

# Clinical placements for medical students

Advice supplementary to *Tomorrow's Doctors* (2009)

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## Key points

	Clinical placements	Student assistantships
<b>Extracts from <i>Tomorrows Doctors</i> (2009)</b>	'The curriculum will include practical experience of working with patients throughout all years, increasing in duration and responsibility so that graduates are prepared for their responsibilities as provisionally registered doctors. It will provide enough structured clinical placements to enable students to demonstrate the "outcomes for graduates" across a range of clinical specialties, including at least one student assistantship period.' ( <i>Tomorrow's Doctors</i> (2009), paragraph 84)	'A student assistantship means a period during which a student acts as assistant to a junior doctor, with defined duties under appropriate supervision.' ( <i>Tomorrow's Doctors</i> (2009), Endnotes 8)
<b>Definitions in this advice</b>	<p>A clinical placement can be defined as any arrangement in which a medical student is present in an environment that provides healthcare or related services to patients or the public. Placements can take place in primary, secondary or community healthcare or social care settings. Students can be actively involved in patient care or they can be observing health or social care processes.</p> <p>However, it may not always be feasible for schools to apply to student electives the requirements set out in <i>Tomorrow's Doctors</i> (2009) in relation to clinical placements. An elective is a type of educational experience that has been chosen by an individual medical student. Electives are often organised by the student themselves and in some cases they will take place overseas. It would not be reasonable to expect medical schools always to undertake the type of activities set out in <i>Tomorrow's Doctors</i> (2009), let alone in this advice, in relation to electives. (Paragraphs 19 and 20)</p>	A student assistantship is a type of clinical placement. It should be designed to increase the preparedness of the medical student to start practice as an F1. Although some direct care of patients is implicit and necessary, it is primarily an educational experience which should provide a number of hands-on learning experiences that allow the medical student to gain experience of working within clinical settings and practise clinical skills (Paragraph 21).
<b>Key points</b>	<ul style="list-style-type: none"> <li>• Medical schools should bear in mind their obligations under the Equality Act 2010 when organising placements for their students (paragraph 29).</li> <li>• Medical schools should have comprehensive agreements with the organisations that provide placements for their students (paragraphs 31-38).</li> <li>• Medical schools should ensure that their students are aware of their responsibilities in relation to patients' rights (paragraphs 40-52).</li> <li>• Medical schools should evaluate the effectiveness of their clinical placements (paragraphs 53-58).</li> <li>• Medical schools should ensure that their students are effectively supervised while on clinical placements (paragraphs 64-71).</li> </ul>	<ul style="list-style-type: none"> <li>• Students should be adequately prepared to undertake their student assistantship (paragraphs 72-74).</li> <li>• Medical students should be fully integrated into a clinical team while on a student assistantship (paragraph 77).</li> <li>• The types of tasks that students should undertake while on a student assistantship are set out in paragraph 79.</li> <li>• Student assistantships should take place towards the end of a student's final year at medical school (paragraph 81).</li> <li>• Medical schools should evaluate the effectiveness of their student assistantships in preparing students for working as F1s (paragraphs 89-93).</li> </ul>

## Introduction

### Background to the GMC's production of supplementary advice

- 1 The GMC sets requirements for medical schools in *Tomorrow's Doctors*. The 2009 edition reflects lessons from the first full cycle of the GMC's process of Quality Assurance of Basic Medical Education (QABME) and responds to issues that emerged since the 2003 edition. It aims to ensure that new graduates will be fit to practise and prepared for training in the Foundation Programme and employment in the NHS and for their further education and training beyond that. The 2009 edition followed an extensive period of development, engagement and consultation and drew on research on the preparedness of graduates commissioned by the GMC.
- 2 Medical schools are required to comply with the standards and outcomes in *Tomorrow's Doctors* (2009) by academic year 2011/2012.
- 3 The GMC has supported medical schools in implementing the new requirements. This has involved a series of implementation workshops across the UK and asking schools to produce Enhanced Annual Returns (EARs) on their progress. The workshops brought together representatives from the medical schools in a region as well as students, postgraduate training bodies and employers. They provided an opportunity for schools to discuss their progress in becoming compliant with *Tomorrow's Doctors* (2009) and to highlight any challenges they were facing.
- 4 It became clear that the schools felt that they needed extra advice from the GMC as to how certain requirements in *Tomorrow's Doctors* (2009) should be taken forward.
- 5 The GMC has therefore developed a series of advisory documents supplementary to *Tomorrow's Doctors* (2009) in the following areas:
  - assessment
  - clinical placements, particularly student assistantships
  - developing teachers and trainers
  - involving patients and the public.

The documents have been developed with drafting advice from experts in these fields. Their support is gratefully acknowledged.

- 6 The advice contains some examples of local arrangements, as described by the medical schools or institutions involved or as set out in previous publications. These are included as snapshots which may be of interest and use to other schools as they

develop arrangements appropriate for their own needs and circumstances.

- 7 Schools are free to make use of this advice insofar as they find it helpful in light of local circumstances. It covers relevant issues and includes suggestions. The advice is expressed as steps that schools 'could' or 'should' take, but it does not indicate any new regulatory requirements or standards.

### What does *Tomorrow's Doctors* (2009) say about clinical placements?

- 8 The 2009 edition of *Tomorrow's Doctors* puts increased emphasis on students gaining practical experience in a variety of healthcare settings. It introduces student assistantships for all medical students where they can put the skills they have learnt at medical school into practice with real patients. It also encourages medical schools to arrange a period of shadowing where students can assist the F1 whose job and programme placement they will assume after graduation. The importance of medical students receiving increased levels of practical experience in preparing them for medical practice was highlighted in research commissioned by the GMC and undertaken by Illing et al<sup>1</sup>.
- 9 To further put this advice in context it is helpful to review the overarching requirements of *Tomorrow's Doctors* (2009) in respect of clinical placements.
- 10 These requirements are primarily contained in 'Domain 5 – Design and delivery of the curriculum, including assessment'. However, other Domains also apply including those relating to quality assurance and patient safety. The applicable paragraphs of *Tomorrow's Doctors* (2009) are contained in an Annex to this advice.
- 11 Domain 5 states that medical schools' curricula should include practical experience of working with patients throughout all years. It also states that the level and duration of contact with patients should increase throughout the duration of the course. Paragraph 109 sets out the requirement that all medical students undertake a student assistantship where they undertake work as similar as possible to that of an F1 doctor. Paragraph 110 states that all students should undertake a period of shadowing as close to graduation and starting work as an F1 as practicable.

### Purpose of the supplementary advice

- 12 This advice was developed in order to consider aspects of the standards and requirements set out in *Tomorrow's Doctors* (2009) which relate to clinical placements for medical students. It defines what is meant by clinical placements, student assistantships,

shadowing and induction. In addition it discusses medical schools' responsibilities in relation to both clinical placements and student assistantships. The guidance also draws on examples of local practice in order to illustrate how medical schools are delivering clinical placements and student assistantships at present. These examples are set out in the schools' own words.

- 13** We understand that ensuring that clinical placements have genuine educational value can be difficult for medical schools. The relationship with local NHS services can be challenging, especially at a time when budgets for all services are under pressure. Nevertheless schools and the NHS should acknowledge that they have a shared interest in enabling new medical graduates to enter practice safely and efficiently. Neither can do this in isolation.
- 14** This document is advisory. It provides pointers on how medical schools can achieve compliance with *Tomorrow's Doctors* (2009) in relation to clinical placements and other requirements such as those relating to quality assurance. The divergence in teaching styles and curricula between medical schools is an important aspect of medical education in the UK. This advice is designed to respect these differences.

### Who is the advice for?

- 15** This advice is primarily for medical schools. However, as it concerns clinical placements it will be of importance to those with responsibility for organising and funding these opportunities for students, particularly NHS bodies.
- 16** Medical students should also be aware of this advice as it sets out what they can expect from clinical placements and learning opportunities including student assistantships. *Tomorrow's Doctors* (2009) emphasises that students have responsibilities in relation to their education. A number of these responsibilities relate to the way in which students behave while on clinical placements and their obligations to the organisations that provide their placement opportunities. Students should therefore have a good understanding of the issues covered in this advice.

### Distinguishing clinical placements, student assistantships, shadowing and induction

- 17** This document provides general advice on clinical placements and specific advice on student assistantships. In order to clarify the difference between these two activities brief definitions are set out below.

- 18** *Tomorrow's Doctors* (2009) also refers to shadowing and induction. Definitions of these activities are included in this section.

### Clinical placements

- 19** A clinical placement can be defined as any arrangement in which a medical student is present in an environment that provides healthcare or related services to patients or the public. Placements can take place in primary, secondary or community healthcare or social care settings. Students can be actively involved in patient care or they can be observing health or social care processes.
- 20** It may not always be feasible for schools to apply to student electives the requirements set out in *Tomorrow's Doctors* (2009) in relation to clinical placements. An elective is a type of educational experience that has been chosen by an individual medical student. Electives are often organised by the student themselves and in some cases they will take place overseas. It would not be reasonable to expect medical schools always to undertake the type of activities set out in *Tomorrow's Doctors* (2009), let alone in this advice, in relation to electives.

*The curriculum will include practical experience of working with patients throughout all years, increasing in duration and responsibility so that graduates are prepared for their responsibilities as provisionally registered doctors. It will provide enough structured clinical placements to enable students to demonstrate the 'outcomes for graduates' across a range of clinical specialties, including at least one student assistantship period. (Tomorrow's Doctors (2009), paragraph 84)*

### Student assistantships

- 21** A student assistantship is a type of clinical placement, undertaken towards the end of the student's undergraduate course. It should be designed to increase the preparedness of the medical student to start practice as an F1. Although some direct care of patients is implicit and necessary, it is primarily an educational experience which should provide a number of hands-on learning experiences that allow the medical student to work within clinical settings and to practise clinical skills. The students should be fully integrated within a clinical team and should be responsible for carrying out specified duties under appropriate supervision.

*A student assistantship means a period during which a student acts as assistant to a junior doctor, with defined duties under appropriate supervision. (Tomorrow's Doctors (2009), Endnotes 8)*

## Shadowing

- 22** Shadowing is a period of time when a medical student goes to the site where they will be working as an F1 doctor and assists the F1 whom they will replace when they start employment. This time period should ideally take place as near to the date that they will start their F1 position as possible.
- 23** Shadowing is primarily about familiarising the student with a specific site where they will be working in the future. Some form of induction should be provided for students who are undertaking shadowing as for all clinical placements. It is likely that students should have already met the outcomes set out in *Tomorrow's Doctors* (2009) by the time they start this shadowing period. It may therefore not be included within the time frame of the course or feature in the school's assessments. Medical Education England is undertaking work to develop a national shadowing strategy which will influence how the requirement for shadowing will develop in the future<sup>2</sup>.

*Students must be properly prepared for their first allocated F1 post. Separate from and following their student assistantship, they should, wherever practicable, have a period working with the F1 who is in the post they will take up when they graduate. This 'shadowing' period allows students to become familiar with the facilities available, the working environment and the working patterns expected of them, and to get to know their colleagues. It also provides an opportunity to develop working relationships with the clinical and educational supervisors they will work with in the future. It should consist of 'protected time' involving tasks that enable students to use their medical knowledge and expertise in a working environment, distinct from the general induction sessions provided for new employees and Foundation Programme trainees. The 'shadowing' period should normally last at least one week and take place as close to the point of employment as possible. (Tomorrow's Doctors (2009), paragraph 110)*

## Induction for new employees and Foundation Programme trainees

- 24** Induction is normally understood to be the mandatory process whereby a new employee, such as a medical graduate about to take up a Foundation Programme position, is introduced to the environment and employment policies of a new position. It is fundamentally about ensuring that all members of staff have received the information that they need in order to start their new job and is normally the responsibility of a Human Resources department. Induction sessions should be clearly distinguished from shadowing.

- 25** Elsewhere in this advice we use the term 'induction' to cover students' structured introduction to their course and to individual placements.

## General advice on clinical placements

- 26** This section sets out general principles that medical schools should consider as they set up and design their clinical placements.

## Organising clinical placements

- 27** It is important that medical students receive clinical experience in a range of healthcare settings. The healthcare system in the UK is varied, increasingly decentralised and subject to change. A varied medical education and clinical experience can help students adapt to these differences and changes when they graduate. Clinical placements should start early in the undergraduate curriculum.

### St Andrews medical school – early clinical placements

“ In setting up the early clinical course at St Andrews we have attempted to address healthcare in its broadest sense. Our students visit funeral directors to learn about the issues surrounding death, NHS 24 to learn about telephone communications/clinical management of emergencies etc, nursing homes to discuss patient journeys and issues surrounding loss of independence with residents.

As part of a 'virtual patient journey' students hear the story of an illness from volunteer patients and then visit the areas of the health service that have been involved in their care. As well as the usual NHS services this may also include community pharmacists, self help groups and carers organisations. ”

- 28** All students should have the opportunity to undertake clinical placements in a variety of care settings. More generally, *Tomorrow's Doctors* (2009) states:

*106. Clinical placements must be planned and structured to give each student experience across a range of specialties, rather than relying entirely upon this arising by chance. These specialties must include medicine, obstetrics and gynaecology, paediatrics, surgery, psychiatry and general practice. Placements should reflect the changing patterns of healthcare and must provide experience in a variety of environments including hospitals, general practices and community medical services.*

- 29 When organising clinical placements for individual students medical schools should be aware of the following statement in Domain 3 of *Tomorrow's Doctors* (2009):

67. Medical schools should have clear guidance on any areas where a student's culture or religion may conflict with usual practice or rules, including when on placements – for example, dress codes or the scheduling of classes and examinations.

This means that medical schools should be aware and inform placement providers if a medical student has specific requirements in relation to their clinical placement. Medical schools should also keep in mind their obligations under the Equality Act 2010 not to discriminate unfairly on the grounds of religion or belief, age, sex or gender, ethnicity, sexual orientation and disability as they organise clinical placements.

- 30 Medical schools should ensure that reasonable adjustments are made for students with disabilities to enable them to have the same opportunities to undertake a range of clinical placements as other medical students. A list of reasonable adjustments is available in the annex of the GMC guidance *Gateways to the Professions – Advising medical schools: encouraging disabled students* (revised in 2010)<sup>3</sup>. Reasonable adjustments that have been made by medical schools are listed in *Gateways* and include:

- (a) allowing students time off for treatment schedules, therapy and out-patient appointments
- (b) putting students in placements with good transport links or which are otherwise easy to access
- (c) providing the student with an electric scooter for getting around a hospital.

#### Sheffield medical school – Accident and Emergency placements

“An Acute and Critical Clinical Care attachment of eight weeks helps students to recognise patients with acute medical problems and develop an understanding of how to care for them in the first 48 hours of an acute illness. Students work as part of an Accident and Emergency team and with anaesthetists.”

#### Hull York medical school (HYMS) – GP clinical placements

“HYMS clinical attachments are arranged so that about half the clinical placements should be in primary care. This was the aim of the founders of HYMS and has largely been achieved in practice.”

In Phase I students have clinical placements for half a day (year one) and for a whole day (year two). Groups of four to five students alternate each week between primary and secondary care throughout the two years. These clinical placement sessions are integrated into the Problem Based Learning structure of the course in such a way that both the secondary care and primary care perspective is integrated and understood within the context of the rest of the course.

In Phase II (years three and four) four students are attached throughout to 'teaching partnerships' consisting generally of two secondary care and two primary care doctors. The Phase is divided into eight blocks each covering a group of related specialties. The objectives for each are common to both primary and secondary care. Some can be better met in primary care, some in secondary care, most in both. There is no intention to teach 'general practice' as a discipline. Although the objectives are common, the members of the partnership have some freedom to develop their teaching so as to make the best use of the clinical opportunities related to their practice and develop their own unique weekly teaching timetable. As well as addressing some of the specific objectives related to the specialty block, primary care doctors will also address the generic competencies of consultation skills within a wide variety of contexts, not just those related to the specialty block. Because the general practice attachment provides ongoing exposure to all types of problems, it provides continuous reinforcement in all areas at all stages of the course. For example, students will see children in primary care every week from the beginning of the Phase to the end, not just during the child health block.

In Phase III (year 5) the arrangement is a more traditional eight week attachment to a practice with the learning opportunities described above.”

### Relationships with clinical placement providers

- 31 Medical schools should have formal, written agreements with all clinical placement providers.
- 32 Paragraphs 50, 157 and 165 of *Tomorrow's Doctors* (2009) state the following.
- (a) Agreements should set out roles and responsibilities for the placement.
  - (b) Agreements should contain the learning objectives for that particular placement.

- (c) Agreements should set out the arrangements needed to ensure that medical students have appropriate learning opportunities to meet the learning outcomes.
- (d) Resources will be covered in agreements. This includes access to facilities in NHS hospitals and other premises.
- (e) Agreements will set out the process by which the medical school can be clear about the allocation of financial resources received to support undergraduate medical education.

Where the placement is not taking place within the NHS, the medical school should ensure that it still meets the relevant requirements in *Tomorrow's Doctors* (2009).

- 33** Throughout this advice various provisions are mentioned that medical schools could consider including in their agreements with placement providers. For ease of reference they are as follows:
- (a) measures to clarify how funding for medical student education is utilised within the organisation
  - (b) clarification on who is responsible for organising clinical placements within both the medical school and the placement provider
  - (c) the process whereby either party can raise concerns as to the way the placement is being run and how these problems will be addressed
  - (d) student access to the placement providers' IT systems. This should include who is responsible for ensuring students understand the protocols relating to their use
  - (e) induction processes for students should be clearly set out
  - (f) clarification as to the indemnity cover for medical students if they are under the supervision of an independent contractor
  - (g) in the case of student assistantships, agreements should emphasise the importance of students being integrated into clinical teams and obtaining practical experience. Medical schools may want to list the experiences and practical procedures they wish students to undertake.

These suggestions apply equally to placements that take place in non-NHS settings.

- 34** The process for the allocation of financial resources for undergraduate medical education varies across the four countries of the UK. Medical schools will be aware of the processes in their own areas and should

keep up to date with any developments or changes in the way that funding is allocated. They should seek to influence the allocation of funding among and within the local organisations that provide clinical placements to their students. Medical schools should seek clarification from placement providers as to how they use the money allocated for training in their agreements, ensuring, where appropriate, that designated teaching and supervision time is reflected in job plans.

- 35** The agreement should clearly state who at the medical school is responsible for coordinating clinical placements for their students. This individual should be available as a point of contact for placement providers if a problem arises with a placement. Equally, the agreement should state who is responsible for organising clinical placements at the placement provider. If a placement provider provides placements for students across more than one site, the medical school should take a view as to whether they require a named individual to be responsible for clinical placements for medical students at each individual site.
- 36** Agreements between medical schools and placement providers should set out a process whereby either party can raise concerns, for example about the way the placement is being run, the content of the placement or the behaviour of the participants. The agreement should contain a clear series of steps whereby the concerns of either the school or the placement provider can be raised and appropriate action taken to address the situation.
- 37** Medical schools should evaluate the effectiveness of their agreements with placement providers. This should form part of their internal quality assurance processes. These processes should identify weaknesses within individual placements. Any weaknesses identified should be discussed with the placement provider. If appropriate the agreement for that placement could be amended with additional provisions designed to rectify these weaknesses.
- 38** Medical schools should ensure that their agreements with placement providers are consistent with their equality and diversity action plans and policies.
- 39** In addition to formal agreements medical schools should also seek to engage informally with their local placement providers and Foundation School. This is, for example, to facilitate support available to teachers and trainers and enable clinical teachers' involvement in the development and management of students' learning outcomes as well as their own developmental programmes.

### Newcastle medical school – working with the Foundation School

“Medical education is a continuum, so to assist in a seamless transition from undergraduate to postgraduate learning we have reciprocal representation between the Northern Foundation School and the Newcastle Board of Medical Studies. We meet fortnightly to oversee the undergraduate programme. This synergistic collaboration helps to close feedback loops, improves continuity of learning and the transition of information between stages of education. It helps to ensure that graduates are ‘fit for purpose’.”

### Patient safety and patients’ rights

- 40** The safety of patients should be the primary concern of medical schools, placement providers and students. Paragraph 26 of *Tomorrow’s Doctors* (2009) says:
- The safety of patients and their care must not be put at risk by students’ duties, access to patients and supervision on placements or by the performance, health or conduct of any individual student.*
- 41** In order to safeguard patients, students should be aware of the following guidance and follow it while on a clinical placement:
- (a) the GMC’s guidance *Good Medical Practice* and other guidance issued by the GMC relating to specific issues such as consent, confidentiality and end of life care
  - (b) the guidance *Medical students: professional values and fitness to practise* published by the GMC and the Medical Schools Council
  - (c) guidance issued by the UK health departments on professional practice, for example:
    - i. *Reference guide to consent for examination or treatment*, Department of Health (England)
    - ii. *Confidentiality: NHS Code of Practice*, Department of Health (England)
  - (d) guidance and protocols used in the specific placement to protect patient safety.
- 42** In order to ensure that students have a good knowledge of guidance designed to protect patients, medical schools may wish to ask their students to ‘sign up’ to these protocols and guidance.
- 43** Patients should be informed, for example through patient leaflets, admission leaflets and outpatient letters that students are present at a site for the purpose of learning. This information should also be available in accessible formats so that all patients are able to access this information. This should also include information about their right to refuse to take part in education without prejudice to their care and how they can object to the involvement of medical students in their care.
- 44** Where students are more directly involved in patient care, for example being present in consulting rooms or observing treatment, specific consent should be obtained from the patient to ensure that they are comfortable having a student present. This consent should be obtained by the doctor or other registered healthcare professional responsible for the treatment. The process of obtaining consent for the students’ presence should be obtained without the student being physically present wherever possible. As part of the consent taking process the doctor or other healthcare professional should explain to the patient how the student will be supervised.
- 45** Where a medical student undertakes any element of treatment or investigation of a patient, the responsibility for obtaining the patient’s consent to this treatment or investigation lies with the healthcare professional responsible for that investigation or treatment.
- 46** Paragraph 26 of the GMC’s guidance *Consent: patients and doctors making decisions together* states that a doctor may delegate the task of obtaining consent to someone who is suitably trained and qualified, has sufficient knowledge of the proposed investigation or treatment and understands the risks involved, and understands and agrees to act in accordance with the GMC’s consent guidance. In our view, a medical student does not meet these criteria<sup>4</sup>.
- 47** Medical students should observe the consent process and in certain circumstances, for example if the student has a large amount of clinical experience, the doctor responsible for the patient’s treatment or investigation may decide that the student can contribute to the consent process, perhaps by providing information to the patient.
- 48** For more detail on issues relating to consent, see the GMC’s guidance *Consent: patients and doctors making decisions together*<sup>5</sup>. Paragraphs 26-27 discuss who is responsible for obtaining consent to investigation or treatment. Paragraphs 44-50 set out the ways in which consent can be given, including the differences between express and implied consent and the circumstances in which consent should be in writing.

- 49 Medical schools should also ensure that their students are aware that they should approach all communication with patients with sensitivity and empathy. Students should also feel comfortable communicating with a variety of patients from different backgrounds and with different needs. This should include older or younger patients, patients with learning difficulties and patients whose first language is not English. Role play and simulation exercises are often used to teach these skills.
- 50 Medical schools should ensure that their students are aware that they are subject to the same obligations as NHS staff concerning confidentiality and patients' consent to the use of their health records. Medical students may need access to their placement provider's IT system in order to carry out their placement objectives effectively. For example when on a student assistantship students must be able to access IT systems in order to gain a realistic experience of patient care. Medical schools should ensure that their agreements with placement providers cover student use of IT systems. The agreement should also make it clear who is responsible for ensuring that the student understands and follows the rules and procedures for IT use in that placement.
- 51 Medical schools should be aware of the GMC's supplementary guidance, *Confidentiality: disclosing information for education and training purposes*<sup>6</sup>, and in particular:
10. *If students need access to a patient's personal information, but are not providing or supporting the patient's care, anonymised information should be used whenever possible. This may not be practicable when they are directly involved in the provision of care, for example, on ward rounds, but it will then usually be practicable to seek the patient's express consent to disclosure.*
11. *It might be necessary to disclose personal information, or not practicable to anonymise it, and also not practicable to seek a patient's express consent to disclosure. However, if information has been made readily available to the patient about the disclosure and of their right to object, and they have not objected, you may disclose personal information necessary for the education of medical and other healthcare students.*
- 52 Additional advice on situations where patients lack the mental capacity to consent to the disclosure of their personal information is available at paragraphs 13 to 17 of *Confidentiality: disclosing information for education and training purposes*.

### Dundee medical school – working with employers

“ NHS Tayside has appointed a Director of Medical Education who is a senior clinician, a member of University Medical Education Committee (UMEC) and has a focus on undergraduate education. An additional appointment is a full time Quality Assurance Coordinator who is a member of the Curriculum Management Team. These appointments have significantly improved the process by which undergraduate teaching is coordinated and delivered by NHS partners and is quality monitored.

Specific initiatives and approaches to ensuring a range of quality experiences which have to date resulted from this strategic appointment include:

- overall quality monitoring provided for in the Service Level Agreements by way of the *Tayside Teaching Quality Document*
- a memorandum of understanding between NHS Tayside and the University of Dundee with a requirement that clinical teachers show evidence of taking part in staff development activities relating to teaching
- QA processes overseen by NHS Education Scotland (NES)
- use of the Additional Cost of Teaching (ACT) Development/Support Fund to encourage innovative ways to influence improvements in the quality of teaching eg discipline based teaching leads, staff development, clinical skills appointments and IT and e-learning development support
- ACT local and regional groups overseeing quality monitoring and strategic planning
- development of a Scotland-wide performance management framework to monitor quantum and quality of teaching in partnership with Dundee Medical School
- improvements in communication with NHS staff in respect of teaching via the NHS Tayside Intranet/ 'Blackboard' and Newsletters
- formal accountability criteria for new positions or projects to monitor performance
- Faculty of Medical Educators (FaME) awards which acknowledge and celebrate excellence in teaching
- development of a voicing concerns policy to enable students to voice concerns about teaching or patient care
- the joint funding (NHS and University of Dundee) of new education facilities. ”

## Evaluation

- 53** Medical schools should evaluate the effectiveness of their clinical placements.
- 54** All placements should have clearly defined learning objectives and these objectives should be linked to the outcomes set out in *Tomorrow's Doctors* (2009). These learning objectives should be communicated to those responsible for delivering teaching in the placement and their individual roles in delivering objectives should be clearly defined.
- 55** Medical schools should be aware that many placement providers will have internal quality assurance processes that they may be able to utilise in evaluating the quality of their clinical placements. Additionally, schools should be prepared to share appropriate data requested by the placement provider for use in their quality assurance processes if asked, subject to legislation on the correct use of personal data.
- 56** The effectiveness of the placement, for example in delivering the set learning objectives, should be evaluated. This may include:
- (a) the quality and quantity of teaching, supervision and feedback in the placement
  - (b) the availability of resources such as libraries and IT systems
  - (c) the personal support available to students on that placement, bearing in mind that some groups may need to have more support than others
  - (d) staff development availability and take-up
  - (e) the ability of students with specific requirements, for example a disability, to access resources and learning opportunities.
- 57** Effective evaluation can take many forms. Two or more data sources could be used in order to triangulate the data and produce an accurate evaluation as to the quality of the placement. Stability of the data can be assessed by longitudinal studies.
- 58** Some suggestions as to how schools can collect data for evaluation include:
- (a) surveying medical students
  - (b) analysing the portfolios or logbooks used by students on the placement
  - (c) surveying clinical supervisors and those who have been involved in delivering the placement
  - (d) obtaining the views of former students who are now F1s
  - (e) obtaining the views of non-medical staff who have been involved in delivering the placement
  - (f) obtaining the views of patients where appropriate, including those involved in teaching and assessing students
  - (g) analysing the amount of time dedicated to teaching in the job plans of consultants and other doctors involved in teaching.

### Newcastle medical school – evaluating GP placements

“ To evaluate our third and fourth year GP placements we use a feedback loop. Students are invited to complete not only the usual online end-of-placement evaluation, but also a personalised evaluation of the individual practice they worked in. This evaluation goes directly to the practice so students are reminded to be mindful of the usual rules for giving constructive feedback.

The questions we ask students are:

- a. What worked well?
- b. What could be changed or improved?
- c. What five things can you take away from the attachment?
- d. What topics you would have liked to have covered that weren't?
- e. Has the placement impacted on your career plans?

A copy of this evaluation also goes to the local GP teaching coordinator (we call them Senior Medical Tutors) who will contact the practice as appropriate to discuss any problem areas. ”

### St Andrews medical school – evaluation and improvement methods

“ The School has been experimenting with different methods to encourage students to provide timely and accurate feedback by utilising different technologies. We have developed a website which allows the students to provide feedback on the range of placements they attend. This website feeds information back to a database which then analyses the data and provides standard reports. Bespoke reports can also be sourced using the raw data held in the database.

We have recently piloted a system of sending a text message to each student immediately after a placement requesting feedback on the session. Those that respond are sent a further three text questions relating to the attachment. As a result of this pilot we intend to use the text system as an

early warning system for attachments that may have gone less well than planned. Such immediate feedback allows us to investigate any problems immediately and make any required changes to the attachment before the next group of students attend for teaching.

On a two year cycle, a member of the clinical team visits each of the clinicians to discuss not only their own feedback but also the anonymised feedback pertaining to other similar attachments so that they are able to learn what the students have felt to be of value and what they felt the issues were with the course as a whole. This allows good practice to be shared and helps all clinical teachers avoid problems with attachments. ”

#### Glasgow medical school – evaluation of the new Preparation for Practice (PFP) Block

“ We evaluated the first year of the initiative by:

- repeat cohort questionnaires at start and end of PFP
- analysis of free comments in these questionnaires
- content analysis of portfolios
- focus groups with F1s who have recently graduated
- interviews with educational supervisors. ”

### Preparing students

- 59** Students should be adequately prepared for all clinical placements. They should be aware of the learning objectives for each placement and have had the educational preparation necessary to meet these objectives.
- 60** Students should be made aware by schools of the expectations of being present in an employment environment and the need to behave as if they are employees. This includes acting truthfully, following protocols, following instructions from colleagues and supervisors, good time keeping, being courteous to staff and patients and not unlawfully discriminating against anyone.
- 61** Medical schools should ensure that their students fully understand that they must explain to patients and colleagues that they are students and not qualified doctors. Schools may wish to consider providing all their students with badges that clearly state that they are students.

#### Birmingham medical school – preparing students

“ The Hospital Preparation Course complements existing early placements in community based medicine and helps students to adjust to hospital-based learning. It provides familiarity with the hospital where they will spend semester one, and helps them make links between prior and future learning. A handbook, self-directed learning activities and reflective tasks are provided.

Medical school sessions highlight the inter-professional context of hospital medicine. The clinico-pathological conferences deliberately draw upon year one and two learning.

Students also appreciate time in their hospital placements, where the variation in the student experiences highlight that hospital learning is often dictated by the effort spent on grasping learning opportunities.

Lively group reflection sessions generate their top ten tips for success in semester one. ”

### Induction into placements

- 62** Induction is required for every clinical placement. Medical schools should ensure that induction takes place and the requirement for induction should be part of their agreements with placement providers.
- 63** Induction should be provided by all placement providers and should include the following elements:
- (a) familiarisation with the physical setting and layout of the placement environment
  - (b) briefings so that the student understands the protocols, rules and procedures specific to that placement
  - (c) introduction of the student to relevant staff members, including levels of supervision and lines of accountability
  - (d) access to records and IT systems as appropriate
  - (e) appropriate conduct and behaviour such as dress codes, good time keeping and treating patients and visitors with respect.

### Supervision

- 64** *Tomorrow's Doctors* (2009) says:

*31. Although medical students may not be directly observed or supervised during all contact with the public – whether in hospitals, in general practice or in the community – there must be a general oversight of students on placement to ensure patient safety. Closer supervision will be provided when students are at lower levels of competence, ensuring that they are not put in*

*situations where they are asked to work beyond their current competence without appropriate support.*

- 65** The development of a medical student on a placement should be overseen by a named Educational Supervisor (although job titles may vary). The Educational Supervisor will be responsible for considering the student's progress against learning objectives set either by themselves or by the medical school. The Educational Supervisor should also facilitate the student's reflective learning by discussing with them the patients and procedures they have experienced during their placement. The Educational Supervisor can either be based within the placement provider where the student is undertaking their placement or within the medical school.
- 66** Medical students must be supervised by a fully registered doctor with a licence to practise. The supervising doctor to whom the student is attached should determine the degree of supervision required and should provide such supervision personally or arrange for its provision by one or more identified fully registered healthcare practitioners. The supervising doctor may determine that an F1 doctor can oversee the student in certain contexts but the responsibility for the student and their supervision ultimately remains with the supervising doctor who makes this decision. Overall responsibility for supervising medical students will normally be undertaken by the consultant or consultants of the clinical team where the student is undertaking their placement or by the General Practitioner to whom they are attached.
- 67** Different grades of doctors are able to provide different levels of supervision for medical students.
- (a)** Consultants or General Practitioners should be the doctors who have overall responsibility for the supervision of medical students. They can make informed judgements as to the day-to-day supervision that the individual medical student requires based on the previous experience of that student and the types of tasks they may have to complete.
- (b)** Middle grade doctors, including specialty trainees and specialty doctors, can support students by providing educational and coaching opportunities. They are able to provide supervision to medical students where a consultant has approved for them to do so.
- (c)** F1 and F2 doctors can oversee students in carrying out simple tasks but they should not have overall responsibility for supervision of the medical student. F1 and F2 doctors should act in this limited capacity only where they are fully competent to carry out the task that they
- are observing themselves. Other registered healthcare professionals may observe the work of medical students in a similar way to an F1 or F2 doctor\*.
- 68** All those responsible for supervising, coaching or overseeing medical students should be trained, supported and briefed to carry out this role.
- 69** Clinical teams or departments will be best placed to devise the details of a system whereby medical students are monitored at all times. Medical schools should provide guidance where necessary and should ensure that students are briefed on what to expect.
- 70** Medical schools should ensure that students are aware that if they have any concerns about the amount of supervision they are receiving or feel that they are being asked to work beyond their level of competency they must stop immediately the work that they are doing at that time. Concerns about the level of supervision should be fed back to the consultant in charge of their team and their medical school.
- 71** Medical schools should also ensure that their students are aware that they should immediately talk to the consultant in charge of their team if they have any reason to think that a complaint may be made about them by a patient or they believe that they may have acted inappropriately.

## Student assistantships

- 72** Schools should be confident that each individual student has been adequately prepared to take on the increased responsibility inherent in a student assistantship. Students may need to be prepared by the medical school for the reality of working in a clinical environment. This preparation should include reassuring students that the school will be available to provide support and advice if they encounter difficult ethical issues.
- 73** NHS Employers has recommended, following consultation with employing organisations, that students be taught in the following areas by their medical school before they undertake a student assistantship:
- (a)** development of clinical competences within curriculum progression
- (b)** safe prescribing policy
- (c)** safe working practices: hand-washing; infection control; occupational health information; health and safety in the workplace

\* With thanks to Glasgow Medical School. This wording is based on their definitions of supervision in their final year courses.

- (d) working hours and working patterns: different working arrangements; controls over hours worked (in light of the Working Time Regulations); good time management skills and how to prioritise tasks; how and when to take a break; safe handover arrangements
- (e) patient confidentiality
- (f) working in an identified multi-disciplinary team
- (g) treating colleagues, patients and visitors with courtesy and respect
- (h) career patterns and pathways
- (i) NHS structures and commissioning arrangements
- (j) portfolio preparation and completion
- (k) understanding learning outcomes.

**74** NHS Employers also suggests a list of areas that medical students should research:

- (a) local NHS structures
- (b) hospital hierarchy and ward or clinic arrangements
- (c) working patterns and hours controls within their local placement
- (d) local support structures – where to go for help (for example, Doctors in Difficulty, BMA)
- (e) careers advice – where to go for help
- (f) how to access IT support
- (g) dress codes
- (h) how portfolios relate to curriculum development and learning outcomes
- (i) identifying personal skills, abilities and interests with specialty or GP career options\*.

**75** In consultation with placement providers, medical schools should consider whether it would be appropriate for the medical student to sign a 'contract' with the provider where they will undertake their student assistantship.

\* These lists comprise suggestions received from some of NHS Employers' contacts (including consultants, HR staff and medical staffing departments). There are two lists to indicate a distinction between what medical schools should teach and what students should research themselves, although the areas covered overlap and feed into each other.

## Tasks

- 76** A student assistantship is not defined by its length or the specialty that the student is working in. It is defined by what the student does and learns during their assistantship and how this period of time helps to prepare that student for practice.
- 77** Student assistants should be fully integrated within a clinical team. They should be on the rota for that team and should have a defined role with defined responsibilities. They should participate in activities similar to those of a newly qualified doctor wherever possible subject to patient safety and consent and legal requirements.
- 78** The tasks that students should carry out while on their student assistantship include:
- (a) clerking patients so that their notes, although checked by a doctor, can form the basis of the patient record
  - (b) carrying out practical procedures on real patients under supervision. These could include procedures from the list of practical procedures listed in Appendix 1 of *Tomorrow's Doctors* (2009)
  - (c) managing acute patients under supervision
  - (d) prioritising patients and tasks
  - (e) working shifts and out of hours
  - (f) managing patient paperwork under supervision
  - (g) making recommendations for the prescription of drugs to real patients. This could take the form of producing duplicate 'dummy' prescriptions on which the student is given feedback from a registered doctor or pharmacist.
- 79** Student assistantships should have clear learning outcomes relating to the tasks they are asked to perform. These outcomes should be communicated to those at the placement provider who are responsible for organising and supervising student assistantships. It is the responsibility of medical schools to set the outcomes for individual placements but the areas they should consider for student assistantships include:
- (a) complex communication skills, for example breaking bad news
  - (b) prioritising a complex workload
  - (c) understanding and applying legal and ethical considerations
  - (d) understanding the operation of the NHS
  - (e) knowledge of prescribing<sup>7</sup>.

- 80** Medical schools should seriously consider discussing with placement providers whether their governance procedures will allow students to write up actual prescriptions under the supervision of a registered doctor which are then checked and signed by that doctor. The advantage of students performing this key skill 'for real' will be improvement in their preparedness for practice on qualification.

#### **Hull York medical school (HYMS) – assistant internship in year five**

“ This is based on the final year course at King’s College, London and the Internship arrangements which have been common in New Zealand.

The principle is that final year students (Phase III) should be involved as much as possible in the diagnosis and ongoing care of patients, both in primary and secondary care within the necessary legal constraints. At HYMS the course is organised as three blocks of eight weeks each (surgery, medicine and primary care on rotation) and one block of six weeks at the end where students are able to choose from all available attachments to meet their perceived learning needs. The process is governed by a contract between the student and the supervisor, GP or consultant. Immediate supervision in hospital is by the appropriate FY1 or FY2.

The objectives build upon those in Phase II, with additional objectives particularly in the fields of therapeutics and critical care and anaesthesia. In secondary care students are allocated a number of in-patients, usually five, for which they have prime responsibility. Students clerk patients, write notes, arrange investigations, visit in-patients and write daily continuation notes on in-patients, liaise with other staff, explain management plans to patients, take part in discharge planning and are present during informed consent, or during procedures which are not within the competence of students. They keep a 'parallel prescription form' for their patients that are checked by pharmacists. Students are expected to take part in the general medical and surgical 'takes' and there are 'sign-up' clinics in other specialties to broaden the experience. In primary care they consult with patients in their own consulting rooms, part of that consultation being unsupervised, then take part in the management process.

HYMS believes that students are able to take this level of responsibility because at the end of year four they have a rigorous theory and practical examination involving real patients, which covers all aspects of medical practice, apart from prescribing (though pharmacology is included). ”

## **Timing and duration**

- 81** The student assistantship should take place in the final year of the student’s medical degree. It is the responsibility of medical schools to determine exactly when it should take place in line with their own individual curriculum. However, it is recommended that it should be towards the end of the final year.
- 82** The student assistantship should be a distinct period of time that is of sufficient length to provide students with an adequate level of hands-on practical experience and to facilitate their preparedness for practice.

- 83** *Tomorrow’s Doctors* (2009) says:

*109. In the final year, students must use practical and clinical skills, rehearsing their eventual responsibilities as an F1 doctor. These must include making recommendations for the prescription of drugs and managing acutely ill patients under the supervision of a qualified doctor. This should take the form of one or more student assistantships in which a student, assisting a junior doctor and under supervision, undertakes most of the duties of an F1 doctor.*

Therefore, medical schools can design their courses so that their students undertake more than one student assistantship. The minimum requirement is that medical students undertake at least one distinct clinical placement equivalent to a student assistantship.

- 84** A principal defining characteristic of a student assistantship is that the student is integrated into a healthcare team and is able to have hands on experience of the type of work that is typically carried out by a newly qualified doctor. The time necessary for the assistantship will be influenced by the school’s arrangements for developing students’ preparedness through previous experiences of clinical placements and in simulated environments.
- 85** Schools should carefully assess the experience and duration of each assistantship. Long placements promote team working but limit the breadth of experience, especially with increased specialisation.

#### **Dundee medical school – preparation for practice**

“ In the final year of the Dundee medical course there are a number of teaching and learning opportunities specifically designed to prepare students to enter Foundation training. These are the foundation apprenticeships, foundation preparation block and the Scotland-wide common shadowing week. The foundation apprenticeship blocks consist of two four week attachments one in surgery and one in medicine. These placements are now well developed having been part of the

Dundee curriculum for the past ten years. Students work with the foundation doctors on the ward and undertake appropriate clinical duties under supervision. Learning plans are developed and there is regular review by the supervising consultant. The foundation preparation block takes place at the end of the year and is a one week consolidation of the practical and legal elements of practice as a junior doctor. The common shadowing takes place in the unit where the student will take up his/her post in the week before doing so and provides a transition period into practice. ”

## Indemnity

- 86** Medical schools should understand the issues around indemnity relating to students in clinical placements and ensure that placement providers appreciate how indemnity applies to student assistantships. The legal position is that where students are working under the supervision of an NHS employee they will be covered by NHS Indemnity. Where a student is working under the supervision of an independent contractor General Practitioner, that is a GP who is not employed by the health service, then the student will need to be included in the contractor's own indemnity cover. Statements to this effect from the relevant legal bodies in England, Northern Ireland, Scotland and Wales are available in an Annex to this document.
- 87** Accordingly medical schools should ensure that when a medical student is in a placement with an independent contractor that contractor's indemnity cover also applies to the student. This should be clearly signposted in the agreement with the independent placement provider.
- 88** Medical schools may also wish to consider whether their students should be members of a medical defence organisation when they are undertaking student assistantships.

### Cambridge medical school – final year student assistantships

“ In the final year Stage 3, 'Preparing for Practice', there are four attachments in primary care throughout the eastern region, and in Addenbrookes or our associated regional teaching hospitals:

- General Practice (four weeks)
- Acute Care (nine weeks)
- Senior Surgery (nine weeks)
- Senior Medicine (nine weeks).

Senior students are attached to practices and hospital firms singly or, at most, in pairs and all work with an increasing degree of responsibility.

Acting throughout as assistant F1s, they are directly involved (under close supervision) in the assessment and management of patients with a wide range of medical and surgical problems within primary and secondary care. As the year progresses they are expected to take on more responsibility for patient care. The Practical Skills assessment (October) and Therapeutics and Prescribing assessment (March) facilitate the development of the required graduate competencies so they can perform basic procedures during their attachments. The programme also includes seminars and workshops in 'wardcraft' including communication skills for multidisciplinary teamwork, an intensive 'clinical management of acute cases' small group teaching day in the high fidelity simulator and the two day 'Death and Dying' course. ”

### Glasgow medical school – Preparation for Practice Block

#### “ Overview

The University of Glasgow Medical School final year has been restructured to permit a 9 week block devoted to familiarising students with the activities involved in early practice as an F1 doctor. Students spend 3 weeks in the University followed by 6 weeks in a clinical placement related to the site of their forthcoming F1 post for August.

- During the six week clinical block students gradually assume the majority of the roles of the F1 to whom they are attached.
- Each student spends time with both F1s in Medicine and Surgery and are involved in significant exposure to acute duties.
- They access reporting (lab/x-ray) systems that they will use as an F1.

They don't:

- perform procedures unless with patient consent and supervised by a competent supervisor
- provide signatures for prescriptions
- prescribe x-rays.

#### *DOTS*

They are supported by access to Doctor Online Training System F1 materials.

#### *Portfolio*

This specifies the intended minimum level of training exposure to clinical activities.

- It covers the six domains of Preparation for Practice (PFP):
  1. Prescribing and drug administration
  2. Advanced Clinical Skills
  3. Managing the acutely ill patient
  4. Life skills

5. Ethics, Law and risk management
6. Practical working as a Foundation Year 1 Doctor.

- The aspects of each that are regarded as important in the training experience are outlined in a series of 'Structured Assessments' undertaken at the time of the work activity and similar to DOPS used for Foundation and Specialty trainees.
- In addition, a set of 'Reflective Discussions' is suggested, for which students write answers to case-based questions prior to meeting for a brief discussion with their PfP 'Coach'.
- The portfolio is returned by the student to the University at the end of their attachment and then presented to their FY1 Educational Supervisor at their first meeting. ”

## Evaluation and evidence

- 89** Just as medical schools evaluate their clinical placements in general they should also evaluate the effectiveness of their student assistantships. In particular evaluation should primarily focus on whether the student assistantship provides hands-on experience and contributes to their students' preparedness for practice.
- 90** As student assistantships are primarily about preparing students for practice it is recommended that medical schools contact their recently qualified graduates to assist in the evaluation of their student assistantships. F1 doctors are well placed to provide feedback as to whether the student assistantship experience provided by their medical schools adequately prepared them for working as a qualified doctor.
- 91** Medical schools should ensure that their quality assurance mechanisms are able to check that there is consistency across student assistantship placements. While the experience of every student will be different, students at any one school should receive a broadly similar experience to their peers and medical schools should take steps to ensure that this is the case.
- 92** Medical schools should be able to show the GMC evidence that their students were fully integrated in the clinical team and that they were able to carry out the activities suggested in this advice. This could take the form of logbooks, portfolios or the results of student surveys. The agreement between the education provider and the medical schools for these placements should also emphasise the need for students to gain practical experience while on their placement.

- 93** Foundation schools and the employers of new graduates could provide a view on their preparedness which could help medical schools to consider the effectiveness of their student assistantships.

## Annexes

### Extracts from *Tomorrow's Doctors* (2009)

#### Introduction

- 6** Students are responsible for:
- (a) their own learning, including achieving all the outcomes set out in *Tomorrow's Doctors*, whatever their personal preferences or religious beliefs
  - (b) ensuring patient safety by working within the limits of their competence, training and status as medical students
  - (c) raising any concerns about patient safety, or any aspect of the conduct of others which is inconsistent with good professional practice
  - (d) providing evaluations of their education for quality management purposes
  - (e) keeping to the guidance *Medical students: professional values and fitness to practise* developed by the GMC.

#### Domain 1 – Patient safety

- 30** The medical school has a duty to ensure that systems are in place to minimise harm to anyone taking part in the training of medical students. Therefore, all those who teach, supervise, counsel, employ or work with medical students are responsible for protecting patients. The medical school must ensure that teachers and others are provided with relevant contextual information about what stage students are at in their training, what they are expected to do, and, if necessary, any concerns about a student. Medical schools must consider providing initial training in a clinical skills facility to minimise the risk to patients.
- 31** Although medical students may not be directly observed or supervised during all contact with the public – whether in hospitals, in general practice or in the community – there must be a general oversight of students on placement to ensure patient safety. Closer supervision will be provided when students are at lower levels of competence, ensuring that they are not put in situations where they are asked to work beyond their current competence without appropriate support.

**Domain 2 – Quality Assurance**

- 41** The medical school will have agreements with providers of each clinical or vocational placement, and will have systems to monitor the quality of teaching and facilities on placements.
- 50** As part of quality management, there must be agreements in place with providers of each clinical or vocational placement. These agreements should set out roles and responsibilities, the learning objectives for the placement, and arrangements to ensure that medical students have appropriate learning opportunities to meet the learning outcomes.

**Domain 5 – Clinical Placements**

- 108** During the later years of the curriculum, students should have the opportunity to become increasingly competent in their clinical skills and in planning patient care. They should have a defined role in medical teams, subject to considerations of patient safety, and this should become more central as their education continues.
- 109** In the final year, students must use practical and clinical skills, rehearsing their eventual responsibilities as an F1 doctor. These must include making recommendations for the prescription of drugs and managing acutely ill patients under the supervision of a qualified doctor. This should take the form of one or more student assistantships in which a student, assisting a junior doctor and under supervision, undertakes most of the duties of an F1 doctor.
- 110** Students must be properly prepared for their first allocated F1 post. Separate from and following their student assistantship, they should, wherever practicable, have a period working with the F1 who is in the post they will take up when they graduate. This 'shadowing' period allows students to become familiar with the facilities available, the working environment and the working patterns expected of them, and to get to know their colleagues. It also provides an opportunity to develop working relationships with the clinical and educational supervisors they will work with in the future. It should consist of 'protected time' involving tasks that enable students to use their medical knowledge and expertise in a working environment, distinct from the general induction sessions provided for new employees and Foundation Programme trainees. The 'shadowing' period should normally last at least one week and take place as close to the point of employment as possible.

**Domain 8 – Educational resources and capacity**

- 166** Students must have opportunities to develop and improve their clinical and practical skills in an appropriate environment (where they are supported by teachers) before they use these skills in clinical

situations. Skills laboratories and centres provide an excellent setting for this training.

- 167** Learning in an environment that is committed to care, based on evidence and research, can help medical students to understand the importance of developing research and audit skills to improve their practice. It also helps to make sure that those responsible for their learning are aware of current developments in clinical theory and practice.

**Indemnity**

Statements from the relevant legal bodies in England, Northern Ireland, Scotland and Wales concerning indemnity cover for medical students on student assistantships:

**England: NHS Litigation Authority, September 2009**

*I can confirm that NHS Indemnity will continue to apply to students in these circumstances, provided that they are working under the supervision of NHS employees ie not privately employed clinicians or independent contractors such as GPs. This should be made clear in the agreement between the NHS body and the student's educational body. I note the requirements which are set out in the document re. supervision.*

*Where a student is working on a placement under the supervision of a non-employed (ie independent contractor) GP, then they will not be covered. They will need to ensure that the GP's own Medical Defence Organisation's cover extends. If however the student is on a placement under the supervision of a PCT or a PCT employee then cover will apply.*

*... More generally, there is nothing in the document [Tomorrow's Doctors (2009)] which causes us concern.*

**Northern Ireland: Health and Social Care Northern Ireland, November 2010**

*Medical students engaged by Health and Social Care Trusts in Northern Ireland will be indemnified by those Trusts where they are working under the supervision of Trust employees, including clinicians or teaching staff: but this indemnity does not extend to privately employed clinicians or independent contractors such as GPs or Independent Sector providers. This should be made clear in the agreement between the Health and Social Care Trust and the student's Educational Body. Where students are working on a placement under the supervision of a clinician who is not a Health and Social Care Trust employee, they will need to ensure that the clinician's indemnity arrangements with his/her Medical Defence organisation covers them.*

**Scotland: NHS National Services Scotland, October 2010**

*I can confirm that NHS Indemnity will apply to students engaged by Health Boards in Scotland, or who are working under the supervision of NHS Health Board employees, or under the supervision of clinicians or teaching staff, holding honorary contracts with the relevant Health Board, ie not privately employed clinicians or independent primary care contractors, such as GPs. This should be made clear in the agreement between the NHS Health Board and the student's educational body. Where a student is working on a placement under the supervision of a clinician who is not a Health Board employee or an honorary contract holder, they will need to ensure that their supervisor's own Medical Defence Organisation's insurance cover includes the student.*

**Wales: Welsh Health Legal Services, October 2010**

*The Welsh Risk Pool take a similar stance to the NHS Litigation Authority [see above] in that they will provide indemnity cover for Student Assistants as long as they are closely supervised by staff directly employed by the NHS. They will not provide indemnity when a student is supervised by doctors undertaking private work or doctors who are independent contractors such as GPs. There would need to be agreement as to what constituted close supervision and this would need to be accepted by the supervising doctors and their employing Health Board.*

**Related documents**

Jan Illing and others, *How prepared are medical graduates to begin practice?* GMC, 2008. [www.gmc-uk.org](http://www.gmc-uk.org)

*Reference guide to consent for examination or treatment*, second edition, Department of Health (England), 2009. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_103643](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643)

*Consent: patients and doctors making decisions together*, GMC, 2008. [www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance\\_index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp)

*Confidentiality: NHS Code of Practice*, Department of Health (England), 2003. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4069253](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253)

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*Supplementary Guidance on Confidentiality: disclosing information for education and training purposes*, GMC, 2009. [www.gmc-uk.org/Confidentiality\\_disclosing\\_info\\_education\\_2009.pdf\\_27493403.pdf](http://www.gmc-uk.org/Confidentiality_disclosing_info_education_2009.pdf_27493403.pdf)

*Medical students: Professional behaviour and fitness to practise*, GMC and the Medical Schools Council, 2009. [www.gmc-uk.org/education/undergraduate/professional\\_behaviour.asp](http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp)

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- 1 Illing, J. et al. 2008. *How prepared are medical graduates to begin practice? A comparison of three diverse UK medical schools*. GMC
- 2 [www.mee.nhs.uk](http://www.mee.nhs.uk)
- 3 GMC. 2010. *Gateways to the Professions – Advising medical schools: encouraging disabled students* (second edition). GMC
- 4 GMC. 2008. *Consent: patients and doctors making decisions together*. GMC
- 5 GMC. 2008. *Consent: patients and doctors making decisions together*. GMC
- 6 GMC. 2009. *Confidentiality: disclosing information for education and training purposes*. GMC
- 7 Illing, J. et al. 2008. *How prepared are medical graduates to begin practice? A comparison of three diverse UK medical schools*. GMC