

# Report of the visit to the University of Glasgow

10-11 November 1999

We should like to express our thanks to the Dean of the Faculty 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.

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## **Introduction**

1. Our visit had two purposes
  - a. To review progress made by the Faculty towards implementing the recommendations in *Tomorrow's Doctors* since our last visit in 1996, with a focus on the predominantly clinical years of the course.
  - b. To monitor progress towards implementing our guidance on the pre-registration year, as set out in *The New Doctor*.
2. Our team was led by Professor Graeme Catto, the Chairman of the Education Committee. The other members were Professor Andrew Elkington and Dr Gillian Markham, both former members of the Committee, and Mrs Eileen Walker, a lay member of the Committee.
3. Our visit lasted two days, with the first day devoted to the undergraduate curriculum and the second day to the arrangements for general clinical training.
4. Our report is in two parts, reflecting the nature of our visit. In part one we look at the further progress made towards implementing the recommendations in *Tomorrow's Doctors* and discuss the Faculty's plans for future development. In part two of our report we consider the arrangements for general clinical training in the light of our guidance in *The New Doctor*.
5. In both parts of our report we have identified areas of good practice and issues where further progress is required.

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

### **Background information**

6. The completed questionnaire and other supporting information which the Faculty provided in advance of our visit were not sufficiently detailed to allow us to prepare adequately for the visit. Although we made comprehensive enquiries in the course of the visit, and requested further documentation to be sent to us subsequently, we were not able to take full advantage of the opportunity provided by the visit to satisfy ourselves, and the Education Committee, about the progress being made.

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

7. The day began with a meeting with senior members of the Faculty to gain an overview of the curriculum and to discuss developments since our last visit. Later we met members of the Curriculum Management Group, the body responsible for the day-to-day management and development of the curriculum. We also had discussions with key staff involved in the delivery of Years 4 and 5 of the undergraduate programme and with a group of students drawn from each year of the course. During the day we were able to view some of the excellent clinical skills teaching facilities and learning resources available to students.

### **The Glasgow undergraduate curriculum**

#### **Curricular development**

8. When we last visited in May 1996, the Faculty was refining its plans prior to the introduction of its new problem-based curriculum in October of that year. Based around the objectives set out in *Tomorrow's Doctors*, its key aims included a drastic reduction in the factual overload on students and the promotion of active independent learning.

9. The Faculty has successfully 'rolled out' of the first three years of the new curriculum. However it seemed to us, (and this was confirmed by the students whom we consulted), that many clinical teachers were neither aware of nor were fully 'signed up' to the concept of problem-based learning. Conscious that the first cohort of students will complete the new programme in July 2001, the Faculty is taking urgent steps to clarify curricular aims for both staff and students, particularly those in Years 4 and 5.

### **Structure and content of the new curriculum**

10. A diagram giving an overview of the new curriculum is at Annex A.

11. Problem-based learning (PBL) is the main means of delivering teaching and learning, although there is a major shift from group to individual work after the end of Year 3 when students undertake their clinical attachments.

12. Years 1 to 3 are organised in five week blocks during which students undertake a series of PBL sessions based around a core of clinically-based scenarios. These sessions are supported by a diverse range of timetabled learning resources, described as Fixed Resource Sessions (FRS).

13. Running parallel with but closely related to the PBL core during the first three years of the course is the Vocational Studies (VS) programme. This is an integral part of the curriculum, providing students with opportunity for early contact with patients in a variety of settings and the means to develop their clinical, communication and reasoning skills.

14. The Special Study Module (SSM) programme starts in Year 2. Students undertake one SSM in that year and two the following year, all of five weeks' duration. At the end of Year 3 students complete a four-week period of elective study.

15. Years 4 and 5 comprise a series of clinical attachments based in hospitals and the community. Two SSMs will be undertaken in each year. A second period of elective study at the end of Year 4 provides an opportunity for students to continue their research into the subject matter of a previous SSM. During the final term of Year 5 students will shadow the pre-registration house officer in the unit where they will be taking up their first PRHO post.

### **The management of change (Principal Recommendation 13)**

#### **Supervisory structures**

16. The diagram at Annex B describes the current organisation structure of the undergraduate curriculum.

17. The Standing Committee for Medical Education (SCME) is a Faculty Sub-Committee charged with the twin tasks of approving and monitoring undergraduate medical education in Glasgow. The Curriculum Management Group (CMG), which reports to the SCME, is responsible for:

- managing the development, implementation, monitoring and renewal of the undergraduate programme
- co-ordinating the day-day management and administration of the undergraduate curriculum
- receiving reports from individuals and groups responsible for component parts of the undergraduate curriculum and for staff development and evaluation
- recommending to SCME proposals for developments to the undergraduate curriculum

- liaising with groups responsible for financial planning and resource allocation, admission of students, student welfare, student progression, quality assurance and research.

18. The membership of the CMG comprises:

- the Associate Dean for Education
- the Curriculum Development Officer
- The Year 1 Co-ordinator
- the Year 2 Co-ordinator
- the Year 3 Co-ordinator
- the Year 4 and 5 Co-ordinator
- the Co-ordinator of Vocational Studies
- the Co-ordinator of the SSM programme
- the Clinical Skills Co-ordinator.

19. We were pleased to learn that the CMG has established a network of sub-deans to manage and supervise the quality of teaching and learning activities available to students. One sub-dean has been allocated to every hospital where students undertake their clinical placements.

### **The contribution of students**

20. Although we were disappointed to discover that there is currently no student representation on the CMG, we were assured that students and junior doctors had contributed generously to the development of the new curriculum.

21. Students are invited to comment on the new MB ChB programme in a variety of ways, including:

- an individual or group approach to their Year Co-ordinator
- through their Year Staff-Student Liaison Group. These groups meet regularly and are chaired by students
- through the evaluation questionnaires submitted at the conclusion of each teaching block or clinical placement.

22. Information is specifically sought in the questionnaires on the quality of the learning experience and the contribution made by members of staff in each block or placement. These returns are analysed and the results fed back to the individuals concerned, to the year co-ordinators and to the Medical Education Unit. We were told that feedback received through the above channels had been instrumental in bringing about some changes.

23. The students we met in Glasgow were a lively, articulate and well-motivated group. We would encourage the Faculty to consider ways of making greater use of student input when planning, implementing and managing curricular change.

### **Staff development**

24. We were informed that the Faculty had established an extensive staff development and training programme to prepare its teachers for the demands of the new curriculum. This has continued following the introduction of the new course with additional components being added, as required, to the training programme. The Faculty insist that all staff involved in the delivery of the new undergraduate curriculum must first have completed relevant training in one or more of the following components as:

- a Year 1 or 2 facilitator
- a Year 3 hospital facilitator
- a Year 4 and 5 educational supervisor
- a Year 1 and 2 Vocational Studies tutor

- a Clinical Skills tutor.

25. Team meetings have also been arranged to support facilitators in all PBL teaching blocks in Years 1 and 2 and throughout the entire Vocational Studies programme in Years 1 to 3.

26. Notwithstanding these measures, we were told that some staff teaching in the later years of the course remained unaware of or unsympathetic to recent curricular change. This observation has not escaped the notice of the Faculty. Earlier this year it appointed a full-time Staff Development Officer to cope with the crucial task of meeting the expanded need for staff development and training as students begin the transition to the predominantly 'clinical' years of the course in 16 hospitals and a large number of general practices across the west of Scotland.

### **The promotion of teaching as a valuable activity**

27. The Faculty has a policy of encouraging teaching excellence and demonstrates this by including teaching ability among the key criteria to be met by those seeking promotion.

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

#### **The core curriculum**

28. The core curriculum is defined by:

- the cases, and issues which comprise the scenarios of the Problem-Based-Learning (PBL) programme
- the Master List of Clinical Presentations for Years 4 and 5.

29. The Master List of Clinical Presentations, devised by the Year 4 and Year 5 Working Groups, is reproduced at Annex C.

#### **Defining the core curriculum**

30. Initially and well before the decision to develop a PBL based curriculum was taken, the Faculty convened a series of 'systems groups'. Each group comprised experts in the system under consideration but was chaired by a non-expert. It was the task of every group to identify a limited number of index cases about which the teaching and assessment of the systems involved could be planned.

31. These groups were disbanded once it was decided to introduce a PBL-centred course but their lists of cases and presentations were retained, becoming a significant resource in the development of the PBL case-mix.

32. Year 3 Co-ordinators led the way in planning the framework for the vertical and horizontal integration of the course. A general plan for each of the first three years was identified. In Year 1 there would be a progressive focusing on the individual and society in sickness and in health. The second year would concentrate on the body systems and their integration and co-ordination in health and in illness. In Year 3 the emphasis would be placed on the range of common and important problems for patients.

33. Having established this general plan, the year co-ordinators and their block teams proposed the contents of the blocks that would make up their year, and elaborated these as a series of possible cases. Ultimately, the case mix was examined and refined by the Theme Advocates. This group of senior staff is responsible for ensuring that each of the themes described in Annex D is adequately represented throughout the course.

34. To monitor progress the SCME has appointed a group to review each year of the new curriculum and to report back on its findings.

35. Work is well advanced in the development of a curriculum database. The intention is to develop

software that will enable the Faculty to access the essential points of each PBL case, FRS session or any other component of the core, so that they can be searched systematically by themes and keywords. In time this will enable the Theme Advocates to look in detail at the first three years of the course and to identify the extent to which individual themes and topics are being addressed.

### **Reducing the factual burden on students**

36. Making the transition from a traditional lecture-based curriculum to an innovative problem-based course has allowed the Faculty to reduce didactic learning substantially. This is most dramatically illustrated in the comparison between the number of lectures in Year 1 of the old course (311) and those in the first year of the new curriculum (30).

37. We understand that the factual content of Years 1 to 3 has been reviewed in the light of feedback from students and facilitators. The outcome of this review had caused some scenarios to be re-written and others to be re-scheduled within the timetable in order to take account of student learning and progress.

38. It was evident to us and the student body that the introduction of a problem-based learning (PBL) curriculum had reaped dual benefits. It had allowed the Faculty drastically to reduce factual overload in the course and had encouraged students to develop their capability as independent learners.

### **Integration**

39. The Faculty has confidence in the influence of PBL ensuring integration of clinical medicine and basic science throughout all five years of the course.

40. Certainly we were impressed by the approach taken in the PBL sessions in Years 1 to 3. Students work closely together in small groups, with support if necessary from a facilitator, and are actively encouraged to use an interdisciplinary framework, the 'Hierarchy of Systems' to consider issues raised in the scenarios. This framework invites students to reflect on different aspects of a topic from molecules, cells and organs at one extreme, through major body systems to societies, groups and families at the other. The students with whom we spoke regarded this as a helpful means of structuring their learning.

41. Continuing this integrated approach to learning in Years 4 and 5 has presented the Faculty with some difficulties. Students undertaking their clinical attachments are dispersed across a much wider geographical area. They have also lost the services of their PBL facilitator from Year 3 and have met opposition to the problem-based learning approach of the new curriculum from some clinicians. We would encourage the Faculty, as part of its curricular review, to consider strengthening vertical integration throughout the course and particularly in Years 4 and 5 to enable a smoother transition from the PBL years to the predominantly clinical years of the curriculum.

### **Learning through curiosity**

42. The Faculty is convinced that PBL with its emphasis on finding, understanding and using information, and the attitudes it engenders, is a major factor in stimulating student enthusiasm and curiosity about medicine in Glasgow.

43. Students are required to attend all PBL sessions. They organise these themselves, appointing a chairperson and scribe from within the group. Once the scenario is read out and the issues it raises are described, the students hold a brainstorming session, admitting perplexities, sharing knowledge and identifying the research that needs to be undertaken in order to meet the learning objectives which they have set for themselves. A facilitator is present who may choose whether or not to become involved in the discussion, depending on the progress of the group. The students with whom we spoke regarded the sessions as a valuable learning experience once initial concerns over the appropriate level of

research required had been allayed. They told us that the sessions were particularly helpful in instilling them with the confidence to approach patients.

44. The Faculty estimates that these sessions have proved successful in identifying around 85% of the learning objectives it had itself defined for students. To ensure the efficacy of the process it is Faculty policy to withhold its learning objectives from students until the end of each teaching block though details are issued to PBL facilitators. We were therefore concerned to learn that some groups of students were given advance notice of these objectives. This did not appear to us to be either a robust or equitable way of proceeding and we would urge the Faculty to give further thought to the best way of co-ordinating learning objectives for all its students.

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

45. At Annex E is a list of Special Study Modules (SSMs) available to students in Years 2-4.

46. The SSM programme comprises seven 5 week modules one undertaken in Year 2 and two in each of the subsequent years. The Faculty has not finalised details of the modules available in Year 5 but we were told that arrangements were being made so that students in Years 4 and 5 undertake two SSMs consecutively, in a ten week block.

47. The amount of student time allocated to SSMs in each year of the course is as follows:

Year 1 0%

Year 2 17%

Year 3 33.3%

Year 4/5 25%

48. The SSM Committee reviews SSM proposals received from staff to ensure adequacy of intellectual content as well as appropriateness of assessment methods. In order to maximise choice, students are encouraged to propose their own SSMs. Such proposals, developed in conjunction with a named supervisor, are also reviewed. Students are encouraged to undertake different types of SSMs throughout the course. These choices are monitored and may be challenged by the SSM Committee if too narrow in scope. Every SSM has specific objectives and it is the responsibility of each SSM supervisor to ensure that these have been met. This is monitored by the SSM co-ordinator who compares the outcomes with the stated objectives at the conclusion of each SSM.

49. Students are informed of the availability of the SSMs via the student intranet. Outlines for each module are provided to allow students to make an informed choice. They respond electronically by listing a number of modules in order of preference. Students are then allocated on a first-come first-served basis to the modules. Those who are not allocated their favoured option are given preference in the next round.

50. Students are encouraged to devise and to propose SSMs themselves and many had taken this opportunity, particularly when denied their first choice of SSM. Detailed information on this process is given in the SSM handbook, and is also available on the Faculty website. An abbreviated version of this document has been produced as a student guide and is electronically transmitted to every student enquiring about SSMs, as well as being available as a hard copy.

51. The SSM supervisor provides academic and pastoral support to students undertaking SSMs whilst the Advisor of Studies is also available to students in personal difficulty. Students whose performance in an SSM is identified by the supervisor as borderline are referred to the external examiners. Such students may be offered remediation and subsequently be required to resubmit written or other work.

52. Clear written guidance is provided for all SSM assessors. Assessment can be undertaken by the SSM supervisors provided that those individuals did not significantly contribute to the development of the work. If this is the case a colleague is invited to assess the work. The Faculty insists that criterion referenced marking is used to achieve parity between different modules.

53. Assessment instruments vary between SSMs but in all cases at least 50% must be in a form accessible to the external examiners. In cases where one of the major assessment instruments is a group report or some other form of group presentation then some means of assessing individual student contribution must be included. Merit cannot be awarded on the basis of group assessments alone. An assessment proforma must be completed for each student. Prior to graduation students must pass any six of the seven SSMs offered.

54. The diverse range of SSMs available to students was impressive as were the arrangements which had been introduced for their assessment. Students particularly welcomed the flexibility to generate their own options. We commend this initiative.

### **Delivery of the curriculum (Principal Recommendation 11)**

#### **Teaching methods**

55. Excluding time spent on SSMs, the Faculty has supplied us with the following percentage breakdown of learning opportunities in Years 1-3:

Private or group study 50%

PBL tutorials 13%

Plenary meetings 7%

Fixed Resource Sessions 13%

Vocational Studies 10%

Clinical skills 7%

56. We were told that it would be for individual students to decide how they wish to allocate their learning opportunities in the predominantly clinical settings of Years 4 and 5.

57. The Fixed Resource Sessions (FRS) in Years 1 to 3 are specifically designed to assist students in seeking answers to the questions they have identified in PBL tutorials. The FRS can take virtually any form and may include a variety of activities, such as:

- plenary lectures
- plenary question and answer sessions
- tutorials
- seminars
- workshops
- anatomy dissection and prosection
- laboratory sessions
- visits to clinical settings
- films.

58. To complement and stimulate student learning in Years 4 and 5, the Faculty has introduced a series of Academic Days devoted to consideration of a range of issues, including clinical and basic science topics, ethics and the legal aspects of medicine. We were told that these sessions are designed to serve a purpose similar to the FRS in Years 1 to 3.

59. We thought that the Vocational Studies (VS) programme in Years 1 to 3 was commendable. Closely linked to the PBL curriculum it is designed to enable students to consider a wide range of professional and ethical issues directly related to their development as doctors. Its key features include:

- early involvement with patients and healthcare professionals in a variety of settings
- practice in the skills of physical examination
- communication skills training
- debates on legal, moral and ethical issues.

60. Most of this work is undertaken in small groups, in tutorials or through visits to clinical settings. Each VS group and its tutor remain unchanged throughout Years 1 and 2 unlike the PBL groups, whose constitution alters with each teaching block. The student perception, which we share, is that the VS programme provides practical and valuable preparation for the predominantly clinical years of the course.

### **Computing and computer-assisted learning (CAL) facilities**

61. In addition to the University computer network, students have access to three dedicated computer clusters and we were told by the Faculty that these resources are being increased. The students with whom we spoke were generally satisfied with the number of PCs provided for their use.

62. Computing facilities are available in all hospitals used for student placements in years 4 and 5. Most of these are now linked to the University by either modems or optical networks. Where this is not the case we were told that work is in hand to ensure that all hospital sites will be so linked during 1999/2000. However, computing facilities are not generally available for students' use during general practice attachments.

63. A network of CAL resources has been established, permitting access to most of the major databases of importance to medicine, an extensive collection of specific teaching packages, (some of which have been developed in house) and a growing collection of formative assessment packages.

64. The third year PBL tutorials take place in hospitals, and use specially created 'Electronic Patients' to present the scenarios to each group. New IT facilities have been established in each hospital for this component of the core.

65. To assist in the allocation of SSMS, the topics are posted on the web allowing students to make their six selections in order of preference.

66. Students can obtain information on the course by logging in to the web. Data available include lists of plenary sessions and details of any mandatory coursework which needs to be produced as well as useful links to other sites. Our attention was drawn to two interactive features:

- a noticeboard, established by the leaders of each teaching block, allowing the immediate transmission of important notices to students. A secure administrative web page is used to enter and to delete notices.
- a Frequently Asked Question (FAQ) section. Students submit questions to the block team via a web page. A notification programme on the web server automatically e-mails the FAQ co-ordinator each morning with a list of new questions. The co-ordinator can then directly answer the question (in which case it appears automatically on the FAQ web page), forward it via e-mail to another member of staff for answer, or simply advise the student and mark the question as deleted. All questions are kept for subsequent analysis, whether posted on the FAQ web page or not. The co-ordinator is alerted via the web server if answers have not been received, prompting reminders to be sent. Received answers may be pasted in to the database via a web page, thus appearing automatically on the FAQ web site.

67. Staff responsible for most core teaching blocks have also arranged a website hotline for urgent questions from students in difficulty. We understand this initiative is welcomed and used by students.

### **Changing patterns of health care (Principal Recommendation 10)**

68. In devising Years 4 and 5 of the new curriculum the Faculty has made it clear that it expects community aspects of medicine to form an integral part of traditional clinical attachments. Thus students are actively encouraged to see patients in community settings during their hospital-based attachments in medicine, surgery, obstetrics and gynaecology and paediatrics.

69. As a matter of course, students accompany community midwives on visits to patients in their homes during the obstetrics and gynaecology attachment. The Faculty also informed us that it has increased the number of hospitals it uses for teaching psychiatry as part of its drive to widen student exposure to psychiatry in the community. This has resulted in greatly improved teacher/student ratios as now each psychiatrist is allocated only two students during the 5 week attachment in the discipline.

70. Students complete a 5 week attachment in general practice in Year 4. In addition, general practitioners are heavily involved in teaching during the early years of the course, particularly as part of the clinical skills training which takes place in Years 1 to 3. Taking as their theme 'General Practitioners and the Community', Blocks 3 and 4 in Year 1 consider a range of community aspects and ethical issues relating directly to the family, society and the public health.

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

#### **Attitudes (Principal Recommendation 3)**

71. The need to inculcate in its students appropriate attitudes and the professional behaviour required for medical practice is keenly appreciated by the Faculty. From the very start of the first year students are encouraged to reflect on their attitudes and behaviour towards their peers, teachers and patients. They are taught specific 'routines' for analysis and reflection and are repeatedly invited to undertake critical analyses of themselves and of their colleagues. This is a feature of most PBL tutorials and of many Vocational Studies sessions. We were told that the assessment grid (used as the basis of block summative assessment in years 4 and 5 and for formative assessment throughout the course) was specifically designed to ensure that the need to demonstrate appropriate attitudes and professional behaviour is firmly rooted in the heart of the curriculum and in the minds of its students. A copy of the assessment grid is at Annex F.

72. Students receive the Duties of a Doctor card in the week prior to commencing their studies. The text of Good Medical Practice and the principles underpinning it are discussed by students and by the general practitioners who act as tutors during the Vocational Studies (VS) programme starting in Year 1.

73. Students with attitudinal problems in Years 1-3 are quickly identified by PBL facilitators or VS tutors. In years 4 and 5 this responsibility falls to educational supervisors who are allocated pairs of students at the start of each clinical attachment. The educational supervisor is expected to spend a period of up to one hour with the students during each week of the attachment. This affords students the opportunity to discuss the learning opportunities that they are being exposed to each week and to plan those for the following week. At the conclusion of each attachment, educational supervisors are expected to provide feedback on the grading that each student receives under each of the various categories (including communication skills) listed on the assessment grid.

74. The students with whom we spoke were aware of the desirability of having good role models as teachers and clinicians and were easily able to identify those whom they considered were not adequately fulfilling this role. We were told that the Faculty's Staff Development Officer emphasises the

importance of role models in her meetings with hospital sub-deans and educational supervisors.

75. We were impressed by the way that the Faculty had used the tenets of Good Medical Practice to inform much of its teaching, particularly in the early years of the course.

### **Essential skills (Principal Recommendations 4 and 8)**

#### **Study skills**

76. Students receive early and clear guidance, mainly in the form of plenary and workshop sessions, about the learning skills that they will need to acquire in order to complete the course successfully. Their independent learning skills are evaluated in the Medical Independent Learning Exercise (MILE) examination in Year 1. Students must pass this assessment to proceed to the next stage of the course.

#### **IT skills**

77. Students are encouraged to use PCs as a natural means of accessing, exchanging and communicating information throughout the course. In preparation for this, an IT training programme is arranged in Year 1 and all students must demonstrate competence in IT skills during the University Foundation Assessment.

#### **Communication skills**

78. Communication skills teaching figures prominently in the undergraduate curriculum in the early years of the Glasgow curriculum. In Year 1 six teaching sessions are delivered as part of the VS programme, with five in Year 2 and four in Year 3.

79. Role play situations form an integral part of the training programme. Students in Year 2 are video-taped whilst they interview both simulated and real patients to enable them to review their performance. This was perceived by students to be a particularly instructive and educational experience. In Year 3 the accent is on providing information to patients. Students work in small groups, undertaking role play sessions devoted to issues such as breaking bad news to patients and to their relatives. An Objective Structured Clinical Examination (OSCE) assesses proficiency in communication skills at the end of Years 1, 2 and 3.

80. We were told by the Faculty that students will have the opportunity to attend additional communication skills training sessions in Years 4 and 5, where they will be formatively assessed in their performance. During the Finals examination students will be observed whilst they take a history from a patient and will be required to return to the bedside to explain to the patient the future management of their illness.

#### **Clinical skills**

81. Clinical skills teaching is delivered throughout each of the five years of the course in dedicated sessions, some of which are integrated with PBL exercises during Years 1 to 3.

82. At the start of a typical teaching session students watch, with their tutors, a video, approved by the Faculty, providing instruction on specific aspects of clinical skills training. The class then divides into small groups, numbering between 6-8 students, in order to develop and practise these skills on models or mannequins. Each group is assigned a tutor who is on hand to provide further instruction and guidance where necessary. Students spoke enthusiastically of the high quality teaching which is characteristic of these small group sessions.

83. Clinical skills are summatively assessed by means of OSCEs in Years 1-3. During their clinical attachments in Years 4 and 5 students' clinical proficiency is observed by their educational supervisors and formally assessed at the end of the attachment. The list of competencies in which students must be

proficient prior to graduation is reproduced at Annex G.

84. The Faculty is still in the process of drawing up its plans for the Final Professional Examination but we understand that the intention is to hold an integrated clinical assessment, including both a long case and a clinical skills examination.

### **Aspects of the knowledge base**

#### **Public health medicine (Principal Recommendation 9)**

85. It seemed to us that Blocks 3 and 4 in Year 1 provided the major contribution to the teaching of public health medicine in the Glasgow curriculum, supported by a number of 'Academic Days' in Years 4 and 5 dedicated to these issues.

86. We were told that students are actively encouraged to consider and address the preventative and epidemiological aspects of medicine in all their core work throughout the course, using the 'Hierarchy of Systems' framework to which we referred in paragraph 39.

87. We nevertheless believe that the profile of public health teaching needs to be raised within the curriculum and its aims and objectives more clearly and widely stated. We were pleased to learn that the Faculty has recently appointed a Theme Advocate to take this work forward.

### **Legal and ethical issues**

88. Students are given opportunities to explore legal and ethical issues at various points in the course, in particular during the VS programme in Years 1 and 2 where one component, entitled 'The right thing to do', is convened by a lecturer in medical philosophy. Ethical topics also form the subject of some of the Academic Days in Years 4 and 5, and we learned that much of the final two months of the course is devoted to preparing students to cope with many of the legal and ethical problems which they may face as doctors.

89. A Theme Advocate has been appointed to oversee this important area and to consider ways of increasing its incidence throughout the curriculum. In this respect it occurred to us that the Faculty might wish to consider making use of additional resources available to it within the University, for example in medical ethics.

### **Medicine in a multicultural society**

90. Matters relating to the practice of medicine in a multicultural society are considered in some of the PBL sessions and in parts of the VS programme. We were told that the Faculty is planning to introduce an 'Academic Day' on this subject at the end of Year 4.

91. It appeared to us that more opportunity could be found within the curriculum to increase student exposure to multicultural medicine. This will be a key task for the Theme Advocate charged with this responsibility.

### **Complementary medicine**

92. The Faculty acknowledges that little or no teaching is dedicated to complementary medicine, though an SSM in the subject is offered.

93. We would encourage the Faculty to explore ways of providing its students with more opportunity to learn about treatments that do not conform to conventional practice, so that they are as well informed about these as their future patients. One possible approach might be to consider holding joint seminars on this subject with nurses and other healthcare professionals.

### **Basic and advanced life support**

94. Students undertake basic training in cardio-pulmonary resuscitation (CPR) during Year 1 and advanced training in Year 3. The Faculty told us that it is considering the possibility of holding a mini-Advanced Life Support session in Year 5, which would be summatively assessed by an OSCE.

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

#### **>The outcome of the course**

95. The Faculty has based the aims and objectives of the curriculum on the recommendations set out in *Tomorrow's Doctors*, giving due emphasis to the development of appropriate attitudes, skills and a sound knowledge base.

96. It aims, through the rigour of its assessment scheme, to produce graduates who:

- are able to apply underpinning knowledge in the clinical context
- have the ability to be skilled self-learners
- have the attitudes and the skills that are required for the early years of clinical practice

#### **The scheme of assessment**

97. The Faculty uses a variety of systems to assess student progress both formatively and summatively.

98. Formative assessment methods include:

- Self Assessment Questions
- self assessment
- peer assessment
- feedback from tutors
- mock examinations
- practice OSCE sessions

99. Active learning sessions have recently been introduced, in which groups of volunteer students aim to set challenging questions and to answer those posed by their peers. We were told that these sessions have produced questions of such quality that they have been used in formal examinations.

100. In addition, educational supervisors formatively assess the core presentation (based on a real patient) which all students are required to write up during each week of their clinical attachments in Years 4 and 5. These core presentations culminate in a portfolio of clinical cases which the student is invited to keep.

101. Summative assessment takes the form of coursework and end of year tests, including the Medical Independent Learning Exercise (MILE), OSCEs and written papers. A diagram outlining the summative assessments in the curriculum is at Annex H. As we have mentioned earlier in our report, details of the arrangements for the Final Professional Examination have yet to be formally agreed though we understand that this will take the form of an integrated summative assessment including written papers, an OSCE and an Objective Structured Long Examination Record (OSLER).

102. We were told that assessment criteria are published and made available to both students and staff.

103. At the end of each of their clinical attachments in Years 4 and 5 students are formally assessed by their educational supervisors. In each attachment they must satisfy the criteria set out in the assessment grid, reproduced at Annex F, in order to proceed to the next stage of the course. However, fourth year students complained to us that this marking scheme was not standardised across all hospitals. There was uncertainty as to whether the grading awarded at the end of attachment would

contribute to their final assessment at the end of Year 5. When we sought clarification from the Faculty we were told that a decision had not yet been taken on the matter. At present gradings received at end-of-attachment assessments in Year 4 will provide feedback on performance and determine progression to Year 5.

104. We would ask the Faculty to clarify as soon as possible, for both students and staff, the assessment procedures in Years 4 and 5 of the course, including the arrangements for the Final Professional Examination.

### **Preparation for the pre-registration year**

105. In 1998, as part of an exercise piloted by the Faculty and the deanery final year students at one hospital spent a week shadowing the pre-registration house officer in the unit where they would be taking up their first PRHO post. This year the scheme has been extended to all hospitals in the region with students being offered a 'shadowing' attachment of between two days and one week's duration.

106. The feedback we received from pre-registration house officers confirmed that they found this 'shadowing' experience in Year 5 to be invaluable preparation for their work as pre-registration house officers. We understand that the Faculty is considering proposals to extend the duration of the 'shadowing' period, (a suggestion which drew unqualified support from both educational supervisors and trust managers) and to relocate it after the Final examinations at the end of Year 5.

### **Other issues**

#### **Student support**

107. The students whom we met spoke positively about the framework established by the Faculty to ensure they were well supported both academically and personally.

108. This appreciation extended to the induction programme. The first of its three days is termed Integration Day when students meet key members of staff and receive information about the format of Year 1. The remaining two days comprise further introductions to PBL and to the VS programme.

109. In the early years of the course academic support is provided to students through their PBL facilitator, whom they meet at the end of each five week block to discuss their individual progress, and their VS tutor. In Years 4 and 5 educational supervisors take on this responsibility.

110. The Faculty has identified a team of 28 Advisers of Studies, headed by the Associate Dean for Student Welfare, each of whom is responsible for offering pastoral support to students. Advisers are predominantly clinical staff, providing support to approximately eight students from each year. Students are allocated the same Adviser for the duration of their undergraduate career. They meet for the first time at Integration Day and are encouraged to meet regularly thereafter. We were told that if a student experiences problems when their Adviser is not available the Medical School Office will arrange for another Adviser to see the student.

111. Students experiencing difficulties are normally identified by the teaching staff and occasionally by their peers or they will come forward to seek help themselves. Those in academic difficulty are referred to an appropriate member of staff. Students with personal problems are usually seen by the Adviser of Studies or, where the difficulty is more marked, by the Associate Dean for Student Welfare. Additional levels of support are available to students with serious personal problems. They are interviewed by both the Associate Dean for Student Welfare and the Chair of the Progress Committee and may be subsequently referred to the psychiatric services. In the most exceptional circumstances, where it is thought that the problem will affect the student's ability to practise in the future, the case would be considered by the newly formed Faculty Professional Practice Committee.

112. Students in breach of Faculty Progress Regulations are referred to the Progress Committee. This is an informal committee which has extraordinary powers, including the right to set aside the Progress Regulations where appropriate. Its members meet the student to discuss all the aspects of the case and to arrive at a decision about future action. Students excluded from the course at this stage have a right of appeal to the formal Faculty Appeals Committee.

113. All students leaving medicine are seen by the Associate Dean for Student Welfare and are offered assistance in transferring to another course or university if appropriate. Careers counselling is also available from the University Careers Service.

114. As we mentioned initially in paragraph 19 of our report, a system of sub-deans has been established whereby a clinician is identified at each hospital to organise the teaching and to ensure the students are supported both academically and personally. The sub-deans have one session per week funded for this function from ACT monies. Administrative support is included in the funding.

115. We were impressed by the 'culture of care' fostered by the Faculty which ensures that students in difficulty are quickly identified and fully supported.

### **Feedback to students**

116. The Faculty has introduced a number of measures to provide students with feedback on their performance. In Years 1-3 this is delivered through:

- each PBL session in the form of reflection on the group process
- the VS programme, particularly during the clinical skills sessions. Tutors are encouraged to emphasise the positive aspects of student performance
- question and answer sessions
- regular staff/student meetings.

117. In the senior years of the course the weekly meetings between the educational supervisors and students provide the main channel for giving and receiving feedback. During these meetings, the assessment criteria employed for end of attachment summative assessment form the background for part of the discussion about student progress. Staff are also actively encouraged to provide feedback on student performance during the teaching sessions in Years 4 and 5.

118. We were told that at the request of the students the individual Year Co-ordinators will arrange additional informal feedback sessions.

119. Students were generally satisfied with the level of feedback they received on their performance throughout the first three years of the course but considered this to be variable in Year 4. We were told that some educational supervisors only took account of student performance in their end-of-attachment assessment rather than considering their progress throughout the entire placement. We are sure that the Faculty will wish to address this matter and clarify for students and staff alike the arrangements for providing feedback in the senior years of the course.

### **Quality control**

120. The current organisation structure of the curriculum is described in the diagram reproduced at Annex B.

121. It seemed to us that the Faculty had established sound mechanisms for ensuring the quality of teaching and learning. These included:

- the appointment of hospital sub-deans to manage and supervise the quality of teaching and learning activities available to students during their clinical placements
- questionnaires allowing students to comment on their clinical attachments. These are analysed

and referred to the hospital sub-deans for action

- staff/student review groups which meet regularly
- the robust use made of the external examiner system. External examiners are appointed for each year of the Glasgow curriculum and play an active part in the quality assurance process.

### Areas of good practice

122. *Hospital sub-deans:* We were pleased to learn that the CMG has established a network of sub-deans to manage and supervise the quality of teaching and learning activities available to students. One sub-dean has been allocated to every hospital where students undertake their clinical placements (paragraph 19).

123. *Reducing the factual burden on students:* It was evident to us and the student body that the introduction of a problem-based learning (PBL) curriculum had reaped dual benefits. It had allowed the Faculty drastically to reduce factual overload in the course and had encouraged students to develop their capability as independent learners (paragraph 37).

124. *Problem-based learning sessions:* The students with whom we spoke regarded the sessions as a valuable learning experience once initial concerns over the appropriate level of research required had been allayed. They told us that the sessions were particularly helpful in instilling them with the confidence to approach patients (paragraph 42).

125. *Special Study Modules:* The diverse range of SSMs available to students was impressive as were the arrangements which had been introduced for their assessment. Students particularly welcomed the flexibility to generate their own options. We commend this initiative (paragraph 53).

126. *Vocational Studies programme:* The student perception, which we share, is that the VS programme provides practical and valuable preparation for the predominantly clinical years of the course (paragraph 59).

127. *Good Medical Practice:* We were impressed by the way that the Faculty had used the tenets of Good Medical Practice to inform much of its teaching, particularly in the early years of the course (paragraph 74).

128. *Clinical skills teaching:* Students spoke enthusiastically of the high quality teaching which is characteristic of these small group sessions (paragraph 81).

129. *Preparation for the pre-registration year:* The feedback we received from pre-registration house officers confirmed that they found the 'shadowing' experience in Year 5 to be invaluable preparation for their work as pre-registration house officers (paragraph 105).

130. *Student support:* We were impressed by the 'culture of care' fostered by the Faculty which ensures that students in difficulty are quickly identified and fully supported (paragraph 114).

### Areas for further consideration

131. *The contribution of students:* The students we met in Glasgow were a lively, articulate and well-motivated group. We would encourage the Faculty to consider ways of making greater use of student input when planning, implementing and managing curricular change (paragraph 23).

132. *Staff development and training:* It seemed to us, (and this was confirmed by the students whom we consulted), that many clinical teachers were neither aware of nor were fully 'signed up' to the concept of problem-based learning (paragraph 9). The Faculty needs to ensure that all teachers receive training that will help them to implement the new curriculum.

133. *Integration:* We would encourage the Faculty, as part of its curricular review, to consider

strengthening vertical integration throughout the course and particularly in Years 4 and 5 to enable a smoother transition from the PBL years to the predominantly clinical years of the curriculum (paragraph 40).

134. *Learning objectives in PBL sessions:* We were concerned to learn that some groups of students were given advance notice of learning objectives in contravention of Faculty policy. This did not appear to us to be either a robust or equitable way of proceeding and we would urge the Faculty to give further thought to the best way of co-ordinating learning objectives for all its students (paragraph 43).

135. *Public health medicine:* We believe that the profile of public health teaching needs to be raised within the curriculum and its aims and objectives more clearly and widely stated. We were pleased to learn that the Faculty has recently appointed a Theme Advocate to take this work forward (paragraph 86).

136. *Medicine in a multicultural society:* It appeared to us that more opportunity could be found within the curriculum to increase student exposure to multicultural medicine. This will be a key task for the Theme Advocate charged with this responsibility (paragraph 90).

137. *Complementary medicine:* We would encourage the Faculty to explore ways of providing its students with more opportunity to learn about treatments that do not conform to conventional practice, so that they are as well informed about these as their future patients. One possible approach might be to consider holding joint seminars on this subject with nurses and other healthcare professionals (paragraph 92).

138. *Assessment:* We would ask the Faculty to clarify as soon as possible, for both students and staff, the assessment procedures in Years 4 and 5 of the course, including the arrangements for the Final Professional Examination (paragraph 103).

139. *Feedback to students:* Students were generally satisfied with the level of feedback they received on their performance throughout the first three years of the course but considered this to be variable in Year 4. We were told that some educational supervisors only took account of student performance in their end-of-attachment assessment rather than considering their progress throughout the entire placement. We are sure that the Faculty will wish to address this matter and clarify for students and staff alike the arrangements for providing feedback in the senior years of the course (paragraph 118).

## **Conclusion**

140. We congratulate the Faculty on its boldness in introducing a new problem-based curriculum designed to promote active and to reduce didactic learning. This has proved very successful in its first three years. Although we have identified a number of areas requiring further consideration, particularly as the course enters its predominantly clinical years, we are sure that the Faculty will wish to make the necessary adjustments speedily and effectively.

141. We look forward to receiving a detailed account of progress in a year's time.

## **Part 2 : General Clinical Training**

### **Background information**

142. Prior to the visit we were issued with helpful background information about the arrangements for general clinical training in the region. This included a summary, reproduced at Annex I, showing the extent to which the recommendations in *The New Doctor* have been implemented to date.

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

143. Before meeting a number of PRHOs from a variety of locations and specialties we were given an

overview of general clinical training provision by the Postgraduate Dean and the Associate Postgraduate Dean. We then met with chief executives and medical directors from various NHS trusts in the region and had discussions with groups of postgraduate tutors and educational supervisors from different hospitals. After meeting the PRHO Committee, the body responsible for overseeing arrangements for general clinical training, we reported back to the deanery on our impressions of the day.

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

144. There are 14 NHS trusts in the Glasgow region involved in the training of PRHOs.

#### **Supervisory structures**

145. The Postgraduate Dean, with the assistance of the PRHO Committee, is responsible for the overall management of the pre-registration year.

146. The PRHO Committee meets once or twice a year under the chairmanship of the Postgraduate Dean. The rest of its membership comprises:

- the Dean of the Faculty of Medicine
- the Associate Postgraduate Dean
- Professors of medicine and surgery
- Specialty Advisers and Chairmen of Postgraduate Training in medicine and surgery
- representatives in medicine and surgery from the district general hospitals
- medical executives from Trusts in and outwith Glasgow.

147. We were disappointed to learn that there is no PRHO on the membership of the PRHO Committee.

148. We were told that the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) plays an important part in helping to advise on and to co-ordinate arrangements for PRHO training in the region. The Postgraduate Dean meets regularly with representatives from SCPMDE and annually with officials from the Scottish Office Home and Health Department.

#### **The approval of posts**

149. Under the direction of the Associate Postgraduate Dean, it falls to the PRHO Committee to approve and to monitor the quality of PRHO posts in the region. As the document at Annex J makes clear, the criteria for approval of individual posts are based on those set out in *The New Doctor*.

150. The opinions of PRHOs are sought by means of confidential questionnaires completed at the end of each post and through enquiries made by the PRHO Committee during each inspection visit. A copy of the questionnaire recently introduced in the deanery is at Annex K.

#### **Communicating the aims and objectives of the PRHO year**

151. All PRHOs, educational supervisors and postgraduate tutors receive copies of *The New Doctor*.

152. The aims and objectives of the PRHO year, as defined in *The New Doctor*, are reiterated in the Record of Progress and Assessment booklet, given to PRHOs at the start of their training. At the initiative of SCPMDE this booklet is now being used to provide PRHOs from all four medical schools in Scotland with a personal and confidential record of the guidance and monitoring they received during their general clinical training. We thought this was an excellent document, setting out clearly and concisely what is expected of all parties involved in the delivery of the PRHO year.

#### **The selection of PRHOs**

153. For PRHO appointments up to July 2000 students apply direct to individual consultants within the

region. The Postgraduate Dean is notified of each selection made by return of a multi-part form.

154. A new process has been introduced for PRHO appointments made from August 2000 as the deanery joins a national computer matching system, the Scottish PRHO Allocation Scheme (SPA). SPA is another SCPMDE-inspired enterprise designed to provide a centralised means of assigning each prospective PRHO to either:

- a single 12 month rotational appointment, or
- a pair of 6 month surgical and medical posts, or
- a single 6 month medical or surgical post in Scotland

155. In making these appointments, SPA creates a match which best satisfies the applicants' and units' preferences. There will be two runs of the matching programme. If applicants have any part of their PRHO year unassigned at the end of the first run they are eligible to apply on the second run to units with appropriate vacancies. There are sufficient PRHO posts in Scotland to accommodate all graduates of the Scottish clinical medical schools. The SPA scheme is open to graduates of medical schools outwith Scotland under current employment and equal opportunities legislation. Units will be actively encouraged to observe good employment practice. Each applicant will be invited to complete an Equal Opportunities Monitoring Form (reproduced at Annex L) which will be analysed by the Postgraduate Office.

156. We were impressed by steps taken by the deanery to announce the introduction of SPA. These included:

- the Associate Postgraduate Dean meeting students once in Year 3 and twice in Year 4 to keep them informed of developments
- a 'Pack Day' held in August 1999 when final year students received their SPA application packs and were taken step by step through the administrative process of making an application
- a Careers Fair where fourth-year students had the opportunity to meet consultants, postgraduate tutors and educational supervisors from each of the hospitals in the West of Scotland.

### **Monitoring the quality of PRHO posts**

157. The deanery assesses the quality of general clinical training through:

- confidential questionnaires completed by PRHOs at the end of each post
- normal inspection visits carried out by the PRHO Committee

158. The PRHO Committee formally inspects each PRHO post in the deanery every three years as part of a rolling programme, though more frequent visits will be made if specific problems are identified in the interim. Where deficiencies in a particular post are identified these are immediately drawn to the attention of the educational supervisor, the postgraduate tutor and the hospital management and recommendations and a timescale for their resolution are made. The hospital is required to report back to the PRHO Committee on the action it has taken. If this is not deemed sufficient, a further reinspection visit will take place and withdrawal of approval from the post remains an option.

159. We were told that approval had recently been withdrawn from one post in the deanery on the grounds that it did not offer general clinical training, permit the acquisition of generic skills nor afford adequate supervision of trainees. It seemed to us that robust systems had been put in place to ensure that all PRHO posts conformed to an appropriate standard.

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

#### **Induction**

160. Each centre offers PRHOs at least one full day's induction and many hospitals have extended the programme to two full days. The content and format of these programmes are discussed during inspection visits. The deanery's perception, shared by PRHOs and the visiting team, is that the induction period affords a positive and helpful introduction to general clinical training. We have previously referred in paragraphs 104 and 105 of our report to the PRHO 'shadowing' attachment which has been introduced for final year students. In terms of providing practical preparation for the PRHO year, we believe that this attachment admirably complements the formal induction programme.

### **Educational opportunities**

161. All hospitals involved in general clinical training run educational programmes for PRHOs. These sessions are organised by postgraduate tutors or educational supervisors and PRHOs are encouraged to select topics for presentation and discussion. Although their format varies between centres, most sessions are scheduled for an hour at lunchtime and comprise a talk and often a presentation.

162. Although PRHOs are informed that educational sessions are mandatory and they know that their attendance is monitored by the deanery, uptake is very variable across centres with some hospitals drawing large gatherings (including final year students and junior doctors) to lunchtime sessions whilst programmes at other hospitals are poorly attended. Postgraduate tutors write formally to all trainees who fail to attend. Although there is no clearly established policy in respect of persistent poor attendance, we were told that some units are considering the possibility of refusing to 'sign up' as suitable for full registration those PRHOs who fall into that category.

163. It seemed to us that the provision of 'bleep-free time' was a common factor in those centres whose educational sessions were well attended. We understand that it is the responsibility of educational supervisors to ensure that all PRHOs are given protected time in which to attend educational sessions. However, many of the trainees with whom we spoke indicated that bleep-free time was not available to them. Others were reluctant to attend these sessions as this resulted in an unacceptable increase in their workload as tasks accumulated in their absence. We were disappointed to learn that at one centre (Falkirk) some consultants failed to appear for the sessions which they were scheduled to conduct. We invite the deanery to consider ways of obviating the pressure of work on PRHOs so that they are able to attend scheduled educational sessions.

164. The deanery is keenly aware of the need to ensure that PRHOs do not routinely have to carry out inappropriate tasks and has taken steps to improve the level of support to trainees, particularly in the increased provision of IV and phlebotomy services. However, some minor areas of difficulty were still apparent. The phlebotomy service was variable across centres; some had on-call phlebotomists, others a twice-daily service, some a service every second day and others no service at all on Sundays. PRHOs continued to encounter difficulties at most hospitals in obtaining the results of laboratory and radiological investigations. We encourage the deanery to continue to seek solutions to these problems with PRHOs and trust managers.

### **Educational supervision**

165. Each approved PRHO post in the region is allocated an educational supervisor, whose major responsibilities are to oversee the education and training of PRHOs and to act as their mentors. Additionally s/he is required to:

- encourage PRHO participation in educational programmes
- ensure careers advice is made available to PRHOs.

166. Unlike postgraduate tutors, educational supervisors do not have a contract with either the postgraduate dean or the trust. There is no formal selection process for educational supervisors. Their suitability is assessed by fellow consultants who pass their nomination to the Postgraduate Office. The

appointment is endorsed by the PRHO Committee and ratified by the Faculty.

167. Following the procedure laid down in the Record of Progress and Assessment educational supervisors are required to meet with their trainees on at least three occasions at the start of the post, at mid-point and at the end of placement to provide advice and feedback on performance. We were encouraged to hear that all the PRHOs with whom we spoke had at least met their educational supervisor. However, with the exception of the supervisors in general practice and accident and emergency medicine, the level of support and feedback provided was variable. The deanery is confident that it is able to identify unsatisfactory performance by educational supervisors through the enquiries it makes on formal inspection visits and via comments made on PRHO questionnaires. In such cases, individuals are interviewed and asked to improve their performance or face the possibility of being replaced as educational supervisors.

168. We were told that in previous years, the deanery had run a series of training workshops for educational supervisors. It may wish to consider re-introducing these workshops as one means of ensuring that educational supervisors are made fully aware of the key role they have been allocated.

### **Clinical training and supervision**

169. The deanery uses its formal inspection visits and information received from returned PRHO questionnaires to ensure that core generic training, as defined in *The New Doctor*, is being delivered. In general, PRHOs were positive about their clinical training but many who were ward-based did not regard themselves as belonging to a team. As such they considered themselves disadvantaged and suggested that their learning experience would be greatly enriched if they were able to follow through the treatment of patients they had admitted. We would support this principle whilst recognising that the introduction of the partial shift system, on which all PRHOs in Glasgow are working, has severely reduced opportunities for clinical team-working.

170. PRHOs were satisfied with the level of clinical supervision they received; none of those we asked had ever been placed in a position where they were unable to seek direct support or guidance from a senior colleague.

### **Monitoring the progress of PRHOs**

171. The educational supervisor has primary responsibility for assessing the progress of pre-registration house officers but we were told that PRHO performance is also monitored daily by the staff in the unit where they are working. As we have mentioned earlier in our report the educational supervisor will now be required to meet formally with PRHOs three times during their placement in order to provide feedback on their progress. At the final interview of the placement the overall performance of the PRHO will be discussed and recorded against the skills and competencies listed on the assessment forms enclosed in the Record of Progress and Assessment. The categories set out in these forms relate to general, professional, clinical, communication, procedural and practical skills. We were told that educational supervisors seek and take into account the views of nursing and other staff before determining and delivering their final assessment.

172. Currently, many PRHOs considered the quality of the feedback they receive on their progress to be variable. Few obtained regular and frequent reports on their performance whilst others only received feedback when their progress was deemed to be poor. We hope that the introduction of the new formalised Record of Progress and Assessment system will improve the quality and consistency of feedback to PRHOs.

173. If any deficiencies in performance are noted, these will be discussed with the PRHO by the educational supervisor and other consultants in the unit and remedial action agreed. If no improvement is forthcoming or more serious problems, such as unsatisfactory clinical performance, are identified, the

postgraduate tutor would become involved and the PRHO would be interviewed by the postgraduate dean. We were told that the deanery would refuse to 'sign up' the PRHO as being suitable for full registration if these deficiencies were not addressed. In the event of a PRHO missing a substantial amount of training through ill health, the postgraduate dean would assess the particular circumstances of the case, including the nature of the health problem and the performance of the PRHO thus far, before deciding whether to extend the term of pre-registration training to make good the shortfall.

## **Professional development and personal well-being**

### **Careers advice**

174. Early advice is provided to fourth year students during the annual Careers Fair where they have the opportunity to meet and discuss possible career paths with specialty advisers in medicine. We were told that, just prior to the end of PRHOs' first six-month placement, educational supervisors organise seminars giving advice on different career options in medicine, whilst the postgraduate dean also makes himself available to talk to trainees on this matter.

175. The PRHOs with whom we spoke were largely self-reliant in terms of seeking careers advice, preferring to obtain this informally from other trainees and junior doctors.

### **Support for PRHOs**

176. PRHOs are encouraged to approach their educational supervisor or the postgraduate tutor and other hospital staff for advice on the practical and educational aspects of the PRHO year. The postgraduate dean also plays a key role in providing support to PRHOs, particularly those who find themselves in difficulty.

177. Each trust is required to provide occupational health services for its PRHOs. We were very interested to learn that the deanery is seeking to establish, in the form of a personal passport, a West of Scotland Occupational Health Record for its trainees. We commend this initiative.

178. PRHOs told us that in terms of personal support they were well served by the close 'esprit de corps' they had developed. This was clearly evident in the group which we met.

### **Accommodation, catering and personal safety**

179. The deanery monitors the standard of accommodation and catering and ensures the safety of its PRHOs through:

- feedback from PRHO questionnaires
- PRHO inspection visits.

180. Any unsatisfactory comments or findings are reported to the educational supervisor and postgraduate tutor and are taken up with the trust management. The threat to withdraw approval from the post in question invariably stimulates remedial action.

181. PRHOs were generally content with the arrangements made for their accommodation and personal safety, though some complained of a long wait for porters to escort them in poorly lit areas at night. Catering was perceived to be a problem with no comprehensive provision of hot food at many hospitals after 7pm and at weekends. We were told that a hot 'soup and toastie' service had been successfully introduced in West Glasgow and it was suggested that this might usefully be extended throughout the city to provide out of hours catering.

182. Trust chief executives and medical directors told us they convened liaison committees to discuss with PRHOs a range of issues relating to their service. However, it transpired that none of the trainees we encountered had met or knew the chief executive at their hospital.

## **Contractual matters**

183. The trainees with whom we spoke all considered the hours they worked to be excessive. The deanery sees this as a managerial rather than an educational problem. It is continuing to monitor the situation to ensure that each trust conforms to the requirements set down in The New Deal.

## **General clinical training in general practice**

184. In August 1999 the deanery introduced six new PRHO rotations, including four months in general practice.

185. The early indications are that these are proving successful. We were particularly impressed by the enthusiastic response they had evoked in the PRHOs, who spoke positively of the quality of the learning experience.

## **Areas of good practice**

186. *Monitoring the quality of PRHO posts:* It seemed to us that robust systems had been put in place to ensure that all PRHO posts conformed to an appropriate standard (paragraph 158).

187. *Induction programmes:* Each centre offers PRHOs at least one full day's induction and many hospitals have extended the programme to two full days. The deanery's perception, shared by PRHOs and the visiting team, is that the induction period affords a positive and helpful introduction to general clinical training (paragraph 159).

188. *Clinical supervision:* PRHOs were satisfied with the level of clinical supervision they received; none of those we asked had ever been placed in a position where they were unable to seek direct support or guidance from a senior colleague (paragraph 169).

189. *Support for PRHOs:* We were very interested to learn that the deanery is seeking to establish, in the form of a personal passport, a West of Scotland Occupational Health Record for its trainees. We commend this initiative (paragraph 176).

190. *General clinical training in general practice:* The early indications are that these posts are proving successful. We were particularly impressed by the enthusiastic response they had evoked in the PRHOs, who spoke positively of the quality of the learning experience (paragraph 184).

## **Areas for further consideration**

191. *Educational opportunities:* We were pleased to learn that all hospitals involved in general clinical training run educational programmes for PRHOs (paragraph 160). However, we invite the deanery to consider ways of obviating the pressure of work on PRHOs so that they are able to attend these scheduled educational sessions (paragraph 162).

192. *Inappropriate tasks:* The deanery is keenly aware of the need to ensure that PRHOs do not routinely have to carry out inappropriate tasks. Whilst applauding the steps it has taken thus far to improve the level of support to trainees, we encourage the deanery to continue to seek solutions to these problems with PRHOs and trust managers (paragraph 163).

193. *Educational supervision:* With the exception of the positive comments made of educational supervisors in the general practice and accident and emergency medicine rotations, the level of support and feedback they provided to PRHOs was variable (paragraph 166). We were told that in previous years, the deanery had run a series of training workshops for educational supervisors. It may wish to consider re-introducing these workshops as one means of ensuring that educational supervisors are made fully aware of the key role they have been allocated (paragraph 167).

194. *Clinical training:* In general, PRHOs were positive about their clinical training but many who were ward-based did not regard themselves as belonging to a team. As such they considered themselves disadvantaged and suggested that their learning experience would be greatly enriched if they were able to follow through the treatment of patients they had admitted. We would support this principle whilst recognising that the introduction of the partial shift system, on which all PRHOs in Glasgow are working, has severely reduced opportunities for clinical team-working (paragraph 168).

195. *Feedback to PRHOs:* Currently, many PRHOs considered the quality of the feedback they receive on their progress to be variable. Few obtained regular and frequent reports on their performance whilst others only received feedback when their progress was deemed to be poor. We hope that the introduction of the new formalised Record of Progress and Assessment system will improve the quality and consistency of feedback to PRHOs (paragraph 171).

196. *Accommodation, catering and personal safety:* PRHOs were generally content with the arrangements made for their accommodation and personal safety, though some complained of a long wait for porters to escort them in poorly lighted areas at night. Catering was perceived to be a problem with no comprehensive provision of hot food at many hospitals after 7pm and at weekends (paragraph 180). We hope the deanery will explore other options and initiatives in order to provide out of hours catering for its trainees.

## **Conclusion**

197. We were impressed by the many changes made to general clinical training in Glasgow since our last visit in 1996. These have undoubtedly improved the quality of life for PRHOs and have made the pre-registration year a more positive educational experience.

198. The deanery is keenly aware of the areas requiring further consideration which we have listed in our report. We look forward to hearing in due course how its plans to resolve these issues are progressing.