

Quality Assurance of Basic Medical Education

Report on School of Clinical Medicine and School of Biology, University of Cambridge

**General
Medical
Council**

Regulating doctors
Ensuring good medical practice

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The GMC's role in medical education

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

Introduction

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

5. 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 standard medical course, initially completing a BA (Hons) degree in the Medical and Veterinary Sciences Tripos (MVST). This three-year course covers the core 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 three year programme leading to the MB BChir or to one of its partner clinical schools. These are at Oxford, University College London, Imperial College, King's College, Barts and the London and St George's Medical Schools. In addition, there is a four-year graduate entry MB BChir medical degree which takes approximately 20 students per year. This course is referred to as the Cambridge Graduate Course (CGC) in medicine.

6. The previous GMC report in 2001 found that students spoke warmly of the friendliness of staff and thought highly of the system of supervision. However the School was required to strengthen the Preparing for Patients (PfP) teaching strand. It was also advised to continue integrating its undergraduate programme, to streamline its supervisory structures for undergraduate medicine, and to expose students to other forms of healthcare provision within the community.

The QABME team

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

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

8. Miss Coreen Beckford (GMC Education Quality Officer) supported the team.

Our programme of visits in 2006/07

9. The team conducted seven quality assurance visits on: 28 November 2006; 21 February; 8 and 9 May; 7 June; 12 June; 22 June; and 19 July 2007.
10. The findings of the team have been reached by reviewing evidence submitted by the School and undertaking the following activities:
 - a. Meetings with a variety of representatives from the School.
 - b. Observation of teaching sessions in GP practices and both district general hospitals and the main university teaching hospital, university departments and colleges.
 - c. Observation of the examination of clinical skills.
 - d. Analysis of exam papers.
 - e. Observation of the final examination board.
 - f. Site assessments to various NHS Trusts.
 - g. Site assessments to various GP practices.
 - h. Discussions with students.
 - i. Discussions with teachers, including general practitioners and clinical consultants.
 - j. Discussions with Foundation Year 1 doctors and their supervisors.

The report

Summary of our key findings

11. We found that, subject to the requirements in paragraph 16, the School's MB BChir programme meets the requirements of *Tomorrow's Doctors* in accordance with Section 5(3) of the Medical Act 1983.
12. Since the 2001 GMC report, the School has made considerable changes. It has implemented a Cambridge Graduate Course (CGC) and revised both the pre-clinical (Years 1 - 3) and clinical (Years 4 - 6) of the standard course. The revised curriculum for Year 6 of the standard course will be implemented in October 2007.
13. The School has made significant progress since its last review, in particular by:
 - a. Introducing patient exposure into the pre-clinical years.
 - b. Extending of the clinical course to allow more time to address the need for sound clinical knowledge and patient communication skills.
 - c. Introducing teaching about complementary therapies into the course.
14. We agreed with the School that a GMC visit should occur in 2007/08 to confirm the progress of the revised Year 6 curriculum and assessments.
15. Although we have identified a number of requirements and suggested some areas for additional consideration by the School, these should be read in the context of our finding that the School has made commendable progress since the last GMC report.

Requirements

16. The School is required to:
 - a. Ensure that it uses appropriate tools for its assessment scheme (paragraph 72).
 - b. Move to a formalised method of standard setting to secure robust judgements over all assessments, departments and years (paragraph 80).
 - c. Quality control the content and assessment of the student selected components (paragraph 44).
 - d. Ensure integration of clinical context with science teaching, throughout the pre-clinical years (paragraph 25).

- e. Ensure the Fitness to Practise Committee structures and procedures are robust (paragraph 87).

Recommendations

17. We have identified the following recommendations for the School and university to address. The School is advised to:

- a. Make assessments, particularly in the pre-clinical years, much more relevant to the clinical context (paragraph 24).
- b. Expand its provision of early patient contact in the pre-clinical years (paragraph 21).
- c. Develop methods to enhance student perspectives on whistle-blowing (paragraph 86).
- d. Review the delivery of the examiner and student briefings to ensure that both students and examiners are clear on the assessment process (paragraph 76).

18. The University of Cambridge is advised to ensure an experienced and medically qualified person is a member of every university appeals panel considering fitness to practise matters (paragraph 87).

Areas of innovation and good practice

19. We commend the School on the following areas of good practice:

- a. The online therapeutics and prescribing facility (paragraph 26).
- b. The communication skills programme (paragraph 32).
- c. The staff development strategy for the induction training of its clinical supervisors, the next step of which is to receive course accreditation (paragraph 51).
- d. The on-line learning environment, ERWeb, which delivers core curricular material across different regional hospital sites and promotes the development of students' self-directed learning skills (paragraph 65).
- e. The level of pastoral and academic support provided through the collegiate system (paragraph 68).
- f. The MBPhD programme, which provides ongoing clinical exposure (paragraph 39).
- g. The Hub and Spoke clinical skills model (paragraph 55).

Curricular outcomes, content, structure and delivery

Curricular outcomes

20. The School is in the process of revising its guidance on the learning outcomes for attachments to make them clearer for both students and staff. The clinical teachers reported that they liked the newly revised, clear learning objectives identified for the primary care teaching and we encourage the School to continue these revisions throughout the curriculum.

Relationships with patients

21. Although the School has strengthened the Preparing for Patients programme (PfP) enabling students to meet patients in pre clinical years, we concluded that the School should expand this programme to increase student interaction with patients. Pre-clinical supervisors suggested that patient contact appeared to be separate and artificially attached to the pre-clinical years rather than integrated within it. Year 1 and 2 students viewed the current PfP programme as providing only disjointed contact with patients. This may be a particular problem for students who complete their medical degrees outside Cambridge. We agreed with the School that there should be further development of contextualised early patient contact in the first two years of the standard course as has been done successfully in the Cambridge Graduate Course (CGC).

Content

22. We were satisfied with the content of the CGC.

The scientific basis of practice

23. The School's curricula strongly emphasise basic science knowledge and this is reflected in the high standard of scientific knowledge required within the exam papers. Recently, the School has revised the pre-clinical curricula to teach sciences in a manner more relevant to medicine. This has worked well in some areas, however progress is needed in other areas as detailed below.

24. We commended the School on the integration of anatomy with clinical work and the progress with integrating pathology teaching and clinical application. For example, those anatomy questions set in a clinical context within exam papers were excellent. We recommended that this approach be extended to the rest of the anatomy paper and to other pre-clinical papers.

25. We reviewed a sample of departmental minutes and examination papers from the pre-clinical years. The assessment style of biochemistry and physiology in the standard course, as demonstrated in written examination papers, indicated that the School had not made sufficient progress integrating biochemistry and physiology within a clinical setting. The questions predominantly sought to elicit isolated

scientific knowledge rather than that related to clinical context. The course content for both biochemistry and physiology appeared detailed and not sufficiently integrated. The School is required to ensure that all the sciences are integrated with clinical learning and contextualised within the clinical setting.

Treatment

26. We were impressed by the School's online Pharmacology and Therapeutics course and was pleased to note that the School utilised a chief pharmacist and clinical pharmacologist to develop the course. The online facility allowed students to use colour-coded practice sheets to consolidate their knowledge of prescribing and drug charts. Students independently learn how to spot errors in their prescriptions. The online course is supported by practical prescribing sessions. Although this course facility is still under development, we consider this to be an example of good practice in progress.

27. The School has responded to the previous GMC report in 2001 and students are now introduced to complementary medicine through research exercises, presentations and lectures.

Clinical and practical skills

28. The curriculum of both courses is predominantly science based for the first two years although as noted in paragraph 22, some steps have been taken to introduce pre-clinical students to patients via the PfP programme. Although CGC students cover the same science content, they receive an increased proportion of clinical teaching as a result of their course structure.

29. The School reported that there will be increased emphasis on patient management within Year 6 of the standard course. We will triangulate this in 2008 when we revisit the School to observe the delivery of the revised Year 6 curriculum.

30. We commend the School on its breadth of practical skills training which not only covers the requirement of *Tomorrow's Doctors* but also provides instruction on additional skills which the students find valuable for becoming F1 Doctors.

31. Overall we found the clinical content within the CGC and standard course to be appropriate.

Communication skills

32. We commend the breadth of the communication skills programme throughout the course. In the new Year 6 of the standard course, the School plans to use ethnically diverse interpreters to teach students how to communicate and overcome language barriers with patients whose first language is not English.

Teaching skills

33. The F1 trainees reported that their undergraduate teaching had equipped them with confidence to teach others. CGC students also reported that they had opportunities to teach students in later cohorts. We commend the School on its initiatives to recruit and train senior students to teach their peers.

Medico-legal and ethical issues

34. The School has recently appointed a medical sociologist to integrate the existing four strands of the PfP, Medical Sociology, Medical Ethics and the Introduction to the Scientific Basis of Medicine. The School plans to assess this new integrated strand by rationalising existing assessments into one single assessment strand, and to introduce law as it relates to medicine. We will monitor progress in this area.

The individual in society

35. The School's programme involves students working in small groups with simulated patients from black and minority ethnic backgrounds. Students are exposed to urban health issues at Addenbrooke's Hospital. All students complete half of their clinical placements outside Cambridge so that they encounter people from diverse socio-economic and cultural backgrounds.

Structure

36. The University of Cambridge operates within a collegiate system, with individual colleges as well as the medical school being responsible for the student experience.

37. Students studying the standard course complete three pre-clinical years (Second MB and Tripos) followed by three clinical years of study. There is a separate admissions process for students wishing to progress to the clinical course. Partly due to improvements in the School's clinical course there has been a substantial increase in applications. Approximately 30 - 40 Year 3 Cambridge students who chose Cambridge as their first choice for the clinical teaching programme are not accepted as only 130 places are available. The fact that the School continues to provide a course divided into pre-clinical and clinical phases may pose a problem for students who complete their medical degrees elsewhere.

38. There are two options for graduate entry students; a tailored four year CGC and the 'affiliated' programme. Affiliated programme students already have a first degree but complete the first two years of the Medical and Veterinary Sciences Tripos (MVST) and then progress straight to the clinical years of the course.

39. Students may intercalate a PhD after the first clinical year of the standard course, making the MBPhD option nine years in duration. An MBPhD student receives two hours of supervised time with patients each week during their PhD component.

40. In addition to taking their medical degree, students are required to complete the requirements for the Cambridge Tripos degree. The Tripos consists of basic sciences for the first two years with specific bio-medical science examinations separate from the MB BChir examinations. The subject specificity of the Tripos is decided by Year 3 choice, which the School counts as a year of student selected components (SSCs).

41. Students have the opportunity to take any subject within the University as part of Year 3 of their Tripos as long as they have the appropriate A-Levels and are qualified for their subject choice. The third 'Tripos' year does not contribute to the student MB BChir ranking and need not be taken in medically related subjects. The School reported that each year around 20 students take subjects not directly related to medicine.

42. Students on the standard course must pass each year of the Tripos to progress with the MB BChir. The School reported that typically three or four students fail in Year 1 of the Tripos and then one or two students fail in Year 2. Failures usually occur because of personal reasons rather than academic performance. Clinical year students and pre-clinical supervisors reported that it was unusual to fail Year 3 of the Tripos.

43. Year 3 of the Tripos is counted as 24-weeks of overall SSC learning. Overall 26% of the standard curriculum is allocated to SSCs. The quality control system for SSC Year 3 Tripos year, is dependent on the departmental external examiners. We require the School to implement a form of monitoring to ensure parity in standards of the SSCs in Year 3.

44. In addition to the Tripos, SSCs across the course are largely controlled by the individual departments, making consistency in quality and assessment difficult to achieve. The SSC coordinators are responsible for delivering and assessing SSCs with the SSC Management Group covering the clinical years only. The role of the group is to ensure that the quality of the SSCs is appropriate and options are wide ranging. We require the School to quality control the content and assessment of all SSCs.

Delivering the curriculum

Supervisory structures

45. The Medical Education Committee (MEC) has overall responsibility for the strategy, planning and development of the medical degree. The School of Biology is responsible for Years 1-3 of the standard course. The School of Clinical Medicine is responsible for Years 4-6 of the standard course. The CGC is overseen by a committee of management responsible to the MEC. The School gave an example of how a change regarding a pre-clinical curriculum issue would progress through the committee structures. The course management team for anatomy teaching first discusses its course content. Any proposals produced are presented to the MVST Committee. The MVST Committee focuses on content, level, spread and assessment of the anatomy component and its relation to other components. Once

the MVST Committee is satisfied, the proposals progress to faculty board level and then the MEC for sign off.

46. We found effective communication loops between the colleges and faculty boards of Biology and Clinical Medicine. Colleges have a pre-clinical Director of Studies and a Director of Clinical Studies. College representatives from both these groups sit on the faculty committees to maintain communicational links. Changes required by the MEC are communicated through the faculty boards to the colleges and departments for implementation. The department's response is fed back through the Faculty Boards to the MEC. In the Clinical School, the Deanery Team deals with practical issues raised by the Education Quality and Curriculum Committees.

47. Each cohort elects student representatives. Students expressed satisfaction with their input on supervisory committees. The student feedback is factored into committee decisions on curriculum development and the School gave examples of student-initiated change.

48. The MEC reported that clinical teaching was included within the pre-clinical years through co-operative working between the faculties of Biology and Clinical Medicine. Each pre-clinical year course committee maintained clinical input through their clinical members and hospital consultants taught some of the basic science lectures.

49. We found the School to be progressing with its internal quality assurance and reporting mechanisms. We noted that the Clinical School had recently established three senior committees reporting to MEC (curriculum, quality, assessment). In the School of Biology, each department still has substantive control over its learning content and assessment. We strongly encourage the MEC to continue with its efforts to implement a more strategic approach.

50. We were satisfied that students, clinical teachers and colleges are able to feed into curriculum changes.

Teaching and learning

51. The School reported that no supervisor is permitted to teach supervision tutorials without completing the centralised university teacher training. Clinical supervisors, who are also junior doctors, receive an induction before they start teaching as part of their annual staff development programme and participate in the 'Teaching the Teachers' course. All supervisors are taught how to assess and how to feedback. The School plans to have this induction programme accredited. We commend the comprehensive teacher training strategy and commitment to investing in teaching staff development as an area of good practice.

52. We were satisfied with the quantity of GP teaching within the CGC and the standard course. The School is proactive to evaluations and acts on student feedback as this was a prominent theme within its reports and seminar evaluations. The CGC students receive the equivalent of 58 days teaching from general-practice spread throughout their 4 years. The standard course students receive 38 days in Years 4-6.

53. We observed teaching sessions in the university and colleges and case based learning within NHS Trusts and General Practices. We found that the teaching sessions promoted patient-centeredness, and were good at modelling behaviour appropriate to patient care. Teachers were enthusiastic and linked sessions to broader community health issues. We observed some very good one-to-one clinical teaching within a relaxed atmosphere. We found the college anatomy supervision observed to be of a particularly high standard. Students were knowledgeable and engaged throughout the supervision observed.

54. Having observed teaching at Addenbrooke's and at regional hospital sites, we found that some clinicians were teaching beyond the required undergraduate level and the School was advised to monitor this to ensure that it was not to the detriment of the core learning outcomes.

55. The School delivers its clinical course through a 'Hub and Spoke' model focused on consistency of clinical skills teaching across sites. The Clinical Skills Unit in Addenbrooke's Hospital acts as a 'hub' to deliver teacher training to tutors and ensures equivalent learning of core practical skills. Regional placement sites are the 'spokes', reinforcing learning and increasing student exposure to ethnic diversity. Clinical skills are taught in a sequential manner across all sites at the same time. Clinical students were happy with the 'Hub and Spoke' concept and were confident that clinical teaching received in a District General Hospital (DGH) was at least as good as that received at Addenbrookes. We consider this to be good practice.

56. The new Year 6 of the standard course will include a shadowing period although not necessarily in the student's post of choice. We will investigate the shadowing period in next year's follow up visit.

57. Students have opportunities to develop inter-professional team working skills. Students spend time with physiotherapists and occupational therapists and all students are expected to attend multidisciplinary team meetings when on placements. Students are also encouraged to observe and comment on the patient journey.

58. Throughout their course students use portfolios to reflect on professionalism. In the CGC, students have 360-degree appraisal in Years 1 and 4. In Year 6 of the standard course, students will have a 360-degree appraisal. The School have emphasised to students that they must satisfactorily complete this prior to sitting the final examination. While satisfied with the structure of the assessment, we consider the 360-degree appraisal might be usefully carried out earlier in the course to allow sufficient time for remediation.

59. We found that overall students demonstrated awareness of appropriate professional behaviours and commended the School's approach to inter-professionalism. We encourage the School to continue its planned development, endorsing its direction.

Student selection

60. Students apply to individual colleges to study medicine rather than through a central admissions process. The Directors of Studies at colleges reported that there is always a practising clinician and a lay person involved in college interviews. They also reported that all interviewers received training. Interviews are structured but flexible as banks of questions are available for interviewers to work with. We were satisfied that the student selection is conducted in a manner consistent with Tomorrow's Doctors.

61. We were satisfied with the School's admission policy on students with a disability, which appropriately separates academic selection from the issues of fitness to practise and support for any disabilities.

62. The School reported that every college is linked with a different Local Education Authority (LEA) and they work together to promote academic interest within all University subjects within the schools of that LEA. Cambridge students currently act as ambassadors across England to create good links with prospective state School students. The School reported that it runs a Summer School specifically for students from State schools that do not usually send students to Cambridge. We reported that the School's widening participation initiatives were commendable although its impact was as yet unclear.

Learning resources and facilities

63. We observed the Clinical and Biological School facilities and were impressed by the radiological teaching facilities and simulator. Every undergraduate student had at least one session in the state-of-the-art simulator facility but it was more used by the Foundation Year 1 doctors. We found the anatomy and pathology resources at the School of Biology to be excellent.

64. The School's placement area crosses that of the University of East Anglia Medical School (UEA) however UEA utilises certain GP practices and two specific hospitals for their secondary care attachments, none of which is used by Cambridge. We were satisfied that there is no risk regarding securing placement sites to support the delivery of the School's curriculum.

65. We found the ERWeb to be a very useful educational resource. All peripheral sites can access the ERWeb, which stores all learning objectives and resources. Regional tutors reported that a specialist tutor from the central School staff delivers effective training sessions on the ERWeb.

Student support, guidance and feedback

66. We questioned pastoral care staff on student data protection, the transferring of student information, student records and admissions and were satisfied.

67. Two students including one with severe deafness gave personal examples of the School and college supporting them through academic struggles. Students gave

examples of friends who had been in poor financial positions or had health problems who had received help from the School and their college.

68. Students had a very close relationship with their college. Colleges were well placed to act informally on student concerns. Despite the short terms and heavy workload, Year 3 students had significant extra-curricular commitments. Year 4 and 5 students still obtained support through the collegiate system including support from the College nurses.

69. The University of Cambridge does not participate in national student surveys. We encourage the School to implement a routine formal mechanism for gathering student feedback for the whole course.

Assessing student performance and competence

The principles of assessment

70. The medical course involves biomedical sciences examinations in Years 1-2 and clinical theory, clinical and communication skills and practical assessment in the clinical years. The new final MB examinations do not include Viva Voce (viva) examinations. Vivas only take place in Final MB Part 1 (Pathology) examinations for the award of Distinction.

71. From 2008 all students on the standard and graduate-entry courses will sit final exams at the same time. CGC students to date have sat the same examinations as the standard course but at a different time of year. The School reported that all final exams had been blueprinted against the curricula. We will consider these blueprints when the School is re-visited in 2008.

72. We found the School's assessment framework to be thorough and was impressed by the examples of vertical integration in the anatomy and pathology assessments. We endorse the move away from the true-false style of multiple choice questions (MCQ) towards the single best answer style of MCQ in accordance with good educational practice. However other assessments, particularly in the pre-clinical years, are required to be much more relevant to the clinical context. Although much progress has been made in assessment in the clinical years the examples of the extended matching questions that were observed were rather idiosyncratic. The School has already identified this issue. We require the assessment committee to address the use of assessment tools to ensure that the tools are appropriate to the assessment scheme and reflect best practice.

Assessment procedures

73. We noted that it appeared the School had addressed issues raised on assessment in the Quality Assurance Agency's 2000 report but the School is encouraged to further work on assessing clinical attachments.

74. We observed a wide range of exams across the standard course and CGC including; a Steeplechase examinations (histology component of Homeostasis), the Simulated Clinical Encounter Examination, the Final Objective Structured Practical Examination (OSPE), the Final MB Clinical Examination OSCE, the Obstetrics and Gynaecology OSCE and the Paediatrics OSCE. We commend the School for the progress it has made in introducing OSCEs to the clinical years.

75. We noted that although the Homeostasis Steeplechase and pathology practical exam is very traditional, it tested students' knowledge well.

76. While the briefing for the Paediatrics OSCE was satisfactory, some other student and examiner briefings were unstructured, brief and without supporting documentation. In addition the environmental conditions were not conducive to an effective briefing process. The examination rooms used for the OSCEs were cramped and there was an obvious increased noise level. We consider that the School should investigate ways to improve the OSCE facilities. Furthermore, we recommend that the School improves the briefing process for all OSCEs.

77. The number of stations in Paediatric and Obstetrics and Gynaecology OSCEs was not sufficient to make them a robust assessment in isolation. A proportion of the stations did not test skills but tested factual knowledge or were semi-structured vivas. The School reported that in future it would consider combining the Paediatrics, Obstetrics and Gynaecology exams rather than running them separately. Although the exams had been set by clinical teachers, we noted that no formal reference to course outcomes or blueprinting was mentioned. We recommend that the School carries out its plans to improve the robustness of the Paediatrics, Obstetrics and Gynaecology OSCEs which should include the exams being blueprinting to the learning outcomes.

78. We were satisfied with most of the marking schemes of the examinations. We commend the School on the development of the Simulated Clinical Encounter Examination and overall the exams were fair and adequately tested the skills of future F1 doctors.

79. The School reported that its large numbers of external examiners were all inherited from the old system. Steps were being taken to reduce the number of external examiners.

80. We found the School to be relying on external examiners to quality control the SSC and Tripos assessments. We require the School to move to a formalised method of standard setting to secure robust judgements over all assessments across the course; in particular for the Tripos degree and SSCs across the course, including those in Year 3 of the Tripos.

81. We noted that the Final Exam Board was well run and we were satisfied that the School applied a fair and transparent system for deciding on pass, fail and the awarding of prizes.

Appraisal

82. We were satisfied that overall the School appropriately provided students with information on their progress and performance. However the School is encouraged to review feedback given to students after placements at District General Hospitals as students reported that they often received more detailed feedback from junior medical staff than from consultants.

83. Year 1 and 2 students reported that at the end of each term they had an interview about their progress carried out by college staff.

Student progress

84. The Final Exam Board discussed a candidate who had passed their Final Exams according to regulations but was extremely close to the borderline. We were pleased to hear the Dean of the Clinical School confirm that, with the candidate's permission, this information would be forwarded to the Post-Graduate Medical Dean.

85. The School reported that students with mitigating circumstances were considered prior to the Exam Board meeting. The decision of the Exam Board on students with mitigating circumstances was confirmed by the faculty board. We agreed that the School used appropriate procedures for its compensation and exam re-take policy.

Student health and conduct

86. The Student Support Liaison Committee minutes from previous years revealed that students were apprehensive about raising concern about unprofessional behaviour amongst staff or fellow students. Students reported that they needed reassurance that their feedback would not place them in a bad light. Interviews with students were inconclusive regarding the prevailing culture towards whistle-blowing. Some students expressed concerns at 'rocking the boat' but others were confident they would be able to recognise appropriate situations and act accordingly. The School reported that it would work to address student perspectives on whistle-blowing.

87. We found that the Fitness to Practise Committee structures needed to be made more robust. We acknowledged that the Fitness to Practise process was newly implemented and had been active for only 18 months. Despite the clearly detailed procedures, members of the Committee varied in their views and interpretation as to the roles and process of the Committee. Additionally the appeals from the Committee are heard by a University Board that does not include a medically qualified person. The Board may overturn a decision of the Fitness to Practise Committee regarding student suitability to progress with the MB BChir even when professional Fitness to Practise issues are present. The School reported that it was awaiting the forthcoming advice from the General Medical Council and planned to review the operation of the Fitness to Practise Committee and its procedures in the light of that advice. We require that the procedures be reviewed to ensure clarity and appropriateness of individual roles. The School should ensure that training is

given on the procedures. The University should ensure that the appeals panel includes an experienced medical practitioner.

Acknowledgement

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

Professor J G P Sissons MD FRCP FRCPATH FMedSci
Regius Professor of Physic

20 December 2007

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**UNIVERSITY OF
CAMBRIDGE**

School of Clinical Medicine

Dear Professor Rubin

**Final Report of QABME Visits to School of Clinical Medicine and School of Biology,
University of Cambridge for 2006/07**

Thank you for sending us the report of the assessment visits for the School of Clinical Medicine and the School of Biology in the University of Cambridge.

I now attach the response to the report from the University's Medical Education Committee, representing the School's joint response. The response outlines how we intend to address the requirements and recommendations in the report, and makes reference to the specific actions we intend to take, and the timing of these.

Best wishes.

Yours sincerely

A handwritten signature in black ink that reads "Patrick Sissons".

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Response of the University of Cambridge's Medical Education Committee to the GMC's Education Committee Final Report of QABME Visits to the Schools in 2006/07

This response to the final report of the GMC Education Committee following the visit of the QABME team to the University of Cambridge during the academic year 2006/2007 comes from the University's Medical Education Committee. The Committee, on behalf of the Schools of Clinical Medicine and Biological Sciences, wishes to thank the visiting team for the time they spent here and their interest in the course. The community involved in medical education in Cambridge is appreciative of their carefully considered and constructive report. Before responding to the requirements and recommendations of the report in detail, the Committee wishes to make two observations which it believes are important in considering the report as a whole.

1. The Committee is pleased to note that the report is broadly favourable in its overall conclusions on the quality of the medical course in Cambridge. They welcome the recognition of areas of innovation and good practice listed in paragraph 19 of the report. They note that, in addition to those listed, there are other areas of good practice which are commended in the main body of the report, namely:

- The integration of anatomy with clinical work and the progress with integrating pathology teaching and application (Para 24)
- The breadth of practical skills training (Para 30)
- Initiatives to recruit and train senior students to teach their peers (Para 33)
- The School's approach to interprofessionalism (Para 59)
- The development of the Simulated Clinical Encounter Examination (SCEE; Para 78).

2. As summarised in paragraph 5 of the report, there is a disparity between the number of students admitted to the standard medical course for the BA (Hons) degree in the Medical Sciences Tripos in Cambridge and the number of places in the School of Clinical Medicine, which allows about half the students to continue their medical education in Cambridge. Applications from students wishing to stay in Cambridge for their clinical studies now exceed the number of places available by 30 – 40 per year, reflecting the success of the revised course in Cambridge. Students who cannot be accepted do get places in London medical schools, but this is not their first choice: this is not satisfactory from the student point of view, nor is it desirable in terms of educational continuity. The University is seeking to increase the number of HEFCE funded clinical places in Cambridge (to about 200). The additional resource would make it more feasible to increase patient exposure in the pre-clinical years (as recommended in paragraph 21 and recommendation 17b of the report) and to develop a more integrated curriculum. The distinctive nature of the Cambridge course would be retained by allowing students to undertake clinical studies elsewhere if they so wished. The educational consequences of this disparity between pre-clinical and clinical student numbers were raised with the visiting team: however limited time was

available to discuss the implications for the course, and it is important that the GMC Education Committee is aware of this issue.

Responses to the requirements and recommendations of the GMC visiting team

Requirements

Requirements (a), (b) and (c) relate to assessment and the need to develop an assessment strategy that applies across the six year teaching programme. Under the auspices of the Medical Education Committee (MEC), the School of Biology's MVST Committee and the Clinical School's Assessment Committee will establish reviews of the issues raised in the report in the Lent and Easter Terms 2008. Major developments in the format or in standard setting, marking or quality assurance processes will be presented to the University General Board Education Committee during the Academic Year 2008 – 2009. Reports from the MEC Assessment Review will be included in the annual reports to the GMC Education Committee.

The School is required to:

- a. Ensure that it uses appropriate tools for its assessment scheme (paragraph 72)***

The comments in paragraph 72 relating to the need to increase the clinical relevance of some of the pre-clinical assessments will be addressed in the assessment reviews outlined above. In the Clinical School we continue to develop our examination question banks in all subjects and the quality of the items will continue to be reviewed routinely.

- b. Move to a formalised method of standard setting to secure robust judgements over all assessments, departments and years (paragraph 80)***

As part of the MEC assessment review, the MVST I Committee will examine methods for setting standards in years 1- 3. The relationship between the core 2nd MB and Tripos components of the MVST Part 1A and 1B examinations is complex and the committee intends to take advice from Cambridge Assessment (formerly UCLES) on approaches to standard setting in this situation. The standards and Quality Assurance of the Cambridge Tripos examinations (Year 3) form one of the principal concerns of the university as a whole (see below, point c).

The School of Clinical Medicine has introduced recognised standard – setting methods alongside the new curriculum and assessment programme, using Ebel and borderline group methods as appropriate.

- c. Quality control the content and assessment of the student selected components (paragraph 44).***

We welcomed the opportunity to discuss the student selected components with the visiting team, as these have been recently developed and extended within the changes to both parts of the curriculum that have occurred since the last GMC visit in 2001. As far as the Tripos is concerned, we understand that the system is unique to Cambridge and were appreciative of the efforts made by the visiting team to understand its complexities in a short period of time. All Cambridge students undertake Part II (year 3) Tripos courses of their own choosing and in medicine we regard this as a part of the SSC programme. The maintenance of standards and quality control for Year 3 programmes is fundamental to all Schools within the University of Cambridge as the Tripos system constitutes a major part of the university's reputation for educational excellence. One of the important features of the Tripos is that it allows students to take Part II (year 3) courses in Schools and departments outside their main subject area. For this reason all Schools within the university accept the Quality Assurance procedures of the university itself. It is not within the remit of the MEC to develop independent monitoring procedures for Tripos courses and we should not seek to do so. If the GMC Education Committee seeks further reassurance on this point, they may wish to review the University's submission to the Quality Assurance Agency, which has recently been signed off in advance of a visit in February 2008.

The SSC programme in the Clinical School is recently established as part of the new curriculum. We found the discussions with the visiting team relating to the SSCs to be helpful. The SSC Management Group will review the Quality Assurance procedures for clinical SSCs and we have engaged the assistance of an external advisor to help in this process.

d. Ensure integration of clinical context with science teaching throughout the pre-clinical years (paragraph 25)

The MVST Committee is aware of the need to emphasise the clinical context and relevance of the biomedical science teaching and welcome the favourable comments made by the visiting team on the progress that has been made, particularly in anatomy and pathology. We will continue this process into the other components of years 1 and 2.

e. Ensure the Fitness to Practise Committee structures and procedures are robust (paragraph 87)

We appreciated the opportunity to discuss our Fitness for Medical Practice procedures. Immediately prior to the visit we had need to follow the procedures through to the Appeal stage and had ourselves identified areas for improvement. The visitors' comments together with the newly developed guidance from the GMC will be used to inform a review of procedures, including the introduction of a medically qualified individual onto University Appeals Panels.

Recommendations

The School is advised to:

a. Make assessments, particularly in the preclinical years, much more relevant to clinical context (paragraph 24)

We assume this recommendation refers to paragraph 25. This recommendation will be considered as part of the MEC review of assessment described above. We believe that a significant amount of progress has been made in integrating clinical context in the assessment programme in Years 1 – 3 and we will continue to introduce appropriate clinical context in all parts of the biomedical science assessment process. We believe our assessments in the clinical years to be fully relevant to clinical context.

b. Expand its provision of early patient contact in the pre-clinical years (paragraph 21)

We agree with the visiting team that we should work to increase the clinical relevance of some parts of the pre-clinical course. We are in the process of developing a new theme, Preparing for Clinical Studies, which will pull together and strengthen the Preparing for Patients programme with the other non-biomedical science aspects of the curriculum. Ultimately this theme will be integrated with the parts of the clinical curriculum onto which it maps. We will continue to develop the Preparing for Clinical Studies theme in the way which seems most appropriate for the curriculum as a whole and which maximises the educational value for our students.

c. Develop methods to enhance student perspectives on whistle-blowing (paragraph 86)

We were interested to receive this feedback as the policy on whistle-blowing is given to all the students and their attention drawn to it. We have already incorporated further discussion into the Personal and Professional Development theme and will continue to monitor students' attitudes and behaviour in this respect.

d. Review the delivery of the examiner and student briefings to ensure that both students and examiners are clear on the assessment process (paragraph 76)

We recognise the comments made in paragraph 76 and have already begun work to produce a more standardised format for the delivery of student and examiner briefings in clinical examinations.