unit
DOMVE	Director of Medical and Veterinary Education in the Faculty of Biology
EC	Examinations Committee (clinical course)
FAB	Functional Architecture of the Body course
FTPC	Fitness to Practise Committee
GP	General practitioner
HOM	Homeostasis
JANET	Joint Academic Network IT hub
JPRC	Joint Pre-registration Committee
MCQ	Multi-choice question
MEC	Medical Education Committee
MIMS	Molecules in Medical Science
MODA	Mechanisms for Drug Action (
MVST	Medical and Veterinary Sciences Tripos
NHB	Neurobiology with Human Behaviour
PBL	Problem-based learning
PFP	Preparing for Patients course
PREMEVEC	Pre-Clinical Medical and Veterinary Education Committee
PRHO	Pre-registration house officer
PWF	Personal workstation facility
QAA	Quality Assurance Agency for Higher Education
SSEARP	Scientific, Social and Ethical Aspects of Reproduction and Populations

Foreword to the visit reports 1998-2001

The Education Committee is accountable for ensuring that its recommendations on basic medical education are implemented by every medical school in the UK.

When our latest guidance on undergraduate education, *Tomorrow's Doctors*, was published in December 1993 we made it clear that we intended to monitor the progress of curricular change, through both written enquiries and on-site visits. We are taking a similar approach towards implementation of our recommendations about the pre-registration year, published in *The New Doctor* in April 1997.

The first round of visits, to 25 medical schools, took place between 1995 and the spring of 1998. A second round of visits began in the autumn of 1998. These are focusing on the rolling out of the 13 principal recommendations in *Tomorrow's Doctors* during the primarily clinical years of the undergraduate course, as well as the introduction of improved arrangements for the training of pre-registration house officers.

The Quality Assurance Agency also began its review of medicine in the autumn of 1998 and at the request of the medical schools concerned a number of our visits have been synchronised with those of the QAA. This has enabled both bodies to minimise the burden which would otherwise have been imposed on the schools as a result of two separate visits within a relatively short space of time. We have, for example, been able to share documentation, and hold some joint meetings with medical school staff, students and recent graduates. Where collaborative working with the QAA has taken place, we state this in our reports.

The purpose of the QAA reviews is described in detail in their own documentation, including the reports of visits their teams have undertaken. The visits we ourselves are presently making are informal and are designed to be facilitative and supportive of curricular change, rather than judgmental. For this reason they contain no graded assessments of the quality of the provision available, or the quality of the student experience. They do, however, point up areas which we believe to be in need of further consideration. We will be pursuing progress with regard to these issues through written enquiries of the medical schools 12 months after each report has been published.

As well as informing us in some detail about the extent to which each school has succeeded in introducing a curriculum consonant with our guidance, and in enhancing the clinical experience of its new graduates along the lines advocated in *The New Doctor*, the visits provide us with opportunities to identify examples of good practice which we can share with other medical schools. These too are detailed in our reports.

The reports of individual visits will normally be available on our website (www.gmc-uk.org) one month after these have been sent to the schools concerned. In addition, we will be publishing a summary of our findings at the conclusion of the current round of visits in 2001.

Introduction

1. Our visit, which took place on 7 and 8 February 2001, had two purposes.

These were:

to monitor the progress made by the University of Cambridge in implementing *Tomorrow's Doctors* since our last visit in 1998;

to consider the progress made towards implementing the recommendations set out in *The New Doctor*.

2. Professor Graeme Catto, Chairman of the GMC Education Committee, led the visiting team. Other members were Professor Sir Cyril Chantler, former Dean of Guy's, King's and St Thomas' Medical and Dental School and GMC member, Professor Roger Green, Dean of Medicine at the University of Manchester and GMC Education Committee member, Professor Reg Jordan, Director of Medical Studies at the University of Newcastle upon Tyne, and Dr Peter Barnes, Medical Director at the Hope Hospital, Salford.

3. The first day of our visit was devoted to considering the undergraduate programme at the University of Cambridge, while the second was spent reviewing general clinical training in the Eastern Deanery (formerly the East Anglian Deanery).

4. Our report of the visit to Cambridge is in two parts. Part one considers developments in undergraduate medical education since 1998. In part two, we explore the Deanery's compliance with the recommendations made in *The New Doctor*, and review plans for the further development of general clinical training.

5. In both sections of this report we have identified areas of good practice and aspects of the programme where we believe further progress is required.

Part 1: The undergraduate curriculum

Background information

6. The School of Clinical Medicine provided us with background information on undergraduate medical education at Cambridge prior to our visit, including the completed GMC questionnaire.

7. The University of Cambridge does not have a formally constituted School of Medicine to which new undergraduate students are admitted. Each year, approximately 280 students are admitted to the University to study for a BA (Hons.) degree in the Medical and Veterinary Sciences Tripos (MVST). This three-year course covers the basic sciences fundamental to medicine. Thereafter, graduates who wish to qualify as doctors must seek admission either to the University of Cambridge School of Clinical Medicine, which offers 130 places on its 27-month course, or to Oxford, London or another UK medical school.

8. The University of Cambridge operates a collegiate system. Upon enrolment at Cambridge, students become members of one of the 31 colleges. The Colleges are independent, self-governing corporate bodies distinct from the University, with their own property and income. The governing body of a College consists of a

Master (Provost, President, Principal, Warden or Mistress) and a number of Fellows.

Form of the visit

9. The first day of our visit began by meeting members of the Medical Education Committee (MEC), including the Regius Professor of Physic, the Clinical Dean, the Postgraduate Dean and the Director of Medical and Veterinary Education in the Faculty of Biology. We then met members of the Clinical Curriculum Committee (CCC) which is responsible for management of the clinical years of the undergraduate curriculum. Our morning session concluded with a discussion with staff involved in the proposed Cambridge Graduate Course (CGC).

10. Over lunch the team spoke with a group of medical students from each year of the Cambridge undergraduate medical course.

11. In the afternoon, we met members of the Pre-Clinical Medical and Veterinary Education Committee (PREMAVEC) which is responsible for the first three years of the Cambridge undergraduate medical programme.

12. During the first day we also had the opportunity to visit the University's Clinical Skills Centre, the Clinical and Biomedical Computing Unit and the Institute of Public Health.

13. The regulations for the MB BChir programme are at **Annex A**.

14. A map of the Cambridge undergraduate medical programme is at **Annex B**.

MVST/ Second MB course

15. Each of the first three years of the undergraduate course consists of three 8-week terms, although only 20 weeks per year are available for formal teaching. The remaining time is set aside for end-of-year examinations.

16. In the first two years, students take courses leading to both the Second MB qualification required to proceed to the clinical component of the undergraduate programme, and to Parts IA (first pre-clinical year) and IB (second pre-clinical year) of the MVST.

17. We learned that the Pre-Clinical Medical and Veterinary Education Committee (PREMAVEC) has recently revised certain aspects of the first two years of the pre-clinical curriculum. The intentions of PREMAVEC in undertaking this exercise were to:

a) effect a 20 per cent reduction in practical sessions and lectures during the pre-clinical years;

b) develop explicit aims and objectives for all courses;

enable earlier student contact with patients;

promote teamwork and communication skills amongst students;

increase the profile of problem-solving approaches to learning and emphasis on ethics and public health in the pre-clinical years.

18. The revised MVST Part IA was implemented in October 2000. The Faculty of Biology will introduce Part IB of the revised MVST in October 2001. A list of the revised MVST Part IA and Part IB courses is at **Annex C**.

19. At the time of enrolment students are issued with a copy of in *The Grey Book – Medicine at Cambridge: The First Two Years*. This details:

the aims and objectives of the of the first two years of the pre-clinical course;

- b) information on vaccination against Hepatitis B;
- c) information on the structure of Tripos and Second MB examinations;
- d) the knowledge, skills and attitudes necessary to study medicine;
- e) the Faculty of Biology's policy on student health and conduct.

The latest version of *The Grey Book* is at **Annex D**.

20. In Year 1 students take the following courses:

- a) Functional Architecture of the Body (FAB);
- b) Homeostasis (HOM);
- c) Molecules in Medical Science (MIMS).

21. The aims and objectives of each new course, as well as lecture plans and information on practical sessions, were provided to us in draft form prior to our visit. An example is at **Annex E**.

22. A new vertical strand Preparing for Patients (PFP), introduces students to patient care and communication issues in Year 1 (PFPA). The objectives of this course include enabling students to develop the skills required to conduct a simple medical interview and to acquire understanding of consent and confidentiality issues. More information on the PFP course is contained in *The Grey Book*.

23. Students will complete four courses in Year 2. These will be assessed for the Second MB and the Tripos. The courses are:

- a) Biology of Disease (BOD);

- b) Mechanisms for Drug Action (MODA);
- c) Neurobiology with Human Behaviour (NHB);
- d) Scientific, Social and Ethical Aspects of Reproduction and Populations (SSEARP).

24. As part of the revised MVST, students will study two special options during Year 2 of the undergraduate programme. These will count towards the MVST Part IB. Further information on the special options programme is at paragraphs 83-85.

25. PFP will continue in Year 2 (PFPB). In view of recent public concerns over clinical incidents and the behaviour of doctors, we believe the University should strengthen the PFP vertical strand by enhancing clinical teaching in Years 1 and 2. This will ensure that core student learning opportunities in relation to patient contact and communication skills are firmly anchored in the formative years of medical education at Cambridge. They should of course, extend throughout the undergraduate curriculum.

Clinical course

26. An overview of the Cambridge clinical course is at **Annex F**.

27. The month long introductory course provides students with a foundation in clinical method, history taking and the physical examination of patients.

28. The three main phases of the clinical course are as follows:

Phase I (6 months) - Basic clinical skills and knowledge. Students learn the basic concepts of clinical assessment and the fundamentals of medicine and surgery. Students undertake clinical attachments in:

- Accident and emergency
- Epidemiology
- General practice
- Medicine for the elderly
- Pathological sciences
- Junior medicine and surgery

Phase II (13 months) – ‘The specialties’. Students undertake clinical rotations in the following specialties:

- Paediatrics
- Obstetrics and gynaecology
- Neurosciences and rehabilitation
- Ophthalmology
- Orthopaedics
- Cardiology
- Respiratory medicine
- General practice

Dermatology
GU medicine
Plastic surgery
Urology
ENT surgery
Psychiatry

c) Phase III (6 months) – ‘The senior attachments’. During this time students refine their clinical skills and take a more active role in patient care. While doing so, they complete:

Senior medicine
Accident and emergency
Oncology
Peri-operative medicine
Senior surgery
Public health medicine

29. Five vertical strands permeate the various clinical attachments. These are:

Clinical pharmacology

Comprehensive clinical method (encompassing communication skills)

Medical ethics and law

Practical skills

e) Radiology

The core curriculum summary document is at **Annex G**. A diagram illustrating vertical strand learning at Cambridge is at **Annex H**.

30. A clinical course guide provides information on the structure of the clinical programme, student performance and monitoring, and practical advice on working in a clinical environment. The students with whom we spoke thought this was a most useful resource.

The Cambridge Graduate Course (CGC)

31. The proposed Cambridge Graduate Course (CGC) is a four-year medical programme open to graduates of any discipline, with an intake of 20 students per annum. At the time of our visit, the University was seeking GMC approval for the CGC course, which it hoped to commence in September 2001. A map of the CGC course is at **Annex I**.

32. The CGC provides an opportunity to widen access to the medical profession by admitting individuals other than traditional school-leavers with ‘A’ level science qualifications.

33. We understand that in the development of the CGC, special attention has been given to fulfilling the recommendations set out in *Tomorrow's Doctors* and in particular, the integration of basic sciences with clinical medicine.

34. We were told that the CGC would have a separate identity from the existing Cambridge course. However, core medical sciences teaching will be common to the standard undergraduate course. CGC students will pursue only the core elements of the MVST course. CGC students will acquire the Second MB partly during Year 1 and partly in Year 2. Clinical teaching will be integrated into the first two years of the course by taking advantage of the University vacation periods. There will be four SSMs.

35. Early patient contact with students will be facilitated through the PFP course and clinical skills attachments at the West Suffolk Hospital. Index cases will be used to enhance the integration of basic sciences with clinical aspects of the course.

36. Eight vertical strands will run through the CGC. These are:

Comprehensive Clinical Method

Ethics and law

Practical clinical skills

Public health medicine

Clinical pharmacology

Radiology

Primary care

Literature in medicine

37. The CGC student admissions policy is at **Annex J**.

The management of change (Principal Recommendation 13)

Supervisory structures

38. A diagram illustrating the University's supervisory structures for undergraduate medicine and explanatory notes are at **Annex K**.

39. The General Board has ultimate responsibility for the delivery of teaching at the University of Cambridge, although many of its tasks have been devolved to various Faculty Boards. The two Faculty Boards responsible for medical education at Cambridge are:

The Faculty of Biology - pre-clinical medical education

The Faculty of Clinical Medicine – clinical medical education

40. The Medical Education Committee (MEC) co-ordinates the strategic aspects of medical education at Cambridge, and draws its membership from the Faculty Board of Biology and the Faculty Board of Clinical Medicine. The MEC is chaired by the Regius Professor of Physic.

41. The MEC has made a start in advancing integration within the Cambridge undergraduate curriculum. We commend this approach and believe that the MEC should now assume overall jurisdiction of both the MVST/Second MB and clinical courses, strengthening its responsibilities in order to accelerate integration.

MVST/ Second MB course

42. Co-ordination of the individual departments and University Colleges involved in pre-medical education is the remit of the Director of Medical and Veterinary Education in the Faculty of Biology (DOMVE). The DOMVE is the chairman of PREMAVEC. His other responsibilities include:

- a) the development and implementation of the decisions of the Faculty Board of Biology about aspects of medical and veterinary education;
- b) liaison with the Clinical Dean in co-ordinating medical education at Cambridge;
- c) liaison with Senior Tutors and College Directors of Studies in Medicine.

43. Within the Faculty of Biology, each component course has a management committee whose membership includes all lecturers involved in the day-to-day operation of the course. These report to PREMAVEC, which exercises, through its inter-departmental course panels, a management function in reviewing curriculum and assessment for the entire course. Each component of the revised course will be reviewed on a two-yearly rotation. Year 1 of the revised course will be reviewed during the academic year, 2002/ 03.

Clinical course

44. The Clinical Curriculum Committee (CCC) has oversight of the clinical component of the MB BChir programme. Its terms of reference are at **Annex K**. Two sub-committees assist in the work of the CCC. These are:

- a) the Curriculum Development Group – responsible for the design and implementation of the revised clinical curriculum;
- b) the Curriculum Advisory Group – prepares curricular proposals for the CCC and considers methods of supporting students who require remedial help.

45. The role of the Clinical Dean is integral to the management of all aspects of

undergraduate medical education at Cambridge and in particular, the operation of the clinical course. The Clinical Dean is supported in his work by:

the Associate Clinical Dean;

the Associate Clinical Dean, Staff Development;

Clinical Supervisors;

Attachment Directors;

Clinical Sub-Deans;

Strand Co-ordinators (for the various curricular strands);

University and clinical lecturers;

College Directors of Studies.

We found the supervisory structures for the undergraduate medical course at Cambridge to be extremely complex and confusing. We hope the University will consider modernising aspects of its supervisory structures in the near future so that these become more meaningful for both staff and students to interpret.

The contribution of students

46. PREMEVEC has one student representative, while two students participate in meetings of the MEC, one each from the Faculty of Biology and the Faculty of Clinical Medicine. We assume that the MEC will consider the appointment of a representative from the graduate-entry programme when it begins later this year.

47. There is greater emphasis on the contribution of students as they progress to the clinical years of the course. Annually, two clinical students are elected to serve as members of the Faculty Board of Clinical Medicine. They also serve on the CCC and are invited to canvass student views, present these to the Committee and provide relevant feedback to their peers. Students told us that during the pre-clinical years they are able to contribute feedback on curriculum management issues to College Supervisors and College Directors of Studies.

48. Students on clinical attachments nominate a representative to attend meetings of the CCC. In addition, the Clinical Dean holds regular informal meetings with student groups and societies. Junior medical staff are integrally involved in the clinical course as Clinical Supervisors and are encouraged to contribute their comments on aspects of the curriculum to the CCC.

Staff development

49. The Faculty of Biology has found it difficult to encourage long-serving staff members to participate in continuing professional development (CPD) programmes. However, we were told that in future, applicants for promotion within

the University would be required to show evidence of professional development. Induction and training sessions arranged by the University's Academic Staff Development Committee are compulsory for all new recruits. Associate Lecturers and Recognised Clinical Teachers are also eligible to attend these sessions.

50. The uptake of professional development courses amongst staff from the School of Clinical Medicine has been better than that of the Faculty of Biology. At least half of School teaching staff have attended 'Teach the Teacher' courses. The Clinical School organised its first Staff Development Week in March 2000, and has plans to make this an annual event. The next one is scheduled for May 2001. The Staff Development Calendar of Events for 2000/2001 is at **Annex L**.

51. We were concerned to be told that it was not yet compulsory for serving College tutors to participate in professional development programmes, including 'Teach the Teacher' courses. In the past, the University had made recommendations on tutor training but the Colleges had been able to veto such proposals. However, in recent years, Colleges have taken a more pro-active approach to this issue. In 2000, many Colleges made provision for tutors to attend development programmes. We recommend that the Colleges continue with these endeavours to ensure 100 per cent attendance by all staff involved in the delivery of the undergraduate medical programme.

Promoting teaching

52. The Associate Clinical Dean, Staff Development is responsible for professional development programmes amongst Clinical Supervisors and Recognised Clinical Teachers. We were told that the School has recently established a 'peer review of teaching' system, and that about half of all clinical teachers attached to the Cambridge undergraduate course have expressed an interest in participating in this. We did not have the opportunity to explore how this system works or to judge how successful it has been thus far in promoting good practice amongst clinical teachers.

53. NHS teachers are encouraged to attend courses organised by the Postgraduate Dean for example, 'Teach the Teacher', 'Train the Trainer' and 'Educating Consultants'.

54. The University of Cambridge encourages teaching staff to acquire and develop their teaching skills through its general staff development programme. This includes courses in teaching, assessment and management skills. New staff are supported in the establishment of teaching portfolios leading to membership of the Institute of Teaching and Learning (ILT).

55. We were pleased to see that good performance in teaching and teaching-related activities is integrated into academic promotion criteria. The University has instituted a promotion scheme to the University Senior Lecturer grade for which two criteria include excellence in teaching and the performance of administration duties.

56. NHS teachers in the main teaching hospitals are recognised by the

University through their appointment as Associate Lecturers. As they are appointed and re-appointed, Associate Lecturers are required to give evidence of their expertise in teaching. The title Recognised Clinical Teacher is awarded to acknowledge teaching as a valued activity in regional hospitals.

Aspects of the core curriculum (Principal Recommendations 1,2,5 and 7)

Defining the core curriculum

57. As was the case in 1998, we found little evidence of an overarching, integrated core curriculum in medicine at the University of Cambridge. Rather, the pre-clinical and clinical courses operate as two separate, distinct parts of the undergraduate programme. We would prefer to see a more integrated core curriculum in operation at Cambridge, the benefits of which are well illustrated in medical school programmes throughout the UK.

MVST/Second MB course

58. PREMAVEC has overall responsibility for defining the first three years of the undergraduate programme.

Clinical course

59. In preparation for a revision of the clinical curriculum in 1997, the School recruited a team of Attachment Directors whose role was to monitor aspects of the undergraduate programme by:

- a) advising the CCC on the content and structure of the curriculum and on matters concerning the effective delivery of teaching programmes by specialists;
- b) supervising curriculum delivery and student assessment at teaching hospitals, and monitoring the provision of teaching and learning facilities;
- c) co-ordinating specialty elective placements at teaching hospitals;
- d) liaising with undergraduate Specialty Tutors and other Attachment Directors;
- e) preparing annual specialty reports at the end of each main block of the curriculum.

60. During 1998, the Clinical Dean began a series of individual meetings with Attachment Directors and key consultants. The objectives of the meeting were to:

- a) finalise the core curriculum documents;
- b) consider options for improving the provision of teaching for the current intake;

- c) review the co-ordination of teaching throughout the region;
- d) review teaching methods and CAL packages.

61. The information gathered from each meeting was presented to the CCC and a revised clinical programme introduced in September 1999. Strand Co-ordinators and Undergraduate Specialty Tutors were also involved in the curriculum development process. The Clinical Dean told us that he continues to meet with Attachment Directors to further refine aspects of the curriculum. We noted that Attachment Directors would participate in a major review of the clinical curriculum and Final MB during 2000/2001.

Reducing the burden of factual information

MVST/Second MB

62. PREMAVEC is primarily responsible for monitoring the burden of factual load and reports to the MEC on this issue. In the report of our 1998 visit, we commended the University for achieving a 20 per cent reduction in the burden of factual information during the pre-clinical years. We were told that the subsequent implementation of Parts IA and IB of the revised MVST/Second MB programme has resulted in a 20 – 25 per cent reduction in student contact time since 1998.

63. PREMAVEC informed us that the core knowledge component of each pre-clinical course had been defined more carefully to reduce duplication between courses and the number of timetabled hours for students. However, the students with whom we spoke said that their work programmes were consistently intensive. We understand that timetabled hours for third year single-subject-courses vary between departments, but are generally 100-120 hours per course spread over the 20-week teaching year.

64. While we recognise that the Faculty of Biology and PREMAVEC are committed to reducing the factual content of the pre-clinical course, it seemed to us that progress had been only modest since our last visit. We consider that a further reduction in the factual burden should be made.

65. We do not accept that further reducing the burden of factual information would compromise the integrity or quality of the scientific component of the undergraduate course that had drawn students to apply to Cambridge.

Clinical course

66. The Clinical Dean told us that the CCC has overall responsibility for monitoring the burden of factual information within the undergraduate clinical programme. Staff teaching specific clinical subjects and Attachment Directors report to the CCC on factual load.

67. The School of Clinical Medicine established the annual specialty reporting system referred to in paragraphs 59 and 178, in order to monitor the content and

delivery of the clinical course.

68. We were told that Colleges review students' workload and progress and are quick to complain to the School if they believe students to be overburdened.

69. We will be seeking information from the School about the steps it is taking to monitor the workload of clinical students when we follow up our report in a year's time.

Integration of the course

70. The existence of two distinct courses at Cambridge prevents the University from offering a fully integrated systems-based medical curriculum. We have commented on this at paragraph 57.

71. In our 1998 visit report, we noted 'that despite physical and resource constraints, as well as the structure of the MVST and clinical course, vertical integration is being achieved, and some systems-based teaching introduced.' Pre-clinical and clinical inter-departmental staff panels have been established to promote discussion and debate across the spectrum of medical education. We thought this was a useful tool in encouraging greater integration within the undergraduate curriculum. However, we consider that there is a need to achieve further vertical and horizontal integration in the near future.

72. Members of PREMAVEC told us that most of the revised pre-clinical courses have been designed to incorporate aspects of clinical relevance. Examples include:

the Molecules in Medical Science (MIMS) course in which carbohydrate metabolism is illustrated with reference to diabetes;

the cell cycle, genetics teaching, DNA synthesis, mutation and repair are linked to tumour biology and cancer;

the Functional Architecture of the Body (FAB) course is based on clinical examination and investigation. Students learn to inspect and observe anatomical features in living subjects, to listen to the sounds the body makes, and to communicate effectively and sensitively about body structure;

the involvement of clinicians in the Biology of Disease course during Year 2.

73. We were told that the PFP vertical strand serves to enhance opportunities for horizontal integration in the first two years of the pre-clinical curriculum. We remain concerned that many of the benefits of the PFP programme will not be realised unless steps are taken to strengthen clinical training during the formative years of the course.

74. The Clinical Dean and others believe that lengthening the clinical course by six months is essential to allow students more time for reflective learning. We

strongly support this initiative and look forward to reviewing the University's plans on this issue in a year's time.

Learning through curiosity

75. The Cambridge curriculum offers a range of opportunities for student learning through curiosity.

MVST/ Second MB course

76. The Faculty of Biology now uses problem-based learning (PBL) methods in some of its pre-clinical courses and students seem to enjoy this approach to learning. Most students have responded well to the PFP course and told us that debriefing sessions with tutors have enabled them to improve the way in which they interact with patients from diverse backgrounds.

77. Part II of the MVST (Year 3) provides a unique opportunity for students to undertake a year of research on a topic of their choice.

Clinical course

78. At the end of Phase II, students embark on the clinical elective; those with whom we spoke thought that this was a most interesting and rewarding aspect of the course. Many students travel abroad to learn how medicine is practised in other countries, while others remain in the UK to undertake specialist clinical research. Information on the elective programme is provided in the clinical course guide. On their return, students prepare a 1000 word elective report. There are three annual prizes awarded for the most original elective reports.

79. Some students opt to follow the MB/PhD programme offered by the University of Cambridge. This leads to the MB BChir and PhD degrees, and enables students who are planning an academic career in medicine to intercalate three years of research with their clinical training. More information on the MB/PhD programme is at **Annex M**.

Special study modules (Principal Recommendation 6)

80. The Cambridge undergraduate programme does not feature special study modules (SSMs) as they were intended in *Tomorrow's Doctors*. Nevertheless, the University believes it will meet the objectives of the SSMs through Part II of the MVST (Year 3) and the new special options programme, due to commence in September 2001.

81. Part II of the MVST resembles the intercalated year which some medical students undertake during their training at other UK medical schools. However, the unique Cambridge course affords all medical students the opportunity to embark on a period of specialised research during their third year.

82. In Year 3, students choose a variety of subjects to qualify for the BA degree. These include:

- a) a single subject from Part II of the natural sciences MVST;
- b) part II of the MVST which includes a choice from a large range of biomedical courses including history of medicine, human impact on the environment and medicine, ethics and law;
- c) a subject which is less medically related, such as social anthropology, law, management studies or philosophy.

83. The new special options programme will take place during the second term of Year 2. Students will select two course options from the following list:

Addiction (Pharmacology);

Environmental physiology; responses to perturbation (Physiology);

Control of pain (Pharmacology);

Developmental biology for medicine (Anatomy);

Experimental psychology (Experimental Psychology/Anatomy);

Infectious disease in animals and man (Pathology/Veterinary Medicine);

The biochemistry of diabetes, obesity and cardiovascular disease (Biochemistry);

Molecular intervention and disease: chemotherapy and gene therapy (Biochemistry/Genetics/Pharmacology);

Sensorimotor neurobiology (Physiology);

Toxicology (Pharmacology);

Tumour biology (Pathology).

84. Each course will occupy 20 units of teaching time where a unit is equivalent to an hour-long lecture or two hours of practicals, seminars or problem-based learning sessions.

85. The Faculty of Biology intends to assess each special options course with a single three-hour written examination. Students will answer two questions, one on each of their options. The special options paper counts for the same amount of marks as each of the major Year 2 courses, although it does contribute to the Second MB. We look forward to hearing how the special options programme is progressing in a year's time, including its relationship to the core curriculum.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

86. The University of Cambridge provided us with the following information on the various learning opportunities for students in the MB BChir course.

<i>Teaching method</i>	<i>Years 1-2</i>	<i>Year 3</i>	<i>Years 4-6</i>
Supervisions/PBL/ small group learning	15 - 25 %	50 – 85 %	10 %
Lectures/ structured seminars/ practicals	70 - 75 %	15 – 50 %	15 %
Patient-based learning	< 5 %	-	75 %

MVST/ Second MB course

87. In Years 1-3, a variety of teaching methods are employed including lectures, computer-based learning programmes, practicals, self-directed learning, PBL, small group teaching sessions, and seminars.

88. Throughout the first two years, the College supervision system operates as a small-group teaching programme, which is highly effective in reinforcing and complementing the formal lecture and practical teaching, provided by the Faculty of Biology. Students with whom we spoke thought that College supervisions were invaluable in enabling them to refine their research, critical analysis and communication skills.

Clinical course

89. We were told that aspects of the introductory course and the Phase I portfolio assist in developing students' transferable skills at the beginning of the clinical course. The development of these skills is embedded in the clinical course and students are made aware of the experiential basis of learning in the clinical environment.

90. The clinical dean told us that lectures are kept to a minimum during the clinical course, and are used to support core curriculum learning in the introduction to specialties, and in revision for Final MB. Students endorse this approach.

91. Learning in small groups is important, with an average of six in a Clinical Supervision Group and a maximum of 23 students in an Attachment Group. In addition, general practice tutorials are given on a one-to-one or one-to-two basis

and are used to reinforce clinical experiences and presentation skills or develop problem-solving approaches to diagnosis and management.

92. Students were extremely enthusiastic about their clinical teaching sessions. These are organised on the basis of firms, with groups which range in size from two (regional hospitals) to seven (Addenbrooke's medicine and surgery rotations). Several attachments require students to research and present case-based reports highlighting an aspect of their experiences.

Computer assisted learning (CAL)

93. In 1998, we commended the University of Cambridge on its innovative approach to computer-assisted learning (CAL). The team found it useful to see how the momentum to develop these resources had increased in recent years.

94. The University has an extensive IT infrastructure. All students have e-mail accounts and a personal workstation facility login, and the Colleges provide generous computing facilities. Many students told us that they had their own personal computer or laptop.

MVST/Second MB

95. A number of CAL packages are used for teaching in Medical Sociology, Anatomy, Histology and the Biology of Disease courses. All students have access to networked computers in the departments involved in undergraduate teaching.

Clinical course

96. The Addenbrooke's hospital site is linked to the University's Joint Academic Network (JANET) IT hub.

97. The Clinical School IT Support Service provides and maintains the hardware within the PWF, Medical Library and other teaching areas. Clinical students are offered training in the use of these facilities during the Introductory Course. The Clinical and Biomedical Computing Unit (CBCU) is located in the Clinical School and largely funded by innovative use of NHS SIFT funds. Its activities include:

- a) the provision of IT resources for students and CAL course ware;
basic and advanced IT training;
- c) maintenance of the School's web pages and a secure intranet system, which can be accessed on all Addenbrooke's Hospital wards;
- d) development of an ER Web to provide students with a personalised environment integrating teaching and administrative resources, that is accessible from the Addenbrooke's site, Colleges and some district general hospitals;

- e) development of systems for student feedback and course evaluation.

Other learning resources

98. Students confirmed that the University of Cambridge has excellent library and research support facilities. We heard that the medical library provides information to students either in groups or individually. All students may attend the library's regular training sessions or request individual instruction. Senior students receive a refresher tour of the library upon joining the clinical course.

99. During our visit, some of us had the opportunity to visit the School's Clinical Skills Development and Resources Unit (CSDRU). Learning resources within the CSDRU include networked personal computers, educational videos, mannequins for learning basic life support, a communication skills area, and space for the teaching and the assessment of clinical skills.

Changing patterns of health care (Principal Recommendation 10)

100. The Clinical School has identified the following factors as having contributed to changing patterns of health care:

- a) managing the complexities of healthcare in a multidisciplinary team environment;
- b) the early discharge of patients and increased patient through-put;
- c) constant demands on financial and manpower resources.

101. In Phase I (see **Annex F**), students spend time at a hospice and an elderly care facility. During Phase II, they experience the work of a Child Psychiatry Unit, Community Paediatric Services, and a Drug and Alcohol Dependency Unit.

102. Other opportunities to experience medicine in the community are provided during the child health component of the clinical course when students spend one day a week in a community health setting, although opportunities for training alongside health visitors and district nurses are extremely limited.

103. A new admissions ward has promoted student learning opportunities in trauma medicine. The outpatients ward provides numerous educational opportunities in medicine and surgery. We heard that at least half of the time students spend in outpatients is devoted to observing consultants or doing 'hands-on' tasks such as taking medical histories.

104. General practice training currently constitutes two weeks each in Phases I – III, as well as a two-day general practice session during the introduction to the clinical course. We understand that course organisers are considering increasing the amount of general practice education in the undergraduate programme. We strongly encourage the School to make this, and wider clinical education in the community, priorities within the undergraduate programme. We also believe that it is appropriate for the School to begin to enhance opportunities

for multiprofessional education within the undergraduate course.

The goals of undergraduate education –attitudes, skills and knowledge

Attitudes (Principal Recommendation 3)

MVST/Second MB

105. We understand that all students receive *Duties of a Doctor* at their introductory lecture with the Regius Professor of Physic and the DOMVE.

106. Students are introduced to the importance of attitudes to their colleagues and others during anatomy teaching in FAB. Reflection on the importance of appropriate attitudes for the practice of medicine is a significant component of the PFP course, which draws upon the information in *Duties of a Doctor*. There is further reinforcement of these issues at intervals during the first two years for example, in the SSEARP course during Year 2.

Clinical course

107. The Clinical Dean gives a personal introduction to the Clinical Course focusing on *Duties of a Doctor* and *Good Medical Practice*. This guidance is also considered in the comprehensive clinical method and medical ethics vertical strands.

108. During the general practice component of the clinical course, students participate in seminars on ethics and attitudes. These focus on conflicting ethical scenarios and the appropriate response of doctors to such situations. Actors are used in the 'breaking bad news' training sessions. The corrective input given in these sessions is said to be a most useful aspect of student training.

Essential skills (Principal Recommendations 4 and 8)

MVST/Second MB course

109. We heard that students' study and information technology skills are developed through lectures, practical sessions and the College supervision and tutorial system. They are also encouraged to acquire independent study methods through the use of the web for accessing libraries and other sources of information.

110. Communication skills are acquired through College supervisions, and further enhanced in small group teaching in Years 1-3. These are assessed through student presentations to their peers and teaching staff on subjects in which they have been engaged either in PBL or journal sessions, or through research projects. The documentation with which we were provided did not include specific criteria or marking plans used for assessing students' communication skills.

111. Students develop team working skills during PBL sessions in Years 1 and 2, in dissection groups in anatomy and in other small group teaching sessions.

Supervisors told us that students tend to learn about teamwork independently of the formal course, for example through extracurricular activities like team sports or participating in student societies.

Clinical course

112. Students receive guidance on essential skills during the introductory phase of the clinical course. The Clinical Dean told us that through this course students should:

- a) be cognisant of the community and environment in which they will learn clinical medicine and be aware that their learning will be more self-directed and experiential in the clinical course;
- b) have developed an initial understanding of the comprehensive clinical method which is sufficient to establish a relationship with the patients to be encountered in Phase I, and which enables them to begin learning clinical medicine through the effective exploration of disease and illness;
- c) be aware of the multiprofessional nature of clinical practice and the importance of team working.

113. Essential skills are also emphasised in a two-day practical nursing experience session in the first week of the clinical course. Comprehensive clinical method and practical skills are vertical strands running throughout the clinical course, and all clinical attachments focus specifically on the importance of team working.

114. Both the School and the University offer IT training courses to students. A number of innovative IT-based programmes have been prepared by the School to assist with communication skills teaching. Some of the team had the opportunity to see these teaching tools in action during our visit and were most impressed with the School's initiative in this area.

115. The Practical Skills Strand incorporates interactive sessions on the acquisition of basic life support skills (BLS). This training is co-ordinated by accident and emergency physicians. From December 2001, students will be required to pass assessments related to these sessions before they can proceed to the final MB examination. We understand the School does not as a matter of course, offer training sessions in advanced life support (ALS), although demonstration of proficiency in ALS is one of the skills objectives of *Tomorrow's Doctors*, section 40.2 (b).

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

116. In 1998, we recommended that the University increase the profile of public health medicine in the undergraduate curriculum. It was therefore, pleasing to learn

of the School's recent plans to strengthen this aspect of the course.

MVST/ Second MB course

117. During this stage of the course, public health medicine comprises:

- a) An introduction to the scientific study of medicine course in Year 1. The aim of this lecture course is to introduce students to aspects of the philosophy of medical science and epidemiology with a focus upon experimental design (statistics, epidemiological methods, testing hypotheses, trial methodology and interpreting research);
- b) An interactive CAL programme in medical sociology which Year 1 students complete independently;
- c) Three lectures on demography during the Year 2 SSEARP core course.

Further information on public health teaching in Years 1-3 is at **Annex N**.

Clinical course

118. Senior students have lectures in epidemiology during the introductory phase of the clinical course, reinforcing what they learned during the pre-clinical programme. There is an 'epidemiology day' for all students in Phase I. Elements of public health medicine and medical sociology, especially in relation to the doctor-patient relationship, are incorporated into the comprehensive clinical method vertical strand and the Phase I general practice course.

119. During Phase III, there is a two-week attachment in public health medicine combining seminar and small group self-directed learning sessions. Each group produces a component of a web-based public health medicine teaching resource, presenting this to their colleagues.

120. We noted that the CCC has plans to alter the time when the public health component of the clinical course is taught. This is currently delivered at the end of Phase III, immediately prior to the Final MB examinations. The CCC intends to enhance integration of public health medicine in the undergraduate course through the development of a public health vertical strand. We support this initiative and believe it should be introduced without delay.

Legal and ethical issues

MVST/ Second MB course

121. During the pre-clinical course students receive the following instruction on the ethical aspects of medicine:

an introductory medical ethics lecture which forms part of the FAB course in

Year 1;

b) five Year 2 lectures, together with four practical sessions. (These will continue next year in the new SSEARP course, in the human reproductive biology teaching);

c) in Year 3 students following the MVST Part II are offered an optional single-paper subject: Medicine, Ethics and the Law.

Clinical course

122. During Phase III (medical ethics and law strand) students attend a series of seminars during which leading ethics and medico-legal specialists promote discussion on these issues.

123. The MEC has identified a need to strengthen its ethics teaching and recently established a working group to review options for creating a full-time lecturer post in ethics and law. This post would be based jointly in the faculties of Biology and Law, with responsibility for teaching ethical and legal principles to medical students. We encourage this initiative, although we were not told when this appointment would be made.

Medicine in a multicultural society

124. The Clinical Dean told us that about 30 per cent of the medical students admitted each year are from an ethnic minority community. Cambridge and the surrounding area both lack a diverse population base, although we were told that there are significant ethnic minority populations in some of the local communities whose hospitals contribute to the teaching of undergraduate students such as Whipp's Cross, Luton and Dunstable.

125. Transcultural medicine is referred to briefly during the communication skills component of the undergraduate programme. A Cultural Liaison Group has been established by one of the Associate Deans to promote a better understanding of cross-cultural issues in medical education, although we did not get an opportunity to discuss the progress made by this group in meeting its objective. Overall, we believe that the Cambridge course affords students a very limited experience of medicine in a multicultural environment. We urge both the Faculty of Biology and the Clinical School to ensure that students are appropriately prepared for the practice of medicine in Britain's ethnically diverse society.

Complementary medicine

126. The Clinical Dean informed us that the University does not consider it appropriate to include in the curriculum medical theories that are 'alternative in the sense that they are outwith the sphere of scientific bases of medical theory and practice'. Hence, there are no formal lectures or teaching sessions on alternative medical therapies within the Cambridge undergraduate programme. However, the comprehensive clinical method vertical strand considers patients' perspectives on complementary medicine. Students are sometimes exposed to such beliefs during

palliative care and general practice attachments.

127. The coverage of information about alternative therapies in the core curriculum disappointed us. We hope that this feature of the course will be reviewed by the University, so as to ensure that all students have a greater awareness of the range of therapies that are available, including their applications and limitations, and that they feel able to discuss these in an informed way with their future patients.

Anti-microbial therapy

128. Students receive guidance on anti-microbial therapies in the MVST/Second MB courses in particular, the Biology of Diseases (BOD). The clinical course incorporates a microbiology component covering the theoretical aspects of drug resistance in a more intensive way than the MVST.

Assessment of the process and the product (Principal Recommendation 12)

Assessment methodology

MVST/Second MB course

129. Pre-clinical students complete a range of formative and summative assessments. Some formative assessments take place within the College supervisions sessions, although most are part of the formal University programme.

130. The Faculty of Biology utilises a variety of formative assessment methods including multiple-choice questions (MCQs) and short answer questions. OSCE-type examinations together with data-handling questions are used for practical assessments, and the production of workbooks and dissertations are also used in the assessment leading to Second MB qualification. Essay questions are used to test students' ability to integrate knowledge and synthesise arguments.

131. The main summative assessments are the end-of-year examinations taken in Years 1-3. These are:

a) MVST examinations - the basis by which students are assessed for the BA (Hons.) degree;

Second MB examinations to determine student progression to the clinical course.

132. We heard that third year students who undertake a MVST single-subject Part II, present literature and laboratory projects which together, account for 20-30 per cent of their total mark depending on the subject. Students doing MVST Part II are required to produce a dissertation on an approved subject.

133. Students must pass the medical sociology and PFP courses before being eligible to sit the Second MB examinations and thus complete the pre-clinical programme. These courses are separate from the MVST course. A classified BA (Hons.) degree is awarded to successful students at the end of Year 3.

134. Information on assessment is set out in *The Grey Book*. Assessment criteria are also published on the Faculty Board of Biology website.

Clinical course

135. An Examinations Committee (EC) monitors the content and operation of all assessments and examinations within the clinical course. The EC reports to the CCC.

136. Attachment Directors define the learning objectives for each clinical rotation. Assessment is formative and unique to each attachment. Criteria for assessment are published in both the *Clinical Course Guide* and on the School's internet website. The School uses various formative assessment techniques including MCQs, multiple-part objective questionnaires (MCPQs), essay questions and viva voce examinations.

137. The attitudes and behaviour of students are assessed as they rotate throughout the various clinical attachments. Their attendance, enthusiasm and practical skills are constantly monitored. On-firm assessments concentrate on testing history-taking and communication skills.

138. The summative Final MB examination is in three parts. The Final MB is designed to confirm that students have achieved the core objectives of the course, and that graduates are fit to continue their medical education as PRHOs. The Final MB examinations in pathology, obstetrics and gynaecology, medicine and surgery take place in March and December of the final year. Students who fail any or all parts of the Final MB examinations may re-sit in the following June.

139. On successful completion of the MB examinations, students are eligible for the award of the Bachelor of Medicine and Bachelor of Surgery (MB/BChir) degrees. The BChir is formally awarded in December, the MB in June the following year to enable attendance at a General Admission for conferment of the degree.

140. The School is in the process of revising the Final MB examinations so that these closely link with the main objectives of the clinical course. Such an initiative would be consistent with modern educational principles and we strongly support the implementation of the revised examination programme, preferably in time for the 2001 – 2002 academic year.

141. From December 2001, all students will be required to complete an OSCE to test communication and practical clinical skills prior to sitting the Final MB. The Clinical Skills Unit and supporting clinical sites will conduct the OSCE. We endorse this initiative. A list of the practical clinical skills required of students and information on how these will be tested is at **Annex O**.

Academic performance and fitness to practise

142. Throughout the pre-clinical course, College supervisions sessions ensure that students in difficulty are identified quickly and given appropriate remedial assistance. Clinical students' performance is monitored on a monthly basis through attachment reports and any problems are brought to the attention of the Clinical Dean.

143. Since our last visit the University has made steady progress in raising awareness of student health, conduct and fitness to practise issues. All medical students are subject to the University's statutory provisions regarding discipline and the Medical Student Code of Conduct. This is reproduced for their information in both *The Grey Book* and the clinical course guide.

144. Clinical students are also asked to agree to the terms of a Medical Students' Register before having access to patients. The Register requires students to observe the Medical Student Code of Conduct. The University hopes to extend this provision to all MVST students in the near future.

145. When we visited, the School was in the process of finalising provisions for a Fitness to Practise Committee (FTPC) and a Fitness to Practise Appeals Committee. The FPTC (formerly the Medical Student Register Committee) will monitor the Medical Student Code of Conduct and make recommendations on student health and conduct matters to the Faculty Board. This body will have the ability to propose the permanent or temporary suspension of medical students from the Medical Students' Register. Draft papers on the FTPC are at **Annex P**.

146. The FTPC will also consider the health and conduct of pre-registration house officers (PRHOs) and will make recommendations to the Clinical Dean on PRHOs' suitability to proceed to full registration. We commend this approach and look to receiving in due course, further information on the progress of the FTPC.

The outcome of the course

147. We were told that throughout the Cambridge undergraduate course, students are frequently reminded of the aims and objectives of the undergraduate programme and in particular, the professionalism that is expected of them whilst training. Specifically, the University aims to:

- a) foster academic excellence and to provide an education of the highest quality so as to produce medical practitioners of the calibre sought by the profession, and in addition provide the teachers and researchers of the future;
- b) help students recognise and construct knowledge, behaviours and skills necessary for the effective and compassionate practice of medicine;
- c) provide students with an intellectually stimulating and diverse environment in which they have the opportunity to develop their vocational and academic enthusiasms to the best of their potential, within the guiding

principles of *Tomorrow's Doctors*;

d) encourage a life-long learning approach to professional, personal and academic development.

Preparation for the pre-registration year

148. There is currently no formal PRHO shadowing period for senior undergraduate students, although the School is considering this as part of its plans to lengthen the clinical course. We strongly encourage the School to incorporate a PRHO shadowing programme as currently practised in a number of medical schools.

149. We noted that the two Associate Deans for the PRHO Year conduct one-to-one interviews with all senior students before they sit the Final MB examinations. This forum provides an opportunity for students to review their progress and discuss likely career goals.

150. The Joint Pre-registration Committee (JPRC) produces a guide, *The Pre-registration Year* which is issued to all senior students before they qualify.

Other issues

Student selection

151. Although student selection is not within our remit, we have an interest in ensuring that only those who are fit to become doctors are admitted to medical school. Therefore, we have sought information about this aspect of the University's procedures.

152. All prospective MVST/Second MB students are interviewed by at least two staff, one of whom is medically qualified. Candidates are made aware of the assessment process when applying to the University. There is a guide to applications for medicine on the University's website.

153. The Colleges (through the College Directors of Clinical Studies) and the University have recently initiated a pilot programme for the admission of medical students. The programme comprises three parts – a screening aptitude test, an elementary (GSCE level) basic science test and an essay on a medically relevant topic. The tests are computer marked. College staff assess the essays, which are subsequently used as the basis for student interviews.

154. Candidates for the clinical course are admitted after interview, having gained qualifying education in the basic sciences relevant to clinical medicine, usually at Cambridge. The University also admits students from the University of Oxford and some of the London medical schools.

155. We were told that staff receive guidance on interview techniques and equal opportunities. An intensive staff debriefing session occurs following candidate interviews and assessments.

Student induction

156. The initial induction of medical students takes place within the Colleges under the supervision of tutors and the Directors of Clinical Studies. Students are issued with email and internet passwords and if necessary, instructions on how to use these services, so that they can access timetables and other course information.

157. The Regius Professor of Physic formally welcomes students onto the course. This is followed by an outline of the curriculum, an introduction to the PFP course, and a brief talk from a representative from the MDU. As mentioned at paragraph 105, the GMC information pack *Duties of a Doctor* is distributed at this session.

158. For the clinical component, the first two weeks of the introductory course prepares students for learning in a clinical environment.

159. Both the Medical Society (for MVST students) and the Harvey Society (for Clinical students) liaise with new 'recruits'. MedSoc organises a series of talks by guest speakers and social events for medical students. The Harvey Society has an organised 'parenting' scheme, under which a clinical student will adopt a small number of pre-clinical students, providing a link to the clinical training later in the course.

Student support

160. The University, Faculty of Biology, Clinical School and Colleges offer a range of resources to support and guide students. This pastoral network may be accessed at different points depending on the nature of the student's problem.

MVST/Second MB

161. Pre-clinical student support is based on the College supervision and tutorial system. This is designed to provide formative assessment of progress, detect those students who are having difficulties either academically or in their personal life. Colleges arrange extra tuition for students when necessary and students have access to the University's health and counselling services.

162. Students spoke warmly of the Collegiate system at Cambridge, especially in relation to the pastoral support they receive and opportunities for networking. College induction programmes were useful although some thought it would have been preferable to have had contact with other Cambridge medical students earlier in the course.

Clinical course

163. Clinical Supervisors are an important source of academic and pastoral support for senior students. Clinical supervisors are doctors-in-training who are attached to a small group of students. Students meet their supervisors each week for an hour to discuss any academic or personal problems. Clinical supervisors are

recruited on the basis of their demonstrated interest in education and possession of a broad range of skills and experience. They take part in a half-day 'Teach the Teacher' course.

164. The Clinical Dean told us that he operates an 'open door' policy to all undergraduate students, but especially those on the clinical course. Clinical students are also encouraged to seek a personal interview with the Clinical Dean or correspond with him by email.

165. The Clinical Dean interviews any student who fails an attachment or has a poor record over several attachments. There is also an individual interview with the Clinical Dean and Clinical Supervisor at the end of Phase I.

166. The Associate Dean has particular responsibility for the progress and welfare of MB/PhD students. During their research years, students maintain weekly contact with their Clinical Supervisor.

167. Students who consider withdrawing from their medical studies at Cambridge receive support and guidance from Faculty/School staff and the University Careers Service. We heard that about half of all pre-clinical students at Cambridge transfer to other universities following the Second MB examination to complete their medical training. The dropout rate of students from the pre-clinical course is about four in a cohort of 280. During the clinical programme, approximately two students withdraw per cohort.

Feedback to students

168. Details on requesting informal feedback are set out in both *The Grey Book* and the clinical course guide. Students regularly contact the Clinical Dean by email and in person to request informal feedback.

169. There is currently no specific feedback to students on formal **Tripes** examinations. No comments are provided when papers are marked and it is not made clear how marking schemes operate for such examinations. We were told that this is a 'structural problem' within the University. We do not believe that this is a satisfactory explanation for the lack of feedback about the outcome of examinations. As a matter of urgency the Faculty of Biology should press for greater accountability within the formal examinations system so that students may obtain appropriate feedback on their performance and overall academic progress. This is particularly important with respect to 'borderline' or failing students.
MVST/Second MB

170. Students told us that feedback on their performance in class assessments and course work is provided in a timely manner by Clinical Supervisors and Directors of Clinical Studies. Supervisors write reports detailing students' attitudes and progress, which Directors of Studies then discuss formally with students at end of each term.

Clinical course

171. Clinical Supervisors meet students to discuss their progress at the end of Phase I. Colleges require supervisors to provide termly reports on student progress; the senior tutor or the Director of Studies refers any serious difficulties to the Clinical Dean. During Phase III, there is a meeting with an Associate Dean at which progress and career opportunities are discussed.

172. All students meet the Clinical Dean individually at least annually during the clinical years, and have weekly sessions with College supervisors throughout the entire undergraduate course. Student assessment results are copied confidentially to College supervisors, who hold informal interviews with students to discuss performance and workload issues.

173. A written Attachment Report is generated for each attachment and completed by the Attachment Director or Undergraduate Specialty Tutor. At least 27 reports are produced per student during the course. A summary of the grades is produced in the form of a Student Performance Report at various stages of the course:

- a) for any student who has a consistently poor record in any area - these students are asked to discuss their performance with the Clinical Dean;
- b) for each Phase I student - for discussion at Phase I assessment interviews with the Clinical Dean and Clinical Supervisors;
- c) in the December of Phase II – for distribution by Clinical Supervisors to each student in their group;
- d) midway through Phase III (from July) – an appointment with the Associate Dean is made for each student to discuss the report and career plans.

Quality control

174. For information on quality control, the University referred us to various self-assessment documents prepared for the Quality Assurance Agency for Higher Education (QAA).

175. Quality control of medical education programmes is the responsibility of the General Board through the MEC. Its tasks include overseeing changes to the teaching programme, monitoring the quality of courses through external examiners' reports, undertaking departmental reviews and promoting good practice in medical education.

176. At a local level, other mechanisms for ensuring quality control within the undergraduate programme include:

- a) pre-clinical course student questionnaires which cover lectures, practical sessions, and self-directed learning sessions;
- b) University employee appraisal system. Academic staff are appraised annually (non-tenured) or biennially (tenured);
- c) soliciting feedback from academic staff via self-assessment reports;
- d) evaluation of the conduct of examinations involving external examiners appointed by the General Board;
- e) student representation on the Faculty Board of Biology and the Faculty Board of Clinical Medicine.

177. During our visit, we heard about the Cambridge Attachment Monitoring System (CAMS). Introduced for all clinical rotations during 2000, students complete standard, optical mark-read, questionnaires for each attachment. Results are incorporated into a database for analysis in the CSDRU. They are used to inform Attachment Directors and prepare Associate Deans for Service Increment for Teaching (SIFT) monitoring visits.

178. The School's curriculum office maintains a database of student comments and responses for the information of the Associate Deans and Attachment Directors. Attachment Directors review all feedback when they compile annual specialty reports in which recommendations for future improvements to the course are made.

Areas of good practice

179. *Undergraduate curriculum*: The Cambridge undergraduate medical programme focuses particularly on the biological sciences, acknowledged internationally as a research strength of the University. That emphasis is made known to students at the time of their application. The staff and many of the students with whom we spoke indicated their support for the distinctive scientific-based undergraduate medical curriculum.

180. We believe that the Tripos year provides a unique opportunity for students to pursue research into an area of interest to them, with the assistance of highly qualified and motivated staff, themselves often leaders in the field of medical research (paragraph 81).

181. *Learning resources*: Students at Cambridge have access to an impressive range of learning resources including high capacity CAL packages and the Clinical Skills Development and Resources Unit (paragraphs 93-99).

182. *Student support*: Students spoke warmly of the friendliness and approachability of staff. They particularly appreciated the way in which the Faculty of Biology, the School and the respective Colleges had responded rapidly to their concerns over aspects of the curriculum. The system of supervision was highly regarded by the students (paragraphs 161-162).

Encouraging plans for the future

183. *Graduate Entry Course (CGC)*: Although a review of the proposed course was not a formal part of our visit, we are hopeful that the model of the new clinical programme planned for the CGC will act as a catalyst for introducing much needed changes to the existing MVST course. We will be monitoring this aspect of the CGC closely over the next year (paragraphs 31-38).

184. *Length of the clinical course*: We endorse the University's desire to extend the clinical curriculum to three years. Both undergraduate students and the PRHOs within whom we spoke supported this view. Staff also acknowledged the distinct benefits that would ensue by lengthening the clinical programme (paragraph 74).

185. *Aspects of the knowledge base (public health medicine)*: In our last report we recommended that further attention be given to public health medicine and the ways in which it should be interwoven with the teaching of the sciences basic to medicine as well as clinical medicine. Therefore, we were pleased to note the School's plans to strengthen and embed public health within the curriculum. Furthermore, we encourage the University to implement these without delay (paragraphs 117-120).

186. *Assessment of the process and the product (Final MB examination)*: We welcome the School's plans to revise the Final MB examinations and expect any resultant changes to be implemented as soon as possible, ideally in time for the 2001 - 2002 academic year (paragraph 140).

187. *Essential skills*: We strongly support the introduction of the OCSE to test clinical skills and attitudes (paragraph 141).

Areas for further consideration

188. *The undergraduate curriculum*: In the light of recent public concern over adverse clinical incidents and the behaviour of doctors, we now require the University to strengthen the PFP vertical teaching strand. This will ensure that more core teaching and clinical learning opportunities are firmly anchored during the first two years of the undergraduate programme (paragraph 25).

189. The University's efforts to begin the integration of aspects of the undergraduate curriculum are encouraging. We believe that this process would be greatly expedited if the MEC assumed strategic jurisdiction of both the MVST/ Second MB and clinical courses, sooner rather than later (paragraph 41).

190. *Supervisory structures*: We would like to see the University streamline its supervisory structures for undergraduate medicine. At present, these seem to us unnecessarily cumbersome and confusing (paragraph 45).

191. *Staff development*: We were interested to hear about the efforts made by the University, the Faculty of Biology and the School of Clinical Medicine to date, to raise the profile of staff development programmes. We recommend that the Colleges continue with its endeavours to promote the development of all staff involved in the delivery of the undergraduate programme (paragraph 51).

192. *Burden of factual information*: We believe that changes to the undergraduate programme should be accompanied by a further reduction in the content of the core curriculum, particularly during the first two years of the MVST. Students themselves wish to see greater clinical relevance and input into the course, a view which we most definitely endorse. We do not accept that such a change would impair the quality of the course's science base (paragraph 65).

193. We received insufficient information to comment to any great extent, about the burden of information placed upon clinical students. However, we intend to closely monitor this aspect of the undergraduate programme in the future (paragraphs 69).

194. *Changing patterns of healthcare*: While we acknowledge the School's desire to increase student learning opportunities in a general practice setting, we would like to see students exposed to other forms of healthcare provision with the community. In addition, we consider that the School should begin to enhance opportunities for multiprofessional education within the undergraduate course (paragraph 104).

195. *Essential skills (advanced life support)*: Notwithstanding the costs involved, the School must initiate a programme of advanced life support for all undergraduate students in accordance with the recommendations in *Tomorrow's Doctors* (paragraph 115).

196. *Medicine in a multicultural society:* We urge both the Faculty of Biology and the School to consider adopting more appropriate methods of preparing students for the practice of medicine in Britain's ethnically diverse society (paragraph 125).

197. *Complementary medicine:* We wish the University to consider reviewing its past decision to exclude complementary medicine from the core curriculum. Students need some awareness of the range of alternative therapies that are available, including their applications and limitations, and feel able to discuss these in an informed way with their future patients (paragraph 127).

198. *Preparation for the PRHO year:* We endorse the School's plans to introduce a shadowing period for all final year students and look forward to reviewing progress in a year's time (paragraph 148).

199. *Feedback to students on assessment:* Consideration should be given to providing students with formal feedback on University examinations (paragraph 169). The review of the clinical curriculum should include appropriate changes to the examination system to ensure greater transparency and consistency.

Conclusion

200. The areas we have identified for further consideration do not detract from the progress that has been made in medical education at the University of Cambridge since our 1999 visit. Staff from the Faculty of Biology and the Faculty of Clinical Medicine involved in developing and implementing revised aspects of the undergraduate programme deserve praise for what has been achieved so far. We strongly encourage the continuation of this work.

201. We were most impressed by the calibre of the students we met during our visit, their motivation to learn and openness at sharing their impressions of the undergraduate programme. Without exception, students were supportive of the Faculty of Biology and the Clinical School, and were well aware of the opportunities for change within the undergraduate medical course at the University of Cambridge.

Part 2: General clinical training

Background information

202. Prior to our visit, the Postgraduate Dean's office provided background information on general clinical training for Cambridge graduates.

203. We were told that the East Anglian Deanery would be subsumed within the Eastern Deanery with effect from 1 April 2001. Further information on the new Deanery and its responsibilities is at **Annex Q**. Reference to the Deanery in this report will relate to the Eastern Deanery.

204. Within the Deanery, 16 NHS Trusts provide opportunities for general clinical training. These are located in Bedford, Basildon, Bury St Edmunds, Cambridge, Chelmsford, Colchester, Great Yarmouth, Harlow, Huntingdon, Ipswich, King's Lynn, Luton, Norwich, Peterborough, Stevenage and Welwyn Garden City.

205. The recognised PRHO posts are as follows:

a)	House Physician posts	100
b)	House Surgeon posts	92
	House Officer rotations (three x four-month rotations in general practice, general medicine, and general or orthopaedic surgery)	4

206. The House Physician posts include appointments in paediatrics at Ipswich and West Suffolk hospitals, and critical care medicine at Ipswich Hospital. It was not clear how many rotations existed in these specialties within the Deanery.

207. We were told that there is currently a plentiful supply of six-month posts within the Deanery. PRHOs usually undertake two six-month posts in medicine and surgery to complete their general clinical training.

208. The Deanery is currently looking at establishing more four-month posts.

Form of the visit relating to general clinical training

209. Our visit began with an overview of general clinical training issues in the Eastern Deanery provided by the Postgraduate Dean, the Clinical Dean and two Associate Deans for the PRHO year. We then met members of the Joint Pre-Registration Committee (JPRC). A meeting with chief executives and medical directors from local NHS Trusts completed the morning session. Over lunch we were joined by a group of PRHOs from a range of locations and specialties. Our day concluded with a discussion involving clinical tutors and educational supervisors from the NHS Trusts and general practices where PRHOs are employed.

Organisation and management of the PRHO year

Supervisory structures

210. The JPRC is responsible for overseeing the provision of general clinical training within the region. The JPRC meets each term and is chaired by one of the Clinical Sub-Deans.

211. Membership of the JPRC is as follows:

- Chairman – elected by the JPRC for three years
- Clinical Dean
- Associate Deans for pre-registration education and training (two)
- Postgraduate Dean
- Clinical Sub-Deans for regional Trusts
- Regional Director of General Practice Studies
- Honorary Medical Education Advisor
- Addenbrooke's representative – medicine
- Addenbrooke's representative – surgery
- PRHO representative
- Senior undergraduate student representative
- NHS Regional Office Director of Workforce Development and Nursing
- JRPC Secretary

212. The functions of the JPRC include:

- providing educational recognition to PRHO posts within the Eastern Deanery;

- assuming responsibility for implementation of *The New Doctor* and any local general clinical training recommendations approved by the JPRC;

- appointing educational supervisors;

- maintaining a detailed register of PRHO posts and educational supervisors;

- managing the PRHO matching scheme for Cambridge graduates;

- conducting visits to NHS Trusts to approve PRHO posts against GMC and JPRC criteria;

- ensuring regular feedback from post-holders about their posts;

- encouraging a seamless transition between undergraduate training and the PRHO year and compliance with the aims and objectives for medical education.

213. Day-to-day responsibility for general clinical training is shared between the Clinical Dean, the Postgraduate Dean and the two Associate Deans for the PRHO year.

The approval of posts

214. The JPRC is responsible for the development and approval of PRHO posts. The information gathered by the Associate Deans during their formal and informal PRHO post visits programme assists the JPRC in this process.

215. New PRHO posts are assessed against the following general criteria:

- a) demonstrated commitment to general clinical training by employing NHS Trusts;
- b) appropriate facilities for educational supervision;
proposed PRHO induction programmes;
- d) facilities for the assessment of PRHOs;
- e) contractual provisions including the hours and working conditions of PRHOs.

Communicating the aims and objectives of the pre-registration year

216. The Deanery has made some progress in implementing the recommendations on communication contained in *The New Doctor*.

217. PRHOs, educational supervisors and NHS Trust staff are informed of the aims and objectives of the pre-registration years in a number of ways:

- twice-yearly PRHO post visits by the Associate Deans and regular JPRC meetings;
- b) presentations on general clinical training to undergraduate students in their second (pre-clinical) and final years;
- c) career development seminars for PRHOs at the beginning of their general clinical training year;
- d) JPRC booklet *The Pre-registration Year – Guide and Record of Progress and Assessment* issued to all students before they sit the Final MB. This is reproduced at **Annex R**.

The selection of PRHOs

218. The Deanery utilises a matching scheme to allocate most Cambridge graduates to PRHO posts within the region. Final year students are informed of the available posts and complete an application form for the matching process. All applicants for posts at Addenbrooke's are interviewed as these posts are in high demand.

219. Unfortunately, the existing matching scheme did not appear to take account of equal employment opportunities legislation. The Postgraduate Dean told us that the Deanery was awaiting advice from the Department of Health on how to integrate equal opportunities provisions into the selection process. Nevertheless, we strongly urge the Deanery to ensure its matching scheme is both transparent and equitable.

Monitoring the quality of PRHO education & training

220. PRHO posts are monitored through:

six-monthly informal visits conducted by the Associate Deans;

three-yearly formal visits conducted by the Associate Deans;

annual monitoring visits conducted by the Postgraduate Dean.

221. Reports of formal visits are presented to the JPRC. The Postgraduate Dean may provide feedback to the JPRC, although there is no formal report of his visits to approved posts.

222. Formal educational approval of the posts is normally conferred for three years, although if there are serious issues to address, temporary approval for a shorter period may be granted, until a second visit has taken place.

223. We heard that in 2000, a general surgery post was suspended. In this case, the Associate Dean identified shortcomings which were brought to the attention of the appropriate NHS personnel. Suggested remedial action was not successful and the JPRC agreed that a post should be removed.

224. The Deanery does not prohibit any specific combination of PRHO posts, although PRHOs are encouraged to select posts that provide a good range of clinical experience while complying with GMC requirements for general clinical training. The Deanery would like to see all PRHO posts in the region become four-month appointments within a 12-month rotation and is working towards this objective. It also hopes to develop a number of innovative specialty and GP posts.

Components of a high quality PRHO post

Induction training

225. As we have mentioned previously in this report, PRHO shadowing is not a feature of the Cambridge undergraduate course. We encourage the Clinical School and Deanery to consider introducing such experience as soon as possible. All the PRHOs with whom we spoke agreed that they would have gained from an 'apprenticeship' period before embarking on their general clinical training.

226. The Associate Deans told us that all PRHO posts provide a formal induction programme, usually lasting two days and including presentations by NHS medical directors and chief executives. During the induction phase, PRHOs' skills in basic

life support, writing drug charts and cannulation are assessed.

227. PRHOs told us that the induction they had received at Bury St Edmunds hospital was particularly comprehensive and that the Trust had made two skills laboratories available for PRHOs to practise their clinical skills. We heard that other NHS Trusts are considering the establishment of clinical skills laboratories elsewhere in the region.

228. Some PRHOs said that they initially struggled with the practical application of clinical skills when they began their first house job. Patient management also presented particular challenges for PRHOs, although they told us that they were always well supported by SHOs and registrars in district general hospitals.

229. The Deanery intends to introduce PRHO logbooks, although we were not told when this would happen. We encourage the Deanery to undertake this initiative as soon as possible.

Educational opportunities

230. Each Trust has its own programme of weekly PRHO teaching sessions arranged by the Clinical Sub-Dean in each location. The teaching sessions usually take the form of small-group seminars with some one-to-one learning at PRHOs' request. Trusts and Clinical Sub-Deans monitor PRHO attendance at educational sessions. These records are made available to visiting Associate Deans. We noted that a draft educational plan for PRHO attachments in surgery is currently being finalised.

231. We were told that the JPRC 'strongly encourages' a bleep-free policy to enable all PRHOs to attend educational sessions. Most PRHOs with whom we spoke had access to protected time for educational purposes although the onus was on them to find someone to take their calls while absent from the ward. At the West Suffolk hospital a dedicated hour-per-week is allocated for PRHOs to take advantage of educational opportunities. At Addenbrooke's Hospital, PRHOs reported that it is now increasingly difficult to give up their bleeps in order to attend educational sessions.

232. The inconsistencies that exist in relation to PRHOs' access to bleep-free time are unacceptable. We wish to see the Deanery develop and implement a Trust-wide policy for managing protected time for all PRHOs so that they may take full advantage of the various educational opportunities on offer to them.

233. PRHOs at Addenbrooke's Hospital regularly organise a 'morning report session' to discuss interesting or difficult clinical cases. Registrars and consultants are invited to these sessions. We commend this initiative and hope it can be replicated in other localities.

Educational supervision

234. Educational supervisors have contracts with the NHS Trusts by which they are employed. These encompass the requirement on Trusts to assume

responsibility for the education of doctors-in-training. Trusts have an agreement with the Postgraduate Dean for the provision of postgraduate medical and dental education. This is reproduced at **Annex S**.

235. The aims and objectives of the PRHO year are detailed in *The Pre-registration Year – Guide and Record of Progress and Assessment*. All PRHOs are allocated an educational supervisor for each clinical rotation. Educational supervisors are required to meet the PRHOs at least three times, usually at the beginning, middle and end of the post.

236. We understand that the Deanery operates a system of PRHO appraisal. One of the Associate Deans and an educational supervisor meet with all PRHOs during the general clinical training year. This forum provides an opportunity to review each PRHOs' performance and consider areas for professional development.

237. There is no formal Deanery requirement for educational supervisors to participate in training for their role, although they are encouraged to do so by the JPRC.

238. Training for educational supervisors is 'delegated to Clinical Tutors and the local postgraduate centres within Trusts'. We were told that 50 per cent of educational supervisors had attended training courses within the last two years. There is a six-month waiting list (about 120 consultants) for some of the more innovative courses offered in the Deanery including appraisal techniques, 'Teach the Teacher' and IT skills.

239. We were satisfied with the progress made by the School so far, to encourage educational supervisors receive training for their role. From now on however, we urge the Deanery to introduce mandatory formal training programmes for all educational supervisors.

240. Educational supervisors' performance is assessed during the Associate Deans' monitoring visits. Performance problems are considered by the Clinical Sub-Dean and Associate Dean, and sometimes referred to the JPRC if not resolved at the local level. Clinical Tutors/Directors of Postgraduate Education have dual responsibilities to the Trust Chief Executives and the Postgraduate Dean.

241. Clinical tutors and Clinical Sub-Deans meet twice per year to discuss PRHO educational activities and to share aspects of best practice.

Clinical training and supervision

242. The Deanery and NHS Trusts aim to foster a supportive training environment for trainee doctors. Most of the PRHOs whom we met enjoyed the experience of working in multidisciplinary teams and found ward work very congenial, particularly in district general hospitals. The Postgraduate Dean encourages multidisciplinary education in all hospitals.

243. General clinical skills are listed in *The Pre-Registration Year - Record of Progress and Achievement*. Ensuring the acquisition of these skills is the

responsibility of the educational supervisor.

244. PRHOs confirmed their intense dissatisfaction at being required to undertake tasks of little educational value. We understand that this is a particular problem for PRHOs on attachments at Addenbrooke's hospital. The Deanery must take immediate action to rectify this situation.

Monitoring the progress of PRHOs

245. The progress of PRHOs in the Eastern Deanery is monitored through the initial, midpoint and end-of-post meetings with educational supervisors, and the PRHO appraisal system mentioned at paragraph 235.

246. Difficulties relating to health, personal problems or concerns about a particular post are initially discussed between the PRHO and educational supervisor. PRHOs may also choose to approach Clinical Sub-Deans, Associate Deans, the Postgraduate Dean, a consultant in occupational health or their GP for assistance. Most often, issues will be resolved at this stage, although the Deanery uses the following procedure should difficulties persist:

Local identification of problem by PRHO and/or educational supervisor

if problem not resolved

Local discussion with hospital Clinical Sub-Dean
with advice from Associate Dean

if problem not resolved

Associate Dean:
prepares informal report including appropriate Occupational Health, Personnel
and Educational reports;
convenes a meeting of all of those involved;
implements action plan agreed at the meeting.

if problem not resolved

Associate Dean:
prepares a report for the Joint Pre-registration Committee's consideration
implements JPRC recommendations.

247. The Postgraduate Dean told us that all reasonable steps are taken to support PRHOs through an illness. If their performance is not satisfactory due to illness, the Deanery can recommend that PRHOs extend their general clinical training by a further six months.

248. PRHOs are issued with Certificates of Satisfactory Service signed by educational supervisors as they progress through the various clinical posts. At the

end of the year the Postgraduate Dean signs the PRHOs' Certificates of Experience.

Professional development and personal well-being

Careers advice

249. Education officers from the human resource sections of various NHS Trusts, provide PRHOs with most of the careers advice they require. The Deanery also expects that these issues will be considered during educational supervision sessions and induction courses. At district general hospitals, careers advice and counselling is offered, although we were told that there was a very low uptake for these services. PRHOs tend to make informal inquiries of individuals in the clinical specialties which are of interest to them.

250. At Great Yarmouth, the Clinical Sub-Dean has set aside a half-hour careers advice session during each clinical rotation. This time is bleep-free and organisers reported 100 per cent PRHO attendance at these sessions.

251. A careers fair for senior clinical students and PRHOs is organised each summer in conjunction with the School of Clinical Medicine.

Support for PRHOs

252. We commend West Suffolk Hospital for offering a 24-hour help-line system for PRHOs. Informal counselling is provided on request. All NHS Trusts provide occupational health and counselling services for PRHOs.

253. PRHOs told us that much of their support came from fellow junior doctors, friends and consultants. PRHOs found that when they had difficulties, consultants were generally approachable and supportive. In most instances though, PRHOs found it easier to refer queries to SHOs and registrars.

Accommodation, catering and personal safety

254. The Deanery monitors accommodation, catering and the personal security of PRHOs through the Associate Deans' visits programme, and any recommendations or adverse comments are noted in subsequent visit reports. The Postgraduate Dean told us that it was the responsibility of employing Trusts to ensure the implementation of these recommendations, although we felt that the Deanery could be more proactive in ensuring this actually occurs.

255. The Clinical Sub-Dean at West Suffolk hospital told us that the local NHS Trust has introduced a zero-tolerance policy for threats to personal safety. CCTV cameras have been introduced and lighting around hospital buildings has been improved.

256. A security guard escort is provided on request in Norwich and CCTV cameras have been introduced. Addenbrooke's NHS Trust plans improvements to accommodation facilities for later in the year and from April 2001, a hot food service

will be available to PRHOs 24 hours a day.

Contractual matters

257. Job descriptions are available for all approved PRHO posts within the Eastern Deanery.

258. Junior doctors meet regularly with the human resources manager at the West Suffolk Hospital to discuss contractual matters and there is a junior doctor representative on the staff committee. At Addenbrooke's Hospital, the New Deal Implementation Group meets bi-monthly to consider PRHO employment issues. In Great Yarmouth, the Trust sends out a questionnaire to PRHOs to canvass their views on general clinical training.

259. PRHOs described their workload as 'significant', telling us that they often provided on call evening and night coverage for at least 100 beds (SHO and PRHO were on call for a maximum of 250 beds). All posts in the Deanery offer 24-hour coverage. Trainees undertake 24 hour on call shifts quite often, with no break. In addition, we heard that PRHO work intensity has increased because of the recent changes to the New Deal. Trusts are apparently employing 'quick fix' solutions to staffing problems hence PRHOs are working harder and longer than previously. This is an unacceptable situation. The Deanery and local Trusts must work together to tackle non-compliance with the provisions of the New Deal, and the particular issues highlighted by the PRHOs, at the earliest opportunity.

260. We were also concerned at the absence of a Deanery-wide policy addressing the issue of informed consent. Trainees reported a variety of experiences in seeking consent and told us that much depended on the particular post or consultant with whom they worked. For example, during the Addenbrooke's surgery rotation PRHOs are asked to obtain consent for nearly all procedures. On other rotations, PRHOs are 'coached' through consent procedures with guidance from consultants.

261. PRHOs were clearly uncomfortable about seeking consent for procedures about which they knew very little. Permitting PRHOs to seek consent from patients for procedures that they do not understand or the potential implications, of which they cannot explain, is a potentially dangerous strategy and one which contravenes the GMC's guidance in *Good Medical Practice*. We urge the Deanery to require that all Trusts take appropriate steps to ensure that all medical staff are fully informed about obtaining consent.

Areas of good practice

262. *Fitness to practise:* We commend the joint arrangements made by the School and Deanery to date, to develop and integrate student and PRHO fitness to practise procedures. We look forward to hearing of progress with this initiative (paragraph 146).

263. *Educational opportunities:* The PRHOs spoke enthusiastically about the range of educational opportunities provided for them during their general clinical

training. We were particularly impressed with the initiative of the Addenbrooke's Hospital PRHOs, who have taken it upon themselves to organise the 'morning report sessions' (paragraph 233).

Encouraging plans for the future

264. *Preparation for the PRHO year:* We support the wishes of the School and Deanery to link PRHO posts more closely to the final undergraduate year. All the groups with whom we spoke believed that a period spent shadowing a PRHO should be introduced as a matter of priority. Ideally, students should shadow the PRHO whose post they will occupy after graduation (paragraphs 148 and 225).

265. *New PRHO posts:* We welcome the progress made in establishing new PRHO posts in paediatrics and intensive care. We support the Deanery in its plans to extend the number of specialty based posts offering general experience of medicine and surgery, and rotations involving four months in general practice (paragraph 224).

266. *Induction training:* We encourage the Deanery in its plans to introduce PRHO logbooks (paragraph 229).

Areas for further consideration

267. *The selection of PRHOs:* The existing PRHO matching scheme did not appear to take account of equal employment opportunities legislation. This situation is unsatisfactory and we strongly urge the Deanery to ensure its matching scheme is both transparent and equitable (paragraph 219).

268. *Educational opportunities:* Many trainees were prevented from attending educational sessions because of their service commitments and a lack of genuine protected time, despite the JPRC's support for a 'bleep free' policy. We believe that the Deanery should take rapid action to ensure that PRHOs can attend scheduled educational sessions (paragraph 232).

269. *Educational supervision:* It was evident from the feedback we received that training for educational supervisors is variable across the Deanery. We regard it as a high priority for educational supervisors to receive the training that is necessary to enable them to undertake the tasks allocated to them in an effective way. This includes responding appropriately to the learning objectives of PRHOs (paragraph 239).

270. *Tasks of little educational value:* Our discussions with PRHOs left us in no doubt that they are expected to undertake far too many tasks of little or no educational value. We invite the Deanery and Trusts to adopt a more co-ordinated strategy in addressing this problem (paragraph 244).

271. *Workload and intensity:* The School and the Deanery should address the hours of work and the workload intensity of PRHOs as a matter of urgency. Trainees told us that they are covering more than 100 beds at weekends and out of hours, which we regard that as unacceptable. Sleep deprivation was apparent

amongst the PRHOs with whom we met (paragraph 259).

272. *Contractual matters* (obtaining informed consent): We were concerned at the absence of a Deanery-wide policy addressing the issue of informed consent. While learning about the practice of obtaining informed consent is part of the education of the PRHO, it is essential for medico-legal reasons that responsibility for obtaining consent should not be left entirely to trainees. PRHOs should not be obtaining informed consent for complex procedures about which they have little or no experience, and whose risks and benefits they are unable to explain to patients (paragraph 261).

Conclusion

273. It is apparent that the Eastern Deanery has made only modest progress in recent years in the management of general clinical training. Under the leadership of the JPRC, the Deanery has sought to integrate systems for monitoring the performance and development of new doctors throughout the region.

274. We wish the Deanery well with its plans for the future and look forward to reviewing its progress in a year's time, particularly with regard to resolution of the issues that are presently detracting from PRHOs' enjoyment of their first experience of being a doctor.