

**EDUCATION COMMITTEE**

**REPORT OF THE VISIT TO THE MEDICAL SCHOOL AND THE POSTGRADUATE  
MEDICAL OFFICE, THE UNIVERSITY OF DUNDEE**

**18 - 19 NOVEMBER 1999**

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

**Contents**

	Page
<b>Foreword</b> .....	i
<b>Introduction</b> .....	1
<b>Part 1: The undergraduate curriculum</b> .....	1
Background information.....	1
Form of the visit relating to undergraduate medicine.....	1
The undergraduate curriculum.....	2
Curricular development.....	2
The new curriculum.....	2
The management of change.....	3
Supervisory structures.....	3
The contribution of students.....	3
Staff development.....	4
Promoting teaching as a valuable activity.....	4
Aspects of the core curriculum.....	5
Defining the core.....	5
Reducing the burden of factual information.....	6
Integration.....	6

Learning through curiosity.....	7
Special study modules.....	7
Delivery of the curriculum.....	9
Teaching methods.....	9
Learning resources.....	9
The changing patterns of health care.....	10
The goals of undergraduate education	
- attitudes, skills and knowledge.....	11
Attitudes.....	11
Essential skills.....	11
IT skills.....	11
Communication skills.....	12
Clinical skills.....	13
Basic and advanced life support skills.....	13
Aspects of the knowledge base.....	13
Public health medicine.....	13
Legal and ethical issues.....	14
Medicine in a multicultural society.....	14
Complementary and alternative medicine.....	15
Infectious diseases and antibiotics.....	16
Assessment of the process and product.....	16
The scheme of assessment.....	16
Academic standards.....	17
Fitness to practise.....	17
Preparation for the PRHO year.....	17
Other issues.....	18
Student support.....	18
Feedback to students.....	19
Quality control.....	19
Areas of good practice.....	20
Areas for further consideration.....	20
Conclusion.....	21
<b>Part 2: General clinical training.....</b>	<b>23</b>
Background information.....	23
Form of the visit relating to general clinical training.....	23

Organisation and management of the PRHO year.....	23
Supervisory structures.....	23
The approval of posts.....	24
Communicating the aims and objectives of the pre-registration year...24	
The selection of PRHOs.....	25
Monitoring the quality of PRHO posts.....	25
Components of a high quality PRHO post.....	26
Induction.....	26
Educational opportunities.....	27
Educational supervision.....	28
Clinical training and supervision.....	28
Monitoring the progress of PRHOs.....	29

Professional development and personal well-being.....	29
Support for PRHOs.....	29
Careers advice.....	30
Accommodation, catering and personal safety.....	30
Contractual matters.....	31
Areas of good practice.....	31
Areas for further consideration.....	32
Conclusion.....	32
Annexes	
Curriculum overview.....	Annex A
The learning outcomes.....	Annex B
The ethical declaration .....	Annex C
The contribution of public health medicine and epidemiology to the learning outcomes.....	Annex D
The scheme of assessment.....	Annex E
Phase 3 portfolio assessment: prompt question support sheet.....	Annex F
The PRHO questionnaire.....	Annex G
Examples of training opportunities from the Block Release Course.....	Annex H
Examples of PRHO assessment forms.....	Annex I

## Foreword to the visit reports 1998-2001

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

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

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

the introduction of improved arrangements for the training of pre-registration house officers.

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

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

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

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

## **Introduction**

1. The purpose of the visit, which took place on 18 and 19 November 1999, was twofold:
  - a. To monitor progress made towards implementing *Tomorrow's Doctors*.
  - b. To consider progress towards implementation of the recommendations contained in *The New Doctor*.
2. The visiting team was led by Professor Graeme Catto, Chairman of the Education Committee. The other members were Professor David Hatch, a medical member of the Education Committee; Dr Christopher Robinson, a lay member of the Committee, and Dr Linda Patterson, the Medical Director of Barnsley Health Care NHS Trust.

3. The visit lasted two days. The first day was concerned with the undergraduate curriculum, and the second focused on general clinical training.

4. This report is therefore in two parts. In the first we consider developments in undergraduate education since our last visit in November 1995. In the second half of the report we consider compliance with the recommendations in *The New Doctor*, and plans for developing general clinical training provision within the region.

5. In both parts of the report we have identified areas of good practice, as well as those where further progress is required.

### **Part 1: The undergraduate curriculum**

#### *Background information*

6. Prior to the visit the School provided us with helpful background.

#### *Form of the visit relating to undergraduate medicine*

7. The day began with a meeting with senior staff to gain an overview of the curriculum and to discuss developments since our last visit. Later we met members of the Undergraduate Medical Education Committee (UMEC), the body responsible for overseeing the curriculum. In the afternoon we had the opportunity to meet a group of students drawn from each year of the curriculum.

8. Members of the team were also able to visit a number of facilities including the Clinical Skills Centre, the Computing Suite, the Integrated Learning Area, the Ambulatory Care Teaching Centre and the Health Promotion Shop.

## *The undergraduate curriculum*

### Curricular development

When we visited in November 1995, the School had just introduced Years 1 and 2 of the new curriculum. On our return visit we were pleased to be told that the School had successfully implemented its new curriculum in full. The first students graduated from the new course in 1999.

### The new curriculum

10. The new course is divided into the following three phases:

Phase 1 – Year 1

Phase 2 – Years 2 and 3

Phase 3 – Years 4 and 5.

11. The School describes its new curriculum as a spiral curriculum. In effect, this means that the course provides opportunities to revisit, consolidate and develop the knowledge, skills and attitudes which students have encountered at previous stages of the course. By adopting this approach the School has ensured that students' learning is reinforced as they progress through the course.

12. Phase 1 is a largely lecture-based integrated body systems course which considers normal structure, function and behaviour. This involves contributions from a number of disciplines and provides opportunities for community based learning.

13. Phase 2 is an integrated systems-based course which focuses on abnormal structure, function and behaviour. Students' knowledge and understanding from Phase 1 are revisited and extended during this part of the course. A variety of teaching and learning strategies are employed including problem based learning (PBL), which involves consideration of clinical problems relevant to students' clinical experience. Students are introduced to important concepts such as the mechanisms of disease, health promotion and basic clinical skills through the Principles of Health and Disease Block at the start of Year 2.

14. During Phase 3 students enhance their understanding of medicine and their clinical skills in the context of a series of clinical attachments. Student learning is centred around 96 clinical tasks or problems which guide and focus clinical teaching and learning. These clinical tasks help students to develop the clinical competencies which they will require as PRHOs.

15. Students have opportunities to learn through curiosity throughout the course. There is an extensive special study module (SSM) programme, which is described in paragraphs 47 to 56. There is also a seven week elective period, which is described in paragraph 45.

16. The final year provides an opportunity for students to prepare for general

clinical training via a PRHO Preparation Block and PRHO Attachments. These are described in more detail in paragraphs 103 to 107.

17. The School uses a variety of techniques to assess the knowledge, skills and attitudes of students. These include objective structured clinical examinations (OSCEs), computer-based multiple choice questions (MCQs), and problem-solving questions.

18. An overview of the medical curriculum is at Annex A.

*The management of change* (Principal Recommendation 13)

Supervisory structures

19. As in November 1995, the Undergraduate Medical Education Committee (UMEC) has responsibility for all curricular matters. This committee, which reports to the School of Medicine Board of Studies, is responsible for overseeing the structure and assessment of the curriculum, curricular development, student support, staff development and admission to the course.

20. A number of groups report to this Committee including:

- a. Phase Committees, which are responsible for running each phase of the course.
- b. The SSM Committee, which oversees the SSM programme.
- c. The Clinical Skills Centre Committee, which oversees the running and use of the Clinical Skills Centre.
- d. The Admissions Committee, which is responsible for student selection policy.

The supervisory structures seemed to us to provide a sound system for managing the curriculum. The fact that the School has been able to fully implement its new course is a reflection of the hard work which has been carried out by all those involved.

The contribution of students

22. We were pleased to learn that students play a full and active role in the management and development of the undergraduate curriculum. Student representatives from Dundee's Medical Student Committee (MSC) are members of the School's principal committees, and ensure that the views of students are heard.

23. Representatives of the School paid tribute to the proactive involvement of the MSC. We were told that this body had taken forward a number of initiatives such as the production of student questionnaires about assessment, organising sessions about careers advice, and producing guidelines about plagiarism and cheating.

24. The student representatives with whom we spoke confirmed that the School actively sought their views and was willing to implement changes which they had proposed. Students felt that their views were valued and that there was a positive partnership between the School and students.

#### Staff development

25. Within the University responsibility for staff development is devolved to individual faculties. We were told that when the new curriculum was developed and introduced the Medical School ran a series of meetings and training events to ensure that teachers were informed about the changes and had the necessary knowledge and skills to undertake the necessary teaching effectively.

26. As part of a more general programme of the staff development the following opportunities are made available to teachers.

- a. A once a term meeting which provides an opportunity to discuss curriculum matters. This is open to academics and NHS clinicians.
- b. Open sessions on specific educational topics.
- c. Courses on medical education which are organised by the University's Centre for Medical Education.
- d. Distance learning programmes leading to a certificate, diploma or masters degree in medical education.
- e. A regular newsletter.
- f. Regular meetings with Phase 3 block organisers.

#### Promoting teaching as a valuable activity

The School believes that teaching is of vital importance and is keen to ensure that good teachers are rewarded appropriately. We were pleased to learn that annual promotions take account of contributions to teaching and that one senior lecturer appointment last year was largely as a result of teaching excellence.

All staff are encouraged to regard teaching as important and to undertake six hours of training each year. New teachers within the School are encouraged to study for the certificate of medical education, and are assigned a mentor who helps with their development. Although the School has contractual control over University teachers, and GPs that are employed to provide teaching, it cannot compel NHS clinicians with undergraduate teaching responsibilities to undertake such training.

29. The School has drafted a 'Tayside Teaching Quality Document', which summarises the teaching responsibilities of its NHS partners in return for the additional cost of teaching (ACT) monies provided by Tayside Health Board. This

suggests that all undergraduate teachers should be contractually obliged to attend staff development programmes. We thought this was a helpful document and would be interested to see how it is taken forward.

30. The School is aware that teaching is a big commitment and wishes to ensure that those making a contribution to the running and development of the course are adequately resourced. Thus, it has carried out an exercise to quantify the contribution of departments to the course so that financial resources can be allocated in proportion to their commitments.

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

##### Defining the core

31. The core curriculum was originally designed around the system-based courses of Phases 1 and 2 together with the Phase 3 clinical tasks. It was drawn up by a number of system-based working groups which identified core content for each system. The Phase 3 clinical tasks address key symptoms from a number of conditions which were identified by the Phase 1 and Phase 2 systems working groups.

32. The School is in the process of refining the core curriculum in line with the learning outcomes which have been explicitly defined within the last two years. These are listed at Annex B.

33. First year students are now introduced to the learning outcomes so that as soon as they start the course they are aware of what will be expected of them. The School is also considering its scheme of assessment to ensure that the outcomes can be assessed in a valid and reliable manner.

34. We understand that a series of working groups are in the process of reviewing the course to see how teaching and learning contributes to each of the learning outcomes. The School believes that this process will ensure a much more clearly defined core curriculum.

35. We think this review is necessary. The students we met seemed slightly uncertain about the core content of the course. Students in Phase 3 particularly welcomed the explicit definition of the learning outcomes. We were told that they had found the move from the systems-based courses of Phase 1 and Phase 2 to the task based clinical experience of Phase 3 confusing. They said that when they started the final phase it seemed quite different to the earlier years of the course and they had been uncertain about what was expected of them.

36. While undertaking this review we feel that the School should bear in mind the following points:

- a. A more explicit linkage between the curricular outcomes and the GMC's guidance, particularly *Tomorrow's Doctors* and *Good Medical Practice*, would help to ensure that students are more aware of the professional standards to

which they should aspire.

- b. The process should be managed in a planned and rational manner.
- c. Students and staff must be informed of any proposed changes so that they are aware of what is expected of them.

#### Reducing the burden of factual information

37. The School was confident that the introduction of the new curriculum had led to a reduction in the demands on students. By providing detailed study guides for the course it believed that all students had a clear understanding of what was expected of them. It was hoped that by redefining the core in terms of the learning outcomes, demands on students would be kept within reasonable limits.

38. Given students' concerns about a lack of clarity in relation to the current core curriculum, discussed at paragraph 35, we were uncertain whether realistic demands were being imposed. This was particularly the case with Phase 1, which seemed to us to be a very knowledge-based, didactic course that was not well integrated with the rest of the curriculum. However, the students we spoke to did not feel unduly overburdened and commented positively on Phase 1 which they, and the School, considered an important transition between school and medical school.

39. The School was aware of the need to monitor course content and we hope that as the curriculum review progresses this will be borne in mind.

#### Integration

40. The current curriculum, particularly the systems-based courses in Phase 1 and Phase 2, displays a high degree of horizontal integration. We were particularly pleased to note the active role which general practitioners play in course management and development.

41. The approach adopted in Dundee, which allows areas and disciplines to be revisited and consolidated, lends itself well to promoting vertical integration. Particular strategies which have been embraced by the School include:

- a. The involvement of clinicians and basic scientists in teaching throughout the course.
- b. Exposure of students to patients early in the course so that they can understand the clinical relevance of their learning experiences.
- c. Case discussions in the later years of the course in which students are expected to draw upon relevant basic sciences.
- d. Theme-based SSMs in Phase 3 which allow students to explore in more detail areas that interest them, including basic medical sciences.

We share the School's hope that the increased focus upon learning outcomes will provide the opportunity to further enhance this aspect of the curriculum. We think that particular attention should be paid to integrating Phase 1 more closely with the rest of the curriculum. Identifying the contribution that each element of the course makes to the learning outcomes should certainly assist this process.

#### Learning through curiosity

43. As well as the SSM programme, which is described in the next section of the report, students are given a number of opportunities to study areas that interest them and to influence their own studies.

44. Students are provided with study guides which set out course objectives and aims and provide them with information about what is expected. This encourages them to plan their own learning activities. In addition, the excellent learning resources described in paragraphs 58 to 60 provide ample scope for students to undertake self-directed learning.

45. Students must undertake a seven-week period of elective study at the end of their fourth year. This allows them to gain experience of medicine in an area that interests them, and many choose to undertake their elective outside the UK. Students must produce an elective report which is marked by the elective supervisor. The elective report and grade are considered as part of the Phase 3 portfolio assessment, described in paragraphs 95 to 97.

46. Students can undertake an intercalated one year Bachelor of Medical Science degree between Phase 2 and Phase 3. Courses are offered in a number of disciplines and provide interested students with another element of choice.

#### *Special Study Modules* (Principal Recommendation 6)

47. There is an extensive SSM programme which is overseen for UMEC by the SSM Committee. The programme constitutes approximately 30% of the teaching time of the undergraduate course and is designed to ensure that all students have:

- a. An understanding of research method.
- b. The ability to conduct literature reviews.
- c. Self-study skills.
- d. An opportunity to consider their career intentions.

48. Students are provided with detailed handbooks for each phase of the course which offer information about the SSM programme and the process for selecting a module. There is a supervisor for each module who oversees study and assessment, and an SSM convenor for each phase.

49. In Phase 1 students spend four hours a week undertaking an SSM chosen from a menu of options. Modules have been developed to encourage the development of study skills, clinical thinking, problem-solving and IT skills. Students are assessed on a written report which they must produce.

50. In Phase 2 students spend eight weeks at the end of their second and third years carrying out SSMs. They can choose modules ranging from two to eight weeks duration. Modules on offer include:

Clinical practice.  
Community medicine.  
Medical science.  
Ethics and law.

51. In Phase 3 students have the following opportunities:

- a. A fourth year four week assignment on a project relevant to future career intentions, past work or academic experience, or clinical experience and academic curiosity.
- b. Three four week clinical SSMs in the final year, one of which must take place in a primary care setting.
- c. Two four week theme-based SSMs in the final year. These contribute to the vertical integration of the course by allowing students to return to the study and application of relevant basic sciences within a clinical context.

52. Students can also propose their own modules. However, proposals must be approved by the SSM Committee.

53. In order to progress through the course students must pass a certain number of SSM each year, as well as the core curriculum assessments. However, students who perform poorly on the core part of the course must undertake directed study modules (DSMs) in place of SSMs and re-sit core assessments. Such students therefore have fewer opportunities to undertake SSMs than their more successful peers. The minimum number of modules, including DSMs, which students must pass is as follows:

The Year 1 SSM.

The equivalent of two SSM blocks in Year 2. The second year DSM may count as one SSM block.

The equivalent of two SSM blocks in Year 3. The third year DSM may count as one SSM block.

The Year 4 assignment, which is equivalent to one SSM block.

Five four week SSMs in the final year. This may include up to two DSMs and

the seven week elective block.

54. The students that we spoke to found the SSM programme immensely rewarding and educationally beneficial. The opportunity to exercise choice was much appreciated and a common perception amongst students and staff was that modules proposed by students generally received higher marks than those offered by the School. The major reason for this disparity was considered to be the drive and enthusiasm of students who had designed their own modules, rather than any leniency in the assessment process.

55. Modules are assessed by a variety of techniques depending on the type of module undertaken. Assessment methods must be approved by the SSM Committee. Given the range and diversity of modules on offer we were not clear how the School could ensure that consistent standards are applied in the assessments. We were informed that this was an area that the School has identified as a concern, and is currently seeking to address. We understand that marking schemes, which focus on performance against the learning outcomes, are being devised for each phase. It is hoped that these will allow parity of assessment.

56. The SSM programme is clearly a very important element of the Dundee curriculum, and one that is appreciated by the students. However, as in 1995, we were somewhat concerned by a process which allows students who have successfully negotiated the core to take more SSMs than their less successful colleagues. There is a danger that this could devalue the SSM element of the course. We were pleased to be told that this aspect of the course is still under review and welcomed the School's decision to consider this matter further.

#### *Delivery of Curriculum (Principal Recommendation 11)*

##### Teaching methods

57. A number of innovative methods are used to assist the development of students. Training in communication skills involves interviews with simulated patients, role-playing and the videotaping of consultations.

##### Learning resources

58. Students at Dundee are fortunate to enjoy a range of excellent learning resources including:

- a. The Clinical Skills Centre at Ninewells Hospital.
- b. Extensive library facilities.
- c. Good IT and multi-media facilities.
- d. The Integrated Learning Area.
- e. The Ambulatory Care Training Clinic, which provides access to

outpatients for teaching.

59. The Clinical Skills Centre provides opportunities to use a number of mannequins and simulators to practise and develop clinical skills. We were particularly impressed by the School's success in using this resource in the course. Students have timetabled slots in the Centre devoted to the development of relevant clinical skills. This has ensured that the Clinical Skills Centre has become an integral element of the course, and one which is much appreciated by students.

60. We were also impressed with the teaching and learning opportunities provided by the Integrated Teaching Area. This facility is designed principally to support Phase 2 students and provides opportunities to:

- a. Consider case studies which draw together areas they are studying concurrently.
- b. Actively extend their learning by participating in discussions and undertaking tasks and exercises.
- c. Assess their understanding of areas studied.
- d. Undertake self-learning by using the area in their own time.

*The changing patterns of health care* (Principal Recommendation 10)

61. Although the increased throughput of patients and shorter hospital stays have posed problems, the School has sought to adapt to the changing face of health care by providing students with opportunities to be taught in a range of settings including:

- a. Day care units at Ninewells and in health centres.
- b. Clinics run by midwives in general practices and health centres.
- c. Outpatient departments.
- d. Specialist units such as the infertility, ultra-sound and colposcopy clinics.

62. Students spoke highly of the education offered in primary care, where they have the following opportunities to gain experience:

- a. In Phase 1 students are introduced to communication skills training by an attachment to a local GP surgery.
- b. In Phase 2 student groups are attached to a GP tutor from the Tayside Centre for General Practice, to work on the development of communication and teamworking skills.

- c. During Year 4 students are attached to a GP surgery for four weeks.
- d. One of the three final year clinical SSMs must be in primary care.

63. Throughout Phase 3 students have the opportunity to gain experience of community medical services. During clinical attachments in Child Health, General Practice and Psychiatry they experience the work of community psychiatric nurses, mother and child clinics, and well-woman clinics.

*The goals of undergraduate education – attitudes, skills and knowledge*

Attitudes (Principal Recommendation 3)

64. The importance of developing and displaying sound professional behaviour and conduct is stressed at all stages of the course. *Good Medical Practice* is given to all students at the start of the course and a number of important themes, for example confidentiality and consent, are explored in introductory meetings with students. The full set of booklets describing the *Duties of a Doctor* are given to second year students in preparation for increased clinical experience.

65. A Practise of Medicine Group has been established to ensure that the concepts of *Good Medical Practice* permeate the course and student assessment. We were particularly pleased to learn that the School has introduced an ethical declaration which all students must sign when they join the course. A copy of this is at Annex C.

66. The School is aware that student conduct is greatly influenced by the role models with whom they come into contact. As a consequence the need to adhere to *Good Medical Practice* is stressed in staff development courses. The GMC's new guidance, *The Doctor as Teacher*, is being distributed to all those involved in teaching students.

67. The students we met were aware of the role models they come into contact with during the course. In the second year of the course they are shown a video of two doctors displaying quite different conduct towards patients and colleagues, and then have an opportunity to discuss and analyse what they have seen in order to identify the good and poor role model.

68. Students are able to draw poor role models to the School's attention, secure in the knowledge that their concerns will be taken seriously. We understand that one consultant whose behaviour towards students was deemed inappropriate has been removed from the teaching programme.

Essential skills (Principal Recommendations 4 and 8)

IT skills

69. The teaching of IT skills has been integrated into mainstream teaching and students are encouraged to word process written reports and coursework. A

number of Phase 2 systems-based courses involve timetabled sessions in the School's Computer Suite. There is also an SSM on computer literacy for those wishing to extend their skills in this area. The Year 4 assignment, which all students must undertake, involves literature searches, data handling and the production of a word-processed report.

70. The students we spoke to felt that IT skills were addressed informally in the course. Those in the later years felt it had been possible to avoid developing their IT skills if they so wished. The School agreed that coverage of basic IT skills needed further thought, but was confident that by focusing on the relevant learning outcome the refinement of the curriculum would address this problem. We were told that the School intends to introduce a formal course in the first year of the curriculum to ensure that all students have the necessary basic IT skills.

### Communication skills

71. The ability to communicate effectively and appropriately is one of the key skills of the course, and has been identified as one of the learning objectives around which the core curriculum is being recast.

72. Students are introduced to communication skills training during the Phase 1 GP attachment. In Phase 2 basic communication skills are developed and enhanced through the systems-based courses in small-group work and patient consultations in hospital settings, the Clinical Skills Centre, the primary care settings and the Ambulatory Care Training Centre. Phase 3 provides students with opportunities to:

- a. Demonstrate active listening skills.
- b. Enhance their communication skills.
- c. Learn how to deal with a variety of situations, for example, breaking bad news and dealing with verbal conflict.
- d. Enhance their ability to communicate appropriately with other members of the health care team.
- e. Further develop an awareness of their own strengths and weaknesses in respect to communication skills.
- f. Consolidate their ability to communicate clearly using the written word.

73. A variety of teaching methods are used to help students to develop and review their communication skills. These include:

- a. The videotaping of a consultation (involving history taking and physical examination) with a simulated patient in Year 2. Part of the second year OSCE involves a review of the recording in which the candidate is asked to analyse their performance and discuss what insights they have gained from the

process.

- b. Primary care attachments which allow students to conduct a number of consultations and receive feedback from the patients involved.
- c. Role plays designed to help them to break bad news during which student performance is observed by a tutor and peers so that informed feedback can be provided.
- d. The use of simulated patients from different ethnic and cultural groups. This helps students to gain experience of medicine in a multicultural setting.

74. Communication skills are summatively assessed to ensure that students have achieved an appropriate standard. Phase 2 and 3 OSCEs involve stations which are primarily designed to assess these skills. An extended viva voce examination in the final year is used to review students' experience and learning during Years 4 and 5, including the SSMs they have undertaken and their experience during clinical attachments.

#### Clinical skills

75. As students progress through the course their clinical skills are developed and consolidated. Basic clinical skills are introduced in Phase 1, for example students learn how to take each others blood pressure and blood, and visits to patients' homes to begin to develop their history-taking skills. During Phase 2 their basic clinical skills are enhanced through bedside learning on the wards or in the outpatient department. In addition, students have one afternoon a week to learn and practise clinical skills in the Clinical Skills Centre, and another afternoon to work in a primary care setting. The intensive Phase 3 clinical attachments, in which experience is focused by the core clinical tasks, provides an opportunity for students to consolidate and refine their clinical skills.

76. It seemed to us that the School has devised an excellent programme to ensure that its graduates are clinically competent. As mentioned in paragraph 59, the Clinical Skills Centre is an excellent learning resource which has been skilfully integrated within teaching programmes. The students we met felt they had many opportunities to develop their clinical skills, and were particularly appreciative of the teaching and learning opportunities provided by the Clinical Skills Centre.

77. The course learning outcomes now make explicit the clinical and practical skills that Dundee graduates should be able to perform.

#### Basic and advanced life support skills

78. Cardio-pulmonary resuscitation is one of the practical skills assessed in the Year 4 OSCE. This skill is introduced in Phase 1 during a First Aid Course that all students must take, and consolidated in the Phase 2 Medical Skills Course.

79. We had the opportunity to observe the recently acquired cardiac simulator

which is housed in the Clinical Skills Centre. This will clearly be a major teaching resource in the future.

### *Aspects of the Knowledge Base*

#### Public Health Medicine (Principal Recommendation 9)

80. The School told us that Public Health Medicine is integrated within the course. As study guides for each part of the curriculum were devised they were considered by the Department of Public Health to ensure appropriate coverage of this subject.

81. However, it was not entirely evident to us that this subject area received sufficient coverage. The students with whom we spoke agreed that Public Health Medicine did not appear to be a very prominent part of the course, and would welcome greater emphasis on this subject.

82. The School was confident that this subject is embedded within the course. Nevertheless, it was keen to ensure that the focus on learning outcomes should strengthen and make more explicit this part of the course. Accordingly, two learning outcomes, health promotion and disease prevention, and understanding of basic clinical and social sciences, address this area.

83. We were pleased to note that this area has been identified as one of the first to be considered in the curricular review. An initial analysis of the public health contribution to the course is at Annex D. We welcome the School's approach and are confident that the review will lead to a more explicit and rigorous coverage of this important subject.

#### Legal and ethical issues

84. Ethics is a theme which runs throughout the course. Students have the opportunity to consider a range of ethical and legal issues while understanding the professional standards which they will be expected to display on graduation. As mentioned in paragraph 65, we were impressed by the introduction of an ethical declaration which all students must sign.

85. In Year 1 three weeks of introductory lectures involve consideration of *Good Medical Practice* and issues relating to consent and confidentiality. The teaching related to ethics and law is linked to the systems-based courses in Phase 2, but is also opportunistic in terms of discussions about issues which arise during clinical experience. The Phase 3 PRHO Preparation Block involves ethical and legal teaching about issues that will be relevant during general clinical training.

86. We were also pleased to learn that some teaching is multi-professional and involves nursing and midwifery students. We understand that the greater clinical experience of many nursing students has provided an excellent learning resource for medical students during the discussion of ethical dilemmas.

## Medicine in a multicultural society

87. The School is located in a city in which there is little ethnic and cultural diversity. Consequently, providing experience of working in a multicultural environment is not as straightforward as in some other parts of the UK. However, a number of ways have been devised to give this matter the consideration it deserves.

- a. Students are able to gain experience of multicultural groups through their attachments to GP surgeries and other hospitals within the region.
- b. Phase 2 training in communication skills considers dealing with patients from a variety of backgrounds and involves simulated patients from different ethnic and cultural backgrounds.
- c. The student body has a rich cultural mixture and provides a diverse learning resource during discussions about health care and beliefs.
- d. During the fifth year PRHO Preparation Block students consider relevant issues such as different religious beliefs and how these might impact on health care. For example one ethical session involves discussion of Jehovah's Witnesses and the administration of blood transfusions.
- e. The seven week elective period is an opportunity which many students take to study outside the UK and to gain experience of working in a different cultural and ethnic environment.

88. The School is clearly unable to draw upon the range of cultural and ethnic diversity that some other medical schools enjoy within their local community. Nevertheless, it has made great efforts to provide students with the necessary experiences and to inculcate sensitivity to the needs and beliefs of patients. We hope that as the core is reassessed against the learning outcomes opportunities to bolster this aspect of the course will be explored.

## Complementary and alternative medicine

89. The core curriculum aims to promote an awareness of a number of complementary and alternative therapies that are available. Students have opportunities to learn about such therapies at:

- a. The Pain Relief Clinic at which hypnosis is used regularly.
- b. Tayside Breast Service, which sends selected patients to osteopaths.
- c. The surgical outpatient department's counselling room where aromatherapy is used.
- d. GP surgeries where students come into contact with patients who are taking or seeking alternative therapies.

90. For those students who are particularly interested in this subject a Phase 1 SSM allows them to develop a greater in-depth knowledge of complementary and alternative therapies. We were also told that students sometimes propose their own SSMs in this field and are allowed to pursue their special interests.

91. We thought that coverage of a range of complementary and alternative therapies in the core curriculum was not as strong and explicit as it should be. We therefore hope that this feature of the course will be reviewed by the School with the intention of ensuring that all students have a greater awareness of the range of therapies that are available, including their applications and limitations.

## Infectious diseases and antibiotics

92. Students are introduced to the use of antibiotics in the Systematic Health Module in Year 2. During Phases 2 and 3 there are a number of sessions relating to this subject in the context of clinical practice. One of the topics covered is the appropriate use of antibiotics.

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

#### The scheme of assessment

93. The School has established an Assessment Office to review the assessment techniques used so that the most appropriate methods can be employed to assess the learning outcomes.

94. The current scheme of assessment, which is outlined in Annex E, includes the following methods of assessment:

OSCEs

Objective written tests

Patient management problems

A viva voce examination reviewing students' experience in Phase 3.

95. The Phase 3 portfolio review and viva voce examination is a particularly innovative method for assessing student performance at the end of the course. During this Phase students develop a portfolio which includes:

- a. Patient presentations relating to the 96 core clinical tasks. These are reviewed and graded by clinical teachers during the clinical attachments.
- b. A record of the practical procedures they have completed.
- c. The elective report and grade awarded.
- d. SSM reports and assessment forms.
- e. The Year 4 assignment with the grade awarded.

96. The portfolio is submitted for consideration by four examiners, including one external examiner, who review and grade it against the twelve learning outcomes of the course. Students then undertake an oral examination with two separate pairs of examiners in which their portfolio is discussed using the common questions included in the prompt sheet at Annex F. A final grade for the portfolio is then agreed at a meeting of all the examiners.

97. The School believes that one strength of the Phase 3 portfolio assessment is its ability to encompass a broader range of curriculum outcomes than could be assessed by the traditional techniques of assessment.

98. During our last visit we were concerned that students were over-assessed. On our return we were pleased to learn that the scheme of assessment had been reviewed and the number of summative assessments reduced by 50%. The students that we spoke to confirmed that in their view, the level of assessment was now appropriate. Students were particularly appreciative of the Phase 1 computer-based formative assessments which allow them to gauge their progress and performance. These also provide excellent training for the Phase 1 summative examination, part of which follows a similar format.

99. Students in the later years of the course had found the new focus on learning outcomes in the assessments difficult to come to terms with, given that these had not been explicitly defined when they had joined the course. However, their main concern was about the timing of the final core curriculum examination at the end of Year 4. This was a particularly hectic time when they were busy arranging their electives. It was also suggested that holding the last formal examination of the core in Year 4 undermined the importance of the fifth year. Students thought that it might be more appropriate to reschedule the examination for the end of the autumn term in Year 5.

#### Academic standards

100. Assessment criteria are made known through the student handbooks for each year of the course, in the degree regulations and through meetings with staff and students. The School is currently working to define more accurately the necessary level of achievement, in terms of the learning outcomes, for each phase of the course.

#### Fitness to practise

101. The School is attempting to identify students with poor conduct and attitudes as early as possible so that remedial measures can be taken or they can be advised to leave the course.

102. We understand that the School and Postgraduate Dean wish to establish an advisory committee to consider and determine the future of students about whom there is concern, other than poor academic performance, such as those with a poor attitude, a serious communicable disease or drug abusers. This proposal is to be considered by the University's senate. We would urge the University to accede to this proposal so that this important body can be established swiftly.

#### Preparation for the PRHO year

103. The final year is designed to consolidate the knowledge, understanding, skills and attitudes that have been developed throughout the course, and to ensure that students are prepared for the pre-registration year.

104. Preparation for general clinical training is organised in two principal ways:

PRHO attachments.

## The PRHO Preparation Block.

105. Students have the opportunity to undertake two four week attachments to the medical or surgical teams that they will be joining as a PRHO. They are expected to participate in patient care as part of the health care team. During the attachments they must develop a learning plan with their supervising consultant, and carry out a series of exercises and tasks. Supervising consultants and students' tutors monitor and provide feedback about performance.

106. The three week PRHO Preparation Block is designed to smooth the transition from student to PRHO by ensuring that students have:

- a. The skills required by PRHOs.
- b. The necessary organisational skills.
- c. A core knowledge of common medical and surgical conditions.

107. The block involves coverage of a core curriculum through a series of plenary sessions, and opportunities for self-directed learning including practising clinical skills under supervision and using computer assisted learning (CAL) packages.

### *Other issues*

#### Student support

108. The School has put in place the following support systems for students:

- a. An introductory course for first year students which explains the course and outlines the various support mechanisms available.
- b. Student handbooks for each part of the course which explain what is expected of students.
- c. A personal tutor scheme for Phase 1.
- d. Tutor groups for Phases 2 and 3, which provide tutor and peer support.
- e. An e-mail problem page with answers to common problems and concerns.

109. The School's website also provides details of the support services and offer and advice about how these can be accessed.

110. In addition to these systems the MSC has established a mentoring scheme in which senior students support new students. They run a Nightline telephone support service and have produced a *Student Survival Guide* for new students.

111. The University also provides:

- a. A student counselling service.
- b. A Student advisory service.
- c. Support for students with disabilities.

112. The students we spoke to confirmed that support during Phase 1 is uniformly excellent. The tutorial system in Phases 2 and 3 was thought to be more variable, although all students were confident that they would be able to find support, guidance and assistance if it were required.

#### Feedback to students

113. Students are provided with feedback about their progress through formative assessments in Phases 1 and 2. Performance in Phase 3 clinical attachments is assessed using a standard assessment form which is included in the portfolio. Students are also given marks following summative assessments.

114. The Dean of Teaching did not think the School had been as successful in providing feedback to students as he would have wished. However, we understand that the School is intending to introduce a new system that will provide students with information about their performance against the learning outcomes in every summative assessment on the course.

115. Students confirmed that feedback about performance, particularly during the Phase 3 clinical attachments, was not always helpful or consistent. We would therefore suggest that this aspect of the course be kept under review and welcome the intention to introduce a new system of feedback on performance in the summative assessments.

#### Quality control

116. The medical curriculum is monitored by the Medical School Academic Standards Committee which reports to UMEC.

117. Procedures to monitor the quality of the provision include:

- a. End of course student feedback questionnaires.
- b. Regular meetings with student representatives.
- c. Feedback from teaching staff.
- d. The involvement of external examiners in summative assessments, including reports about the conduct of examinations.

118. It seemed to us that there is a sound system in place to ensure that the

undergraduate course is of a high quality. However, as mentioned in paragraph 36, the School must ensure that all students and staff are kept informed about changes and developments to the course. Some of the students we spoke to did not feel that information was always presented in a way that was clear and helpful.

#### *Areas of good practice*

119. *Curricular review:* The School's review of the curriculum, and its intention to make the learning outcomes the heart of the course, is welcomed. Given the uncertainty of some students, particularly those in the later years of the course, about the core curriculum, we think this initiative is timely. UMEC will wish to ensure that this process is coordinated and that staff and students are kept informed of any changes.

120. *Promoting teaching as a valuable activity:* The School has made great efforts to provide all teachers, both University appointees and clinicians, with appropriate staff development opportunities. It has also sought to ensure that clinicians appreciate the importance of teaching and that good teachers are both recognised and rewarded.

121. *Learning resources:* Students in Dundee are fortunate to enjoy some fine learning resources and facilities. We thought that the Clinical Skills Centre and the Integrated Learning Area provided students with excellent teaching and learning opportunities. The integration of such resources within timetabled teaching has been very successful.

122. *Student support:* All the students that we spoke to confirmed that the School has created a very caring and supportive environment in which to study medicine. The Phase 1 personal tutor scheme was identified as an excellent system which provides students with the necessary academic and pastoral support.

123. *Changing patterns of health care:* The School has adapted well to the changing patterns of health care and provides students with teaching and learning in a range of clinical and community settings. We also welcome the opportunities which students have to train with nurses and midwives, and the mutual understanding and respect which this engenders.

124. *Ethical matters:* We were pleased to note the introduction of an ethical declaration which all students must sign. This is a clear indication to students that they are expected to develop and display the highest levels of conduct and behaviour.

125. *Phase 3 portfolio:* The introduction of the Phase 3 portfolio review and viva voce examination is an innovative development which offers the potential for measuring student performance against a wide range of learning outcomes. We shall be very interested to be kept informed about how this development progresses.

#### *Areas for further consideration*

126. *Defining the core curriculum:* When reviewing the course we would like the School to consider how further integration of Phase 1 with the rest of the course can be achieved. We appreciate that opportunities for clinical experience have been included in this part of the course, but feel that it is still very didactic. We would encourage the inclusion of a wider range of teaching and learning methods than is currently the case.

127. The relationship between the standards of professional conduct set out in *Good Medical Practice* and the curricular learning outcomes should be strengthened. Students should be made aware that the professional standards to which they aspire are based upon the GMC's guidance.

128. *Special study modules:* The SSM programme is much valued by students and staff and clearly makes an important contribution to the course. We would invite the School to consider ways of ensuring that students who fail to perform well on the core elements of the course have the same opportunities to undertake SSMs as their more successful peers.

129. *Public health medicine:* It was not evident to us that public health medicine features prominently in the current course. We welcome the decision to focus on the contribution this subject can make to the curriculum, in the review being undertaken, and would encourage the School to consider ways of enhancing this aspect of the course.

130. *Medicine in a multicultural society:* We hope the School will take advantage of the review of the core curriculum to provide students with greater opportunities to gain experience of practising medicine in a multicultural environment.

131. *Complementary and alternative medicine:* We did not think that there were sufficient opportunities for all students to gain an appreciation of the range of complementary and alternative therapies available. We would wish the School to identify further opportunities for students to address such issues as part of the core curriculum.

132. *Final core curriculum examination:* The School will wish to discuss with students their concerns about the timing of this examination at the end of Year 4. Students that we spoke to were quite adamant that this was not the best time to take such an important examination and we think that an exploration of the issues involved would be mutually beneficial to students and the School.

133. *Feedback to students:* Although the supportive and caring environment is much appreciated by students, particularly during the early years of the course, it was apparent that feedback on performance is not always consistent or helpful. Students in the primarily clinical years of the course were particularly critical of the lack of consistency. We would like the School to work with clinical teachers to ensure that the quality and consistency of feedback is improved.

*Conclusion*

134. On our return to Dundee we were pleased to learn that the School has successfully implemented its new curriculum. All those that have been involved in this process are to be commended for their achievements.

135. Although we have identified a number of areas for further consideration, the School was already aware of many of these. We welcomed the review of the curriculum which is being carried out to ensure that the highest standards of medical education are maintained. We look forward to hearing about further progress in a year's time.

## **Part 2: General clinical training**

### *Background information*

136. Prior to the visit we were provided with helpful background information about general clinical training within the region.

### *Form of the visit relating to general clinical training*

137. The day began with an overview of general clinical training from the Postgraduate Dean and members of the Pre-Registration Committee (PC). We then met the Director of Postgraduate General Practice Education and a group of educational supervisors and clinical tutors from a variety of hospitals and trusts, and had the opportunity to have discussions with PRHOs from a number of locations and specialties. In the afternoon we met medical directors from NHS trusts in the region.

### *Organisation and management of the PRHO year*

#### Supervisory structures

138. The Pre-Registration Committee, which is chaired by the Postgraduate Dean, is responsible for PRHO training within the region. Its main functions include:

- a. Monitoring PRHO posts within the regions.
- b. Monitoring the adequacy of PRHO training.
- c. Providing advice for Educational Supervisors in their training role.
- d. Collating feedback about PRHO posts.
- e. Undertaking targeted re-inspections of the training posts.

139. It meets at least three times a year, but extra meetings are arranged to deal with specific issues or concerns. Although representatives from NHS trusts and primary care are involved, we were disappointed to note that the Committee does not have a junior doctor representative. We were told that the inclusion of a junior doctor was under consideration and we would strongly urge the Committee to make this change. Other deaneries have derived enormous benefit from involving PRHOs on their principal committees.

140. The work of the Deanery is coordinated with other regions within Scotland through regular meetings of the Scottish postgraduate deans and via the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE).

141. SCPMDE has established a group to consider and co-ordinate the implementation of *The New Doctor* within Scotland. SCPMDE's initiatives include:

- a. Providing PRHOs with better feedback through the introduction of a common Record of Assessment (see paragraph 169).
- b. The establishment of a Scottish matching scheme for PRHO posts.

#### The approval of posts

142. The PC is responsible for the approval of PRHO training posts within the region.

143. Bids for new posts must comply with the requirements set out in *The New Doctor*. Trusts must submit detailed information about the educational opportunities that would be provided in a new post, together with information about the supervisory structure that would be put in place.

#### Communicating the aims and objectives of the pre-registration year

144. A number of mechanisms have been put in place to ensure that the aims and objectives of this period of training are understood by the NHS trusts, clinical teachers and the trainees themselves. These include:

- a. Widespread distribution of *The New Doctor* to NHS trust managers and educational supervisors.
- b. The undergraduate PRHO Preparation Block, described in part one of this report, which allows discussion of the aims of this period of training.
- c. The aims of PRHO training are addressed in training programmes which educational supervisors undertake to enhance their teaching and appraisal skills.
- d. The SCPMDE Record of Achievement, which is used to monitor PRHO performance, contains information about the goals of this period of training and refers to the guidance set out in *The New Doctor*.
- e. The establishment of liaison committees for the NHS trusts within the region, which allow for discussion of issues relating to PRHO training.

145. Great emphasis is placed on staff development for educational supervisors. We understand that 16 out of 30 educational supervisors have been on training courses intended to assist them to carry out their role. The Deanery is establishing a database to monitor the training which individuals have undertaken, and to provide information about further training opportunities.

146. The Deanery is aware that a number of teachers involved in general clinical training also teach undergraduates. Accordingly, it is seeking to co-ordinate the staff development opportunities it provides for teachers with those of the Medical School.



## The selection of PRHOs

147. We were told that from August 2001 the Deanery will be joining the SCPMDE matching scheme for Scotland. This scheme allows students to apply for any post within Scotland.

148. To date, however, the Deanery has operated a local matching scheme for the Tayside region. Students are provided with guidance about the posts on offer within the region and invited for interview. In the light of students' and interviewers' preferences, students are matched to the available posts by a computerised system.

149. Students who are unable to find a post within the region are given support and information to help them to identify a post elsewhere in the UK. Students are advised that they can join the SCPMDE organised matching scheme for Scotland. They are also provided with contact details for deaneries and trusts outside Scotland that offer PRHO posts.

150. The students we spoke to thought that the Tayside matching scheme was an effective method for allocating students to PRHO posts.

## Monitoring the quality of PRHO posts

151. The principal method for monitoring the quality of PRHO posts is by seeking the views of trainees. This information is collected in the following ways.

- a. At the end of each post, typically every six months, trainees are asked to complete a questionnaire which seeks their views about the quality of the training which they have received. A copy of this questionnaire is at Annex G.
- b. The region has a Junior Doctors Forum which is intended to provide an opportunity for trainees and the Deanery to discuss generic issues and concerns regarding general clinical training.
- c. As part of a SCPMDE initiative in Scotland, the Deanery is commencing semi-structured interviews with PRHOs to gather information about trainees' experience and the adequacy of the training which they received.
- d. The midpoint appraisal interview with their educational supervisor is a further opportunity to comment on the training received.

152. All teaching sites within the region are visited on a three-year cycle of inspections. The principal focus of these inspections is senior house officer (SHO) training, although PRHOs are met and the quality of their training discussed. Shortcomings in training are discussed with senior NHS managers who are expected to remedy problems.

153. The PC considers inspection reports and discusses cases where problems have been identified. Additional visits to trusts are carried out if the problems

identified are considered serious. We were told that the Deanery had recently been working closely with one of the hospitals in the region to overcome shortcomings in SHO training.

154. Our discussions with trainees revealed that while the majority of them were content with the training which they were receiving, a number of medical PRHOs had grave concerns about work intensity and support from senior house officers (SHOs). These concerns are discussed in more detail in paragraphs 165 and 174 respectively.

155. We were concerned to learn that a number of recent Junior Doctor Forum meetings had been cancelled. Our concerns were heightened when PRHOs professed ignorance of the Forum and the role it was set up to perform. Clearly such ignorance, allied with infrequent meetings, has undermined the efficacy of this body. These problems must be addressed so that the Forum can carry out its responsibilities effectively.

156. In the light of the problems identified by trainees, we wondered whether the process for monitoring PRHO training is sufficiently robust. Trainees told us that the Deanery was aware of problems, but changes were slow in coming to fruition. We hope that the Deanery will work with its NHS colleagues to address this matter and introduce an inspection process specifically for PRHO posts.

### *Components of a high quality PRHO post*

#### Induction

157. As mentioned in the first part of the report, the Dundee undergraduate curriculum provides preparation for PRHO training, including the opportunity to shadow a PRHO in the hospital that a student will be working in. The trainees we spoke to found this experience to be extremely helpful.

158. Trusts are expected to provide induction for trainees when they take up a PRHO post. This is a compulsory element of PRHO training which trainees are contracted to attend.

159. Clinical tutors within the region meet regularly to discuss the content of induction and to ensure consistent provision. The views of trainees about induction are sought, so that perceived weaknesses can be addressed in subsequent years. In the past, areas of weakness which have been identified include dealing with death and bereavement, coping with complaints, and aggressive patients. We understand that there are plans to include a session about dealing with aggression in all induction courses.

160. All the trainees we spoke to had received induction. However, it was clear that trainees were not familiar with the management structure within their trusts, or the role of trust boards. The absence of board members and chief executives from induction training appeared to us to be a weakness.



## Educational opportunities

161. A concerted effort has been made to ensure that all trainees have access to well planned formal educational sessions. Trainees are required to attend 70% of such sessions and a register of attendance is kept. Failure to attend is discussed with educational supervisors in appraisal meetings. If attendance is sufficiently poor it could result in the postgraduate dean refusing to sign a trainee off as having completed training satisfactorily.

162. Within Ninewells Hospital the Deanery has established a Block Release Course which aims to provide training and education that is relevant and appropriate to PRHO training. Examples of the training offered on this course are given at Annex H.

163. The programme offers a range of topics, which are taught by a variety of methods. We were pleased to learn that the Block Release Course is revised each year to take account of comments from trainees. PRHOs felt that this course offers excellent training and experience.

164. The other trusts within the region also offer formal training opportunities. PRHOs in GP posts are provided with training opportunities by GP trainers, and are able to attend the Block Release Course at Ninewells Hospital as well as any vocational training provided for GP Registrars.

165. The Deanery has clearly put an extensive educational system in place. However, discussion with trainees indicated that the efficacy of the system is seriously weakened as a result of service demands. A number of the medical PRHOs that we spoke to felt very strongly that the service demands placed on them were excessive and compromised the educational element of posts. In addition, although training is supposed to be bleep free, few trainees appeared to have experienced this. Thus in some trusts there did not appear to be a clear strategy for filtering bleeps while, in others, all staff were so busy that trainees did not feel able to leave their bleep with a colleague.

166. These failings resulted in trainees not obtaining the full benefit of the educational sessions offered to them. Thus

a. Attendance at educational sessions might be curtailed by a bleep call 10 minutes after it had started. It would therefore appear that trainees had attended a course, although in fact they had derived little or no gain from it because they were called away.

b. On returning from an educational session trainees would be faced with a backlog of tasks which had not been dealt with in their absence. They would then be so busy dealing with these tasks that they would derive little educational benefit from being back on the ward.

167. This situation is clearly unsatisfactory and the Deanery should seek to work with its NHS partners to resolve the problems.

## Educational supervision

168. Within the region educational supervisors are appointed on the basis of proven enthusiasm for the role and a track record of supporting and assisting trainees. As mentioned in paragraph 145, the Deanery places importance upon training educational supervisors to carry out their role.

169. The SCPMDE Pre-registration Year Record of Progress and Assessment has been made the basis of educational supervision within the region. This requires supervisors to meet trainees at the:

- a. Start of a post to discuss the educational aims and goals of training as set down in *The New Doctor*.
- b. Mid-point of a post to ascertain their progress and development.
- c. End of the post to discuss and record their overall performance.

170. The educational supervisors we spoke to confirmed that the Deanery was very supportive and keen to assist them. They thought the SCPMDE appraisal system was helpful because it provided a structure for educational supervision. However, they believed that supervision should be carried out constantly in an informal manner to ensure that trainees develop the confidence and competence to carry out their roles successfully.

171. All the trainees that we spoke to had met their educational supervisors and generally found them to be supportive and helpful. Medical PRHOs who had expressed concerns about work intensity told us that their supervisors were sympathetic but, as they were under pressure themselves, were unable to rectify the problems.

## Clinical training and supervision

172. There is no generic clinical training for PRHOs within the region. However, the Block Release Course contains a number of general elements including sessions on communication skills and basic clinical skills and procedures.

173. The Deanery has sought to develop a supportive environment for trainees. The aim within each unit is to assist trainees and provide opportunities for them to raise issues and concerns.

174. The trainees that we spoke to stated that most teams were very supportive and that in all cases consultants made an effort to make them feel a valuable team member. However, medical PRHOs from one hospital had experience of an SHO who was not very supportive or helpful. We were told that the individual concerned was unreliable and not always willing to take responsibility when the most senior person on the ward. We were told that consultants on the team were aware of the PRHOs' concerns and were monitoring the performance of the SHO.



## Monitoring the progress of PRHOs

175. The SCPMDE Pre-registration Year Record of Progress and Assessment, discussed at paragraph 169, provides the basis for educational supervision and the monitoring of PRHO progress within the region.

176. Educational supervisors are required to meet trainees at regular stages to review performance and monitor progress against the training goals for the pre-registration year. The Deanery maintains a database which allows it to ensure that appraisal meetings are held as necessary.

177. The SCPMDE system requires regular assessments to be carried out. Reports of these must be signed by the educational supervisor and trainee to demonstrate that performance has been discussed. It therefore provides trainees and the Deanery with a record of their progress. Examples of the assessment forms that must be completed are at Annex I.

178. The monitoring system allows educational supervisors and the Deanery to identify shortcomings in performance and set in place remedial measures that will allow a trainee to complete the pre-registration year satisfactorily. We were told that if a trainee's performance is causing concern, the period of PRHO training could be extended so that the additional training, support and experience required by the trainee can be provided. We understand that a similar process would be invoked if a trainee missed a significant period of training due to ill health.

179. As mentioned in the first part of the report, we were pleased to learn that the Medical School and Deanery have proposed the establishment of an advisory committee to support the dean and the postgraduate dean. This body would consider cases where health or conduct provokes concerns about an individual's suitability for a career in medicine. As already stated, we feel that such a body would play a vital role in upholding professional standards.

## *Professional development and personal well-being*

### Support for PRHOs

180. Educational supervisors are expected to provide trainees with academic and pastoral support. Training for educational supervisors is intended to assist them in this aspect of their role. If trainees require counselling this can be provided by the Occupational Health Department. Trusts also provide handbooks and guidelines for trainees which include useful information about trust protocols, and local procedures and services.

181. Within the region the Deanery and trusts have developed a range of facilities and support systems that are intended to assist PRHOs. These include:

- a. Access to the Medical School's Clinical Skills Centre through the Block Release Course. Such opportunities allow trainees to enhance and practise their practical and clinical skills.

- b. Ninewells Hospital provides access to excellent computing and library facilities, and a junior doctors mess for recreational purposes.
- c. Radiology services in Perth Royal Infirmary were considered excellent by the trainees we spoke to.
- d. A number of trusts have employed nurse practitioners and phlebotomists to relieve trainees of tasks which are less educationally beneficial.

182. Given the concerns of some trainees about the service demands placed on them, and the detrimental effect this has on their education, support for PRHOs is vital. We were therefore pleased that the medical directors we met believed that trust boards were becoming increasingly aware of the vital role played by PRHOs in patient care, and the need to provide them with sound educational and training experiences.

183. The trainees we spoke to welcomed measures that have been put in place to support them. Where provided, the support of nurse practitioners and phlebotomists were appreciated. However, we were told that such support varied between hospitals. In some cases phlebotomists were only available once a day which resulted in trainees being burdened with an excess number of blood takes if they missed the service.

#### Careers advice

184. Educational supervisors are expected to provide trainees with careers information advice. This often takes the form of arranging meetings with consultant colleagues who can provide the required guidance. The Deanery has also appointed a Flexible Training Advisor to help trainees interested in flexible training to arrange a suitable programme.

185. Trainees did not feel that careers advice was offered in a formal or proactive manner. However, they all thought that the necessary guidance could be found if they made the effort to seek it from colleagues.

#### Accommodation, catering and personal safety

186. The Postgraduate Dean was confident that the facilities provided for PRHOs within the region had improved in recent years. The Junior Doctors Forum is expected to monitor provision and work with the Deanery and trusts to make sure that any changes that are required are made.

187. The trainees that we spoke to did not have many concerns about the facilities provided. Weekend catering at one hospital, where food is provided via a vending machine, was thought poor, but generally this was not an issue for most trainees. However, there were some concerns about security arrangements at trusts where PRHOs had to travel some distance between wards while on-call. At one hospital the grounds were poorly lit and PRHOs did not feel safe when walking outside.

188. Given our concerns about the functioning of the Junior Doctors Forum, which are discussed at paragraph 155, we feel that the Deanery should continue to check with trainees that they are content with the services and security arrangements that are provided.

#### Contractual matters

189. PRHOs provide the Deanery with information about the hours they work through the questionnaires which they complete at the end of each post. The Junior Doctors Forum is also expected to monitor workload and hours. However the failure of this body to meet regularly, and PRHO ignorance of it, has undermined the Forum's capacity to fulfil this role.

190. In discussions with trainees it became evident that there were some problems in relation to the number of hours worked, and the amount of rest time available between shifts. A number of trainees confirmed that they worked hours which were in excess of those laid down by *The New Deal*.

191. When we last visited trainees had expressed concern about their workload. For some medical PRHOs these concerns did not appear to have been addressed. Thus, the workload described was too great, and PRHOs were expected to cover too many wards, especially at night.

192. Trainees also reiterated concerns about partial shift systems, which they had voiced to us in November 1995. The introduction of such systems, particularly for medical PRHOs, is eroding the educational structure which has been put in place. Thus, trainees who were ward-based rather than team-based felt that partial shifts disrupted the continuity of their contact with patients and thereby reduced the educational experience of their posts.

#### *Areas of good practice*

193. *Staff development:* The Deanery has identified staff development as one of the principal means of improving the quality of general clinical training in the region. We particularly welcome the establishment of a database for monitoring the training undertaken by staff, and the intention to coordinate staff development with the Medical School.

194. *Educational opportunities:* The Deanery has ensured that formal educational sessions are made available to all trainees. The trainees we spoke to confirmed that these sessions were well organised and very helpful. They particularly appreciated opportunities to comment on the content of such sessions.

195. *Educational supervision:* We were pleased to note that all the trainees we spoke to had met their educational supervisors and received helpful feedback about their performance. The support provided by supervisors was much appreciated by PRHOs.

196. *Clinical training and supervision:* All the trainees with whom we spoke were enjoying appropriate clinical training and supervision. We were told that in the great majority of posts consultants and other colleagues ensured that PRHOs felt like valued members of the medical team.

197. *Fitness to Practise:* The Deanery is commended for having worked with the Medical School to bring forward recommendations to establish an advisory body to consider health and conduct matters.

#### *Areas for further consideration*

198. *Workload and intensity:* The major concern of trainees, particularly those on medical firms, were the service demands placed on them. In some cases these demands seemed to be excessive, were detrimental to the educational content of posts and undermined the morale of trainees. Thus, medical PRHOs complained that service demands prevented attendance at educational sessions, while other trainees said they had insufficient rest between shifts. The Deanery should explore these matters with its NHS partners to ensure that service demands are kept to an appropriate level, and that the requirements of *The New Deal*, in terms of hours of work and work intensity, are met for all trainees.

199. *Monitoring the quality of PRHO posts:* Given the concerns that trainees had about the service demands of some posts, it was not evident to us that the system for monitoring PRHO posts is sufficiently rigorous. An inspection process designed specifically to monitor PRHO posts should be established.

200. *Junior Doctors' Forum:* This body is supposed to play a central role in monitoring service demands and providing trainees with a means of expressing their worries and concerns. However, it was failing to fulfil this role. The Deanery should ensure that trainees are made aware that this body exists, informed of its role and encouraged to participate.

201. *Junior doctor representation:* Many deaneries have derived enormous benefit from including junior doctor representatives on the body which coordinates and manages general clinical training. We recommend that the Deanery should include PRHO representatives on the Pre-registration Committee.

#### *Conclusion*

202. On our return to Dundee we were pleased to see that many improvements have been made to general clinical training. The Deanery has ensured that formal educational opportunities are made available to trainees and has put in place a sound structure for providing educational supervision.

203. However, we were concerned to hear that the enjoyment of many trainees, and the benefits they derived from training, was being reduced as a result of excessive hours and the intensity of work. The Deanery must work with its NHS partners to ensure that working practices are not detrimental to the educational content of PRHO posts. It is also clear that the Junior Doctors Forum has not been

as active as its integral role in the monitoring process suggests it should have been. We look forward to hearing about how the Deanery intends to address the problems we have identified.